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SENATE—*Wednesday, November 18, 2009*

The Senate met at 9:30 a.m. and was called to order by the Honorable TOM UDALL, a Senator from the State of New Mexico.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Eternal God, the Lord of life, we love You but not enough. We look to You but depend too often on our own strength. We listen for You but make a lot of noise ourselves at the same time. We try to understand, as long as it doesn't change us more than we desire.

Today, draw our Senators closer to You. Empower our lawmakers to become what You desire them to be. Give them Your continual guidance so that they will console the downhearted and provide deliverance to those held captive by evil. Help our lawmakers to hear Your invitation to move to a higher level of ethical fitness.

We pray in Your strong Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable TOM UDALL led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, November 18, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable TOM UDALL, a Senator from the State of New Mexico, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. UDALL of New Mexico thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will be in a period of morning business. Senator ROCKEFELLER will then be recognized for as much time as he may consume. Following his remarks, there will be an additional 2 hours of morning business. The majority will control the first hour and the Republicans will control the next hour.

Following morning business, the Senate will resume postcloture debate on the nomination of David Hamilton to be U.S. circuit judge for the Seventh Circuit.

The postcloture debate time expires about 11 p.m. tonight. It is my hope that time will not be necessary because it is basically wasted Senate time.

Yesterday, we were able to reach an agreement to consider S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 upon disposition of the Hamilton nomination. Senators should expect votes in relation to the Coburn amendment and passage of the bill.

CONGRATULATING SENATOR ROBERT BYRD

Mr. REID. Mr. President, when baseball legend Lou Gehrig retired after playing 2,130 consecutive games, every expert drew the same conclusion: This record will never be broken. Of course, they were wrong.

Throughout history, forecasters have sentenced themselves to ridicule for prematurely assuming a skyscraper's height would never be topped, for promising an invention's ingenuity would never be outdone, or for contending an athletic feat would never be surpassed.

Even so, I am willing to risk predicting that many of Senator ROBERT BYRD's records will never be matched. Since coming to the Senate in 1959, Senator BYRD has cast more than 18,500 votes. No one else, past or present, even comes close. He is the only Senator who has ever been elected to nine full terms in this body. He has presided over both the shortest session in Senate history—not even one second long—and presided for the longest continuous period—more than 21 hours. No one has ever served on a Senate Committee longer than Senator BYRD. Just days after being sworn in, he joined the Appropriation Committee he would later chair. He has held the most leadership positions in Senate history, and continues to serve as our President Pro Tempore.

And just moments ago, when this body was gaveled into session, Senator BYRD realized one more unparalleled accomplishment: he has just become the longest-serving Member of Congress in U.S. history.

Every day since January 3, 1953—that is 56 years, 10 months and 16 days—West Virginians have been proud to be presented in Washington, by ROBERT BYRD.

He began his service in the House the same day Alaska became our 49th State, and was months into his Senate service when Hawaii became our 50th.

Senator BYRD has served in this Nation's Congress for more than a quarter of the time it has existed. And he has served in Congress longer than more than a quarter of today's sitting Senators—and the President of the United States—have been alive. That doesn't even count one Senator who was born just days after his first election to represent West Virginia's Sixth Congressional District, and a second who was born just weeks after that.

A dozen men have called the Oval Office his own while Senator BYRD has called the Capitol building his office.

He twice won every single one of West Virginia's 55 counties. And throughout one of the longest political careers in history, no one ever has defeated ROBERT BYRD in a single election.

But though each one of those campaigns—after each of the 12 times he

● This "bullet" symbol identifies statements or insertions which are not spoken by a member of the Senate on the floor.

has taken an oath to represent the people of West Virginia—on every single one of the 20,774 days he has served—he has never taken the privilege for granted.

As a former leader of both the majority and the minority caucuses in the Senate, he knows better than most that legislation is the art of compromise. It is telling that the man who has served here longer than any other American has come to the conclusion that we must work together as partners, not partisans, for the good of our country—and, of course, the State of West Virginia.

He has seen partisanship and bipartisanship; war and peace; recession and recovery; and his perspective is invaluable to the way we carry ourselves as U.S. Senators.

Senator BYRD's legislative accomplishments are many, and he continues to accumulate them. And while those accomplishments fortify his incomparable legacy, he is perhaps best known in this Chamber as the foremost guardian of the Senate's complex rules, procedures and customs.

He has not concerned himself with such precision as a pastime or a mere hobby. He has done so because of the unyielding respect he has for the Senate. And on this momentous occasion, I say to my friend that the Senate returns that unyielding respect to him.

By virtue of his longevity, ROBERT BYRD has known and worked with many of the greats of the United States Senate. By virtue of his integrity, he has long since established himself among the greats.

There will never be another Senator like Senator BYRD, and today's milestone is another record that will never be broken.

Congratulations, ROBERT C. BYRD, an orphan who changed history.

RECOGNITION OF THE MINORITY LEADER.

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

CONGRATULATING SENATOR ROBERT BYRD

Mr. MCCONNELL. Mr. President, it has been nearly 30 years now since Senator BYRD started delivering a series of lectures that ultimately became the book that all of us are familiar with and which all of us admire. And the story of how those lectures came about says a lot about the man who has now served in Congress longer than any other man or woman in the history of our country.

The story goes that it was a quiet Friday morning here in the Senate and Senator BYRD, as the majority leader, went down to the floor without planning to say much of anything at all, except that there wouldn't be any votes that day. But then he looked up to the gallery, and he saw one of his granddaughters up there with some of her classmates, and he thought it might be a good idea if they had something to talk about when they got back to school.

So, quite extemporaneously and quite by happenstance, he delivered a speech to an empty Chamber on the history of the Senate. A week went by, and the same thing happened again. Senator BYRD came to the floor to make some brief statement about the floor business. He looked up to the gallery, and he saw another one of his granddaughters. Of course he couldn't give a history lesson to one and not to another. So he gave another history lesson.

Well, 7 years and about 2 million words later, he stopped giving those history lessons. And now we will always have them. And we are grateful for that, and for this man. ROBERT BYRD once said that what is sometimes considered to be the result of genius is more the result of persistence, perseverance, and hard work. To be a good Senator, he said, one has to work at it. And now, longer than anyone else in our history, he has lived by those words.

Today, ROBERT CARLYLE BYRD sets a record that has been more than 56 years in the making. The records just keep adding up. Three years ago, he became the longest serving Senator in our Nation's history. A few month after that, he became the only person ever elected to nine full terms in the Senate. He has now served in the U.S. Congress for 20,774 days.

He has cast 18,500 votes in the well of this Chamber. He is the longest serving member of the Senate Appropriations Committee. He has presided over the Senate's shortest session and its longest continuous session. He is the only sitting Member of Congress to receive a law degree, a degree that was presented to him by President John F. Kennedy, just one of 12 Presidents that Senator BYRD has served alongside during his distinguished career.

Senator BYRD will tell you that he has been anchored over the years by the values he learned at the feet of his foster parents, by the support and love of his beloved Erma, whom we were all sad to lose, by the U.S. Constitution, and by his faith in God. In a long life, he has known his share of hardships and triumphs. But he has run the race as if to win. He is still at it and we are grateful for his astonishing record of service to the people of West Virginia, to the United States Senate, and to the Nation he loves.

In achieving this latest milestone, Senator BYRD surpasses a former colleague of his—Carl Hayden, another legendary figure who served the people of Arizona in the Senate for 42 years. Carl Hayden was known to many as the ''Silent Senator.'' That probably isn't a phrase many would use to describe Senator BYRD. But what they both share is an undying love of this great country of ours and of the U.S. Congress. So I would like to join my colleagues, my fellow Americans, the people of West Virginia, and the Byrd family in celebrating this historic occasion. Senator BYRD, congratulations.

GUANTANAMO

Mr. MCCONNELL. Mr. President, this morning, the Attorney General will appear before the Senate Judiciary Committee for an oversight hearing. Among other matters, he will be asked questions about the Administration's recent decision to voluntarily bring terrorist detainees from Guantanamo Bay, Cuba, into the United States, including for purposes of civilian trial.

I, myself, have questions for the Attorney General.

The administration justifies sending Kahlid Sheik Mohammed and his fellow 9/11 plotters to civilian court, while prosecuting other foreign terrorists in military commissions because, it says, the former targeted civilians on American soil, while the latter attacked military targets overseas, like the warship USS *Cole*. I find this a truly troubling distinction.

First, is that rationale not internally inconsistent and, frankly, disingenuous? Everyone knows the Pentagon is a military target. Indeed, it is our Nation's foremost military command and control installation. What does it say to the military families of those service men and women who were killed that day to ignore that Kahlid Sheik Mohammed attacked a military target on 9/11?

Second, under this rationale, is the administration not telling terrorists that if they target defenseless U.S. civilians on our own soil they will get the rights and privileges of American citizens, whereas if they attack a military target, like the USS *Cole*, which can defend itself, they will not get these rights and privileges? Does that approach not reward terrorists with benefits—like potentially providing them access to sensitive information, and providing them a platform for propagandizing—for attacking civilians here in the U.S., rather than military targets abroad?

In short, I think the administration has made an ill-advised decision by bringing foreign terrorists from Guantanamo Bay into the United States. There are a lot of well-known downsides and dangers from doing so. I have not heard of any benefit to us of bringing these terrorists here.

In his testimony before the Judiciary Committee today, the Attorney General has the opportunity to explain the administration's decision—something he has yet to do before the Senate.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, at a time when unemployment is at a 25-year high and with a Federal deficit breaking the $12 trillion mark, the House of Representatives passed a health care bill that raises taxes more than $700 billion. This is the House-passed health care bill on this desk. I expect the Senate version, which may be produced today, will be of similar size.

Who gets taxed under the House-passed bill? Let's take a look.

At the top of the list is small business. A small business surtax in the bill takes $150 billion out of our job creators. That is on page 344 of this massive 2,000-page House bill. We all know small businesses are the biggest job generators in the country. They employ well over half of those who have employment in our country.

Second, we have an employer tax. The employer tax raises $135 billion in taxes through a new mandate on employers. That is on page 281 of this massive 2,000-page bill. The NFIB, the National Federation of Independent Business, which represents small business, estimates that mandate would cost about 1.6 million jobs. That is a 1.6 million job-killing tax at a time when the national unemployment rate is 10.2 percent.

Insured Americans, item No. 4 on this chart—let's look at the tax on insured Americans. Billions of new taxes to pay for comparative effectiveness research rationing in this 2,000-page bill. That is on page 1179, a tax on those who are insured.

Then we have attacks on those who are uninsured, item 3 on the chart. They get taxed as well, a 2.5-percent income tax on the uninsured. That is on page 303 of this roughly 2,000-page bill.

Medical devices, upon which those who are sick depend heavily, will also be taxed. People needing lifesaving medical devices will also receive a tax increase, on page 347 of this massive 2,000-page bill. There will be a $20 billion tax on medical devices. Of course, that will be passed straight on to the consumers. So that will, in effect, be a tax on those Americans who are sick and who need medical devices.

There is also a tax on the chronically ill. On page 332 of this 2,000-page effort to restructure the American health care system, we find flexible spending accounts would be capped at $2,500 and phased out over time. How does that affect the chronically ill? As a result, tens of millions of families, many of whom are managing chronic illnesses, will see billions in tax-saving benefits from these FSAs wiped out, right here on page 332 of this 2,000-page bill.

What does all this mean to small business? David Boland is the manager at Boland Maloney Lumber, Louisville. He wrote to my office to say what it means:

> Health care reform that does nothing to control costs—

And we already know from CBO and from the actuaries that the Health and Human Services bill does not control costs—

> but merely increases the burden on small businesses through mandates and tax hikes is a dangerous and risky proposition that will imperil my company and our national recovery.

Don't take it from me; listen to David Boland. He gets it. He knows that slashing Medicare, increasing premiums, and raising taxes in a recession is not reform.

It was actually a front-page story in the Washington Post this morning, a company in Louisville that kind of underscores what I am talking about. The front-page story in today's Washington Post describes the ongoing struggles of a small manufacturer in my hometown of Louisville who is fighting to save jobs. This business owner wants to be more productive so he can hold onto his workers. But all of these crushing taxes, many of which would apply to his company, are simply not going to be helpful.

Finally, yesterday I spoke about Medicare cuts, the massive Medicare cuts in this bill we are shortly going to be considering. It is important to remember that Senate Democrats recently tried to pass a so-called doc fix that would have forced seniors to pay higher premiums on top of $½ trillion they want to cut from Medicare. Fortunately, this bill was rejected by a wide bipartisan majority. While we all think this problem needs to be addressed, this is not the way to do it. I am confident that should a similar bill pass the House later this week, we will reject it again on a bipartisan basis.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will be a period of morning business, with the Senator from West Virginia recognized to speak first and the next hour under the control of the majority leader or his designee and the next hour under the control of the Republican leader or his designee, with Senators, after Senator ROCKEFELLER, permitted to speak for up to 10 minutes.

The Senator from West Virginia is recognized.

CONGRATULATING SENATOR ROBERT C. BYRD

Mr. ROCKEFELLER. Mr. President, I could not be prouder to rise today to congratulate a public servant without any peer at all, that being Senator ROBERT C. BYRD of West Virginia. On this actually very momentous day, November 18, 2009, my dear friend and colleague becomes the longest serving Member of Congress in the history of this Nation. On Friday, he will also celebrate a warm and joyous birthday.

Senator BYRD passes the incredible Carl Hayden of Arizona who served honorably in the House and then the Senate for 56 years, 319 days. We come together today as an institution to recognize that no Senator in history has cast more votes or has been elected by his colleagues to more leadership positions than ROBERT C. BYRD, no one else—a sign of the enormous warmth and tremendous respect and the unwavering admiration we all share for Senator ROBERT C. BYRD.

I am lucky every day to call Senator BYRD my friend, as I have been able to work with him in the Senate for the last 25 years and for the preceding 8 years when I was a Governor. But most importantly and most powerfully, Senator BYRD always makes me so very proud to be a West Virginian.

At our State capitol in Charleston, they are honoring Senator BYRD with a special celebration today. The same is happening in small towns, cities and communities all across our State. My fellow West Virginians are giving thanks for Senator BYRD's voice and for his vision. We are grateful for his strength and his rock-solid principle, which over the years has come to define West Virginia as surely as our endless hills and beautiful streams.

The people of my State love and respect Senator ROBERT C. BYRD, in part because so many share his very powerful story. So many have battled against the odds and continue to fight every day to try to make a better life for themselves and for their community. They are proud of their State, even knowing their State is not known by many, but they take pride in their unity.

Senator BYRD learned early in life what it meant to be loyal, have a strong work ethic, and possess an untiring faith in God. And it was these values these innately West Virginia values that guided his every action, and made him such a strong fighter for our State. Even in the hardest, youngest days of his life, Senator ROBERT C. BYRD never grew discouraged. It was not his nature. Growing up, he faced enormous challenges, but he had something called an iron will and he had a sense of purpose.

Now years later, we can sum up that purpose with the phrase ''fighting for West Virginia.'' It has always rung true, whether it is his 50th birthday or, in fact, his 92nd birthday. Whether he was a freshman in the House or the Senate's longest serving Member, it has never changed with ROBERT C.

BYRD. His fight for West Virginia is fundamental to his world, which is West Virginia's world. It is in his blood. It is a sacred cause.

It is not just the building of roads, that which is so often associated with Senator BYRD—and to be sure, those roads have transformed our State and connected us with other parts of the Nation and to each other—but so much more. When you pick up a local newspaper, always some institution, some college, some volunteer fire department, some research institute at a university or college has been helped by Senator BYRD. It is his job, but it is also his very special honor at which he excels because of his love for West Virginia.

Ultimately, it is work: it is simply hard work, and ROBERT BYRD never shied away from it for the people of West Virginia, for the Constitution and, yes for this institution, the Senate and its special place in our government and our Nation.

This week, I think of the many birthdays past that he has shared with many of us and with his precious wife Erma, his partner in everything, who gave him the great strength and great faith to reach great heights. It was a little sad to me—and I think to all of us who know him—the cost to him of her death. He changed just a little bit in ways that are hard to explain but ways which are very deep within his soul because he loved and depended on her so much. And I know that as we mark this tremendous milestone today, she is with us with great joy in her heart.

Please allow me to take this special moment to thank my beloved friend and congratulate him on this profound day in the whole history of the Senate, which truly sets him apart from all the rest. I am delighted to celebrate such an incredible milestone.

I wish him a wonderful birthday, many years of service, and all the happiness in the world. But most of all, I thank him for what matters the most to me, and that is his profound service to the people of the State of West Virginia.

For more than half a century, West Virginia has had in ROBERT C. BYRD a great man leading us in our greatest battles. And for that, we are truly blessed.

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

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mrs. SHAHEEN. Mr. President, I rise this morning, along with a group of my colleagues who will be here, to talk about the importance of addressing health care reform to help small businesses. Senator LANDRIEU is leading this effort, and she is going to be coordinating the speakers this morning.

Mr. President, before I begin, I want to thank Senator ROCKEFELLER for his eloquent comments about Senator BYRD. My family lived in West Virginia for about 30 years and truly appreciated the difference Senator BYRD made for the State, and I am very honored to be able to serve with him, even for a very brief time. So I say to Senator ROCKEFELLER, thank you very much for those comments.

HEALTH CARE REFORM

Mrs. SHAHEEN. Mr. President, as the former owner and manager of a small retail business, I know very personally what it is like to worry about meeting the payroll, about whether you can pay for the inventory to keep your business going, about complying with the myriad of regulations you have to comply with.

As a former Governor, I certainly understand it is business and not government that creates jobs and drives new ideas and innovation. But I also know that government has a vital role to play in addressing the challenges businesses and small businesses face, especially in these very difficult economic times. One of those challenges small businesses are struggling with is the high cost of health care.

In New Hampshire, between 2002 and 2006, small businesses paid 42 percent more in premiums for health insurance for their employees; and for our smallest businesses, those with fewer than 10 employees, the increase was almost double that—a 71-percent increase in the cost of premiums.

So what does that mean for the small businesses and their employees who want health care? It means small businesses have to make the tough decision to either drop coverage for their workers or to increase the employee contributions, often to the point where their workers cannot afford coverage.

Everywhere I go in New Hampshire, I hear from small business owners who tell me about these tough decisions they face. I heard this concern from Adria Bagshaw who testified this summer at a Small Business Committee field hearing Senator SNOWE and I did in Portsmouth, NH. Adria and her husband Aaron own the W.H. Bagshaw Company, a fifth-generation family manufacturing company in Nashua, NH. They offer health insurance to their 18 employees and cover a portion of the monthly premium for them. But with those premiums at $1,100 per month per family, they spent more on health insurance for the first half of this year than they spent on the raw materials they need to make their products at their manufacturing company. Understandably, Adria worries they are going to need to cut back on the quality of health insurance plans they offer their employees or the amount the company covers to help pay for those premiums.

I have also heard from people such as Chick Colony who is a small business owner in Harrisville, NH. He has a wonderful weaving company that has been in Harrisville for generations. He e-mailed me, saying:

> The cost of health insurance is the biggest problem that our small . . . business faces.

They have 24 employees. He went on to say:

> The present system is expensive, inefficient and broken. I can't tell you how the 20 to 35 percent annual rate increases depress us all and there is no end in sight. Over the past five years, most of our employees have had to drop coverage because they simply can't afford to pay their share of the premium. I really believe that the time has come to put the existing system out of its misery.

Certainly we hope we can do that.

I have also heard from Kevin Boyarsky, who is an owner of a small printing company in Concord. He told me:

> Health insurance premiums have gone up 30 percent last year and 22 percent the year before. It's now a very big item in our company's budget. We want to grow and be competitive, but the high costs make it hard. From a small business perspective, I can't attract employees without good coverage, but if I hire you now, I'll only be able to offer you 50 percent of the individual plan. It's all I can afford and it isn't very attractive to employees.

Small businesses in New Hampshire and across the country are burdened by high premiums for health insurance. In fact, statistics show us that small businesses pay, on average, 18 percent more than large plans for the same insurance policy. And for small businesses that do not offer their employees health insurance, they cite the high cost of premiums as the reason why.

We need comprehensive health reform to help these small businesses. The small business owners I have spoken with want to offer insurance to their employees, both because they believe it is not only the right thing to do, but it is critical to being competitive, to recruiting and retaining good employees. But as they so often tell me, the high cost of insurance stands in their way.

Health reform is critical to these folks. We can help them by passing comprehensive insurance reforms that rein in health care premiums, so it stabilizes costs, and provide tax credits to small businesses to help them afford the cost of health insurance. I believe we must take these measures to help level the playing field for small businesses and to make insurance premiums more affordable.

Small businesses are the backbone of our economy. That is where most of

the jobs in this country are created. We have to control health care costs to relieve the financial burden, so that so many of these small businesses in New Hampshire and across the country no longer have to face the choice of whether they can keep health insurance or hire employees.

I urge all of my colleagues to work together so we can pass comprehensive health reform legislation. We need to pass it, and we need to pass it soon.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts is recognized.

CONGRATULATING SENATOR ROBERT C. BYRD

Mr. KIRK. Mr. President, as the 100th Member of the Senate, it is my great honor to pay tribute to this body's longest serving Member, Senator ROBERT C. BYRD of West Virginia, on the occasion of his record-setting 20,774th day as a Member of Congress.

I have the fondest memories, as a young staffer here, of listening to the sounds of Senator BYRD's fiddle wafting from his suite on the first floor of the Russell Senate Office Building. And I am proud today, as I do most days, to wear a wristwatch which was given to me, generously, by Senator BYRD over 20 years ago as I was completing my tenure as chairman of the Democratic Party of the United States.

I pay tribute to Senator BYRD on behalf of myself and the people of the Commonwealth of Massachusetts, but I also pay tribute on behalf of my predecessor and a great friend of Senator BYRD's, former Senator Edward M. Kennedy of Massachusetts.

It is true that Senator Kennedy and Senator BYRD did not always see eye to eye on every issue. Senator Kennedy used to joke that it was Senator BYRD who taught him how to count votes in their whip race in 1971. Actually, he taught us both how to count votes because I was a young aide to Senator Kennedy in his whip's office at the time and it turned out that Senator BYRD clearly could count votes more accurately than we could.

Over the years since, Senator Kennedy was always proud to be in this Chamber when his friend Senator BYRD would speak. As Senator Kennedy once said, he knew Senator BYRD was an expert on the Roman Senate, and he was sure Senator BYRD's "wisdom and oratorical skill would make even Cicero envious."

Senator BYRD and Senator Kennedy shared a love of the Senate, and they shared a love of poetry. One poem they returned to over the years was entitled "A Psalm of Life" by Henry Wadsworth Longfellow. Senator BYRD, of course, knows this poem by heart, and so I need not read it all today. Instead, let me recite the last few stanzas to the Senate and for the RECORD, as these words sum up the force that is Senator BYRD:

"Lives of great men all remind us
We can make our lives sublime
And, departing, leave behind us
Footprints on the sands of time;

"Footprints that perhaps another
Sailing o'er life's solemn main,
A forlorn and shipwrecked brother
Seeing, shall take heart again

"Let us then be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait."

Throughout his brilliant career, Senator BYRD has made so many footprints on the sands of time. He has touched, taught, and inspired hundreds of colleagues from every State and thousands upon thousands of Senate staff members have marveled at his genius, his dedication to the people of West Virginia, and his unparalleled service to the Senate and to this country.

I join all my colleagues in wishing him well on this special day in the history of the Senate, and I congratulate him on his incredible service to the State of West Virginia, to the Senate of the United States, and to the United States of America.

We thank you, Senator BYRD, for your service, and we congratulate you.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Virginia is recognized.

Mr. WARNER. Mr. President, let me commend my colleague, the Senator from Massachusetts, for his comments about Senator BYRD. I also want to join in recognizing and celebrating Senator BYRD's service to West Virginia and to our country. As a new Member to this body, I did not have the occasion to work as closely with Senator BYRD as others. However, as a resident of the Commonwealth of Virginia, not only did I follow the enormous respect Senator BYRD has engendered here in the Senate, but I have also watched with awe Senator BYRD's ability to bring jobs back to West Virginia. He was able to relocate many Federal agencies and activities, oftentimes that may have previously resided in Virginia, to the State of West Virginia.

I join my colleagues in commending Senator BYRD, not only for his enormous service to this body and to our country, but as someone who has been a tireless advocate for his home State of West Virginia.

Ms. LANDRIEU. Mr. President, I join my colleagues in commenting on and thanking Senator BYRD for his extraordinary leadership, not just for the people of West Virginia but the people of our Nation—in fact, to millions of people around the world—because of the policies he has driven here, the speeches, the words he has put behind so many of the most remarkable policy decisions over the last half century. His work has had enormous impact, again, not just in his State and in our Nation but worldwide.

I am speaking also as a Senator from Louisiana to give firsthand witness to his sensitive and timely and extraordinary leadership after the Katrina and Rita disasters, now almost 4½ years ago; it will be 5 years this August. That is hard to believe. The hurricanes and the subsequent levee failures devastated one of the great cities in America and one of the great regions. There were very few people who stood up in Washington. The administration at the time had a hard time grasping the scope of the disaster. But there was one person who understood. There were several others, but one in particular understood—amazingly, without even having gone down there, which was very hard to understand if you didn't go to New Orleans or south Louisiana. But he instinctively understood because of his compassion and great empathy that has been developed over a lifetime of caring, giving, understanding, and listening.

Senator BYRD heard the cries of the people and he responded. Because of his leadership on the Appropriations Committee, despite having so much stacked against us, he was able to step up. I will never forget and the people of our State will never forget the friend we have had in Senator BYRD. He continues, to this day, to watch after our recovery and support it. When New Orleans makes its 300th anniversary, which will be 2018—our city will be 300 years old—there will be a person who needs to be thanked on that day for helping the city to reach its 300th birthday, and that would be the great Senator from West Virginia ROBERT C. BYRD.

Mr. REED. Mr. President, today I have the great privilege of rising to pay tribute to my chairman, the longest serving Senator in the history of this country, the senior Senator from West Virginia, ROBERT C. BYRD.

He has reached a milestone among many in his career. It is an extraordinary record of service and dedication and patriotism to the country, and it reflects the values of the people of West Virginia and of this great Nation. Senator BYRD's extraordinary service is measured not just in length but accomplishments, but the length is impressive, indeed. He has 20,744 days of service as a Member of Congress—over 56 years, 10½ months. Over that time, Senator BYRD has cast over 18,500 rollcall votes, witnessed the inauguration of 11 Presidents, and he has been successful in 15 out of 15 elections.

For over 60 years, Senator BYRD has represented the people of West Virginia tirelessly, with a great deal of energy and a great deal of success. He started in the West Virginia House of Delegates and then was elected to the West Virginia State Senate. Then he went to the U.S. House of Representatives. Finally, he came here to the U.S. Senate,

where he is currently serving in an unprecedented ninth full term.

I think Senator BYRD's success is a reflection of his steady progress, learning first about the people of his home State as he worked among them, knowing them well because they were his friends and neighbors; and then going on into local government and dealing with the concerns as a State representative and then as a State senator; and then coming to the House of Representatives, understanding the operation of the House and how he could help the people of West Virginia; and finally, he coming here to the U.S. Senate.

What is incredibly impressive about Senator BYRD is that he is not only the longest serving Senator in the history of this country, he is the most knowledgeable Senator with respect to the history of our body. He is the author—he literally wrote the book on the U.S. Congress and the Senate, among so many others that he has written. This reflects his incredible talent and intellect but also his incredible hard work and tenacity, and it reflects the range of experience he has had.

No one knows this body better than ROBERT BYRD. No one has served it longer. Nobody has served it with the same kind of energy, insight, and dedication. It has been reflected in West Virginia, across the Nation, and across the globe. For example, in 1947, shortly before Senator BYRD first came to Washington D.C. as a U.S. Congressman, there were only four miles of divided four-lane highway, in West Virginia. Today, as a result of Senator BYRD's work, the expansive Appalachian Development Highway System is nearing completion. He understood, as we must today, that economic development is not only a fundamental need, but that it results largely from the infrastructure improvements that speed commerce and literally connect people to one another.

Senator BYRD also is a tireless advocate for miners, those men and women—principally men—who go down and literally risk their lives in the coal mines. He knows this firsthand. As a result, mining-related injuries in West Virginia have significantly declined since Senator BYRD came here—the results of his actions, the results of his understanding, and the results of his commitment to the people he served. He worked hard each and every day for those who risk their lives in a dangerous occupation and deserve the attention and respect of this body and our country.

He has done much more than help the people of West Virginia. As I indicated before, as the greatest scholar in our body, he has demonstrated a profound understanding and respect for the Constitution of the United States. He has shown that not just in words but in deeds. He has been prepared to stand up when he thought constitutional values were being impaired. Indeed, no commitment is greater to Senator BYRD than his commitment to the Constitution and the values therein. He has stood up forcefully and persuasively on so many occasions to defend the Constitution and to serve truly the oath we all take to preserve, protect, and defend the Constitution.

On Friday, Senator BYRD will celebrate his 92nd birthday. He will celebrate that in his usual fashion: He will work, I am sure. He will work for the people of West Virginia, for the people of this country, and for the people of the world. He will reflect back on his dearest partner, his wife, who was his support, comfort, and inspiration. He will reflect upon his children, grandchildren, and great-grandchildren. He will reflect upon a life well lived in service to his country. But more important, he will look ahead to the work he will do as he finishes this term and prepares for his next election to represent the people of West Virginia.

Mr. ALEXANDER. Mr. President, I would like to acknowledge the service of Senator BYRD, the senior Member of the Senate who, today, will become the longest serving Member of the U.S. Congress ever in our Nation's history.

When I first came to this body as a young aide to Senator Howard Baker 42 years ago, Senator BYRD had already been here as a Senator for 10 years. He had been in the Congress 6 more years than that.

I remember when he, Senator Baker, was elected majority leader and Senator BYRD was the Democratic leader, Baker went to BYRD and said: BOB, I have a proposal for you. I will never learn the rules as well as you know them, so I won't surprise you if you won't surprise me.

Senator BYRD said to Senator Baker: Howard, let me think about it.

So he thought about it overnight, came back, and that was their deal the next day, and that is the way they worked for 4 years in managing this Senate. Senator BYRD and Senator Baker both read David McCullough's book. Senator BYRD told me it changed their minds about the Panama Canal in 1980 in a decisive decision that was controversial in the Senate. I worked with him and the late Senator Kennedy, whom the Presiding Officer succeeded, on American history, and we have legislation pending which I hope we will pass when we reauthorize the Elementary and Secondary Education Act consolidating all the Federal Government's activities to encourage our children to learn U.S. history so they will know what it means to be an American.

Senator BYRD now more than ever is a part of that history. He is an indispensable Member of this body. He teaches us as well as serves with us and we honor him for his service.

I yield the floor.

HEALTH CARE REFORM

Mr. WARNER. Mr. President, I rise today to once again join my colleagues in addressing the need for comprehensive health care reform. The Senator from New Hampshire, Mrs. SHAHEEN, earlier spoke on health care reform and its effect on small business. I know my colleague, Senator UDALL from Colorado, is going to be speaking soon. And I know we are going to be joined, as well, a little bit later by Senator LANDRIEU, who takes a leadership role on the issues affecting small businesses, as chair of the Small Business Committee. I rise today to stress how important health care reform is to the small business community. Currently, there are small businesses across America that have been hit very hard by the effects of the recession. Small businesses are struggling as they try to keep their doors open, with the enormous constriction of credit that is taking place. Small businesses are struggling to have the finances to expand; even healthy small businesses, as we have seen. Banks continue to draw back in capital and try to build up their own balance sheets. The people who have taken the hardest hit by the restriction on capital and the restriction on lending have been small businesses across this country.

So we have the enormous challenges small businesses have felt by the recession that has been exacerbated by the constriction of lending, and then we add on top of that the enormous challenges that small businesses face in the health care market. The only people who pay retail—who pay full price for their health care benefits in America today—are small businesses and those who purchase health care on the individual-based market. There is no group that will more benefit, or have more to gain from meaningful health care reform, than small businesses.

Small businesses currently lack the bargaining power of large firms and pay as much as 18 percent more for the same health insurance as larger companies. If you work in a large company you get the benefit of the larger pool, and you are better able to bargain for your health insurance rates. If you are poor and cannot afford health insurance, you get access to Medicaid. If you are a senior, you get access to Medicare. Small businesses are the group that falls through the cracks. They don't have access to this purchasing power, and consequently pay, on average, about 18 percent more for health insurance than larger companies.

As health insurance costs continue to rise, more and more small businesses can no longer even afford to offer health insurance to their employees. And if they do, their employees can't afford the co-payments to purchase health insurance. In fact, nearly one-quarter of the uninsured in our country works for small businesses. Between

2000 and 2009, the percentage of firms with less than 10 employees—the heart of small businesses—offering insurance coverage fell from 57 percent to 46 percent. Among people with employer-based coverage in January of 2006, one-sixth lost their coverage by 2008. Nearly three-quarters of small businesses that do not offer coverage to their employees cite high premiums as the reason. Small businesses want to offer health benefits to their employees, but are priced out of the market and cannot afford it.

Many small business employees are left uninsured and, in turn, rely on the health care system to pick up the costs when they get sick. It is these people who show up at emergency rooms and access the most inefficient part of our health care system. They are oftentimes not people who are unemployed, but employees of small businesses. Enacting market reforms such as creating insurance exchanges will finally give small businesses affordable options. Their employees will have a place to purchase insurance at large pool rates and, by insuring more people, reform will help drive down the cost of health insurance for all Americans. Insurance exchanges will also significantly reduce administrative costs for small businesses by enabling them to easily and simply compare the prices, benefits, and performance of health care plans.

I know a number of us are working on a series of amendments for when the health care bill gets to the Senate floor to try to make sure we add further disclosure requirements and more transparency to our health care system. Right now we don't have a free market in our health care system because nobody knows what the providers actually pay, and what the doctors and hospitals actually charge. Small businesses will benefit by trying to bring transparency to these health insurance exchanges.

Additionally, reform will enact consumer protections such as prohibiting insurance companies from denying coverage based on preexisting conditions and dropping people when they are sick. This is particularly a challenge to small businesses. If you only have a small group of employees and a few have preexisting conditions, those preexisting conditions drive up the cost of providing insurance for this smaller pool. Oftentimes this results in pricing small businesses out of the market. Reforms such as eliminating preexisting conditions will dramatically help small businesses and their employees obtain affordable health insurance.

These protections are vital for small business employees because they help level the playing field in the small group market. They guarantee the option of large pool rates, lower costs, and prohibit insurance companies from arbitrarily penalizing small businesses when one of their employees becomes seriously ill.

Lowering health care costs for employers is also key to our ability to compete in the global economy. If American business is going to come out of this recession and we can compete with countries around the world, we have to take on the cost of health insurance. American workers are more productive than any other workers in the world. But even with that increased productivity, if American businesses have to pay $3,000 to $4,000 more per employee because of higher health insurance costs than our competitors that puts American businesses at a dramatic disadvantage.

As health care costs continue to rise, other business investments are sacrificed. Forty percent of businesses say health care costs have a negative impact on other parts of their business. As I mentioned, with the great reduction of credit availability to small businesses and in this challenging economic climate, American businesses cannot afford to be at such a disadvantage. With health care reform, more of our Nation's dollars will go toward investments in our economy.

Health care costs also stifle productivity. Too many Americans end up staying in jobs simply because the employer provides health insurance. They aren't able to move around, or move into entrepreneurial startup firms where innovation and real growth potential takes place. Startup firms and, again, small businesses are often not able to offer health insurance. Consequently, we have good workers who are not able to move into these firms and help spur job growth because they are caught in dead-end jobs. They are constrained by the security of health insurance offered at their old jobs or perhaps because they have a preexisting condition and can't move to a new situation.

Again, if we do health insurance reform right, it will put in place reforms such as the elimination of preexisting conditions requirements that will allow more freedom of movement within the job workforce.

So, once again, I join my colleagues in making this case. We have made it time and again. Health care reform is necessary to make sure American businesses remain competitive. Health care reform is necessary because health care costs are the single largest driver of our Federal deficit. Health care reform is necessary because if we don't address rising costs, Medicare will be insolvent by 2017. If we don't reform the system, costs will also rise for families; an average Virginia family, for example, within the next decade, will be paying nearly 40 percent of their disposable income to meet their health insurance premiums.

I will close my comments with where I started. Small businesses are the only players in our market who still pay retail for their health care costs and are increasingly being priced out of the market. Reform is imperative for the small business community.

I know my friend, the Senator from Colorado, is about to speak, and our leader on small business issues, the Senator from Louisiana, who has been so diligent on leading these efforts and making sure that small businesses are protected in health care. We must get this right. We must get this bill to the floor. And we must provide needed relief to the small businesses that will generate the economic recovery that we're all hoping for.

Thank you, Mr. President. I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Colorado is recognized.

Mr. UDALL of Colorado. Good morning. I, too, before I speak on health care, wish to join my colleagues in congratulating Senator BYRD. I, too, am in awe of all of his accomplishments, and I, too, admire his affection for the Senate and will endeavor in my service here to model his example.

I join my colleagues this morning to discuss an issue of great importance to Colorado and to me. These past few weeks, as the Presiding Officer has, along with many of us on this side of the aisle, I have spoken about comprehensive health insurance reform as a key to strengthening and securing the lives of middle-class Americans. One of the most important components of that goal is ensuring that we do everything we can to help small business owners and their employees get affordable health coverage.

As the Senator from Virginia mentioned, over the last 15 years, small businesses have created over 65 percent of the new jobs in our country. Yet the power of this job creation machine is being threatened by the exploding costs of health care. It will only get worse if we don't act.

If we do not pass health insurance reform, small business owners will continue to see the costs of providing benefits eat away at their bottom line. In my home State of Colorado, premium costs for small businesses are projected to more than double over the next decade. These unsustainable cost increases not only harm current businesses, but they prevent the growth of new ones. More and more would-be entrepreneurs across the country are deciding not to start their own companies due to the fear that they would not have access to affordable insurance for their families or for their employees.

Unfortunately, this fear is too often justified. In the insurance market today, small businesses lack the bargaining power to get affordable rates that many large employers enjoy. They find themselves subject to unpredictable and massive spikes in premiums.

That is why it is so important that we pass a health care reform bill that takes proactive steps to address the rising costs of health care. I have to tell my colleagues I have been encouraged by the proposals I have seen thus far.

For example, a recent analysis of the nonpartisan CBO, the Congressional Budget Office, score of the Senate Finance Committee bill estimates that the reforms therein would save small businesses $65 billion every year for the next decade. The proposal would do this, in part, by taking steps to transform our health care delivery system to one that produces higher quality care at lower costs. It would also include tax credits specifically designed to help cash-strapped small businesses provide coverage to their employees.

Additionally, new reinsurance programs would reimburse employers struggling with particularly high catastrophic costs. In addition to these probusiness proposals, we also need to make sure the market offers new and affordable options for those employers who want to offer coverage but currently cannot afford to do so. The new health insurance exchanges envisioned under the reform packages before us would permit small employers to purchase policies that spread risk across a much larger population. New consumer protections would also keep costs down by prohibiting insurers from charging higher premiums on the basis of health status or gender.

Right now, being a woman is a preexisting condition under the terms of many insurance policies. That is just not acceptable. Employers would also be able to keep expenses down by promoting personal responsibility—offering wellness premium discounts to employees who make healthy choices.

Enacting meaningful health care reform is necessary for ensuring productive small businesses, new American jobs, and a strong economy. Independent and unbiased analyses estimate that in the next 10 years, reform can save upward of 80,000 small business jobs and raise wages by more than $30 billion annually. Those are very promising numbers.

As the Senate begins its historic floor debate on health insurance reform, you can expect that I and my colleagues will continue reminding the other side of the aisle just how critical reform is to the small business community. No amount of misleading rhetoric or misdirection by the defenders of the status quo will be enough to convince the American people we should continue forward on our current unsustainable path.

I say to all my colleagues: Let's work together over the coming weeks to strengthen this legislation, empower small businesses, and put America's health care system on the road to recovery.

Thank you, Mr. President. As I yield the floor, I wish to acknowledge the great leadership of the chairman of the Small Business Committee, the Senator from Louisiana.

Thank you.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Louisiana is recognized.

Ms. LANDRIEU. Mr. President, I thank the Senator from Colorado and the Senator from Virginia for their remarks earlier this morning on the subject I am also going to speak on, which is the urgency for us to provide important help to millions of small businesses out there that are depending on us to get this reform done right.

I wish to speak for a minute about reforms for small business in America. There were many different reasons expressed by Members of Congress about why they began engaging in this very tough debate on health care. Many different issues brought us to the table. One of the issues that brought me to this table of reform and negotiation was the desperate plight of small businesses in America that have nowhere to turn.

As my colleagues have said in their very excellent statements this morning, the unpredictable and unsustainable and skyrocketing costs of health care to small business in America is damaging their ability to grow, is participating in an uptick of bankruptcies, is diminishing their ability to hire people and create jobs at a time when our country needs those jobs created, perhaps more than ever in the last 25 or 30 years. Until we get health care right for small business, they cannot get job creation right for America. It is as simple as that.

So as difficult as this debate has been—and it has been very long, very arduous, with lots of different views—one thing we must do, in the final weeks and months of the debate, is get it right for small business. I have heard from hundreds of small business owners as chairman of the Small Business Committee. My members have heard from hundreds. We have heard from thousands, through their representative associations, from conservative associations, to moderate, to more liberal associations representing a broad stretch of small businesses in this country, saying this is their No. 1 issue.

Just this week, Barbara Biersmith, who owns Sylvan Learning Center in Monroe, LA, a small business owner—1 out of the 27 million that exist in the United States of America—and 27 million is a lot of people, a lot of businesses and employees. She is one. She is quoted in the Monroe News Star this week:

> As a business owner, I have struggled in vain for more than 22 years to find a way to provide health insurance for my employees.
>
> Health insurance providers tell me I have too few employees to make a group. Or they tell me that some of my employees have preexisting conditions that excludes them from a group and that would make the group too small.
>
> The kind of highly educated, experienced people I prefer to hire nearly always have preexisting conditions. Who doesn't have a preexisting condition by the age 30?

Considering that being a woman of childbearing age is considered a preexisting condition, I think she is right. Who doesn't have one these days based on the interpretation of these policies? She goes on to say:

> Because my business can't provide good health benefits effectively, I am restricted to hiring people who are covered by their spouse's medical insurance.

This is something that is not talked about often. I know my colleague from Washington is waiting to speak. I will go through this as quickly as I can. I hear this over and over again when I am on the streets and in towns and communities back home and I don't hear it here. Let me say it. I have any number of people who come up to me and say: Senator, thank you for working hard on health care. I am a little concerned or confused about what you all are doing but try to get it right because my health care is through my spouse who works for the government or my health care is through my spouse who works for a big company, and if I didn't have that health care, I wouldn't have any.

I was in a restaurant last week, and the gentlemen who owns it told me this: I couldn't be a small business owner but for my health care that is covered through my spouse.

It is right to get the policy right so everybody can have access to affordable health care coverage.

She goes on to say:

> I hope and pray our representatives and Senators soon pass Federal legislation to help the really small businesses of America.

Let me say I hope that help is on the way. If we can negotiate this bill, in terms of robust exchanges, subsidies for small businesses, particularly these very small businesses of under 10 employees or 25 employees, it would help. The situation Barbara is facing is not acceptable and must be corrected. But her situation is not unique, as I said. According to a report by the Small Business Majority, the health care costs for small businesses are expected to increase from $156 billion in 2009 to $2.4 trillion by 2018.

Before I put up the next chart, I need to repeat these numbers because they are dramatic. These are numbers published by the Small Business Majority's report, based on actual data. This is a bill that small business cannot pay. This is a bill they cannot pay. We must get the costs moving in a different direction. It will take some time, but we must get this chart going from up to down. That is why I have pushed every day of this debate to focus on cost containment. Not only is

it important for taxpayers and government, it is absolutely critical for small businesses to have more choices at lower costs.

This chart shows the graph in a different way. This shows the cumulative cost of health care benefits—the first one. This is indicating job loss, and 178,000 small business jobs will be lost in 2018 due to the high cost of health care. That is up from 39,000. Companies can't continue to hire if they have to pay higher premiums for the employees they still have working for them.

Costs are high because of a broken insurance market where insurers, in order to satisfy their stockholders, put a greater focus on their bottom line. I understand that when you are in business, you need to make a profit. I understand that is why you are in business. I have no problem with people making profits—and significant ones—as long as the rules are fair and as long as there is opportunity to keep our values in order. One of the values we have in America is people going into business making a profit but making sure, if you are in the business of insurance and delivering benefits, that is what you are delivering to the people you are trying to serve. So we need some adjustments in those rules and regulations. That is what I think we are doing in our reform bill.

More alarmingly, getting back to the statistics, according to some reports, including a recent New York Times article, the insurance companies are planning to raise rates even higher today in anticipation of our reform effort. This is very unsettling, and the sooner we act the better I think we will be—to help reform this market, to bring some order to the framework. That would be extremely helpful.

Lack of choice and competition is a problem, as I said. In Louisiana, our two top insurers maintain 74 percent of the market. In Alaska, I understand, there are two insurers maintaining 95 percent of the market. This is not real choice. It is not real competition. That is why the exchanges we have in most of the base bills, making them more robust, making subsidies as generous as we can to encourage individuals to assume responsibility for their health care, as well as subsidizing small businesses to encourage them to get into these large pools, I believe—and many of us believe—that will help to drive down costs, as we reform the private market.

To level the playing field for small businesses and to provide working families with more choices at lower costs, the bill we will vote on in the Senate will have as robust an exchange system as possible. These exchanges will allow businesses and individuals to pool to give them the negotiating power and to spread risk.

We estimate today that small businesses pay retail, as the Senator from Virginia. Mr. WARNER said. Everybody else pays wholesale. Small business pays retail. The price of paying retail is a minimum of 18 percent more on premiums that they are paying. So we want to get that savings. The exchanges will achieve that. The exchanges will also achieve lower administrative costs, so you don't have to hire a full-time lawyer or accountant to navigate the wide variety—actually, there are limited choices today, but you will have more transparency, more robust exchanges.

Finally, regardless of the level of benefit choices, there should be a limit on how much individuals must spend out of pocket and a minimum standard of care among all the plan levels. These are some of the protections we are working on for small businesses, which will benefit individuals as well.

Again, I thank my colleagues for being on the floor this morning. I think Senator CANTWELL, the Senator from Washington, who is here to give voice to this important part of the debate. Again, we have hundreds of Members of Congress. We all came to this debate carrying various issues and with greater concerns than others. One of my great concerns has been, as we try to find a way to dig ourselves out of this great recession—some say the worst economic situation since the Great Depression—the only way we are going to do that is for businesses to create jobs. Right now, there is a big burden that they have been carrying alone. They need help, support, and they need more tax credits, more robust subsidies, and a more orderly private market framework that allows the insurance companies to be in business and to make a profit but also allows small businesses to be able to afford quality coverage for American workers, so we can get back to being the most productive workforce in the world.

I yield the floor for the Senator from Washington.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Ms. CANTWELL. Mr. President, I come to the floor to join my colleagues to talk about the rising cost of health care on small businesses. I thank the chair of the Small Business Committee, Senator LANDRIEU, from Louisiana. She has been an outspoken and articulate advocate for small business. She is constantly focusing on what we are going to do to help small businesses in America, and she wants to make sure any health care legislation that is passed out of the Senate focuses on that. That is very important because we know that when we talk about small businesses in this current environment, they are at a disadvantage when it comes to our health care system. That is to say they have long been the backbone of the American economy. Small businesses employ about 40 percent of our workforce. Even in a downturn, the job creation we are going to see is going to come from small businesses. If we can address their concerns in health care reform about the rising cost of health care, then we are going to be doing ourselves a favor because they are going to be able to grow more jobs and grow the economy.

I applaud the Senator from Louisiana for her efforts and join with my colleagues, Senators WARNER, UDALL, and SHAHEEN, in coming down here to describe why we think it is so important that we get health care reform and that we do something about this because we really do want to get our economy going, and we certainly want to control costs so that small businesses can grow jobs.

Why is this so important? We have seen a 120-percent increase in premiums over the last 10 years. That is to say, from 1999 to 2009, insurance premiums have increased 120 percent—120 percent. What family in America can sustain the constant increase in insurance premiums every year? The fact is, they cannot.

In my State, we have seen a sharp rise in those who are without health insurance because the premiums keep going up. More and more small businesses have to make choices between keeping employees on the rolls or cutting back on their health insurance. And they are making those choices. It puts all of us at a disadvantage.

What should we be doing instead about the rising costs of premiums in health care? We should be doing something to bend the cost curve. You will hear many of my colleagues, as you did this morning, talk about bending the cost curve and why it is so important. Right now, if we look at what is happening with health insurance, as I said, it already increased 120 percent over 10 years. The next 10-year period, it is supposed to increase in the same way, double in cost, increase about 7.9 to 8 percent a year. So that means if we do nothing, small businesses are going to continue to see this escalator of costs keep going up for, and that means they are going to employ fewer and fewer people because they cannot afford the health care coverage.

We see that general inflation is about 2 percent, but this increase in premiums is about, as I said, 7 to 8 percent. Why are we seeing this huge increase in the cost of premiums if general inflation is only about 2 percent? This, in my opinion, is what the health care debate should be about. This difference between general inflation and health care cost increases should be the entire debate. What are we going to do to drive down the costs so that health care costs are kept more in pace with inflation?

Why are these statistics so important? The issue is that, according to

the National Small Business Association, only 38 percent of small businesses provided health insurance last year. That is down 61 percent from 1993. So we are continuing to see that shrinkage in people offering coverage. Of those who do offer coverage, 72 percent say they are struggling to continue to offer coverage to their employees.

An MIT study shows that the cost of health care to small business will more than double in the next 10 years, just as it has in the last 10 years, and that small businesses pay up to 18 percent more than the same coverage for larger firms. What that means is small businesses are being disadvantaged. They are being disadvantaged because they do not have the same clout in the marketplace as a large employer to negotiate benefits and drive down costs.

What do we want to do about that? What we want to do is give small businesses the same kind of negotiating power large companies have to negotiate for benefits. In fact, health care reform and helping small businesses should be able to negotiate with insurance companies to drive down the costs of their plans.

This is something that is already part of the underlying bill we passed out of the Finance Committee. I am sure that when we see legislation coming to the Senate floor this Friday, we will see the same kind of provision, at least with the basic health plan, a provision I helped coauthor in the legislation that would allow States to negotiate on behalf of the uninsured, allowing those who are employed in small businesses to help lower the costs. In our State, this plan has driven costs down 30 to 40 percent lower than what those individuals would be able to get in an individual market. That is amazing, the fact that they have been able to pool together 40,000 to 60,000 people, go to the marketplace, and say to insurance providers: If you want access to our insurance business, you have to give us a discount. I call it the Costco model. I don't know how many people here this morning understand the Costco model, but the Costco model is something where you buy in bulk and you make large purchases. You should get a discount. That is what we are saying. We want to give small businesses the same kind of purchasing power large businesses have so they can drive down costs. That is going to be a critical component of this legislation, and this Senator, along with my colleagues who are out on the floor today, is going to make sure that negotiating power exists in a final bill for small business.

Second, we need to make sure we also have provider reform, that provider payments reward not just volume but value. Right now in our health care delivery system, there is a lot of focus given to what I would say is the quantity of health care that is delivered, the fee-for-service system that basically ends up having insurers paying physicians for the number of patients they have seen or the number of tests they have ordered but is not generated or focused on payment to a physician based on the outcome of the patient. There are provider reforms in this legislation that will also help drive down the cost to small businesses because those providers will be focusing on what it takes to deliver health care to those individuals.

Third, we need to have better transparency on drug pricing because transparency of cost is something that will help us in negotiating, as a government purchaser, better health care benefits. Right now, there is a lot of unknown about health care costs in drug pricing because middlemen basically negotiate discounts on behalf of their customers but end up pocketing some of those benefits.

We want to make sure all three of these points are part of vital legislation to help drive down the cost for small businesses.

I have many small businesses come into my office. I met with some in the State of Washington. We are very proud of the diverse array of companies that exist in our State. A lot of people look at some of the major employers such as Boeing or Microsoft or, as I mentioned, Costco, Starbucks. Washington State is home to many entrepreneurs. There are many great companies that may be the big companies of the future but are the small businesses today, and they need our help and assistance.

Two of those, Kent and Linda Davis, run a technology consulting firm and pay $1,500 per month for health insurance—$1,500 per month. They just learned that in 2010 their premiums will increase by another $300 per month. This is the third substantial increase they have had in a row. They want to hire more employees, but they cannot because of the cost of health care.

Another successful entrepreneur who has come into my office, Gene Otto, is the owner of the San Francisco Street Bakery. You might think the San Francisco Street Bakery is in San Francisco, but it is actually in Olympia, WA, and it employs 20 people. Over the past decade, the increases in health insurance premiums have forced them to take dramatic reductions in the level of benefits and the number of employees they can cover. This is a company that wants to grow. They want to expand. They have great products and great services.

It is people such as the Davises and Gene Otto who are the economic engine of our economy. They are going to continue to depend on us to make sure that in this legislation and in this legislative debate, we are going to do everything we can to help small businesses grow.

Small businesses cannot grow if health care costs are going to rise 8 to 10 percent a year. It will hamper the ability of those small businesses to meet the demands and challenges of their workforce and keep them healthy, facing an economy that has been certainly challenged by this big downturn we have seen but that needs to go back to growth in the future. They want to be part of that. They want to be part of that growth, and they want to be part of helping our economy recover. But to do that, we are going to have to do something to control health care costs.

I applaud my colleagues who I know share these same issues and concerns: the Senator from Virginia, who has been very outspoken on the fact that we have to change our system to make sure we are bending the cost curve and focusing on driving down costs with provider reforms; my colleague from Louisiana, who is focused on making sure small businesses have clout and access to small business negotiations that large companies have; my colleague Senator SHAHEEN, who also has been a big supporter of making sure we have provider reform in the system; and Senator UDALL, who comes from a State that knows health care costs are a key component. If we want our economy to grow, we have to drive down health care costs.

Two of our former colleagues have been on the floor in the last few minutes—the Vice President of the United States and the Secretary of Interior. We are glad they have come up to Capitol Hill to continue discussions with us about how important this legislation is. I thank them for that. I thank them for their service to our country and for their willingness to serve in the administration. We certainly miss them in the Senate. But I think it emphasizes the urgency of the health care legislation, that our economy is struggling, that we want it to grow, that we think small businesses are going to be a key component of that, but we have to give them negotiating power. We have to give them the ability to negotiate with insurance plans to drive down the costs, and we have to do better at reforming the system so we can see that growth happen in America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, will you please let me know when 8 minutes has elapsed?

I, too, see the Secretary of Interior on the floor, who formerly was a Member of this body. We miss him. We are glad he is here. We are glad he is taking care of the treasured landscapes of America.

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, an unusual thing is about to happen here: an actual debate is about to break out on the floor of the Senate about health care. Sometimes we are talking past each other. My friends on the other side talk about jobs and small business, so let me start there.

The difference between the Democratic proposals for health care and the Republicans is the Democrats start with a 2,000-page bill, more or less, with a government takeover, with more than $1 trillion in spending, with new taxes, higher premiums, and Medicare cuts, and we don't believe they can spend that much more money without increasing the debt—in other words, all going in the wrong direction.

We believe we ought to be reducing costs step by step, and the Republican proposals say that step No. 1 should be small business health plans. They are saying they have an idea about small businesses, and we are saying the same thing.

In my few minutes today, I would like to show why our proposals are better than theirs. For example, Senator ENZI of Wyoming, who was chairman and is now the ranking Republican member of the Health, Education, Labor, and Pensions Committee, has a small business health plan he has been trying to get this Senate to vote on for years. In fact, this plan came up before the Senate, and our Democratic friends blocked it. They like to say Republicans are the party of no; they are the party of no because on May 11, 2006, they voted no to small business health plans which would lower health care costs for thousands of employees in this country.

Let me be specific about that and why it is superior to the suggestion that has been made in the Finance Committee bill, the 2,000-page bill which has come out of the Senate Finance Committee. In the Enzi plan, the Republican plan, we would allow small businesses to come together and pool their resources. What that means is, if I have a small business with 50 people and you have one with 100 people and you have someone with open heart surgery, you cannot afford to keep paying for health insurance anymore because that one employee's health care costs make it impossible for you to do that or you have to lay people off or you have to reduce wages. That is what happens in the real world. What we are saying is, let's let small businesses come together, pool the resources, and offer insurance that way—spread the risk, in other words.

What does the nonpartisan Congressional Budget Office say the effect of that proposal would be on small businesses and their health care costs?

This is what the CBO said: No. 1, enacting the Republican proposal—which we would hope would gain Democratic support—would extend more insurance to at least 750,000 Americans who are employees of small businesses. That is No. 1, more people insured.

No. 2, it would lower the cost of insurance premiums, not raise them as this 2,000-page bill would—lower the cost of insurance premiums for three out of four employees.

No. 3, it would reduce the cost of Medicaid, the government program for low-income Americans, by $1.4 billion.

More people covered, lower premiums, and a lower cost—that is what they mean by bending the curve. So if that is the proposal, why do the Democrats not allow us to vote on it? You see, we believe these 2,000-page bills with higher premiums and higher taxes, with Medicare cuts—we have these bills all over the place. Senator REID, the distinguished majority leader, has one in his office. He has been meeting secretly for weeks with people—we don't even know who—writing a bill which may emerge as early as today. Then when we get it, we will all have to read it. I am sure we will find more premiums, more taxes, more Medicare cuts, probably additions to the debt, probably more transfers of cost to State governments.

We have Governors who are Democrats and Republicans saying: Please don't do that to us. We are in the worst condition we have been in since the Great Depression, and you are going to dump a lot of costs on us that we didn't volunteer to pay. We can't afford it. We have to balance our budgets.

That is probably what is coming. What should we do instead? We said day after day on this floor that we should set a goal—reducing costs, the cost of premiums, the cost of health care to the government—and we should move step by step toward that goal.

We said step No. 1 should be small business health insurance plans. Step No. 2 should be to allow competition for insurance across State lines. That would reduce costs. Step No. 3 would be to reduce junk lawsuits against doctors, which some States have done, and which everyone agrees drives up costs, encourages defensive medicine, and causes doctors to move out of rural areas so that pregnant women have to drive 60 or 80 miles to Memphis or halfway across Alaska to get their prenatal health care or check into hospitals for 3 weeks in a big city so when they have their baby they will have a doctor available. That is the effect of that.

Then health insurance exchanges so you can shop for cheaper health care, then reducing waste, fraud, and abuse. The General Accounting Office has said $1 out of $10 in the Medicaid Program, which the Democratic proposals will expand, is wasted. It goes down the drain every year—$32 billion.

If we really want to reform health care, why do we keep coming up with these 2,000-page bills and trillion-dollar costs and higher premiums and higher taxes and Medicare cuts and additions to the debt at a time when we have 10 percent unemployment? What is that going to do to small businesses? New taxes are going to create more jobs?

We have the Finance Committee bill with $900 billion of new taxes over 10 years when fully implemented. That is not going to create new jobs. New taxes are passed on.

If you run a business with 40 people or 100 people or 150 people, and you get a big new tax, what do you do? You layoff an employee, you reduce wages, you stop offering health care. You have to do that or you go out of business. That is what happens.

We would like to see a debate. We think the way to reform health care is, instead of these 2,000-page bills, let's set a goal—reducing costs. Let's go step by step in that direction to re-earn the trust of the American people. Instead of talking in grand rhetoric about small businesses—they do have a plan embedded in the Finance Committee bill, but it is typically different from the plan we have proposed. Instead of allowing small businesses to pool their resources in the way I suggested so they, the small businesses, could be in control of their own health insurance, make decisions about it—no; the Democratic small business plan would not allow small businesses to pool their resources. It puts the government in charge of making decisions about what kind of insurance the small businesses could purchase. That is really a debate we ought to have.

As President Obama, correctly said earlier this year, the health care debate is not just about health care. The health care debate, said the President—correctly, I would respectfully say—the health care debate is a proxy for the role of the Federal Government in American lives. So would this debate about how to help small businesses be the same.

The PRESIDING OFFICER. The Senator has consumed 8 minutes.

The Senator from Idaho is recognized.

Mr. CRAPO. Mr. President, I would like to focus my remarks today on health care as many others have done. Actually, I am very glad to see the debate today was focused on small businesses and the impact of what we do on them.

I am surprised, however, to see those who are discussing the current legislation that is before us are discussing it as something that will benefit small businesses and will help to drive down the cost curve because, as remarkable as it may seem, this legislation that both the House and the Senate have had under consideration—hopefully what we will now see in the near future as the final product that we will be able to review—will drive up the cost curve and increase the cost of health

care, not only for small businesses but for everybody in America.

If we ask most Americans what they want in health care reform, they will tell us they want to stop the spiraling cost of health care insurance. Yet the legislation we see does exactly the opposite. Over the last few weeks I have come to this floor to discuss tax increases that were contained in the health care legislation passed by the Senate Finance Committee, both in terms of the big picture and, more specifically, in terms of what it means to middle-income Americans and to small businesses and to any American who wants to answer the question: How would this bill affect me and my family?

We have already heard the answer to that question in a number of different contexts, but I think it bears repeating. Under the Senate Finance bill, if you have insurance, you get taxed. If you do not have insurance, you get taxed. If you don't want to purchase insurance, you get taxed. If you have a job, you get taxed. If you need medical devices, you get taxed. If you take prescription drugs, you get taxed. If you have high out-of-pocket medical expenses, you get taxed.

The list goes on. The reason is this legislation will create new, brandnew massive entitlement programs to the tune of what we do not clearly know yet but which will almost certainly be in the neighborhood of $2 trillion. It pays for them—or offsets the cost of those on the Treasury—by increasing taxes on the American people by hundreds of billions of dollars and by cutting Medicare by hundreds of billions of dollars.

We still do not have the ''merged'' Senate bill before us to review and debate, but we do have the House-passed bill to review. There have been a number of rumors and discussions in the media about what kind of new tax increases the Senate bill will have when it is finally disclosed. In fact, we hear we may find out, as a country—the people of America may find out tonight what this bill that has been negotiated and created behind closed doors actually contains. I would like to take a few minutes to review some of the provisions that we expect to be there.

The House version of the health bill contains more than $752 billion of tax increases. Some of these tax increases are the same ones we have already seen in the Finance Committee bill, such as the medical device tax, the $2,500 cap on flexible spending accounts, the prohibition on prepurchase health care accounts—FSAs and HRAs—and the doubling of tax penalties for those in emergency situations who must use a portion of their health savings account to pay for nonmedical bills.

There are many other new tax increases in the House bill which we have not seen in the Senate finance bill that we also need to review. From the beginning of this process the chairman of the Finance Committee has stated his intention to use only health-related offsets to pay for health-related spending. If there is to be new health-related spending, that is definitely the right approach. We all know what a difficult circumstance our country faces today when it comes to jobs. The current unemployment rate is 10.2 percent. The last thing we need to do is to enact policies that would make it even tougher for U.S. companies, particularly small businesses, to create new jobs. But, amazingly, the House bill contains more than $80 billion in tax increases on domestic U.S. job-creating companies that have no involvement in the health care industry.

Not only do these provisions violate the idea that we should be staying within the health care arena to find offsets on the health care bill, but these antijob tax increases are the last thing we need in this fragile economy. The largest tax increase in the House bill would also have a devastating effect on the job creators in our country, particularly small businesses, that are the top job creators. This $460 billion so-called ''millionaire surtax'' is bad policy for many reasons.

First, like the $80 billion tax increase on domestic companies that I just mentioned, this tax increase grabs hundreds of billions of dollars from outside the health care arena to pay for a massive expansion of a new health care entitlement.

Second, although this provision is being billed as a tax increase on millionaires, the Joint Tax Committee reports that one-third of the revenue it will generate is not from individual income of millionaires but from small businesses. As we know, many small businesses file their taxes as individuals, and it would be these small businesses, the job creators of our economy, that would be facing this new punitive surtax.

Third, although you would think we would have learned our lesson from the alternative minimum tax, like the AMT, this new surtax would also not be indexed for inflation. That means, over time, this would creep further and further down the income scale, and more and more small businesses and middle-income families would be suddenly hit by this surtax.

Fourth, this surtax would not only apply to ordinary income, it also applies to capital gains and dividend income which are currently taxed at lower rates. The capital gains and dividend rates are currently 15 percent. If Congress doesn't act before next year, the rates will go back up to the pre-2003 levels of 20 percent for capital gains and up to a maximum of 39.6 percent for dividends.

The President has said he doesn't intend to extend the current lower rates for individuals making less than $200,000 a year or for families making less than $250,000 a year. But if we add in this new surtax in the House bill, Americans above those thresholds who are currently paying a 15-percent capital gains tax rate would see their tax rate jump to 25.4 percent in 2011, and those currently paying the 15 percent dividends rate would see their rates jump to 45 percent by 2011.

Such a tax increase would violate yet another one of President Obama's tax pledges to the American people. Most of us are very familiar with his promise.

Most of us are familiar with his promise that no individual making less than $200,000 a year or a family making less than $250,000 a year would see any increase in their taxes. In fact, in his words, ''not by one dime''—not an increase of their income tax, their payroll tax, their capital gains tax. In his words, not any of their taxes. Yet we see hundreds of billions of dollars of these taxes falling squarely on the middle class. In a speech in Dover, NH, on September 12, 2008, President Obama said:

> Everyone in America—everyone—will pay lower taxes than they would under the rates Bill Clinton had in the 1990s.

This surtax clearly breaks that promise to millions of additional Americans.

Recent press reports have suggested that, in a need for even more tax revenue to pay for all of the new spending in the Senate, the Senate leader may include an increase and an expansion of the Medicare payroll tax. The Medicare payroll tax is funded by a 2.9-percent payroll tax levied on every dollar earned by employees. Half of this tax is paid by the employee and the other half by the employer, although in reality, the entire burden falls on the employee because the tax is taken from the employee's available wages. Revenue from this tax goes into the Medicare trust fund and is intended to be used for Medicare expenses when that individual enters retirement. Under this new plan, Senate Democrats are considering applying this Medicare tax to capital gains, dividends, interest, royalties, and partnerships for American families earning more than $250,000. None of this income is currently subject to the Medicare payroll tax.

In addition, Democrats are said to be contemplating raising the employee's share of this tax, currently 1.45 percent of wages, to 1.95 percent. Press reports indicate this would raise up to 40 or 50 billion new dollars in revenue. This proposal would make a bad bill even worse. It would fundamentally change the way Medicare financing occurs. By applying what has traditionally been a payroll tax to nonpayroll income and by using this money for a new non-Medicare entitlement, it breaks the

link between the Medicare tax base and Medicare benefits. As the Wall Street Journal pointed out, this new tax would ''sever the link between the tax paid over a lifetime and the medical benefits received, officially making Medicare an income redistribution program.''

It would additionally hurt growth. These additional taxes on savings and investment act as disincentives for these activities which are the primary drivers of wealth creation. It would kill jobs. Imposing these new taxes would hurt small businesses. Because many small businesses pay their taxes at the individual level, imposing higher individual income taxes hurts these engines of job creation.

Finally, it doesn't fully finance health care shortfalls. According to Bloomberg, House Democrats rejected this proposal, now being considered by the Senate, ''because lawmakers concluded they may need to increase the payroll tax in the future to pay Medicare benefits that are projected to outpace revenue.'' The New York Times pointed out that ''the higher payroll tax would not be sufficient in the long run [to even protect Medicare].''

In closing, for all the talk about this need to rush the bill through so we can achieve the objective the American people seek in health care reform, the bill does not reduce the cost of medical care. It increases it. The bill does not reduce the cost curve for health care insurance. It increases it. And in accomplishing this, it also increases taxes across the board on Americans and cuts Medicare by deep rates that will cause Medicare to face insolvency even earlier than it otherwise would have.

For all these reasons, we need to slow down and start working together, step by step, to remember the original objective; that is, to bend the cost curve down and stop these spiraling increases in health care insurance that Americans are facing and that are driving American families to the edge.

I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Arizona.

Mr. McCAIN. Mr. President, from media reports, certainly not because Members on this side of the aisle have been told about it, I understand the majority leader is now corralling the final three Democrats, which I am sure he will succeed in doing, in order to secure 60 votes to move forward with the greatest takeover of the private sector in health care by legislation perhaps in the history of this country. Of course, I would not know that myself, nor would any Member on this side of the aisle, because of the fact that there is no communication between the majority leader and Republicans. I understand they have 60 votes. I understand they will get 60 votes. I understand that they may likely be able to railroad this through the Senate. Then, again, they will gather in a small room, and they will come out with significant changes and revisions in the form of a conference report.

I have been having townhall meetings around my State of Arizona, the second hardest-hit State in America because of the economic downturn. I assure my colleagues on the other side of the aisle, there is a revolution going on out there. It is a peaceful revolution. They do not want increased costs of a reform commitment that would be up to $3 trillion, that would cut Medicare by $500 billion and tax Americans across the entire income spectrum by an additional $500 billion. My friends across the aisle may not have gotten the message from the elections in New Jersey and Virginia not that long ago. Americans want cost control, and they want affordable and available health care. They don't want increases in taxes. They don't want the government taking over the health care system. Yet that is what is going to be delivered.

A lot of people, may I say, may not trust the word of some of us on this side of the aisle and may think we are uninformed or we are just politicians. Maybe we ought to listen to Dr. Jeffrey Flier, dean of the Harvard Medical School. I have never been that great of an admirer of Harvard, but the dean of the Harvard Medical School states in today's Wall Street Journal, entitled ''Health Debate Deserves a Failing Grade''—and he has some criticism for this side of the aisle that perhaps is deserved—

> As the dean of the Harvard Medical School, I am frequently asked to comment on the health-reform debate. I'd give it a failing grade.
>
> Instead of forthrightly dealing with the fundamental problems, discussion is dominated by rival factions struggling to enact or defeat President Barack Obama's agenda. The rhetoric on both sides is exaggerated and often deceptive. Those of us for whom the central issue is health—not politics—have been left in the lurch. And as the controversy heads towards a conclusion in Washington, it appears that the people who favor the legislation are engaged in collective denial.
>
> Our health-care system suffers from problems of cost, access and quality, and needs major reform. Tax policy drives employment-based insurance; this begets overinsurance and drives costs upward while creating inequities for the unemployed and self-employed. A regulatory morass limits innovation. And deep flaws in Medicare and Medicaid drive spending without optimizing care.

During the last campaign, I proposed addressing the issue of employer-provided health benefits, doing away with it in return for a $5,000 refundable tax credit. Tens of millions of dollars in attack ads were leveled against it. I proposed it not because it was easy, not because I didn't think the American people didn't need straight talk. I did it because it is one of the fundamental problems with the cost of health care in America. If someone gets something for free, they are not going to be careful about the money that is spent.

Ronald Reagan once said: Nobody ever washed a rental car. He is right. So when people receive free medical care that they don't have to pay for and that they don't have to have accountability for, it is obvious that that is misused.

Again, there is the story this morning about some $49 billion in wasteful spending in Medicare. The numbers go on and on.

Why is it that the dean of the Harvard Medical School says ''the rhetoric on both sides is exaggerated and often deceptive''? Maybe it is. But the rhetoric on both sides becomes more intense because of a failure to sit down and try to work something out together. At no time during this entire, long, drawn-out process have there been serious negotiations between Republicans and Democrats. Not once. Of course, the rhetoric gets exaggerated on both sides and even deceptive. We are not doing what the American people expect us to do, and that is sit down together and work these things out on one of the greatest financial crises this Nation faces.

Dr. Flier goes on to say:

> Speeches and news reports can lead you to believe that proposed congressional legislation would tackle the problems of cost, access and quality. But that's not true. The various bills do deal with access by expanding Medicaid and mandating subsidized insurance at substantial cost—and thus addresses an important social goal. However, there are no provisions to substantively control the growth of costs or raise the quality of care. So the overall effort will fail to qualify as reform.

Dr. Flier is alleging that there is no control of the growth of costs or rise in the quality of care. We all know that the cost of health care is unsustainable. The Medicare trustees have said in 7 years it will go broke. I believe forcing more Americans into Medicaid, a public program that gets failing grades for access to care and the quality of care, is not the right approach to covering millions more Americans.

Dean Flier goes on:

> In discussions with dozens of health-care leaders and economists, I find near unanimity of opinion that, whatever its shape, the final legislation that will emerge from Congress will markedly accelerate national health-care spending rather than restrain it.

The whole problem with health care in America is not the quality of health care, it is the accessibility and affordability. Dr. Flier says ''the final legislation that will emerge will markedly accelerate national health care spending rather than restrain it.''

Dr. Flier continues:

> Likewise, nearly all agree that the legislation would do little or nothing to improve quality or change health-care's dysfunctional delivery system.

This isn't just Dr. Flier's opinion. Look at Samuelson's article the other day about the effects of what has been passed by the House and will apparently be before us. Democrats are proposing a $3 trillion expansion of government health care, including $1 trillion in Medicare cuts and tax increases. But experts tell us the legislation would do little or nothing to improve quality or change health care's dysfunctional delivery system. Senate committees have spent months writing bills and spinning the benefits of legislation, and experts tell us the efforts fail the basic test.

On March 5 of this year, the President is quoted as saying:

> If people think we can simply take everybody who's not insured and load them up in a system where costs are out of control, it is not going to happen. We will run out of money. The federal government will be bankrupt; state governments will be bankrupt.

The President is right. But the Democratic leadership writing these bills is not listening. Partisan reform designed behind closed doors will bankrupt this country, in effect committing generational theft. The majority leader continues to put his bill together in a secret committee of one with a deaf ear to what experts tell us is needed. And we wait. We wait with great anticipation to see how high taxes and fees will be increased. We wait with great anticipation to finally understand how Senate Democrats will force a government health insurance entitlement into our health care market. We will wait to see how much they will cut Medicare. And these are Medicare cuts, my friends, have no doubt about it. We will wait to see the new mandates on individuals and employers to buy government-designed insurance.

We already know that the Senate Finance Committee bill includes roughly $508 billion in new taxes on individuals and businesses.

Beginning in January of 2010, health insurers would also be required to pay annual nondeductible fees totaling $60.4 billion over 10 years.

Beginning in January of 2010, medical device manufacturers are required to pay $40 billion in new nondeductible fees.

Beginning in January 2010, prescription drug manufacturers are required to pay $22 billion in new nondeductible fees.

By the way, in case my colleagues missed it, surprise, surprise, the pharmaceutical industry has now dramatically increased their prices, while the cost of living has gone down. What a shocker. Those great people from the pharmaceutical lobby who have been willing to make such ''sacrifices'' for the American people are raising their prices in an unprecedented fashion, totally disconnected to the absolutely nonexistent increase in the cost of living. And the administration continues to oppose drug reimportation from Canada, where seniors could get prescription drugs for about half of what it is now costing them.

Beginning in 2013, Democrats raise taxes by $201 billion by increasing taxes by 40 percent on certain family health care plans with higher coverage values, payable by insurance companies or employers.

Beginning in 2013, taxpayers who deduct medical expenses on their tax returns will pay $15 billion more in taxes.

Taxes on individuals who fail to maintain government-approved health insurance coverage will pay $4 billion in new penalties, breaking President Obama's promise that no one with income under $250,000 would pay higher taxes.

Businesses that are struggling to keep the doors open and keep workers employed in this recession will see higher taxes of $23 billion in the form of mandates and penalties for failing to offer government-approved health insurance.

Again, I urge my colleagues to read the article in the New York Post entitled ''Obamacare: Buy now, pay later'' by the well-respected economist Robert Samuelson. He writes:

> There is an air of absurdity to what is mistakenly called ''health-care reform.'' Everyone knows that the United States faces massive governmental budget deficits as far as calculators can project, driven heavily by an aging population and uncontrolled health costs. As we recover slowly from a devastating recession, it's widely agreed that, though deficits should not be cut abruptly (lest the economy resume its slump), a prudent society would embark on long-term policies to control health costs, reduce government spending and curb massive future deficits. The administration estimates these (deficits) at $9 trillion from 2010 to 2019. The president and all his top economic advisers proclaim the same cautionary message.
>
> So what do they do? Just the opposite. Their far-reaching overhaul of the health-care system—which Congress is halfway toward enacting—would almost certainly make matters worse. It would create new, open-ended medical entitlements that threaten higher deficits and would do little to suppress surging health costs. The disconnect between what President Obama says and what he's doing is so glaring that most people could not abide it. The president, his advisers and allies have no trouble. But reconciling blatantly contradictory objectives requires them to engage in willful self-deception, public dishonesty, or both.

Those are not my comments, Mr. President. Those are the comments of Robert Samuelson, one of the most respected economists in America.

I want to take another minute to talk about how the influence of special interests—I mentioned the pharmaceutical companies and the deal they cut so the administration would oppose drug importation from Canada, that there would not be competition for Medicare patients. But let me talk about probably the most powerful force in this whole discussion of legislation, and that is the trial lawyers of America.

There is no provision for medical liability or medical malpractice reform in this legislation. In fact, it was passed by the House that if States have enacted reforms, they will not be eligible for any additional funding to try and fund demonstration projects to reduce the cost of medical malpractice.

Everybody knows, ask any physician, they will tell you, they practice defensive medicine. They do so because of their fear of finding themselves in court and being wiped out. Sometimes these additional procedures and tests are not so comfortable for the patient, but, most importantly, they dramatically increase costs. Time after time after time, any effort we have made to put in medical malpractice reform—and we will do it again when the majority leader gives birth to whatever you want to call this—then, the fact is, they are not seriously interested in reducing costs, but they are seriously dependent on the largesse and generosity of the trial lawyers of America, and it is an outrage. It is an absolute outrage.

I would point out, when the President talks about, ''demonstration projects,'' there is a demonstration; it is called Texas. The State of Texas was hemorrhaging doctors and physicians and medical care practitioners. They reformed the medical malpractice. There have now been reductions in premiums. There have been reductions in lawsuits. There have been doctors and physicians and medical care providers flowing back into the State of Texas. It is proven. It is not everything we want. But it shows that medical malpractice reform can reduce health care costs.

And what have my friends on the other side and a couple on this side done? They have refused to consider in any significant way what everyone agrees could reduce health care costs in America. Outrageous. So do not be surprised when our approval rating is 18 percent. The approval rating of Congress: 18 percent. And in the townhall meetings I have been having, I have not met anybody in that 18 percent.

We need truth and honesty in our national discussion on health care reform, not spin, not budget gimmicks, not cuts to Medicare, not higher taxes, not government takeover, and not trillions in new health care spending.

We have $12 trillion in debt, 10 percent unemployment—17 percent real unemployment in my State—and an economy that is still struggling. Meanwhile, Wall Street makes obscene profits and bonuses that are unbelievable. We cannot afford another $3 trillion open-ended health entitlement. Americans deserve an honest discussion of ideas without artificial deadlines, and real solutions that will bring our skyrocketing health care costs under control.

Finally, I guess we are told that maybe this evening there may be something that will emerge with white smoke from the majority leader's office and we will be given the manifesto that he will call health care reform, and that will begin a great debate. I believe the question will be: Will the special interests and the big spenders and those who are in favor of government control of health care in America win or will the American people win?

That is why the American people are aroused. If they stay aroused, and if we continue to see the tea parties and the townhall meetings and the expressions of anger and frustration the American people feel, we will beat this back and we will go back to the bargaining table—for the first time we will go to the bargaining table and sit down, Republicans and Democrats, together.

History shows there has been no successful reform in America without bipartisanship, and I do not believe this will be the first one. I hope—I hope and pray—it will not be.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, one of the hallmarks of the Democrats' health care bill is that it spends a tremendous amount of money—more than $1 trillion. When the true 10 year costs are reflected, it is actually well over $2 trillion. That is a hefty price tag, and most Americans want to know who is going to pay for this.

Contrary to what Democrats want you to believe, this bill will be paid for by all Americans, including low- and middle-income families and small business owners. So for the next week, I want taxpayers as they go about their daily activities to take a moment to understand why they will be paying a new tax for each day of their hardworking week.

Monday is not usually a favored day for most folks during the week—and if this health care reform passes, it will be absolutely a miserable day for families making less than $200,000 a year. That is because 91 percent of you will start the week off by paying a $200 billion tax on health insurance.

I have talked about this before at length, this so-called tax on ''Cadillac'' plans. It is actually a 40-percent tax on high-cost premium ''Cadillac'' plans. But the people who are going to pay for these plans and for this tax are more likely driving minivans, used cars, and cars that are paid off. That is because it disproportionately impacts middle-income families.

That is new tax No. 1. But there are more.

The 40-percent insurance plan tax is what I just talked about. But all told, there are seven new taxes in this health care bill, and maybe more to come. These new taxes, as shown on this chart, fall on some people directly and on others indirectly. The nonpartisan Joint Tax Committee testified that these new taxes—however they are named—will act as excise taxes and will be passed on to consumers to some extent.

So, on Tuesday, as your kids are getting ready to get off for school, do not forget that you will be paying higher taxes on insurance premiums because of a new tax on insurance companies. It is the insurance tax. I want to quote a letter the Joint Tax Committee wrote. Remember, this is the nonpartisan Joint Tax Committee. They wrote to me in response to my concern over this debilitating tax. I quote:

> An insurer offering a family health plan that exceeds the excise tax threshold and is subject to the excise tax faces an increase in the cost of offering that health coverage. Generally, we expect the insurer to pass along the cost of the excise tax to consumers by increasing the price of health coverage.

So Tuesday is not a great day either in this new week of taxes.

On Wednesday, our small businesses—the engine of our economy—will be taxed if they do not offer health insurance. That is the employer tax, tax No. 3. The employer tax will hit small businesses and make it more expensive to hire workers. I do not think that is a good idea when the Nation is facing an over 10-percent unemployment rate. Those who are hired will see their wages reduced because of the required employer ''responsibility'' payments. That is what they are called.

The Congressional Budget Office—which again is a nonpartisan entity—has explicitly stated:

> Although the surcharges would be imposed on the firms, workers in those firms would ultimately bear the burden of those fees. . . .

The tax credit to small businesses does little to help because it only helps firms with 25 employees or less, and it is temporary. Also, this tax credit drops off so suddenly for firms with more than 10 employees that some firms will be penalized—actually penalized—for adding jobs or raising workers' pay—clearly, a perverse incentive.

So Wednesday is clearly not a good day for small businesses or their employees, especially those making minimum wage. So I hope you didn't have to call in sick on Thursday, because if you go to a doctor and get a prescription, there is a new tax on the pharmaceutical companies that you will pay. This is tax No. 4, the drug tax. Don't think about using your health savings account or flexible spending account for the over-the-counter medication you need as well. Under the House plan, nonprescription medications can no longer be purchased with moneys from these accounts, and under the Senate plan, there is a $2,500 cap for pretax dollars that can be used in these accounts. The weekend is so near on Friday; but wait, if you need some lab work done, you will have to pay a new tax on clinical laboratories. This is the lab tax.

You think your work is over on Saturday, but you will still be paying more taxes under this bill. If you need surgery, there is a new tax on medical devices, such as pacemakers, prosthetics, and hearing aids. This is No. 6. This raises the cost of health care. This is passed on to the consumers. All these taxes have one thing in common: They do raise the cost of health care for middle-income Americans.

My Democratic colleagues may claim they are raising taxes on health care companies, not people, and people will be better off once all this tax money is collected in Washington and then used as subsidies. The truth is, the people are paying and many are in the middle class who Democrats claim would be spared. It is true some people may, on a net basis, get more subsidy than they pay in higher taxes, but over 46 million middle-income families will pay more than they receive. In other words, their health care costs in the net are going to go up. They lose under this health care bill and these are middle-income Americans.

According to the analysis from the nonpartisan Congressional Budget Office, from which I wish to quote now, these taxes:

> Would increase costs for the affected firms, which would be passed on to purchasers and would ultimately raise insurance premiums by a corresponding amount.

So now it is Sunday, historically a day of rest but not for these new taxes. There is one more tax that again falls squarely on lower and middle-income families, a penalty excise tax for failure to obtain insurance. That is tax No. 7. We are faced with a bill where, according to the Congressional Budget Office, at least seventy-one percent of the individual mandate penalties would fall on the backs of American families making less than $120,000 a year. Remember what the President said: No new taxes on anybody making $250,000 a year or less. Actually, probably over 90 percent of this tax will be paid by those on whom the President said not one dime in new taxes will be raised. Yet under this bill that is coming before the Senate, their taxes are raised and they are raised significantly.

Well, we have run out of days of the week, but the Democrats are not finished yet. If you have been using pretax dollars in a flexible spending account, which most Federal employees have and a lot of other people who are employed by other companies have as well, and you pay for services not covered by your plan, such as speech therapy for a child with autism, you are out of luck under this bill. As I said earlier, the Federal spending accounts are capped at $2,500 in this bill, so your income tax will rise as well as your medical expenses. If you have been dealing with extraordinarily high medical expenses and have been counting

on qualified medical expenses tax deductions to pay for care or tuition for a special needs school, again, you are out of luck. The itemized deduction bar will be raised from 7.5 percent to 10 percent of your income in this bill. In other words, this bill hurts those who are being hit hardest by medical catastrophes.

In committee, my colleagues and I on the Republican side tried to inject some limits to this tax mania. We offered an amendment to carve out lower and middle-income families from paying taxes. I offered an amendment to protect the middle class, specifically, from the onerous penalty excise tax for those who fail to obtain insurance. Unfortunately, on party-line votes, the Democrats voted down those amendments.

I offered an amendment to eliminate the growing threat that the 40-percent insurance tax posed to every American with insurance, but, once again, the majority voted it down. We offered amendments to strike some of these specific, heavy-handed new taxes, but, once again, the majority, on party lines, voted them down. We tried to apply limitations so these taxes would not go into effect if they caused consumer costs to rise. The majority, again, voted them down. We tried to prevent these new taxes from hurting veterans, but as Democrats first accepted it, they then passed a second amendment to eliminate the protections. We tried to ensure that vulnerable Americans would not be hit with a tax increase on catastrophic medical costs. Again, the Democrat majority in committee voted it down. After losing every attempt to remove these new, onerous taxes, we tried to preserve the ability of Americans to continue to use their flexible spending accounts. Once again, that was voted down by the majority.

There are at least seven brand new taxes in this bill—one, two, three, four, five, six, seven new taxes—with more taxes being discussed. Before the final bill is completed, I am sure there will be more taxes in this bill. The House bill has a surcharge on small businesses. They are also talking about adding a value-added tax, which would be a regressive national sales tax on everyone, and a new windfall profits tax on insurance companies. There is even talk of a tax on soda pop. All these taxes do is cost Americans more money without giving them much in return. Even if the spending in this bill was worthwhile, these sweeping and unreasonable taxes would more than outweigh the benefits.

It is very clear America's lower and middle classes will bear the brunt of these new taxes. On top of that, they will not be allowed to keep the insurance plans they have. Instead, they will be forced into a new experimental system that will succeed only in exploding our deficit spending for generations to come.

So where is the break for hard-working families, we have to ask. Under this plan, they pay for government-run insurance to cover more Americans. They lose their own insurance—many of them—along the way, and they watch as deficits continue to eclipse their children's futures. That is not even close to the American way.

On behalf of millions of American workers, families, and small businesses that sent us to Washington to be their voice, I cannot stand by and watch the majority destroy our chance for meaningful health care reform that does not bankrupt our Nation. I am going to do everything in my power to stop these new taxes from becoming reality. I am confident, with the American people behind us, we can stop these new taxes. We can start over, in a bipartisan way, and go step by step and come up with health insurance reform that controls costs, preserves and even improves quality, and doesn't end up with a government-run health care system that cuts over $500 billion in Medicare and raises $500 billion in new taxes.

I urge our colleagues to work together—not as Republicans and Democrats but as Americans—so we can preserve the quality of health care we have enjoyed in this country for so long but do it in a way that is more affordable and provides more access to more Americans.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BINGAMAN. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mrs. HAGAN). Without objection, it is so ordered.

Mr. BINGAMAN. Madam President, I ask unanimous consent to speak as in morning business.

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

TRIBUTE TO GOVERNOR BRUCE KING

Mr. BINGAMAN. Madam President, this week, New Mexicans of all political persuasions have been recalling the life of a legendary figure of our State, Bruce King, who served as Governor during three different decades and who taught by example that public service is an honorable calling.

Governor King died last Friday at the age of 85. He used to tell the story about a former Governor who was the graduation speaker at Bruce's high school graduation. The former Governor looked at the very small class of teenagers and said:

> One of you could grow up to be governor of this state.

Bruce looked around at his other classmates and figured that the Governor had to be speaking to him. Sure enough, in the course of time, and after serving as Santa Fe County commissioner, a State legislator, and speaker of the house in New Mexico, he was, in fact, elected Governor. In fact, he served as Governor for 12 years, longer than anyone else in the history of New Mexico.

In all of those years, he never failed to make the people of New Mexico his first priority. With him at every step of the way, from their ranch in Stanley to Santa Fe and back again, was the remarkable Alice Martin King, his wife. She was a great force in her own right. She was a champion for children in our State. She died last December.

My own history with Bruce King began when I was just out of law school. I was serving then as an assistant attorney general in New Mexico and was assigned the job of being counsel to the constitutional convention which our State had in 1969. Bruce, who was then speaker of the house, was elected president of that convention. I learned a great deal about the legislative process and about New Mexico history and about our State in general as a result of the effort to work with Bruce in that capacity. His management of the process and the people involved with the constitutional convention was masterful. He was always inclusive, he was always listening, and he was always working to get the best result. In short, he was the model of a legislative manager.

Today I recall being privileged to serve as attorney general during Bruce's second term as Governor, from 1979 to 1982. We worked closely together on a number of issues. I was impressed all over again at his knowledge of New Mexico and his genuine love for its citizens. He was gregarious and kind. He never knew a stranger. He shook hands with everyone in our State. He shook every hand in our State, whether there was a voter attached to it or not. People were delighted to see Bruce coming and to hear his famous reply when asked: How are you doing, Governor? He would reply: Mighty fine—regardless of how difficult the circumstances the State and he were facing.

Our friendship extended for 40-plus years. With my fellow New Mexicans, I will miss him greatly. His sons Bill and Gary, his brothers Don and Sam, and the entire King family have lost tremendously. Every New Mexican feels this loss and joins his family in honoring his life.

Mr. UDALL of New Mexico. Mr. President, I rise to celebrate the life and mourn the passing of one of New Mexico's great public servants. This past Friday Bruce King, the three-time Governor of New Mexico and a constant advocate for regular folks, for

the average person, left this world after 85 years of devotion to his family, to his community, and to his State.

Bruce King was a self-made man who came from modest roots. Back in 1918, his parents traveled to New Mexico from Texas and traded their Model T for a homestead tract where they raised Bruce and his siblings. Along the way the elder Kings instilled in their children an appreciation for a hard day's work, a compassion for people, and a love of public service.

Bruce carried those lessons into adulthood and into a life defined by public service. He served in the Army in World War II, as a Santa Fe County commissioner, as a member of the New Mexico House of Representatives and later speaker of that same House of Representatives and, finally, as a three-term Governor elected in 1970, 1978, and then, once more, in 1990.

Bruce's legacy as Governor will be felt for generations. Due in no small part to the advocacy of his devoted wife Alice, Governor King created a new cabinet level department focused on the welfare of New Mexico's children. We called it the Children, Youth and Families Department. Thanks to Bruce and Alice's vision, more New Mexico children are safe and secure. More are healthy and ready to learn, and more have the support they need to follow their dreams. Governor King's contributions didn't end there. His leadership was instrumental to the creation of New Mexico's large and enduring rainy day funds which to this day continue to provide substantial support for education. He reformed New Mexico's school funding formula so that money is equally distributed across the State. Thanks to Governor King, State education funding now follows the student, regardless of income or geography. He also was an advocate for aggressive economic development, recruiting a new Intel plant to Rio Rancho, for the creation of a better, safer Statewide road system, and for the establishment of a new border crossing with Mexico.

But despite all of these achievements, what New Mexicans will most remember Bruce for is something more simple and much harder to come by in politicians these days. Bruce was not in politics for the power, for the prestige. He was in politics because of the people. He loved the people of New Mexico and the people of New Mexico—from Lordsburg to Clayton to Shiprock and Carlsbad and everywhere in between—loved him right back. Bruce enjoyed nothing more than talking to New Mexicans. Almost every morning you would find him doing just that at El Comedor Restaurant in Moriarty, NM. He had a booming voice and was famous for greeting friends and strangers alike with a handshake and a down home ''How y'all doing? Fine. Fine.''

I will always remember Bruce as a true cowboy from Stanley who had the most generous spirit. He always saw the best in people. He always did the right thing for New Mexico. My family was fortunate to call Bruce and Alice our friends. Our daughter Amanda even went to work for Alice in her first job out of college. She stayed close with both of them, ever since.

New Mexico will miss the Kings. We all know our State is a better place for their service and dedication to its people. As Governor King is laid to rest this week, I ask my colleagues to join me in honoring this remarkable public servant.

MORNING BUSINESS

Mr. BINGAMAN. I ask unanimous consent that the Senate be in a period of morning business with Senators permitted to speak therein for up to 10 minutes each.

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

Mr. BINGAMAN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Ms. MURKOWSKI. I ask unanimous consent that the order for the quorum call be rescinded.

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

NOMINATION OF DAVID HAMILTON

Ms. MURKOWSKI. Madam President, when the Senate considers the nomination of David Hamilton to the Seventh Circuit U.S. Court of Appeals later this afternoon, I intend to vote no. Some may regard this as perhaps inconsistent with my vote yesterday when I joined with a number of my colleagues on this side of the aisle in voting for cloture on the nomination. I certainly do not regard the two positions as inconsistent.

While I do not believe this nominee should be confirmed, I do believe judicial nominees deserve a straight up-or-down vote. I have come to the Chamber today to explain my views on the Hamilton nomination and expand upon why I voted as I did yesterday.

Our process for consideration of judicial nominees is broken. It has been broken since I came to the Senate in 2003. In fact, on April 30, 2003, I was among 10 freshman Senators, bipartisan, who wrote our respective leaders to say the confirmation process needed to be fixed. For reasons I can't fathom, we still seem to be light-years away from a process in which a President's judicial nominees come to the floor expeditiously for a straight up-or-down vote. This is a far cry from the process I am told the Senate adhered to prior to 2001 when there existed a strong presumption against the filibuster of judicial nominees. A cloture vote on a nomination was virtually unprecedented.

I understand all of that changed in February of 2001 when our colleagues on the other side of the aisle decided they would engage in the regular practice of blocking the confirmation of courts of appeals nominees with whom they had ideological disagreements through the use of the filibuster process.

Miguel Estrada, deemed ''well-qualified'' by a unanimous vote of the American Bar Association, had to suffer through seven failed cloture votes. This was in his bid to serve on the DC Circuit. Finally, he decided to move on with his life.

Priscilla Owen, also a recipient of a unanimous ''well-qualified'' rating by the ABA, suffered through four failed cloture votes before ultimately being confirmed to the Fifth Circuit.

David McKeague, a Sixth Circuit nominee, unanimously deemed ''well-qualified'' by the ABA was filibustered. I could go on.

In the 2003 letter, my cosigners and I noted that in some instances when a well-qualified nominee for the Federal bench is denied a vote, the obstruction is justified on the ground of how prior nominees, typically the nominees of a previous President, were treated.

Without doubt, a number of President Bush's nominees to the U.S. court of appeals were treated unfairly by this body. Off the top of my head, I can probably count 11 nominees to the courts of appeals, each of whom was deemed qualified to serve by the American Bar Association raters, many ''well-qualified'' in that rating, who had to suffer the filibuster.

It would not be my place to venture an opinion whether this entered into the cloture debate yesterday. However, I wish to make clear this is not how I evaluate judges for confirmation. In voting to end debate on the nomination of Judge Hamilton, I wanted to make the point that the qualified nominees of a President to the Federal bench deserve a straight up-or-down vote. This is what I believe the Constitution expects of this body in most cases.

Having said that, I have substantial concerns about the elevation of Judge Hamilton. I have considered his record on the Federal district court in Indiana as well as criticisms of his record. I regard it as my personal responsibility to consider these matters. My confirmation votes reflect my personal judgment as to the qualifications of the nominee.

As a Senator and as a mother, I have grave concerns about Judge Hamilton's judgment in recommending executive clemency for a 32-year-old police officer who was convicted of violating Federal child pornography laws. The defendant pled guilty to Federal charges that he photographed in one case and videotaped in the other sexual encounters with two women, one age 16 and

the other age 17. Although it may have been lawful for the defendant to engage in these encounters under the laws of Indiana, it is not lawful to photograph them under the laws of the United States.

Judge Hamilton went out of his way to argue that the 15-year mandatory minimum sentence imposed by Congress for such violations was a miscarriage of justice in this case. He argued vociferously that executive clemency is warranted. This Senator does not understand why Judge Hamilton would choose this cause to champion. While I understand Judge Hamilton has imposed substantial sentences in other child pornography cases, I do not agree with his reasoning in this matter and cannot, in good conscience, support his confirmation.

With that, Madam President, I appreciate the attention of the Chair. I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

ORDER OF PROCEDURE

Mr. INHOFE. Madam President, it is my understanding—and I wish to reaffirm this with a unanimous consent request—that I will be recognized at the hour of 1:30 for, let's say, 1 hour 10 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. INHOFE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

HEALTH CARE REFORM

Mr. CASEY. Thank you very much, Madam President.

I rise this afternoon to speak about health care. We all have been concentrating on this issue for many months, and we are now into a period of time when we will be getting a bill very soon to the floor. That is our hope and our expectation.

One of the parts of the Health, Education, Labor, and Pensions Committee bill that I voted on, as did the Presiding Officer this summer back in July when we passed our bill out of committee, one of the real priorities in that bill, and what I believe will continue to be a priority in the final legislation before the Senate, is children and what happens to children as a result of health care reform. We have a lot to be positive about in terms of legislation over the last decade or more as it relates to children, and I will speak about that.

In terms of that guiding principle, I have a very strong belief—and I think it is the belief of a lot of people in this Chamber and across the country—that every child in America—every child in America—is born with a light inside them. For some children, that light is limited by circumstances or their own personal limitations, but no matter what that light is, we have to make sure the light for their potential burns as brightly as we can possibly ensure. For some children, of course, that light is almost boundless. You almost can't measure it because the child has advantages other children don't have or they have a family circumstance that allows them to grow and to develop and, therefore, to learn and to be very successful. But I believe every child in America is born with a light, and whatever the potential is for that child, we have to make sure he or she realizes it. We have a direct role to play. Those of us who are legislators, those of us who are working on the health care bill have an obligation, I believe, to make sure that light shines ever brightly.

One of the other themes under this effort to expand health care for Americans is to focus on children who happen to be either poor or who have special needs. I believe the goal of this legislation, as it relates to those children, those who are poor or children with special needs, is four words: ''No child worse off.'' We need to ensure that a poor child isn't worse off at the end of this debate and enactment of health care reform and that a child with special needs is not worse off. I think that is the least we should do when it comes to protecting our children.

There are at least two programs—one older than the other but both very important—that relate to our children. The older of the two programs is the Medicaid Program. It has been around for more than 40 years now. Medicaid, as it pertains to children, is a program we have come to rely upon to provide children with very good medical care, the best medical care, in some ways, that a child can have. We have to make sure we pay attention to how Medicaid is treated in this bill. We will talk a little bit more about that in a moment.

In Pennsylvania, the State I represent, we have a 15-year experiment with the Children's Health Insurance Program or CHIP. The one thing we know about CHIP is it works. It works very well for children. As we know, in a general sense, the Children's Health Insurance Program is for children of low- and middle-income families in America who can't get coverage from their employer, for one reason or another, and don't have a family income that is low enough to qualify for Medicaid. So it fills a gap that had been there for years. We know, with regard to the Children's Health Insurance Program, today there are about 7.8 million children covered. That is wonderful. I am very proud and happy about that, but we are even happier and more positive about the future because the reauthorization of the Children's Health Insurance Program means that by 2013, 7.8 million children covered will rise to 14.1 million children. So an easy way to think about children's health insurance is 14 and 13: 14 million kids covered in the year 2013. That is a tremendous achievement—historic in American history. We have never had anything close to that, to have 14 million children covered in a good program such as CHIP.

The caveat to that is we still have millions—by some estimates 8 million—of children who will not be covered even in 2013. One of the reasons we are debating health care reform is to make sure we are doing everything possible to strengthen the Children's Health Insurance Program and do not allow it to be weakened in any way.

One way to weaken it—and fortunately the Senate Finance Committee did not do this in their final bill—is to take a stand-alone, successful, effective Children's Health Insurance Program and put it in the health insurance exchange. It may sound good—within one system—but I believe, and many others believe, it would be very bad. The Finance Committee, led by Senator ROCKEFELLER, worked very hard to make it possible to keep the Children's Health Insurance Program as a separate stand-alone program. I believe we have to do that.

As we know, legislation passed recently in the House. The health care bill got through not just the committees but through the House itself. One of the problems with the House bill is it would end the Children's Health Insurance Program in 2013. We don't want to do that. We want to make sure, in the Senate, we do it differently than the House did.

One component that is good about the House bill on this subject, however, is it does expand Medicaid. The House bill expands Medicaid for children to 150 percent of poverty for all States, and States would get assistance in paying for this expanded population. But then there is another caveat in terms of what I think has to be improved upon in the Senate. Children above 150 percent of poverty will go into a new exchange, which I think is, as I said before, the wrong way to go. We want to make sure, if something such as that were to happen, they would have cost-sharing protections and better benefits. Unfortunately, if they go into that exchange, they would not. This could

have a direct impact on a State such as Pennsylvania. By one estimate, in Pennsylvania alone, this means that nearly 100,000 children who currently have children's health insurance coverage would lose it because of that change. So we want to make sure we don't go in the direction the House did as it relates to this issue of children's health insurance and the exchange—keeping it out of the exchange.

We do need to expand Medicaid for children and we need to maintain CHIP as a stand-alone program. What are some of the numbers here? We are talking about nationally, in the Medicaid Program, 30 million children enrolled in Medicaid. As I said before, enrolled in CHIP are 7.8 million kids. Putting them together we have one-third of all children in America covered by those two programs. But as I said before, we still have plenty—millions and millions—of children who still are not covered by either program.

We hear a lot of acronyms around here, but one important acronym for this debate, as it relates to children and to health care, is EPSDT: early pediatric screening diagnosis and treatment. The American Academy of Pediatrics has called EPSDT the ''gold standard'' for children's health care. This is essential that we keep that kind of standard in place. That means Medicaid, for example, covers all medically necessary treatment for children, including preventive care, primary care, dental, hearing, vision, and it goes down the list.

Unfortunately, sometimes people say: Well, under commercial coverage you will get as much coverage for children of the same quality. Unfortunately, that is not true. There may be advantages to provider networks of commercial coverage for families who are wealthy enough, have the means to afford it and who can get out of the network and pay for something extra, but, of course, many families don't have that benefit.

I wish to spend a couple moments on EPSDT. I will go to the first chart. The Commonwealth Fund and George Washington University did an excellent comparison of the benefits between commercial insurance and Medicaid. The first benefit we have on this chart is called developmental assessment. Some of these terms get a little long and there is a lot of policy jargon. One of the most important things for any child, especially very young children, is to have regular and high-quality developmental assessments, so we can catch anything that might be going wrong at an early enough age and give that child the benefit of early intervention and treatment in the dawn of their lives, in the early months and years of their lives. We can see, under Medicaid, for example, that this developmental assessment is covered. We can also see that under the Federal Employees Health Benefits Plan, there is a lot of verbiage there which I will not read, but suffice it to say it is limited. It is not covered to the extent it is in Medicaid.

Another example is this phrase down here: ''Anticipatory guidance,'' another fancy term of policy, but it is this simple: It is helping parents understand what they should be expecting from their child physically, emotionally, and developmentally so they can get help, as I said before, early enough in the life of that child. This kind of guidance, again, is covered under Medicaid but not explicitly covered under the Federal Employees Health Benefit Program, which, as a beneficiary of that program, is a great health insurance program for Federal employees, but even something that significant, in terms of coverage and quality, would not be, in my judgment, good enough for poor children who should be covered in terms of developmental and anticipatory guidance with their parents under Medicaid. So Medicaid is better for poor children than even something as significantly good as the Federal employees plan.

Let me go to the next chart. I know we are getting close to our time and I will be observing that. This chart shows EPSDT as it relates to physical, speech, and related therapies. We have heard horror stories from mothers of children with disabilities—either mild or severe. Physical therapy, speech therapy, and occupational therapy, these are all critical to a child who may have a disability. Sometimes early intervention can help a child recover to normal functioning and sometimes it is a disability that persists throughout a child's life. Under Medicaid, again, beyond the medically necessary threshold, basic therapies, such as physical, speech, and occupational therapy, are covered without limitation. I think it is vitally important we ensure that under Medicaid we continue to fortify that program so our children can get that kind of quality coverage.

Let me conclude with a couple thoughts, very briefly. No. 1 is, at the end of this process of getting a health care bill enacted, I believe we have to live up to that basic standard of four words for poor kids: ''No child worse off'' at the end of the road. Dr. Judith Palfrey, a pediatrician, child advocate, and president-elect to the American Academy of Pediatrics, spoke at one of our hearings earlier this year, and here is what she said:

> Sometimes, we as child advocates find it hard to understand why children's needs are such an afterthought and why, because children are little, policymakers and insurers think that it should take less effort and resources to provide them with health care.

I think that challenges all of us to make sure children are not second-class citizens when it comes to health care reform and what we do.

Let me conclude with this thought: As I said before about that bright light inside every child who is born, we have to do everything possible to make sure that at the end of the road, at the end of this debate, and at the end of voting on this bill, we ensure that that light burns ever brightly, especially for children who happen to be poor or have special needs.

With that, I yield the floor and note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. INHOFE. Madam President, I understand that according to the unanimous consent agreement, I have the floor for a period of time now.

The PRESIDING OFFICER. The Senator is correct.

GLOBAL WARMING

Mr. INHOFE. Madam President, next month, thousands of U.N. delegates from over 190 nations, members of the press, and eco-activists from around the world will descend upon Copenhagen as a part of the U.N. Conference on Global Warming. Yet, even before it begins, that U.N. conference is being called a disaster.

Just this morning, the Telegraph—a UK newspaper—noted:

> The worst-kept secret in the world is finally out—the climate change summit in Copenhagen is going to be little more than a photo opportunity for world leaders.

Not too long ago, however, the Copenhagen meeting was hailed to be the time when an international agreement with binding limits on carbon dioxide and other greenhouse gases would finally be agreed upon.

The eco-activists believed that with a Democratic President in the United States and a Democratically controlled House and a Democratically controlled Senate, we would finally push through mandatory cap-and-trade legislation, and the United States would finally be ready to succumb to the demands of the U.N. I say demands of the United Nations because there are so many people in this Chamber who think if something isn't multinational, U.N. or something else, it is not good. You have to ask: Whatever happened to sovereignty in this country?

Not too long ago, the Copenhagen meeting was hailed as a time that all this would come to an end and they would be successful and pass in this country the largest tax increase in history. In reality, it will be a disaster. Failure comes at a high cost. Despite the millions of dollars spent by Al Gore, the Hollywood elite, the U.N., climate alarmists, it has failed.

Perhaps the Wall Street Journal said it best in an article entitled ''Copenhagen's Collapse.'' I will read this because I think it is worthwhile:

The Climate Change Sequel is a Bust.

The editorial states:

''Now is the time to confront this challenge once and for all,'' President-elect Obama said of global warming last November. ''Delay is no longer an option.'' It turns out that delay really is an option—the only one that has worldwide support. Over the weekend, Mr. Obama bowed to reality and admitted that little of substance will come of the climate change summit at Copenhagen next month. For the last year, the President has been promising a binding international carbon-regulation treaty a la the Kyoto Protocol.

We remember that.

But instead, negotiators from 192 countries now hope to reach a preliminary agreement that they'll sign such a treaty when they meet in Mexico City in 2010.

Wait a minute. That is 2010. That is next year. This year, it hasn't even come yet. This is Copenhagen 2009.

I am continuing to read:

The environmental lobby is blaming Copenhagen's preemptive collapse on the Senate's failure to ram through a cap-and-trade scheme like the House did in June, arguing that ''the world'' won't make commitments until the United States does. But there will always be one excuse or another, given that developing countries like China and India will never be masochistic enough to subject their economies to the West's climate neuroses. Meanwhile, Europe has proved with Kyoto that the only emissions quotas it will accept are those that don't actually have to be met.

We say that because many of these Western European countries made commitments for emissions and they have not met them.

During my position as chairman and ranking member of the Environment and Public Works Committee, since 2003, I have been the lead Senator standing and exposing the science, the cost, and the hysteria about global warming alarmism. I will be traveling to Copenhagen leading what has been called the truth squad, to say what I said 6 years ago in Milan, Italy. Let's keep in mind what these meetings are. The U.N.—that is where this all started, with the IPCC at the U.N.—said that the world is going to come to an end because of CO_2 emissions. They started having these meetings, and they have had—I don't know how many. They started in 1999, I think. They had the one in Milan, Italy, in 2003, the only one I went to. They were inviting all the countries to come in and join this club, saying we are going to do away with CO_2.

It is interesting that one of the participants I ran into in 2003 was from West Africa—and I remember this well because I knew this guy knew better. I said: What are you here supporting this for? He said: This is the biggest party of the year. We have 190 countries coming in, and it is a big party. It is all you can eat and drink. So anyway, the United States is not going to support a global warming treaty that will significantly damage the American economy, cost American jobs, and impose the largest tax increase in American history. Further, as I stated in 2003, unless developing countries are part of the binding agreement, the United States will not go along, given the unemployment rate of 10 percent—10.2 now—and given all the out-of-control spending in Washington. The last thing we need is another 1,000-page bill that increases costs and ships jobs overseas, all with no impact on climate change.

That was in Milan, Italy. I remember in Milan, Italy, all the telephone poles had my picture on them, ''wanted'' posters, because of something I said, which I will quote in a minute. I said then that the science was not settled, and it was an unpopular view. Since Al Gore's science fiction movie, more and more scientists, reporters, and politicians are questioning global warming alarmism. I am proud to declare 2009 the year of the skeptic, the year in which scientists who question the so-called global warming consensus are being heard.

Rather than continue down a road that will harm the U.S. economy and international community, we should forge a new path forward that builds on international trade, new and innovative technology, jobs, development, and economic growth.

If you have followed the Senate, you will know that the Senate's position on global warming treaties couldn't be more clear. In 1997, let's remember what happened then. President Clinton and Vice President Al Gore were attempting to get us to ratify the Kyoto treaty. We passed something in the Chamber called the Byrd-Hagel resolution. It passed 95 to 0. It said this: If you bring back anything from Kyoto or anywhere else for us to ratify, and if that treaty we are supposed to ratify either doesn't include developing countries or is harmful to our economy, then we will not ratify it. I think the Byrd-Hagel resolution still commands strong support in the Senate. Therefore, any treaty President Obama submits must meet this criteria or it will be easily defeated.

Proponents of securing an international treaty are slowly acknowledging that the gulf is widening between the United States and other industrialized nations that are willing to do what developing countries such as China want them to do. The gulf has always been wide, but it is continuing to get wider. When we talk about China and about the fact that they are talking about restricting CO_2 emissions in the United States, some think that surely China will follow our lead. It is interesting that China is cranking out two coal-fired power-generating plants every week.

With certain failure at Copenhagen, it is safe to say cap and trade is dead. Look at the record: the Byrd-Hagel amendment in 1997, the defeat in the Senate of the McCain-Lieberman bill in 2003, and defeat of McCain-Lieberman in 2005, defeat of the Warner-Lieberman bill, and no bill on the Senate floor in 2009.

From my very first speech on the Senate floor as chairman of the Environment and Public Works Committee, on July 28, 2003, I outlined the staggering cost of global warming solutions such as Kyoto. In my speech, I said the most widely—I am quoting now from what I stated in 2003:

The most widely cited and most definitive economic analysis of Kyoto came from Wharton Econometric Forecasting Associates.

According to the Wharton School, their economists, Kyoto would cost 2.4 million U.S. jobs, reduce GDP by 3.2 percent, and that would equate to somewhere between a $300 billion and $330 billion tax increase annually—an amount greater than the total expenditure on primary and secondary education.

In terms of a tax, when I looked at that tax—and this was back in 2003 and they talked about a $300 billion tax increase—I wanted to look and see how I could better understand that. I recall, prior to that, the largest tax increase in the last three decades was called the Clinton-Gore tax increase of 1993. That tax increase was a $32 billion tax increase. I thought, wait a minute, we are about to impose upon the American people a tax increase that is 10 times greater than the 1993 Clinton-Gore tax increase. This chart shows what that would be. These are the tax increases. This is the increase we are talking about, the $32 billion tax increase. This is what it would have been had we signed the Kyoto treaty or any of the accords since that time. So we are talking about huge amounts of money. I said that because of Kyoto, American consumers would face the higher food, medical, and housing costs—costs for food, an increase of 11 percent; medicine, an increase of 14 percent; housing, an increase of 7 percent; and at the same time, an average household of 4 would see its real income drop by $2,700 in 2010 and each year thereafter. Under Kyoto, energy and electricity prices would nearly double, and gasoline prices would go up an additional 65 cents a gallon.

Again, we are not talking about JIM INHOFE, a Senator, making these statements. This was actually out of the Wharton School of Economics and their forecast at that time. I went on to note that CBO found that ''cap and tax'' is a regressive tax, arguing that the Congressional Budget Office found that the price increases resulting from a carbon cap would be regressive; that is, they would place a relatively greater burden on lower income households

than on higher income ones. As to the broader macroeconomic effects of carbon cap-and-trade schemes, CBO said:

A cap and trade program for carbon emissions could impose significant costs on the economy in the form of welfare losses. Welfare losses are real costs to the economy in that they would not be recovered elsewhere in the form of higher income. Those losses would be borne by people in their roles as shareholders, consumers, and workers.

Some might respond that government can simply redistribute income in the form of welfare programs to mitigate the impacts on the poor, but CBO found otherwise. They said:

The government could use the allowance value to partly redistribute the costs of a carbon cap-and-trade program, but it could not recover these costs entirely.

Further:

Available research indicates that providing compensation could actually raise the cost to the economy of a carbon cap.

That was what we quoted from the CBO in 2003. Yet, as the saying goes, the more things change, the more they stay the same. CBO, EPA, the DOE, CRS, the National Black Chamber of Commerce, NAM—everyone now agrees that cap and trade would be extremely costly and destroy jobs. No matter how hard alarmists try to recast their cause—whether it is green jobs or clean energy jobs or clean energy revolution—and they are starting to reword it from ''global warming'' to ''climate change.'' The general public has realized global warming isn't taking place, and they cannot use that, so they changed that to climate change. Now they cannot use that anymore, and they can't use cap and trade, so they talk about a green jobs program.

Cap and trade is a loser for America. I have also pointed out the inconvenient fact that cap-and-trade solutions are all pain and no climate gain. In the first speech in 2001, I noted that even Al Gore's own scientist admitted Kyoto would do nothing to solve global warming. Let me refresh the memory of the American people. In 2003, Al Gore had hired Dr. Tom Wigley, a senior scientist at the National Center for Atmospheric Research. The challenge he posed to him was, if we, along with all other developed nations, were to sign on to the Kyoto Treaty and live by its emissions restrictions, how much would this reduce the temperature in 50 years?

The answer was it would be 0.07 of 1 degree Celsius by 2050. It would actually be 0.13 degrees Celsius by 2100. These things are not even measurable. We go through 50 years of the highest tax increase in the history of America. What do we get for it? Maybe you will get, according to his own scientist, Dr. Tom Wigley, 0.07 of 1 degree Celsius.

I also mentioned in the 2003 speech everyone's favorite alarmist, James Hansen. I said at that time:

Similarly, Dr. James Hansen of NASA, considered the father of global warming theory, said the Kyoto Protocol ''will have little effect'' on global temperature in the 21st century. In a rather stunning follow-up, Hansen said it would take 30 Kyotos—let me repeat that—30 Kyotos to reduce warming to an acceptable level. If one Kyoto devastates the American economy, what would 30 do?

Those following the climate debate closely know James Hansen went on record this summer against the Waxman-Markey-Kerry-Boxer bill. It is not going to pass now. At that time, it looked as if it was going to pass. Even James Hansen, one of the strongest proponents, said:

Cap and trade is the temple of doom. It would lock in disasters for our children and grandchildren. Why do people continue to worship a disastrous approach? Its fecklessness was proven by the Kyoto Protocol.

That is James Hansen on the other side of the issue.

Now we have top Obama officials making the same points. EPA Administrator Lisa Jackson was before our committee. Keep in mind, she is an Obama appointee. She is now Administrator of the EPA. She said in response to a question I had—I said: Is this chart correct? In other words, if we were to pass this bill and to restrict our emissions of CO_2, would it have any effect? She said: No, I agree with that chart. Of course, I am encouraged. She said:

I believe the central parts of the [EPA] chart—

That is this chart—

are that U.S. action alone will not impact world CO_2 levels.

I often said how I appreciate the honesty of Lisa Jackson. It is difficult for her to admit that if we passed a bill, it would not have any effect on reducing worldwide emissions of CO_2.

You could carry that argument a little bit further because if we were to ration CO_2 in our country, that would cause jobs to leave. We understand that. They would go to countries such as China, India, and Mexico, where they don't have any restrictions at all. So it would have the effect of increasing CO_2.

Over the past several years, we have seen a growing number of Democrats—yes, Democrats—agreeing with my position. Today, with a Democratic Congress and a Democratic President, some may be surprised by the number of Democrats who want nothing to do with cap and trade.

Politico—we are all familiar with that publication—reported on Monday that:

Lawmakers from coal and manufacturing-heavy States aren't happy that more liberal Democrats are using the Copenhagen negotiations to ratchet up pressure to move the bill forward. ''I'm totally unconcerned about Copenhagen.''

This is a quote by Democratic Senator Jay Rockefeller from West Virginia.

He said:

I'm concerned about West Virginia.

I am glad to hear some of my Democratic colleagues making these statements.

They also reported—still quoting from Politico:

Virginia Democratic Sen. Jim Webb said on Monday he would not back the cap-and-trade legislation sponsored by Sens. John Kerry and Barbara Boxer, another blow to the troubled Senate climate change bill. ''In its present form I would not vote for it,'' he said. ''I have some real questions about the real complexities on cap and trade.'' Webb is the latest in a series of Democratic moderates to raise significant concerns with the climate bill, which has floundered since passing the House in late June.

That is quite some time ago.

Or consider Democratic Senator BEN NELSON from Nebraska. The Hill recently reported on a CNBC interview with Senator NELSON, writing:

''A cap-and-trade bill to address climate change cannot pass Congress this session,'' said Sen. Ben Nelson, Democrat from Nebraska. Nelson, a centrist Democrat whose vote is key to leaders wielding its 60-vote majority in the Senate, said he and his constituents had not been sold on the cap-and-trade system proposed in the House and Senate bills to address global warming. ''No,'' Nelson simply responded when asked if those cap-and-trade bills can pass through this Congress during an interview with CNBC. ''I haven't been able to sell that argument to my farmers, and I don't think they're going to buy it from anybody else,'' Nelson said. ''I think at the end of the day, the people who turn the switch on at home will be disadvantaged.'' The pessimistic assessment makes Nelson a thorn in the side of his party's leaders—

Who are trying to push this through from the Democratic Party.

Perhaps the biggest blow to any Senate climate bill came last week from 14 Senate Democrats, primarily from the Midwest, who in a letter challenged the allocation formula of Kerry-Boxer and Waxman-Markey. The letter was signed by Senators AL FRANKEN, AMY KLOBUCHAR, MARK UDALL, MICHAEL BENNET, ROBERT BYRD, CARL LEVIN, DEBBIE STABENOW, and SHERROD BROWN.

What about the prospects for 2010? As Lisa Lerer of Politico reported last week:

An aggressive White House push on jobs and deficit reduction in 2010 may be yet another sign that climate-change legislation will stay on the back burner next year. ''There is a growing chorus in the party that thinks we should be doing something more to spur job creation and not necessarily tackle cap and trade right now,'' said a moderate democratic Senate aide. White House officials told Politico on Friday that President Barack Obama plans to curb new domestic spending beyond jobs programs and focus on cutting the federal deficit next year. In the Senate, Majority Leader Harry Reid has hinted that Democrats plan to take up a job-creation bill, in the wake of the announcement of the 10.2 percent unemployment rate. In the House, some lawmakers are beginning to push a major highway bill for next year to focus on job creation. None of this is promising for the major climate change bill.

That was a quote that came out of Politico.

Also, Darren Samuelsohn with E&E News reported this week that:

Next November's midterm elections loom large, leaving the climate bill sponsors until about the end of March to notch the 60 votes necessary to pass their bill off the floor and into a conference with the House that would best be finished before the summer. ''Conventional wisdom is that you have until the spring to get controversial issues moving,'' said Sen. Ben Cardin, a lead co-author of the climate bill that the Environment and Public Works Committee passed earlier this month. ''If not, it's difficult to see getting through closer to the elections.''

What he is saying there, when you get closer to the elections, then you want to be more consistent with what Americans believe.

Mr. Samuelsohn reported that the Democrats fear a repeat of the disastrous 1992 Btu tax vote. He quotes Al Gore as saying, ''Yes, I think the Btu [post-traumatic stress disorder] is a factor in this debate.''

To refresh your memory, Madam President, the Btu, back in 1992, was a huge tax increase on energy. People realized they would have to pay for it. That passed the House, ironically, with 219 votes, the same narrow margin this cap-and-trade bill passed 15 years later.

Samuelsohn also writes that according to Democratic Senator JAY ROCKEFELLER of West Virginia, ''the talk on the street'' was that an election year cannot be good for passing the climate bill in the Senate, even though he did not agree with that opinion. ''There's some possibility of people saying that it's too controversial a bill in an election year,'' quoting Rockefeller, ''which is sort of the opposite of how a democracy ought to work.'' I do agree with him on that. ''You go ahead and take your chances on that and get reelected. But people's business should come first.''

By now the message should be clear: It is not just Republicans but Democrats who are blocking passage of cap and trade in the Senate. The sooner we are honest with the international community of the impossibility of the Senate moving forward with cap and trade, the sooner we can begin work on an all-of-the-above energy bill to develop domestic energy resources, create jobs, and provide consumers with affordable, reliable energy.

I don't like the idea that sometimes promoters of cap and trade say this is an energy bill. What you are doing is restricting energy. Right now, we are dependent on coal, oil, gas, and, hopefully in the future, nuclear. Those who are pushing for this green energy, which we all want someday—what do we do 10, 15, 20 years from now? Just 2 weeks ago, they came out with a study that said the United States of America is No. 1 in possession of recoverable natural resources. Yet 83 percent of these natural resources are off limits, primarily due to the moratorium set by Democrats saying: We don't want you to drill offshore or some of these other places. It seems inconceivable to me that we are the only nation in the world that does not develop its own resources.

Anyway, the tipping point from the most memorable tidbit from my 2-hour global warming speech in July of 2003 was my comments about the science behind global warming. Now 6 years later, as I head to the next U.N. global warming conference, I am pleased by the vast and growing number of scientists, politicians, and reporters all over the world who are publicly rejecting climate alarmism, those who want to scare people into some kind of action: Water is going to rise up, the world is coming to an end—all of that. They are rejecting these alarmists now.

When I made those comments on the Senate floor, few people were there to stand with me. Today, I have been vindicated, and I am proud to share the stage with all those who now dare to question Al Gore, Hollywood elites, and the United Nations.

Early in my 2003 speech, 6 years ago, I said:

Much of the debate over global warming is predicated on fear rather than science. Global warming alarmists see a future plagued by catastrophic flooding, war, terrorism, economic dislocations, droughts, crop failures, mosquito-borne diseases, and harsh weather—all caused by man-made greenhouse gas emissions.

For the next 2 hours, I presented arguments by a number of leading scientists who disputed that picture of the future. I argued that activists attempting to propagate fear would fail to convince the American people. I then concluded my remarks saying:

With all the hysteria, all the fear, all of the phony science, could it be that man-made global warming is the greatest hoax ever perpetrated on the American people? It sure sounds like it is.

My remarks were immediately ridiculed by alarmists in the mainstream media. Alarmists then and since have used every name in the book to discredit me. Nevertheless, I continued to make my case in speech after speech on the Senate floor, highlighting arguments by numerous scientists that contradicted the notion that the science behind global warming was ''settled.''

Every time you quote a scientist, they always come back and say: Oh, no, you can't talk about the science; the science is settled.

The first time the McCain-Lieberman bill came to the Senate floor was 2003. McCain-Lieberman was essentially a cap-and-trade bill similar to what we are looking at today. I remember well, Republicans were in the majority. I was chairman of the Senate Environment and Public Works Committee. I can remember we were given 5 days on the floor to debate this bill, 10 hours a day, roughly 50 hours. I remember going over this and debating this on this very floor of the Senate in 2005. It was the McCain-Lieberman bill, and only two Senators came down during that week to give me support. Fast forward to 2008. The same bill came up, except this time it was called the Warner-Lieberman bill, another cap-and-trade bill, just like we are talking about today. At that time, it didn't take 5 days to defeat it; it took 2 days, and 23 Senators came down to join me in that effort. What do I credit for the reversal? You might be surprised by my answer. It is none other than the winner of a Nobel Peace Prize and an Oscar. It is Al Gore.

The media blitz of 2006, which included an avalanche of magazine covers, hour-long global warming documentaries, celebrity rock concerts around the world, and, of course, Al Gore's very own science fiction movie, caused an unprecedented response from scientists from around the world.

Later that year, I took to the Senate floor debunking much of Al Gore's movie and the media hype. I said then—and this is, again, 2006:

In May, our Nation was exposed to perhaps one of the slickest science propaganda films of all time: former Vice President Al Gore's ''An Inconvenient Truth.'' In addition to having the backing of Paramount Pictures to market this film, Gore had the full backing of the media, and leading the cheerleading charge was none other than the Associated Press.

I noted a report that appeared on June 27, 2006, by Seth Borenstein of the Associated Press that boldly declared ''Scientists give two thumbs up to Gore's movie.'' I took issue with the Borenstein article and pointed out—and this is a quote from 3 years ago:

''The article quoted only 5''—listen, Madam President—''only 5 scientists praising Gore's science, despite AP's having contacted 100 scientists.''

They contacted 100 scientists and they could only find 5 scientists who praised it.

The fact that over 80 percent of the scientists contacted by the AP had not even seen the movie or that many scientists have harshly criticized the science presented by Gore did not dissuade the news outlet one bit from its mission to promote Gore's brand of climate alarmism. I am almost at a loss [I am quoting from 3 years ago] as to how to begin to address the series of errors, misleading science and unfounded speculation that appear in the former Vice President's film. Here is what Richard Lindzen, a meteorologist from MIT, has written about ''An Inconvenient Truth.'' He said: ''A general characteristic of Mr. Gore's approach is to assiduously ignore the fact that the Earth and its climate are dynamic; they are always changing even without any external forcing. To treat all change as something to fear is bad enough; to do so in order to exploit that fear is much worse.''

That is Richard Lindzen, one of the top scientists at MIT. In that same 2006 speech I then proceeded to give a brief summary of the science that the former Vice President promoted in either an inaccurate or misleading way. Let me read a list of these.

He promoted the now debunked ''hockey stick'' temperature chart in an attempt to prove man's overwhelming impact on the climate. He attempted to minimize the significance of the medieval warm period and the little ice age.

Let's put them together. If you remember the famous hockey stick, that was the one that showed climate, increasing temperature, and then all of a sudden there is a hockey stick. That is when it started going up.

It ignored the fact that in the 14th century and again in the 16th century we had the medieval warm period and the little ice age. In the medieval warm period it was far warmer than it has been since that time.

In that same movie, insisting on a link between increasing hurricane activity and global warming that most scientists at this time do not believe—and it doesn't exist. The science has come out since that time and said very clearly that science is not there. Every year they say this coming year it is going to be greater hurricanes. It doesn't happen. For 5 consecutive years they predicted that and it hasn't happened.

He asserted that today's Arctic is experiencing unprecedented warmth, while ignoring that the temperatures in the 1930s were warmer than in that time. He claimed the Antarctic was warming and losing ice, but failed to note this is only true of a small region and that the vast bulk has been cooling and gaining ice during that period. He hyped unfounded fears that Greenland's ice is in danger of disappearing.

If you were to say that maybe there is some truth in the global warming issue, I had occasion, I say to my good friend who is presiding, a few years ago, not too many years ago—my background is aviation. I decided to replicate the flight of Wylie Post going around the world. One of my stops there, where Wylie Post stopped, was in Greenland. Their history books are full of the time things were flourishing in Greenland. The Vikings came in, they were growing things that hadn't been grown. Then when the cycle went through and it started getting colder, they died and disappeared. I think you can argue we are going to have these cycles. God is still up there. We have always had Him; we are going to continue to have Him.

Back to the film. He erroneously claimed the icecap on Mount Kilimanjaro is disappearing—and that is not supported—due to global warming, even while the region cools and researchers blame the ice loss on local land use practices.

He made assertions of massive future sea level rise far afield from any supposed scientific ''consensus'' and not supported in even the most alarmist literature. He incorrectly implied that a Peruvian glacier's retreat is due to global warming, ignoring the fact that the region has been cooling since the 1930s and other glaciers in South America are advancing. He blamed global warming for water loss in Africa's Lake Chad, despite NASA scientists concluding that local population and grazing factors are the more likely culprits. He inaccurately claimed polar bears are drowning in significant numbers due to melting ice when in fact they are thriving.

The population of the polar bear has quadrupled since 1960 and today, of the 13 polar bear populations in Canada, they are all increasing except for one and that is in the western Hudson Bay area where they have hunting regulations and issues they are working on now not related to weather.

He completely failed to inform the viewers that the 48 scientists who accused President Bush of distorting science were part of a political advocacy group set up to support Democratic Presidential candidate John Kerry in 2004.

You could make a whole speech on each of the assertions made in that science fiction movie called ''An Inconvenient Truth,'' and they have been disproven. At the end of the speech I challenged those in the media to reverse course and report on the objective science of climate change, to stop ignoring legitimate voices in the scientific community, question the so-called consensus, and to stop acting as a vehicle for unsustainable hype.

The reaction by the American public was so overwhelming that my Senate Web site crashed after that. Thousands of people came to my site to read and watch the speech. In fact, I was flooded with e-mails supporting the work.

I also noted in 2006, in that speech, many scientists were just starting to speak out against the so-called consensus on global warming. In April of that year, 60 prominent scientists who questioned the basis for climate alarmism sent a letter—these were Canadian scientists, 60 of them sent a letter to the Canadian Prime Minister and they wrote:

> If, back in the mid-1990s we knew what we know today about climate Kyoto would almost certainly not exist, because we would have concluded it was not necessary.

I say that because Canada was one of the countries that did sign onto the Kyoto treaty. They are saying today, if we had known then what we know now, we wouldn't have done it.

I discovered how many prominent scientists were disputing the claims of global warming alarmism in 2007 and I released my first report detailing over 400 scientists who did not buy the consensus. If you want to go back to any of these, I have a Web site, inhofe.senate.gov. You can see who they are.

After that report, the list continued to grow and more scientists began publicly challenging global warming fears. In 2008, I updated the report with over 650 scientists and today that stands at well over 700 skeptical scientists. The chorus of skeptical scientific voices continues to grow louder every day as the consensus collapses.

I think this is important. A lot of the scientists were intimidated at that time with the withdrawal of various grants and other things coming from both the Federal Government or some more liberal groups that are out there. The fact is they had the courage to come forward and say the consensus is not there even though everyone thought it was for so many years. This momentous shift has caused the mainstream media to take notice of the expanding number of scientists serving as ''consensus busters.'' A November 25, 2008 article in Politico noted that a ''growing accumulation'' of science is challenging warming fears, and that the ''science behind global warming may still be too shaky to warrant cap-and-trade legislation.'' That was a year ago.

In Canada's National Post, it noted on October 20 of 2008 that ''the number of climate change skeptics is growing rapidly.'' The New York Times environmental reporter Andrew Revkin noted on March 6, 2008, ''As we all know, climate science is not a numbers game. There are heaps of signed statements by folks with advanced degrees on all sides of the issue.''

In 2007 a Washington Post staff writer, Juliet Eilperin, conceded the obvious, writing that climate skeptics ''appear to be expanding rather than shrinking.''

We have seen this happening for the last 2 years. Yet it will be 2009 that will be remembered as the year of the skeptic. Until this year, any scientist, reporter, or politician who dared raise even the slightest suspicion about the science behind global warming was dismissed and repeatedly mocked. Who can forget Dr. Heidi Cullen of the Weather Channel. She was on every week. I don't think she is on anymore; I haven't seen her in quite some time. She was the one who said, in 2007, that the American Meteorological Society should revoke its seal of approval for any television weatherman who expresses skepticism that human activity is creating a climate catastrophe.

She said:

> If a meteorologist can't speak to the fundamental science of climate change, then maybe the AMS shouldn't give them the seal of approval.

This is what she wrote in December 21 in a blog on the Weather Channel:

> It's like allowing a meteorologist to go on air and say that hurricanes rotate clockwise and tsunamis are caused by the weather. It's not a political statement . . . it's just an incorrect statement.

Of course there was Robert Kennedy, Jr., also in 2007, who called anyone who didn't agree with his views on global

warming ''traitors.'' He spoke before a liberal group called the Live Earth Concert in July of 2007. He stated, Robert Kennedy, Jr.:

Get rid of these rotten politicians that we have in Washington, who are nothing more than corporate toadies for companies like Exxon and Southern Company. These villainous companies that consistently put their private financial interest ahead of the interests of all of humanity. This is treason and we need to start treating them as traitors.

Al Gore, of course, said anyone who dares question the science should be equated with those who question the Moon landing.

Aside from the distasteful and derogatory ridicule by such alarmists, a major statement by a manmade-to-global-warming believer severely undercut their claims. This year one of the United Nations IPCC—let me make sure people understand this. The IPCC, Intergovernmental—this is a panel put together in the United Nations of people to try to sell the idea that manmade gases—anthropogenic gases, CO_2, methane—cause global warming. One of the U.N. scientists told more than 1,500 scientists gathered at the conference in Geneva, Switzerland: ''People will say this is global warming disappearing. I am not one of the skeptics. However, we have to ask the nasty question ourselves, or other people will do it.''

Remember, this quote comes from Mojib Latif, who Andrew Revkin from the New York Times describes as ''a prize-winning climate and ocean scientist from the Liebniz Institute of Marine Sciences at the University of Kiel, in Germany.''

This remarkable admission of the need to ask nasty questions comes nearly 2 years after I first pointed out these very facts on the Senate floor in my October 26 of 2007 speech on the Senate floor. This is what I said at that time. I am quoting now. I always hesitate quoting myself but it is important that we were talking about this 2 years ago. I said:

It's important to point out that the phase of global warming that started in 1979 has, itself, been halted since 1979. You can almost hear my critics skeptical of that assertion. Well, it turns out not to be an assertion but an irrefutable fact, according to the temperature data United Nations relies on. Paleoclimate scientist Dr. Bob Carter, who has testified before the United States Senate Committee on Environment and Public Works, noted on June 18 of this year: ''The accepted global average temperature statistics used by the Intergovernmental Panel on Climate Change—that's the United Nations—showed that no ground-based warming has occurred since 1998. Oddly, this 8-year-long temperature stability has occurred despite an increase over the period of time of 15 parts per million or 4 percent in the atmospheric CO_2. Second, lower atmosphere satellite-based temperature measurements, if corrected for non-greenhouse influences such as El Nino events and large volcanic eruptions, show little if any global warming since 1979, a period over which atmospheric CO_2 has increased by 55 parts per million, or 17 percent.

To try to say it is tied to CO_2 is interesting because immediately following World War II, the largest increase in the emissions of CO_2 took place starting about 1946. Yet that didn't precipitate a warming period, it precipitated a cooling period during that time.

The very people who had long called the science settled and those who went so far to say the science behind global warming was unequivocal now admitted that nasty questions must be raised. Those questions are now being raised by the media. On October 8, the BBC, the British Broadcasting Company, stunned the journalism community with an article by their climate correspondent Paul Hudson. The headline asked, ''What happened to global warming?'' Hudson wrote in that article, October 8:

This headline may come as a bit of a surprise, so too might the fact that the warmest year recorded globally was not 2008 or 2007, but [was] in 1998. But it is true. For the last 11 years we have not observed any increase in global temperatures. And our climate models did not forecast it, even though manmade carbon dioxide, the gas thought to be responsible for warming our planet, has continued to rise.

(Mr. CARDIN assumed the chair.)

Mr. INHOFE. The article continues to note the lack of global warming recently and mentions the fact that many scientists are predicting a coming global cooling.

Following the BBC, other British news outlets have run similar headlines. The UK Sunday Times wrote ''Why everything you think you know about global warming is wrong.'' This is coming from Great Britain. The Daily Mail, another major publication in Great Britain, had a headline: ''Whatever happened to global warming? How freezing temperatures are starting to shatter climate change theory.'' Australia's Herald Sun has picked up on the trend as well. Columnist Andrew Bolt, noting the turning tide of media around the world, wrote:

This is like the moment in the Emperor's New Clothes, in which the boy calls out ''but he's naked!''

Let's be clear. Some of the media were already beginning to question the consensus even before that announcement.

Television personalities were coming around as well. In April, Charles Osgood, host of ''CBS News Sunday Morning'' and a noted environmentalist, questioned global warming projections. He asked:

Right now, global warming is a given to so many, it raises the question: Could another minimum activity period on the Sun counteract, in any way, the effects of global warming?

Osgood later scolded himself for even questioning global warming before stating:

I'm sure you'll be hearing more about this solar dimming business, now that the story is out. Remember, you heard it here first . . .

Lou Dobbs, formerly with CNN, has also joined the chorus questioning the alarmists, consensus. In January, Dobbs compared the belief in manmade global warming to a religion.

He stated:

They bring this thing to a personal belief system. It's almost a religion, without any question . . .

Dobbs also criticized what he called ''crowding out of facts and objective assessment of those facts . . . there's such selective choices of data as one discusses and tries to understand the reality of the issues that make up global warming.''

In September, another dramatic announcement came from Houston Chronicle science reporter Eric Berger. He stated:

Earth seems to have at least temporarily stopped warming. If we can't have confidence in short-term prognosis for climate change, how can we have confidence in long-term?

The bright light is also fading on the U.N. IPCC. In August, the New York Times ran the headline ''Nobel Halo Fades Fast for Climate Change Panel.'' The article notes:

As the panel gears up for its next climate review, many specialists in climate science and policy, both inside and out of the network, are warning that it could quickly lose relevance unless it adjusts its methods and focus.

Weeks later, on September 23, the New York Times again acknowledged a shift in public moods and scientific evidence when it stated that the U.N. faced an ''intricate challenge: building momentum for an international climate treaty at a time when global temperatures have been relatively stable for a decade and may even drop in the next few years.''

Given the media's track record, this is hardly surprising. As I noted in my 2006 speech, the media runs hot and cold in their coverage of climate change. Quoting here, I said at the time:

Since 1895, the media has alternated between global cooling and warming scares during four separate and sometimes overlapping time periods. From 1895 until the 1930s, the media peddled the coming ice age.

Everyone is going to die. We are going to freeze to death.

From the late 1920's until the 1960's they warned of global warming. From the 1950's until the 1970's they warned again of a coming ice age. This makes modern global warming the fourth estate's fourth attempt to promote opposing climate change fears during the last 100 years. Recently, advocates of alarmism have grown increasingly desperate to try to convince the public that global warming is the greatest moral issue of a generation. Last year, the vice president of London's Royal Society sent a chilling letter to the media encouraging them to stifle the voices of scientists skeptical of climate alarmism. During the past year, the American people have been served up an unprecedented parade of environmental alarmism by

the media and entertainment industry, which link every possible weather event to global warming. The year 2006 saw many major organs of the media dismiss any pretense of balance and objectivity on climate change coverage and instead crossed squarely into global warming advocacy.

Maybe one reason the media is starting to come around is that the public is shifting as well. It is easy to sell magazines, books, and movie tickets when you have everyone eating out of your hand believing that a climate catastrophe is right around the corner. Once the audience isn't buying that story anymore, it might be time to start acknowledging the other side.

If we look at Time magazine, I remember back in 1975, Time magazine—and Newsweek of the same year—said another ice age is coming. There it is. This is 1974. This was in Time magazine. Another ice age is coming. Then you fast forward to about 3 years ago. That same Time magazine had a picture of the last polar bear in the world standing on the last ice cube and saying: Now it is global warming.

This is why the media is coming around. Polls are showing an unprecedented shift in public opinion on the science of climate change as well as cap-and-trade proposals in Congress. Only a few weeks ago, in October, Politico reported:

As the nation struggles to climb out of a recession, 45 percent rated the economy as the most important issue in deciding their vote if the congressional election were held today, followed by 21 percent who said government spending, 20 percent who chose health care reform and 9 percent who said the wars in Iraq and Afghanistan. Just 4 percent of the people said climate change was the top issue.

I can remember when that was 60 percent.

The people have caught on. You are going to see the media, if they want to sell their stuff, come back and change their position. We are seeing that now.

Economic worries also led a majority of Americans to place jump-starting the economy ahead of concerns about the environment. Even as the Obama administration is pushing for climate protection legislation, 62 percent of those polled agreed that ''economic growth should be given priority, even if the environment suffers to some extent.'' The remaining 38 percent believe that ''protection of the environment should be given priority, even at the risk of curbing economic growth.''

Further, earlier this year Gallup released a poll that found that 41 percent of the people believe global warming claims are exaggerated. What about the effect of Al Gore's climate scare campaign? The Gallup poll editor Frank Newport says he sees no evidence that Gore is winning. Newport said:

It's just not caught on, they have failed. Any measure that we look at shows Al Gore's losing at the moment. The public is just not that concerned. [. . .] Ask people to name the biggest concerns, and just 1 percent to 2 percent cite the environment. The environment doesn't show up at all, it's Al Gore's greatest frustration. We seem less concerned than more about global warming over the years . . . Despite the movies and publicity and all that, we're just not seeing it take off with the American public. And that was occurring even before the latest economic recession.

Again, further quoting Frank Newport:

As Al Gore I think would say, the greatest challenge facing humanity . . . has failed to show up in our data.

Polls have also shown that when looking at environmental issues only, climate change continually ranks dead last among concerns. This wasn't true a few years ago. This is what is taking place now. This is after all the media hype, all the hysteria.

The Gallup poll in March found global warming ranked last in the United States among environmental issues. This is just environmental issues. Air and water pollution, toxic waste, animal and plant extinctions, the loss of tropical rain forests all ranked as a greater concern than global warming.

As Gallup stated:

Since more Americans express little to no worry about global warming than say this about extinction, global warming is clearly the environmental issue of least concern to them.

These are the environmentalists.

In fact, global warming is the only issue for which more Americans say they have little to no concern than say they have a great deal of concern.

The public is also unwilling to accept legislation on climate change that would cost them money. Rasmussen found that 56 percent of Americans said they are not willing to pay any additional taxes or utility costs to fight global warming.

The clear rejection of fear and hysteria is leading many on Capitol Hill to change their tune on climate legislation. Turning away from using scare tactics, the left is now trying to sell cap and trade as clean energy legislation. Don't say climate change, don't say global warming, don't say cap and trade anymore. Say clean energy economy—that is something that sells. So if you keep renaming the same thing, maybe it will sell.

As the New York and the L.A. Times have recently reported, the White House, concerned by the lack of support for their cap-and-trade initiatives, is using poll-tested talking points to help push one of the President's biggest priorities. The New York Times caught on to these new talking points earlier this year, reporting:

The problem with global warming, some environmentalists believe, is ''global warming.'' The term turns people off, fostering images of shaggy-haired liberals, economic sacrifice and complex scientific disputes, according to extensive polling and focus group sessions conducted by ecoAmerica, a nonprofit environmental marketing and messaging firms in Washington.

The L.A. Times also reported:

Scratch ''cap and trade'' and ''global warming,'' Democratic pollsters tell Obama. They're ineffective . . . Control the language, politicians know, and you stand a better chance of controlling the debate. So the Obama administration, in its push to enact sweeping energy and healthcare policies, has begun refining the phrases it uses in an effort to shape public opinion. Words that have been vetted in focus groups and polls are seeping into the White House lexicon, while others considered too scary or confounding are falling away.

Despite his longtime work on cap and trade, Senator JOHN KERRY actually went so far as to say he didn't even know what cap and trade is, saying in September:

I don't know what ''cap and trade'' means. I don't think the average American does. This is not a cap-and-trade bill, it's a pollution reduction bill.

While Senator KERRY says he doesn't know what cap and trade is, the American public knows what it is: a massive new energy tax, plain and simple.

It has been kind of interesting to watch this change, watch the phraseology change as time has gone by. But we know this: Nothing has really changed since Kyoto. It is the same thing, cap and trade, the largest tax increase in the history of America.

Let me conclude by saying just how encouraged I am to say that the tide has turned—not is turning, it has turned. The skeptics' challenge has been heard, and I am glad to see that more and more journalists are no longer reporting the hyped fears that many want the American public to believe. Media outlets around the world are more skeptical today of manmade climate fears, and they are also more aware of the enormous cost of climate legislation. More importantly, polls are showing that the people are no longer buying the hype either.

The bottom line is that efforts to pass the largest tax increase in America's history have clearly failed, handing the American people a tremendous victory.

It has been a long time, some 8 years.

I see the Senator from Vermont is very anxious to counter these things I have been saying. That is perfectly all right. That is one thing about this body—you have the opportunity to do that. There is no one I consider a better friend than the person presiding right now, from Maryland. He and I were elected together many years ago to the House of Representatives. We disagree on this issue.

What I am reporting here is science, and the people have come to an agreement. After 8 years, the truth finally does come out.

Winston Churchill said: Truth is incontrovertible. Ignorance may prevent it. Panic may resent it. Malice may destroy it. But there it is.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

HEALTH CARE REFORM

Mr. SANDERS. Mr. President, I do disagree with my friend from Oklahoma very much, but that disagreement will have to wait for another day because today I want to deal with another crisis, and that is the situation regarding health care.

I come to the floor to urge my fellow Senators to go forward in passing the strongest possible piece of health care reform legislation—legislation which is comprehensive, covering all basic health care needs; legislation that is universal, covering every man, woman, and child in our country; and legislation, importantly, that is cost effective both for individuals and for our Nation.

I think all of us understand the United States today is in the midst of a major health care crisis. Mr. President, 46 million Americans have no health insurance and, importantly, even more are underinsured with large copayments and deductibles. We have heard some of our rightwing friends talk about death panels. Let me tell you about the reality of a real death panel, not a phony death panel, and that is, this year in the United States, according to Harvard University, some 45,000 Americans will die because they lack health insurance and they do not get to a doctor when they should.

Mr. President, 45,000 will die this year. And if we do not take action, 45,000 or more will die next year. This is the United States of America. To see tens of thousands of our fellow country people dying because they do not have access to a doctor is an abomination, it is not acceptable, and that needs to change.

Among many other reforms we need to bring about as we go forward with health care reform is a revolution in terms of primary health care. Today, 60 million Americans, including many with health insurance, do not have access to a doctor. The result of that is, when they get sick, they go to the emergency room, at great cost, or they delay getting health care, and they end up in the hospital being treated for a far more serious illness than they would have had if they were treated initially. Clearly, this is an absurdity. It costs us lives. It costs us money. We have to change that.

I am very happy to say that in that regard I have introduced legislation that has 25 cosponsors in the Senate and which has been incorporated into the Health, Education, Labor, and Pensions bill, which would quadruple—quadruple—the number of federally qualified community health centers in our country over a 6-year period, which would mean there would be a community health center providing excellent quality health care, dental care, mental health counseling, low-cost prescription drugs in every underserved area in the country. We go from about 1,300 centers to 5,200 centers.

Also in this bill, we would increase by 10 times the amount of money for the National Health Service Corps so we can provide debt forgiveness for those people in medical school who want to practice primary health care, which in Vermont and around this country is a desperate, desperate need. We absolutely need to increase the number of primary health care physicians we have.

When we talk about health care reform, we also have to include dental care. Dental care is often sometimes pushed aside. But I can tell you, in many regions of this country, people are finding it virtually impossible to gain access to a dentist and, oftentimes, they simply cannot afford the dental care they need. So when we talk about health care, we have to include dental care in that.

Furthermore, when we are talking about health care reform, it is absolutely imperative we begin to address the fact that in the United States of America we spend far more on prescription drugs than do people of any other country. This is not just a financial issue for the individual; this is a health care issue. I have talked to physicians who tell me—and I think this is common not just in Vermont but all over the country—that some 25 to 35 percent of their patients do not fill the prescription the doctor writes because they cannot afford to do that. So what sense is it when somebody goes to the doctor that the doctor writes out a prescription but that individual cannot afford to fill that prescription? We need to deal with the high cost of prescription drugs, and we can do that in several ways.

No. 1, when I was in the House, I was the first Member of Congress to take American citizens over the Canadian border to purchase prescription drugs there that cost a fraction of what they cost in the United States. So we need to pass what is called reimportation—the right of Americans and the right of people who manage prescription drugs, who are in that business, to be able to purchase safe, FDA-approved medicine from abroad at a fraction of the price the drug companies are selling those products to them in this country. That will lower the cost of prescription drugs for all Americans.

Second of all, we, obviously, have to negotiate prescription drug prices under Medicare Part D. When we do that—and we lower the cost that Medicare is paying—we can end the doughnut hole which is now causing so many problems for senior citizens today who go above the first part, where Medicare is paying about $2,500, and then they have to pay 100 percent of the cost, which is hurting a whole lot of seniors.

Thirdly, we must deal with the biologics issue. My colleague Senator SHERROD BROWN of Ohio has been strong on this issue, so that we stop drug companies from having exclusivity for 12 years, preventing generic companies from getting into the market and lowering the cost of biologics. That is a very important issue.

Any serious health care reform legislation must include strong cost containment. Insurers have increased premiums 87 percent over the past 6 years, while premiums have doubled over the last 9 years—increasing four times faster than wages. If present trends continue, health insurance premiums will double over the next 8 years, which will be a disaster for millions of Americans and, in fact, for our entire economy.

Today, the United States spends far more per capita for health care than any other country on Earth. That is a very important point for us to understand. We are now spending over $7,000 per person, and yet despite spending almost twice as much as any other industrialized country, our outcome in terms of infant mortality, in terms of life expectancy, in terms of immunization and preventable deaths, is often behind other countries. So we are spending huge amounts of money; we are not getting value for what we are spending.

The cost of health care in this country is now 16 percent of our GDP, and it continues to soar at a rate that is basically unsustainable. So this is not, again, just an issue for individuals. This is an issue for our economy and our Nation.

If you look at a company such as General Motors—General Motors which went bankrupt—they were spending more money on health care per automobile than they were on steel. Small business owners in Vermont and across this country are finding it harder and harder not only to provide decent health care coverage for their workers, but in many instances they cannot even provide health care to themselves. What ends up happening is, instead of investing their profits into expanding their businesses and creating more jobs, all of that money is going into the soaring health care costs.

But when we talk about the personal impact of our disastrous health care system on individuals, there is no better example than looking at bankruptcy. In this country today, we have approximately 1 million Americans who are going bankrupt because of medically related costs. It is not hard to understand why: You lose your job in the midst of a severe recession. Somebody in your family becomes very ill. Well, how do you come up with the money if you do not have any health insurance, or even if you do have an inadequate health insurance program? The answer is, you go bankrupt. So, incredible as it may sound, close to a

million people in this country this year are going bankrupt because of medically related illnesses.

I have talked a little bit about some of the problems that are out there—and there are many more. What is the answer? I do not think anyone has a perfect answer. But I do think the United States should be looking at other countries around the world. Why do we end up spending so much and get relatively poor value for what we are spending? When we do that, when we look at countries throughout Europe, Scandinavia, Canada, and so forth, I think it leads one to the conclusion that if we are serious about providing quality, affordable care to all Americans, in a cost-effective way, then we must move toward what many of us call a Medicare-for-all single-payer program.

I understand, as I think many people do, that because of the power of the insurance companies and the drug companies and the medical equipment suppliers, because of their campaign contributions, because of their lobbying, the truth is, a single-payer program has never been on the table from day one since this whole discussion began. I think that is very unfortunate. It is doubly unfortunate because we have many thousands of physicians in this country, including the 16,000 members of Physicians for a National Health Program, and other health care providers, the largest nurses union in this country, in support of a single-payer system. Millions of Americans want us to move that way. But because of big money interests, that discussion does not even begin to get to the floor.

Well, I intend during the course of the debate to offer an amendment on a national single-payer system. We will see how many votes we get. But what I am also trying to do is give States flexibility so that, if they so choose, they can move forward with a single-payer approach. My guess is that if one State does it—whether it is Vermont, California, Pennsylvania—whichever that State may be, if it works well, if everybody in that State has good quality health care, in a cost-effective way, it will spread all over the country. I intend to do my best to see that language is in the bill, which will allow States to do just that.

A single-payer national health insurance program is a system in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private. This is not a government health care program. It is not what they do in the United Kingdom. It is public insurance privately delivered.

The reason we spend more—and this is an issue that has gotten amazingly little discussion—why do we end up spending almost twice as much as any other country? Well, I think that is a good question to ask. I do not hear a whole lot of answers. The reason is we have a patchwork system of for-profit payers. We have private insurance. What is the function of a private insurance company?

Everybody in America understands the function of a private insurance company is not to provide health care, it is to make money. What we end up with are 1,300 private insurance companies, with thousands of separate systems, each geared to a different group, each geared to make as much money as it possibly can. The result is we as a nation are spending about 30 cents of every $1 not on doctors and medicine and nurses; we are spending it on administration and bureaucracy, huge profits, advertising, billing, sales, marketing—you name it; we spend it—rather than spending it actually on trying to keep people healthy or make them well.

Single-payer financing is the most significant way I know to end the waste and bureaucracy of the current system. What the studies suggest is if we move toward a single-payer system, we would save over $350 billion every single year, getting rid of all of that bureaucracy, that waste—the paper shuffling that has nothing to do with making people well.

Under a single-payer system, all Americans would be covered for all medically necessary services, including doctor, hospital, long-term care, mental health, dental, vision, prescription drug, and medical supply costs. In other words, unlike anything else I have been hearing, it would be comprehensive: all of your basic health care needs. Patients, of course, would remain free to choose the doctor and hospital they would want, and doctors would retain autonomy over patient care, which often is not happening today as they have to argue with insurance companies as to what kind of therapies they can prescribe. Physicians would be paid fee-for-service according to a negotiated formulary or receive salary from a hospital or nonprofit HMO group practice. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards. A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and businesses. Costs will be controlled through negotiated fees, global budgeting, and bulk purchasing.

Well, that is where, in my view, we should be going. That is not where we will go. As I said earlier, that approach is anathema to the insurance companies, the drug companies, the medical equipment suppliers, all of the big money interests, and they have, unfortunately, enormous power over what goes on in Congress, so we are not going to go there.

Let me say a few words about where we are going. Obviously, we are in the middle of that right now. Last week the House came forward with their bill. Majority Leader REID is now trying to meld the two bills in the Senate from the HELP Committee and from the Finance Committee, and we expect that new legislation will be out very shortly. I have not seen it; I don't know if anybody has. Let me express a few words of concern about what I have seen in the discussion and the legislation that has been passed in the House.

First of all, the average American is saying—I get this in Vermont every day, and I am sure the Presiding Officer gets it in Maryland every day—all right, hey, good, health care reform. That is great. What is it going to cost me? What do I get? How much am I going to have to pay, and what do I get for what I pay? That is the question on the minds of millions of Americans.

The answer is, at this point—and, again, we have not seen Senator REID's bill which will be out almost momentarily, but let me just tell my colleagues about what was in the Senate Finance Committee bill so everybody has a sense of what we are talking about.

Under the Finance Committee bill—and that is going to change; whether it goes up or down, I don't know, but it will change—a family of four in Vermont earning $44,000 a year, which is not an unusual sum in my State, would pay about $3,087 in annual premiums, while the Federal Government would pick up the rest of the total of $14,700 in premiums. In a year with high medical expenses—in other words, somebody gets ill, somebody has an accident and ends up in the hospital for 3 weeks—that family would pay up to $5,800 out of pocket. So you have premiums of $3,087, out-of-pocket costs of $5,800. That is a total potential payment in premiums and out-of-pocket expenses of $8,887 for health care under the Finance Committee's bill. This would be about 31 percent of the net income, aftertax income, of a family in Vermont, and I don't know that Vermont is any different than Maryland or any other State earning $44,000—31 percent.

Somebody could tell us that is health care reform, but I really don't see it. Asking people in this country who, admittedly, have had a tough year with illness to pay 31 percent, and then say, hey, we passed health care reform, that, frankly, is not good enough for me, and I am going to do everything I can to make sure the final product out of the Senate is a lot better than that for ordinary middle-class families.

The second issue that concerns me as we proceed down the line in terms of this health care debate is the issue of public option. I think there is a lot of confusion about what a public option is, but let me say this: My belief is the

vast majority of the American people want to have a choice as to whether they stay in a private insurance company or whether they go into a Medicare-type public option which is funded by premiums. It is not Medicare; it is funded by premiums. But there are large numbers of Americans, for right reasons—I agree with them—who do not trust private insurance companies because they understand that a private insurance company wants to make as much money as possible off of their premiums. They would like the choice of looking at and maybe going into a public option. My view is we should make that choice available to as many people as possible.

I have the sad thought that many folks out there are hearing us talking about a public option saying: Hey, that is great. I am going to have a choice. I don't like my employer-based health care. Now I am going to have a public option. That is great.

Let me break the bad news to you if that is what you believe. That is not the case as it now stands. Relatively few people—people who are currently uninsured; small, very small, businesses; people who today get their insurance companies privately for themselves or their families; the self-employed, those are the people for whom a public option is currently available based on what has been passed. I think that is wrong. I think we need to expand it. Frankly, I think virtually every American should have that choice.

There is the great debate: Should Members of Congress have the public option as our rightwing friends talk about? Yes, we should. And if the public option is better than Blue Cross Blue Shield or private insurance companies, many of us would take it. But as does everybody else, we deserve the option. That is what it is, an option. If you like private insurance, it is working well for you, stay with it. If you like the public option because it is better for you, you go with it. Let's give as many Americans the choice, not 2 or 3 percent but the vast majority of the people in our country who are now in private insurance.

That takes us to another issue because, in the midst of a bill which is very complicated—and I am not a great fan of complicated. I think when you have a bill that is 1,900 pages, that just begs for the big money interests and the special interests to get their little things in it, and I worry about that a whole lot. This is much too complicated, but there it is. I think the House bill is 1,900 pages. But when we talk about opening the public option for more Americans, it means to say you have to open the exchange, the gateway for more Americans. The gateway means if you choose either your private insurance company or a public option, you are going to get subsidized by the Federal Government. Right now, as this bill stands, there are many people stuck in bad private insurance plans.

Maybe you work for Wal-Mart, maybe you work for Dunkin' Donuts, maybe you work for McDonald's, and they are offering you some kind of insurance program which either costs a fortune or doesn't cover very much. Well, under the current legislation, up to now at least, you are stuck with that. That is what you have. That is not health care reform, to be stuck in a bad Wal-Mart plan. We have to do better than that. So we want to expand that gateway for more people.

The other question is—I don't know what Majority Leader REID's bill is going to end up costing, but the estimates are that we are looking at about, over a 10-year period, $800 billion to $1 trillion. Well, the simple question is, Where is the money coming from? Where is the money coming from?

There are some people who have said: Well, maybe we want to tax good, strong insurance programs out there. That is the way to go. Well, not for this Senator, it is not, and I will do everything I can to oppose any movement in that direction. Workers have fought, in many cases, long and hard—given up wage increases—in order to get decent health insurance programs for their families, and now we are going to tax them? Not me. I am not going to do that. This country has the most unequal distribution of income and wealth. The rich are getting much richer while the middle class is shrinking.

I think it is fair as we move forward in health care reform to ask the wealthiest people in this country to start paying their fair share of taxes.

There is another issue which is kind of a local issue, I admit, and that is on the impact on early-acting States in terms of Medicaid reimbursements. It was just in the newspapers today—and I am very proud of this—that for whatever it is worth, according to some group, the State of Vermont is now the healthiest State in the country. What that tells me and what I know for a fact is that Vermont, which is not a wealthy State, has said we are going to take care of our kids. We are going to make sure that as many kids as possible are involved in what we call our SCHIP program. It is called Dr. Dinosaur. It is a very good, popular program. We are going to have other public health insurance programs. We are going to do the best we can.

I am proud that today Vermont was acknowledged to be perhaps the healthiest State in the country. I am not going to sit by idly while Vermont and Massachusetts—another State that has taken major steps forward—are penalized because we have made reimbursement rates. Because we have done the right thing is not a reason to penalize us. I am all for helping out States that have not done the right thing, but we should not and will not penalize States that have done the right thing.

So let me conclude by saying this: This country faces a major crisis in health care. Because of the power of big money, we are not going to do the right thing and pass a Medicare-for-all, single-payer approach, which is the only way to provide quality, affordable, cost-effective health care for all Americans. What we are now looking at is a 1,900-page bill which is enormously complicated which clearly has been heavily influenced by the drug companies, by the insurance companies, and by every other special interest that is making billions off of health care.

I think it is very important as we proceed down this path to take a very hard look at the end of the day as to what this bill will mean for middle-class families, for working-class families, and for the financial stability of our country as a whole. I am going to do everything I can to make sure this bill is something worth voting for—worth voting for.

So with that, I thank the Chair for the indulgence, and I yield the floor.

Mr. COBURN. Mr. President, I seek recognition to speak on the nomination of Judge Hamilton.

The PRESIDING OFFICER (Mr. MERKLEY). Without objection, it is so ordered.

NOMINATION OF JUDGE DAVID HAMILTON

Mr. COBURN. I come to the floor—I am a member of the Judiciary Committee—to raise significant concerns about this nominee. There is no question he is a fine man. There is no question he has a lot of experience, a great education. But there is also no question in my mind that he is a highly activist Federal judge who will be promoted to a level of making final determinations on most of the decisions that come before him and his circuit.

He does have a distinguished history, but his history is complicated by, in my opinion, a view that it doesn't matter what the Congress says; that it doesn't actually matter what precedent says; it doesn't matter what stare decisis, the precedent of the Supreme Court, says; he believes he can rule against that.

After attending his hearings, I would note there were over 10,000 pages of decisions and his vote on the committee was well before we could actually consider all 10,000 pages of decisions. He was voted out of our committee.

I want to raise in detail some of my problems and then give some case histories to back them up. For example, I asked Judge Hamilton whether he thought it was appropriate for a judge to consider foreign law when interpreting the Constitution. Rather than

recognize the court should not be looking to foreign law when interpreting our Constitution, Judge Hamilton used an analogy of judges considering law review articles of American lawyers with consulting decisions of foreign courts. He stated:

[C]ourts . . . will look to guidance from wise commentators from many places—professors from law schools, experts in a particular field who have written about it. And in recent years, the Supreme Court has started to look at some courts from other countries where members of the Court may believe that there is some wisdom to be gained. As long as it is confined to something similar to citing law professors' articles, I do not have a problem with that.

I have serious concerns with that. Let me put out what those are. What he fails to recognize when he equates the two is that professors who are writing on American law in American journals are writing about the interpretation of our Constitution based on American statutes and American values. They begin their analysis with an understanding of the creation of our Constitution by our Founders and our system of limited government.

When American courts look to foreign law, they are considering opinions and wisdom of people who do not share our values and who are unfamiliar with American statutes and constitutional interpretations. By conflating the two types of references, Judge Hamilton tries to minimize the damage courts can inflict on our Constitution when they look to foreign courts for guidance.

I was even more disturbed by Judge Hamilton's answers to my written questions following his hearing. In his responses, Judge Hamilton embraced President Obama's empathy standard, writing that empathy was ''important in fulfilling [the judicial] oath.''

As a matter of fact, Supreme Court Justice Sotomayor cited just the opposite. What she said was that she looks at facts, not empathy. She rejected the empathy standard.

He also explained why he believed he fit this standard and emphasized his effects-based approach, stating:

Because I will continue to do my best to follow the law, to treat all parties who come before me with respect and dignity, and to understand how legal rules or decisions will affect behavior and incentives for different people and different institutions.

That is nowhere in the oath of a judge. Nowhere is that. Considering the consequences of his ruling and how that might affect people should not be part of the decisionmaking, in making the ruling.

These statements following his hearing only confirmed what I feared prior to his hearing: that Judge Hamilton embraces a liberal activist philosophy and has implemented that philosophy in his legal decisions.

As evidence of his activist tendencies on the bench, I will turn now to some of his opinions as a district court judge that illustrate his propensity to allow his personal biases to influence his decision. In the case of Women's Choice v. Newman, Judge Hamilton succeeded in blocking the enforcement of a valid Indiana law for informed consent for 7 years—7 years. The law required doctors to give certain medical information to women in person before an abortion could be performed and required a waiting period before an abortion was performed.

There is already precedent, clearly by Casey, in the Supreme Court. When overturning Judge Hamilton's ruling, the Seventh Circuit harshly criticized his decision by stating:

[F]or seven years, Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the Fifth Circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey . . . Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own consequences.

That is a harsh review.

Further, Judge Coffee, in his concurring opinion in this case, was even more critical of Judge Hamilton's opinion, and he specifically criticized Hamilton's reliance on one study which was conducted by the Planned Parenthood-affiliated Guttmacher Institute.

Here is what he said about Judge Hamilton's decision:

[His decision] invades the legitimate province of the legislative and executive branches.

That is the problem with judicial activists. They see no limits. They take a personal bias, and they use that bias rather than interpreting the statutes and looking at precedent. They make their own decision. For 7 years Indiana was without a duly-passed statute passed by the elected representatives of that State, in error, because Judge Hamilton believed something different.

He didn't rely on precedent. He relied on his personal bias, a strong personal bias that said that wasn't right, when all the other courts had recognized the precedent by Casey.

Here is what Judge Coffee also said:

As a result, literally thousands of Indiana women have undergone abortions since 1995 without having had the benefit of receiving the necessary information to ensure that their choice is premised upon the wealth of information available to make a well-informed and educated life-or-death decision. I remain convinced that [Judge Hamilton] abused his discretion when depriving the sovereign State of Indiana of its lawful right to enforce the statute before us. I can only hope that the number of women in Indiana who may have been harmed by the judge's decision is but few in number.

As the Seventh Circuit properly notes, as a result of his activism, Judge Hamilton effectively prevented the people of Indiana from enforcing a duly enacted, reasonable restriction on abortion in violation of existing law and Supreme Court precedent.

In two other cases, Judge Hamilton succeeded in excluding traditional religious expression from the public square. In the case of Hinrichs v. Bosma, Judge Hamilton prohibited prayers in the Indiana State Legislature that mentioned Jesus Christ while allowing those that mentioned Allah. The Seventh Circuit reversed that decision.

In another case, Grossbaum v. Indianapolis-Marion County Building Authority, Judge Hamilton's decision prohibited a rabbi from placing a menorah in a public building. A unanimous Seventh Circuit court panel reversed Judge Hamilton's ruling and noted that he had ignored two Supreme Court cases that were directly on point.

Why would a learned judge ignore precedent? There is only one reason for ignoring precedent, and that is a judicial activist bias that he does not have to follow the law; that he is not limited by the Constitution, but he is limited to his personal feelings and his personal beliefs. That is the exact opposite of what we want in terms of neutrality of those directing court proceedings.

Judge Hamilton's record also suggests he is empathetic toward criminal defendants rather than the victims of crimes. According to the Almanac of the Federal Judiciary, local practitioners have said Judge Hamilton ''is the most lenient of any judge in the district. . . .''

''He is one of the more liberal judges in the district.''

''He leans towards the defense.''

''He is your best chance for downward departures.''

''In sentencing, he tends to be very empathetic to the downtrodden or those who commit crimes due to poverty.''

Blind justice doesn't recognize wealth when you commit a crime. It doesn't recognize wealth. If, in fact, that were the case, we should have more severe penalties for people who have greater means. But, instead, we treat everybody the same under the law.

I believe his judicial record confirms the statements of these local practitioners. For example, in the case of United States v. Woolsey, Judge Hamilton ignored the prior conviction of a defendant in order to avoid imposing a life sentence and was reversed by the Seventh Circuit. He ignored a prior conviction. He chose to ignore it. Activist, not following the law, not following the Code of Judicial Conduct. You do not get the choice to ignore it. It is a breach of his judicial oath. Yet he does it.

Here is what the Seventh Circuit said as they criticized Judge Hamilton's decision:

[The] Indiana district court was not free to ignore Woolsey's earlier conviction . . . we

have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court deems them unwise or an inappropriate response to repeat drug offenders.

In yet another case demonstrating his empathy toward criminals, Judge Hamilton took the unusual step of issuing a separate written order of judgment and conviction ''so that it may be of assistance in the event of an application for executive clemency'' because he believed the 15-year mandatory sentence he was forced to impose on a child pornographer was too harsh.

In this case, U.S. v. Rinehart, the defendant, a police officer, pled guilty to two counts of producing child pornography after he took pictures of a 16-year-old girl engaged in ''sexually explicit conduct'' and took videos of himself and a 17-year-old girl engaging in sexual relations. These images ended up on his home computer, and he was charged under the Child Protection Act of 1984.

In a separate written order of judgment, Judge Hamilton concluded by stating his personal views in this case and urging executive clemency. He is stating his personal views in this case, in other words, not that of a judge. He has stepped out of being a judge. Now, using the role of a judge, he is using his personal views to influence clemency. Here is what he said:

This case, involving sexual activity with victims who were 16 and 17 years old and who could and did legally consent to the sexual activity, is very different. But because of the mandatory minimum sentence of 15 years required by 18 U.S.C., 2251(e), this court could not impose a just sentence in this case. The only way that Rinehart's punishment could be modified to become just is through an exercise of executive clemency by the President. The court hopes that will happen.

He later confirmed to us that he thought that action was appropriate. When Congress passed the Child Protection Act of 1984, at issue in this case, it determined that in order to strengthen Federal child pornography laws, a child is defined as someone under the age of 18. So what did Judge Hamilton do? He said what we say doesn't make any difference. The fact that the legislative body signed it, and it was put into law by the executive branch—he didn't think that counted because he didn't agree with it. So he went outside of it to try to get clemency based on him thinking we were wrong. He didn't have any basis of law to do it, but then did it anyway.

In our constitutional system of government the power to create legislation is assigned to the Congress and a judge must simply interpret the law as it is written. This judge refused to do that.

When a judge second-guesses Congress, criticizes its legislative decisions as being unfair, and invites a grant of clemency, he undermines the rule of law and the confidence the American people have in their government. Judge Hamilton's action in this case belies his tendency to empathize with criminal defendants.

These are just a few of the statements and opinions in Judge Hamilton's record that form the basis of my opposition. I believe he is an activist jurist. He has shown that he will allow his personal biases and prejudices to affect the outcome of cases before him. I do not believe he deserves a promotion to the Seventh Circuit where he will be even less constrained by precedent and the possibility of a reversal on appeal.

I will be voting against his confirmation, and I believe the people of this country should be very wary of other judges who have an activist bent, who disrespect the rule of law, who believe they do not have to look at precedent, who, because their personal bias is different than what the law says, believe they can be in a position to effect change in the law rather than have it come through, or all the way to the court, to do that.

The job of the judge is to interpret the law and the facts carefully. This judge does not do that.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

The PRESIDING OFFICER (Ms. STABENOW). The distinguished assistant majority leader.

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

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

Mr. DURBIN. I rise to speak in support of the nomination of David Hamilton, who is President Obama's nominee to serve on the U.S. Court of Appeals for the seventh Circuit.

This appellate court has jurisdiction over three states, including my home State of Illinois. Because the Supreme Court takes so few cases these days, the circuit courts have the final word in 99 percent of Federal cases. In other words, the buck stops with the Seventh Circuit for the vast majority of my constituents when they have a legal grievance.

Yesterday, we had to have a cloture vote on the Hamilton nomination because a majority of Republican Senators wanted to filibuster it. Three-quarters of the Republican caucus voted to filibuster Judge Hamilton. That is astonishing.

Judge Hamilton is a moderate, mainstream judge who has earned an outstanding reputation during his 15 years of service on the Federal district court. He has strong bipartisan support, including the support of Republican Senator RICHARD LUGAR.

Another reason I was surprised to see the filibuster attempt is because, during the Bush administration, Senate Republicans made speech after speech about their fervent belief that every judicial nominee deserved an up or down vote on the Senate floor. If I had a dollar for every time a Republican Senator advocated for this position, I would be a wealthy man.

This was such an article of faith among the Senate Republicans during the Bush years that they tried to change the rules of the Senate to ban the filibuster of judicial nominees and to require up or down votes. This was called the ''nuclear option'' and the Senate spent days and weeks debating this issue. Thankfully, a handful of courageous Republican Senators opposed it, and this cynical effort was defeated.

We are today seeing a complete double standard when it comes to the way some of my Republican colleagues are treating judicial nominations. When President Bush was in office, they wanted to rubberstamp every nomination. Now that the tables have turned and we have a Democratic President, we have seen unprecedented obstructionism from the Republican side.

Under President Bush, over half of his judicial nominees were confirmed by voice vote or unanimous consent. The Democrats consented to their confirmation without requiring time being spent on a rollcall vote on the Senate floor. The Republicans, by contrast, haven't agreed to a voice vote or unanimous consent on a single one of President Obama's judicial nominees.

In addition, many of the Bush nominees were confirmed within days of being approved by the Judiciary Committee. The average circuit court nominee under President Bush was confirmed just 29 days after being voted out of the Judiciary Committee. By contrast, the average Obama circuit court nominee has had to wait 141 days between the committee vote and confirmation. President Obama's circuit court nominees have had to wait five times longer than President Bush's nominees for a vote.

As a result, the Republicans have ground the judicial nomination process almost to a halt. They have agreed to votes on only seven of President Obama's judicial nominees.

Let's compare this confirmation rate with the number of judges who were confirmed by Thanksgiving under past Presidents. Under President Bush, there were 18 judges confirmed by Thanksgiving. Under President Clinton, there were 28. Under the first President Bush, there were 15. Under President Reagan, there were 29, and under President Carter there were 26. President Obama has had only 7 judges confirmed—due to Republican stalling tactics.

The Republican obstructionism isn't limited to President Obama's judicial nominations. As of today, they are

holding up 40 different nominations, including 10 judicial nominees and 30 executive branch nominees. The vast majority of these nominees are non-controversial. They were passed with unanimous support in the Senate committee of jurisdiction.

Many of the individuals who are being held up by Senate Republicans have been nominated for important administration positions and long-vacant Federal judgeships. Without Senate confirmation of these nominees, many Americans will see delays in their ability to seek justice in our courts, and delays in the ability of the Obama administration to tackle some of our most pressing national problems.

Unlike many of the judicial nominees sent up by President Bush, the current President has bent over backwards to identify consensus nominees—like Judge David Hamilton—who have bipartisan support. Many of President Bush's judicial nominees, by contrast, did not have bipartisan support or home-State Senator support. With many of President Bush's nominees, it was clear that the Bush White House wanted to pick a fight, rather than a judge.

President Obama is a breath of fresh air. Every single one of his judicial nominees has the support of their home State Senators, be they Democrats or Republicans.

Senator LUGAR—a conservative Republican from Indiana—came to the Senate floor this week and made a strong and compelling case for Judge Hamilton's confirmation. When he introduced Judge Hamilton to the Senate Judiciary Committee in April, Senator LUGAR said the following:

> I believe our confirmation decisions should not be based on partisan considerations, much less on how we hope or predict a given judicial nominee will "vote" on particular issues of public moment or controversy. I have instead tried to evaluate judicial candidates on whether they have the requisite intellect, experience, character and temperament that Americans deserve from their judges, and also on whether they indeed appreciate the vital, and yet vitally limited, role of the Federal judiciary faithfully to interpret and apply our laws, rather than seeking to impose their own policy views. I support Judge Hamilton's nomination, and do so enthusiastically, because he is superbly qualified.

I hope my colleagues across the aisle will keep these words in mind when they vote on the Hamilton nomination.

Is Senator LUGAR the only Republican in Indiana who supports Judge Hamilton? No. Another prominent Republican supporter is the president of the Indiana Federalist Society: Geoffrey Slaughter. The Federalist Society is an organization of ultraconservative lawyers, and they don't typically support Obama nominees. But the Indiana Federalist Society president has said:

> I regard Judge Hamilton as an excellent jurist with a first-rate intellect. He is unfailingly polite to lawyers. He asks tough questions to both sides, and he is very smart. His judicial philosophy is left of center, but well within the mainstream.

Does that sound like the type of judicial nominee who should be filibustered?

The critics of Judge Hamilton have singled out a handful of decisions in his 15 years on the bench and 8,000 cases. Senator LUGAR has done an excellent job explaining why Judge Hamilton's rulings were sensible and defendable.

The Hamilton nomination has been pending on the Senate floor for nearly 6 months. Enough is enough.

NOMINATION OF MARY L. SMITH

Madam President, I would also like to discuss another nominee whom the Republicans have been stalling: Mary L. Smith. She is President Obama's nominee to be the Assistant Attorney General for the Tax Division at the Justice Department. Mary is from my home State of Illinois, and Senate Republicans have been holding up her nomination for over 5 months.

Mary Smith is a highly qualified nominee who has had a distinguished 18-year legal career. After graduating from the University of Chicago law school, she clerked for a prestigious Federal judge and then litigated at a large Chicago law firm. She then worked as a trial attorney in the Justice Department's Civil Division and as a lawyer in the Clinton White House.

Mary returned to private practice and joined the international law firm of Skadden, Arps, Slate, Meagher & Flom, where she focused on business litigation. After 4 years at Skadden, she went to work at Tyco International, where she managed what has been called the most complex securities class action litigation in history.

Mary has also been deeply devoted to pro bono work and public service, which really tells the story of a lawyer's dedication to the profession. She serves on many bar association boards including the Chicago Bar Foundation, which helps provide free legal services to low-income and disadvantaged individuals.

Mary Smith is not only a highly qualified nominee, she is a historic nominee. Mary is a member of the Cherokee Nation and, if confirmed, she would be the first Native American to hold the rank of Assistant Attorney General in the 140-year history of the Justice Department. She would be the highest ranking Native American in DOJ history.

I was sorry to see that when we took up Mary Smith's nomination in the Senate Judiciary Committee, the Republican members voted against her. They alleged she was unqualified for the job because she doesn't have as much tax law experience as other recent Tax Division nominees.

The Judiciary Republicans are grasping at straws with this allegation. First of all, it is an inherently subjective determination. There is no record of how much time Mary Smith has spent working on tax issues compared with previous nominees.

It is true Mary is not a traditional tax lawyer, but she has worked on tax law and tax policy issues throughout her career. During the years she worked at Tyco International, she worked closely with that company's tax department on responding to IRS subpoenas and assessing the complex tax implications of the $3 billion settlement of the Tyco securities litigation.

When she served in the Clinton White House she worked with congressional offices, the Treasury Department, and the National Economic Council to address tax disparities between Indian tribes and State governments.

And more recently, she served on President Obama's Justice Department transition team, and she helped review and analyze the Tax Division, the very office she has been nominated to lead.

The second reason the Republican allegation about Mary Smith's qualifications is off base is because Mary has more litigation, management, and Justice Department experience than previous Tax Division nominees. Those are critical qualifications to lead the Tax Division. In this respect, Mary Smith is more qualified than her predecessors.

Mary is a seasoned litigator who has had multiple trials and courtroom experience. The head of the Tax Division needs first and foremost to be a person with litigation experience, and Mary Smith fits the bill. She has been a litigator in the Justice Department, in two large law firms, and in one of the largest corporations in the country. Two of the recent Tax Division leaders—whom the Judiciary Republicans hold up as models of what it takes to lead that office—had no litigation experience and never had a single trial.

Mary is also more qualified than some of her predecessors when it comes to management experience. The Tax Division is an office with over 350 attorneys. When she worked on the Tyco litigation, Mary managed over 100 lawyers and a $50 million budget. She managed large litigation teams while working at the Skadden Arps law firm. And during her service in the White House, she helped manage and coordinate the work of multiple Federal agencies. None of the other recent Tax Division nominees had as much management experience as Mary Smith, a fact that has little value to the Judiciary Republicans who voted against her.

Mary also has more Justice Department experience than her recent predecessors. She worked in the DOJ Civil Division as a trial attorney, and she was a key member of President Obama's DOJ review team last winter. She understands the Justice Department as an institution, and the perspective of the DOJ career staff.

In short, Mary has an excellent background to lead the Tax Division. She has litigation experience, management experience, DOJ experience, and tax experience. None of the previous heads of that office had all of these qualifications combined.

One of those prior Tax Division leaders, Nathan Hochman, has come forward in support of Mary Smith's nomination. Mr. Hochman was the head of the Tax Division under President George W. Bush, so he's not exactly a partisan Democrat. Mr. Hochman wrote a letter to the Senate and said the following:

I am confident Mary will provide strong leadership for the [Tax] Division and is a good choice. . . . Mary's private practice experience in complex financial litigation gives her a working background for the type of cases litigated by the [Tax] Division.

I would suggest that President Bush's Tax Division leader has a better understanding of what it takes to lead the Tax Division than a handful of Senators.

Ted Olson is another prominent Republican who supports Mary Smith for this position. Mr. Olson is one of the most respected lawyers in America and he served as the Solicitor General at the Justice Department under President George W. Bush. He worked closely with the Tax Division and represented that office in cases before the Supreme Court.

Ted Olson wrote a letter to the Senate and called Mary Smith ''a first-rate litigator'' and ''a fine choice to be this nation's Assistant Attorney General for the Tax Division.''

The Senate has received dozens of other letters of support for Mary Smith, including many from our Nation's leading Native American leaders. They are eager for the Senate to confirm Mary so she can become the highest ranking Native American in the history of the Justice Department.

The month of November is National American Indian and Alaska Native Heritage Month. We would honor our Native American community by confirming Mary Smith this month.

I urge my Republican colleagues to stop blocking this important nomination and agree to a vote on my Illinois constituent, Mary Smith.

Mr. BUNNING. Madam President, I rise today to speak in opposition to the nomination of Judge David Hamilton for the Seventh Circuit Court of Appeals.

First of all, I would like to speak on the state of the judicial nomination process in the Senate. For several weeks now, I have listened to my colleagues on the other side of the aisle speak on this floor about so-called obstructionism by the minority regarding judicial nominations. For 214 years, the U.S. Senate enjoyed a tradition of holding fair up-or-down votes on judicial nominees regardless of the Senate's political makeup. Beginning in 2003, my colleagues on the other side of the aisle ended that tradition when they successfully filibustered 10 judicial nominations by President Bush whom they considered ''out of the mainstream.'' At the time, we insisted that this was a bad and inefficient precedent to set. However, the other side insisted on traveling down that road. Now the majority claims that if we in the minority care about the good of the country, we should just let any judicial nomination by the President sail through the Senate without any objection. I would encourage those Senators to come to my office to listen to the hundreds of Kentuckians who call and write every day in opposition to the nomination of Judge Hamilton and tell those people that they are being ''obstructionists.''

Judge Hamilton's judicial record is not only insufficient for the Seventh Circuit, it is downright scary. He prides himself on blatant judicial activism. On multiple occasions, Judge Hamilton has argued that judges have the power to change the Constitution when making court decisions. He has stated:

part of our job here as judges is to write a series of footnotes to the Constitution.

If Judge Hamilton would have properly read the Constitution, I am sure he would have realized that it explicitly says that Congress is the only branch which has the authority to make any kind of additional mark to that document.

Looking at his record, Mr. Hamilton has issued some very troubling rulings on child predators. He specifically invalidated a law that required convicted sex offenders to provide information to law enforcement agencies for tracking purposes. In another instance, Mr. Hamilton petitioned the President to grant clemency for someone guilty of producing child pornography. The Supreme Court only hears a small fraction of petitioned cases, and, in many cases, precedent is set at the circuit level. Does anyone want someone on the bench setting this kind of precedent?

Furthermore, in practicing his judicial activist point of view, Judge Hamilton struck down an Indiana law that simply required women to receive medical information on the effects of an abortion before going through the procedure. This is a commonsense law and similar laws have never been invalidated by any other judge in the country. The Seventh Circuit Court, to which Mr. Hamilton has been nominated, reversed and was harshly critical of this ruling. The Seventh Circuit reversed another outlandish ruling of Judge Hamilton's. He prohibited prayer in the Indiana House of Representatives that mentioned Jesus Christ, but inconsistently allowed prayers that mention Allah. These outline a very troubling pattern on the bench.

If any of the President's judicial nominees deserve scrutiny, Judge Hamilton is one of them. His record is clearly out of the mainstream of public opinion and he clearly is motivated to push his own political agenda. A good judge is able to set aside his or her own personal opinions when deciding cases. I do not believe that Judge Hamilton can do this. I strongly encourage my colleagues to oppose this nomination.

Mr. DODD. Madam President, I note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. I ask unanimous consent that the order for the quorum call be rescinded.

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

CREDIT CARD RATE FREEZE ACT OF 2009

Mr. DODD. Madam President, I wish to make some brief comments. I will yield to my colleague from Colorado, Senator UDALL, in a moment, and then at the conclusion of his comments I will propound a unanimous consent request. I will not do that until I know there is an objection that will be rendered, and I would certainly wait until I know that is coming. I will not, obviously, make the request until that person arrives so they can express their objection. Regretfully, I might add, they are going to express that objection, but, nonetheless, I don't want them to be worried that I would somehow try to sneak this in, knowing there is an objection to be filed.

I rise this afternoon in support of legislation that would do something that I think most Americans would support as well, regardless of where you live and what your economic circumstances may be; that is, to freeze interest rates on existing credit card balances until the full protections of the Credit Card Accountability Act we wrote earlier this year go into effect. As many of my colleagues will recall, on a vote of 90 to 5, we passed a bill early this year by a near unanimous vote because we all heard the same stories from our constituents across the country: Credit card companies charging outrageous fees; consumers finding out that the interest rates had been jacked up for no apparent reason whatsoever; families struggling to make ends meet and being driven further and further and further into debt by what I would describe as abusive practices.

On that day, on the day we passed the bill, we declared that credit card companies were unfairly padding profits at the expense of the people we work for, so we put a stop to it. Today, it is no different, unfortunately. Knowing that the Credit Card Act will finally protect consumers from these

abuses, the industry has tried to make one last grab for their customers' pocketbooks, and that is what has been going on over these past several months. I think this behavior is deplorable, to put it mildly. We can, once again, put a stop to it, and that is what I will be proposing shortly.

The legislation I rise to discuss would immediately freeze interest rates on credit cards to ensure that Americans are protected until the full provisions of that law go into effect in February. The holiday season is upon us. Hard-pressed Americans want to go out and do what they can to help their families and to celebrate at a very difficult time. Some joy—and a lot of that will have to occur, obviously, by taking a credit card out to make those purchases during the holiday season, the Thanksgiving break coming up, for putting food on the table, traveling, calling a family member, calling a friend. All those activities, to some degree, given the hardship people are feeling, will require them to use that credit card in too many cases.

To do so, of course, they are watching in this window an industry continuing to skyrocket these rates as well as these fees on people.

Let me tell my colleagues something: The reason we allowed a gap period between the passage of the legislation and the imposition of the regulations or the statutory requirements was because the industry came to me and said: Senator, we are going to need some time to administer—to change how we provide these kinds of benefits to people, so would you give us a little window here to operate. On the basis of that request, we did so. They wanted longer, but we thought February was fine. If that had been what they had done, I think most of us would say we understand that. Unfortunately, they have taken that window and used it as a way to jam in on the consumers of this country, particularly at a time when, again, people are losing their jobs, their homes, their health care, their retirement, and the holiday season is upon us.

Every 6 months, card companies will be required, under our bill, to review each account they hit with a high rate hike since January of 2009 and reduce the rate if the customer has become less of a credit risk.

As consumers, obviously, we have a responsibility to spend within our means and to pay what we owe. We bear that responsibility. But the credit card industry as well has a responsibility to deal with their customers honorably. There is nothing honorable about what has happened with these significant rate increases and fees. Most importantly, they don't have a right to rip off American families, especially when the Congress has already gone on record opposing the very actions they are engaging in and doing so in a timeframe that was given to them to adjust to the new changes that will occur under the credit card legislation. Instead of fulfilling that obligation, they are using it as a window to grab as much as they can out of the pockets of hard-pressed consumers.

So let us help consumers have a break in all this. I see my colleague from Colorado and I will yield to him for a couple minutes and when he finishes his remarks I will make a unanimous consent request that we proceed to the immediate consideration of Calendar No. 189, the Credit Card Rate Freeze Act; further, that the bill be read a third time and passed, and that a motion to reconsider be laid upon the table with no intervening action or debate. This would provide us a window of about 12 weeks—that is what it amounts to, between now and the 1st of February—during this holiday season to put a stop to these outrageous rates and fees being charged to people.

I hope my colleagues, whether you agreed with the bill—although most did; 90 colleagues voted for the bill in the spring—why wouldn't you join us today in allowing 12 weeks for a freeze on these rates that are occurring to give our fellow citizens across this country a chance to meet these obligations.

With that, I yield to my colleague from Colorado.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. UDALL of Colorado. Madam President, I rise in support of the motion that has been made by the senior Senator from Connecticut, which requests consent for the Credit Card Rate Freeze Act. I wish to associate myself with his remarks. I am a proud original cosponsor of his bill. I wish to urge, as our chairman has, our friends on the other side of the aisle to lift their holds on this important legislation.

Credit card companies have forced unfair and abusive practices on American consumers for too long. I have fought for several years and introduced a number of bills that would put an end to these practices. We passed a law this year that will level the playing field for consumers and put an end to the worst abuses by February of next year.

Let me tell my colleagues what has been happening since then. Credit card companies are using that time before the new law goes into effect to get rate and fee hikes in under the wire. It is happening at the worst time possible, as the chairman pointed out. American families are struggling in a recessionary period. The last thing our families need is higher interest rates and extra fees, especially on consumers who are already playing by the rules.

This has been a classic case of a David versus Goliath situation. I say it is time to take on Goliath and stop credit card companies from gaming the system at the expense of American consumers. This bill Chairman DODD and I are supporting would provide consumers and small businesses who play by the rules a better foundation to pay off their debts, or to buy groceries and business supplies, and most important, they should get fair treatment from the credit card companies.

This is a critically important bill for economic recovery. It is the right thing to do. I urge my friends on the other side of the aisle to join us and allow it to move forward.

Mr. DODD. Madam President, I thank my colleague for his remarks. Many others have similar views on this. I regret that there is going to be an objection filed to a measure that would have allowed us to do something meaningful for our fellow citizens at this time of the year.

Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 189, S. 1927, the Credit Card Rate Freeze Act of 2009; further, that the bill be read the third time and passed, and the motion to reconsider be laid upon the table, with no intervening action or debate.

The PRESIDING OFFICER. Is there objection?

Mr. COCHRAN. Madam President, on behalf of several Senators on this side of the aisle, I object.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mr. SCHUMER. Madam President, I am sorry there is an objection. I will yield to the Senator from New Jersey. I will take the floor after the Senator from New Jersey.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. MENENDEZ. Madam President, to my colleague from New York, Senator BENNET and I are here on a different matter. If the Senator will be brief, I am happy to wait until he finishes.

Mr. SCHUMER. I thank the Senator for his usual graciousness. I commend my colleague from Connecticut for the outstanding job he has done on this issue. I regret that the consent to move to the legislation has been blocked.

The bottom line is this: We know there are real problems in the credit card industry. We know that things are happening you would never imagine would happen. People are moving interest rates—maybe you had your balance at $4,000, 7 percent, and you know your family budget, and then it goes up to $23,000. This legislation would have stopped that.

What the banks are doing now is jumping the gun and moving things ahead in a way that is very wrong. To move up the date would simply make sure this legislation affects more people than it would have. It is a good idea. I hope we will still reconsider it later. I hope the public, who cares about this, will let all Senators from

both sides of the aisle know how important this is.

With that, I thank the Senator from Connecticut. He has been such a leader in fighting for consumers throughout this session. He deserves every American's thanks.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. MENENDEZ. Madam President, I know my colleague from Colorado, Senator BENNET, wants to speak to this issue as well. He has been a champion, along with me and several others, to try to bring justice to an issue that is incredibly important.

It is no secret that decades of indifference and discrimination in lending practices at the U.S. Department of Agriculture have made it difficult for minority farmers—specifically Hispanic farmers—to make a living at what they love to do and have done, in many cases, for generations, leaving many no choice but to leave the farms and ranches they have tended to all of their lives.

In the year 2000, 110 Hispanic farmers brought a lawsuit against the U.S. Department of Agriculture for the same egregious discriminatory practices that resulted in a historic settlement with African-American farmers. For 8 long years, under the last administration, thousands of Hispanic farmers who joined the suit waited and waited and waited for justice. Some of them died waiting and will never be made whole. For 8 long years, the Bush administration did nothing.

These hard-working farmers, Hispanic families, who bought a piece of land and built a family farm—their small piece of the American dream—were wrongly denied loans and other benefits in violation of the Equal Credit Opportunity Act by county committees that review Farm Service Administration credit and loan applications for approval. Consequently, these farmers filed suit in the hope that it would change the discriminatory practices at the USDA, how it treated America's minority farmers; but under the Bush administration, nothing changed, the discrimination continued.

Then something did change. We got a new President and a new Secretary of Agriculture, who described past practices at the U.S. Department of Agriculture as ''a conspiracy to force minority and socially disadvantaged farmers off of their land.'' Consequently, the administration committed to appropriate $1.25 billion in the fiscal 2010 budget to settle some of the outstanding discrimination lawsuits but not all of them. To date, Hispanic farmers, women, and Native Americans have not yet seen a settlement.

We need to remedy this situation once and for all. The new U.S. Department of Agriculture Secretary needs to make these farmers whole. Secretary Vilsak has created a task force to review the park and civil rights complaints and announce new efforts for the U.S. Department of Agriculture to end any and all discriminatory practices, and I commend the secretary for addressing this lingering issue. But more needs to be done.

As I said, along with seven of my colleagues, in a letter to the President, quoting from that letter, we said:

The U.S. Department of Agriculture's corrective role in this instance has been clearly laid out, and there remains no legitimate reason to delay action for any of the affected groups.

The fact is that 8 years after a do-nothing Republican administration that earned the U.S. Department of Agriculture the designation of ''the last plantation,'' putting people's lives and livelihoods at risk, we simply cannot wait any longer. Certainly, for example, Alfonso and Vera Chavez cannot wait any longer. The Fresno Bee reported last week that Mr. and Mrs. Chavez stopped farming 7 years ago when they could not get a USDA loan. In fact, they said they not only could not get the loan but they were discouraged from applying and, even worse, they believed they were given misinformation so they would not apply. To quote Vera Chavez, who told the reporter, ''It was like they didn't want us to have the money.''

Mr. and Mrs. Chavez owned 300 acres. They sold off 200 of those acres, shut down their packing house, and leased the remaining hundred acres to survive. Vera said, ''It is why we have been hanging onto those 100 acres, so my children and grandchildren can have a little piece of land we worked so hard to get. I am not going to give up. But we have written so many letters, had so many meetings, and nothing seems to be moving forward.''

We need to move this forward. It is about fairness, about doing what is right. When we see discrimination in any form, and when those who have been wronged because of their race, gender, or heritage are forced to sell what they have worked a lifetime to build—abandoned by the last administration that cared more about Wall Street than Main Street—we have to make things right for them, for people like Vera and Alfonso Chavez. We need to make sure that they can keep their farms and give them back their lives. All these farmers are asking for is a commonsense solution sooner rather than later, because they have waited long enough.

I received a letter that is addressed to the President. It is a letter from the named plaintiff in the landmark case Pigford v. Glickman. That was a case that brought together African-American farmers in that landmark decision, who were also discriminated against. The letter to the President by Mr. Pigford says, referring to Hispanic, Native-American, and women farmers:

They have suffered the same discrimination by the United States Department of Agriculture as African American farmers. Just as USDA addressed the claims of African Americans on a classwide basis, it should similarly settle the discrimination claims of Hispanic and other minority farmers on a classwide basis.

. . . Furthermore, it makes no sense for four minority groups to suffer the identical discrimination from the same federal agency and yet only one of those four groups to be compensated on a classwide basis.

It goes on to say:

Mr. President, fundamental fairness and simple practice demand that you close the entire book on all discrimination at USDA and, consistent with section 14011, ''resolve all pending claims and class actions in an expeditious and just manner.''

I ask unanimous consent to have printed in the RECORD Mr. Pigford's letter to the President.

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

NOVEMBER 18, 2009.

President BARACK H. OBAMA,
The White House,
Washington, DC.

DEAR PRESIDENT OBAMA: As the named plaintiff in the landmark case Pigford v. Glickman, I urge you to direct the Secretary of Agriculture and the Attorney General to begin immediately good faith negotiations to resolve the pending discrimination lawsuits brought on behalf of Hispanic, Native American and women farmers pursuant to Section 14011 of the Food, Conservation and Energy Act of 2008 (''2008 Farm Bill''). They have suffered the same discrimination by the United States Department of Agriculture (''USDA'') as African American farmers. Just as USDA addressed the claims of African Americans on a classwide basis, it should similarly settle the discrimination claims of Hispanic and other minority farmers on a classwide basis.

As you may be aware, between 1997 and 2000, in addition to my lawsuit, three other identical lawsuits were filed in the same courthouse: my suit on behalf of African American farmers, Keepseagle v. Glickman on behalf of Native American farmers, Garcia v. Glickman on behalf of Hispanic farmers and Love v. Glickman on behalf of women farmers.

In my case and the Keepseagle case, two different judges (Friedman and Sullivan) certified the cases as class actions on the basis of USDA's admitted failure to investigate discrimination complaints filed by African American and Native American farmers at USDA's behest. USDA failed to investigate the complaints because it had secretly dismantled its civil rights investigatory apparatus in the early days of the Reagan Administration. In the Love and Garcia cases, however, a different judge, Judge Robertson, refused to certify classes on the same basis that Judges Friedman and Sullivan had applied in my case and Keepseagle, respectively, notwithstanding the fact that the D.C. Circuit had renewed those certifications on at least three occasions and had found no fault with the certifications. Indeed, in my case, the D.C. Circuit expressly approved a settlement that has to date resulted in nearly $1 billion being paid to approximately 15,000 African American farmers.

While USDA and DOJ use the lack of class certification as an excuse to refuse to bring about a just and efficient resolution of these cases through negotiations of classwide settlements, such excuses ring particularly hollow. First, USDA and DOJ have steadfastly refused to settle the Keepseagle case despite the fact that it was certified as a class action eight years ago. Second, tens of thousands of African American farmers who missed the filing deadline to participate in the settlement in my case have filed new lawsuits pursuant to Section 14012 of the 2008 Farm Bill. While none of these cases has been certified as a class action, the government has expressed its desire to settle these on a classwide basis and you have announced your intention to appropriate an additional $1.25 billion to cover their damage claims. Third, of the four identical cases handled by three different judges, two judges have certified classes on the basis of USDA's admitted failure to investigate discrimination claims. Fourth, class certification is a procedural matter that does not address the underlying discrimination that is in fact admitted.

Secretary Dan Glickman, the original defendant in all four cases, has testified before Congress that USDA has "a long history of . . . discrimination" and that "[g]ood people . . . lost their family land not because of a bad crop, not because of a flood, but because of the color of their skin." Rosalind Gray, a former director of USDA's Office of Civil Rights, has testified that "systemic exclusion of minority farmers remains the standard operating procedure for FSA [the Farm Service Agency]."

In addition, both during his confirmation hearing and subsequently, Secretary Vilsack made strong statements expressing the administration's desire, consistent with Section 14011 of the 2008 Farm Bill, to settle all of the pending discrimination cases. Unfortunately, USDA's action have fallen short of the promises contained in Secretary Vilsack's statements. Indeed, the refusal by USDA and DOJ to entertain settlement discussions on a classwide basis is totally at odds with the clearly expressed will of Congress as expressed in Section 14011 and irreconcilable with Secretary Vilsack's repeatedly stated desire to settle all the pending lawsuits. Furthermore, it makes no sense for four minority groups to suffer the identical discrimination from the same federal agency and yet only one of the four groups to be compensated on a classwide basis. The Clinton Administration properly saw fit to order USDA and DOJ to begin negotiations with the representatives of the African American farmers when confronted with the obvious injustice in that case. In announcing last spring an additional $1.25 billion for African American farmers who missed the filing deadline in my case, you stated your hope that your action would "close a chapter" in the sorry history of USDA discrimination against minority farmers. Mr. President, fundamental fairness and simple practice demand that you close the entire book on all discrimination at USDA and, consistent with Section 14011, "resolve all pending claims and class actions in an expeditious and just manner." (Emphasis added.) The only thing standing between "an expeditious and just" resolution of these cases is the will to do it. You, sir, are in a unique position to end once and for all USDA's all-too-well deserved reputation as "the last plantation" and to bring long-overdue accountability and transparency to the USDA-administered farm credit and non-credit farm benefit programs.

Respectfully,

TIMOTHY C. PIGFORD.

Mr. MENENDEZ. We urge Secretary Vilsak to ensure all farmers will be granted the same consideration so they can begin to rebuild their lives and their farms this year. Despite clear language in section 14011 of the Food Conservation and Energy Act of 2008, which urges the administration to settle lawsuits brought by Hispanic and other farmers, the administration clearly needs to assure Hispanic farmers, many who have come to me, Senator BENNET, and others to ask for help, that it fully intends to address these cases consistent with section 14011 of the 2008 farm bill.

We simply cannot continue down this winding road to nowhere. To ignore the plight of the thousands of Hispanic farmers, families who seek nothing more than justice, who want only a chance to keep the farms and ranches they worked so hard for all of their lives, is wrong.

For 8 years, thousands of families like the Chavezes were ignored. Now we need to change that. We need to move quickly to resolve what is clearly and patently unfair and unjust. You will never turn the page on the past discriminatory practices within USDA until all victims—every last one of them—are made whole for the loss of their land, their dignity, and their hope for a decent life for themselves and their families. Let us move quickly to give them the chance they have waited for, the chance to rebuild their lives.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Colorado is recognized.

Mr. BENNET. Madam President, I am very pleased to rise today to join the Senator from New Jersey to discuss the injustices committed against Hispanic farmers over the course of many years. I also thank Senator MENENDEZ, the congressional Hispanic caucus, and my colleagues who have come to the floor to demonstrate their leadership on this issue.

For the reasons Senator MENENDEZ laid out, it is long past time to call attention to this indefensible injustice and to lend our voices to a better way forward. As is well known, for years—decades—minority farmers were systematically discriminated against when they visited local USDA farm service agency offices all across this country. They were denied loans and farm program assistance because of their skin color, ethnicity, or gender. Senator MENENDEZ did a good job describing the case.

I want to give some examples from my State, because in many cases, because of this discrimination, these farmers lost their livelihoods and their way of life. If we choose to let some of them make their case, and deny that chance to others, then we repeat these historic civil rights wrongs all over again.

Among the many letters I have received is a declaration from Mr. Gomez of Alamosa, CO, a former USDA employee who served his country for 30 years. In seven pages of excruciating detail, Mr. Gomez explains how he, as a loan officer, witnessed discrimination in granting of FSA loans. Reasons loans were denied were recorded as "insufficient experience," or other subjective terms. As Mr. Gomez gained more responsibility, he was eventually in a position to review loan applications from around the region he supervised, and he became increasingly aware of a pattern of discrimination.

In another letter, Mr. Sandoval of Antonito, CO, tells of repeatedly being turned away from local loan offices and denied FSA loans on grounds that he did not have the "character" necessary. Mr. Sandoval explains how his inability to access credit through the USDA limited his ability to grow his farming operation and become a more successful farmer.

Another Mr. Sandoval of Commerce City, CO, writes:

> This has been going on for so long that some farmers have lost their lives waiting for justice to prevail.

Mr. DeHerrera, also of Antonito, CO, writes:

> In desperation, I approached [someone] at the . . . FSA to request a loan of approximately $80,000 so I could at least keep the farm from being foreclosed. . . . He told me very hatefully that they refused to approve either my loan or the loan of the Sandoval brothers.

He continues:

> I am convinced [FSA] refused to approve the Sandoval's loan because both the buyer and the seller of the farmland to be purchased were Hispanic American farmers.

Reading through the many letters I have received from Hispanic farmers in Colorado and the meetings I have had all across my State and the letters from people all over the country, a pattern emerges—one of thinly veiled discrimination that starts by discouraging Hispanic farmers from applying for FSA loans in the first place. All too frequently, this discrimination resulted in the loss of a farm and the loss of a way of life.

I have had farmer after farmer say they had to get out of the business of farming, that they could not leave their farms to their children, which is the only dream they have in their life, because of the discrimination they suffered at the hands of our Federal Government.

President Obama's new Agriculture Secretary, Tom Vilsack, has repeatedly, much to his credit, emphasized his commitment to addressing the longstanding civil rights problems that have plagued the Department and to charting a new era. I commend the Secretary's commitment and the dedication the Obama administration has made to chart a new future for the USDA.

Yet that does not fix the wrongs of yesterday. Congress has taken some positive steps, and the administration has created a process for resolving the claims of some minority farmers, even dedicating significant funds toward this end. But a path to justice has not yet been charted for Hispanic farmers.

The best way America can send a message that our government will not discourage minorities from participating in public programs, will not discriminate against them, is proactively to pursue justice.

It is time the administration and Congress come together and do more than just acknowledge past wrong doing at the USDA. It is time to address that wrongdoing.

I will say that my predecessor in this job, Ken Salazar, our great Senator from Colorado, now our Interior Secretary, comes from a part of my State called the San Luis Valley. Ken Salazar's family settled that land long before Colorado was even a State. If you drive down there and visit San Luis, what you will see is an irrigation ditch that was dug before our State was even a State. Among the names of the people, the names of the farmers and the ranchers who were entitled to take water from that ditch because they had been there, and had been there to dig that ditch, is the name Salazar, the proud name Salazar. It is wrong, after generations of people have committed their lives and their families to agriculture in places such as Colorado and all across the country, that we have discriminated against them for decades and, when that discrimination is discovered because of some legal technicality or because they got the wrong judge, they find themselves unable to redress that discrimination.

I am very pleased to have the chance to be here today with Senator MENENDEZ and other colleagues to call this to the attention of the administration and to say that we need to do more than just acknowledge this problem. It is time for us to help address the problem.

Madam President, I yield the floor.

Mr. UDALL of Colorado. Madam President, today I join my colleagues in bringing this body's attention to an issue of fundamental fairness that continues to remain unaddressed.

More than 10 years ago, Hispanic farmers from my home State of Colorado joined other Hispanic farmers throughout the country to stand up against injustice. They chose to confront—rather than accept—discrimination when they filed their case against the U.S. Department of Agriculture on grounds that the Farm Service Agency denied loans and disaster benefits in violation of the Equal Credit Opportunity Act and the Administrative Procedure Act.

Earlier this month, I met some of these farmers in Colorado's San Luis Valley. Many of these men and women proudly trace their heritage to some of the first settlers of Colorado who were the first to till the soil of the San Luis Valley and establish Colorado's earliest farming communities, spurring the development of southern Colorado.

Now, I understand that every farmer takes on enormous risk to keep our country fed and prosperous. Yet when these farmers applied for Federal assistance intended to make them whole again—assistance intended to help family farmers stay in business—the record suggests that this aid was denied or delayed, not because their request lacked merit but because of their Hispanic heritage.

I found that shocking. It wasn't any weather event that led these men and women to financial hardship or the loss of their family farm. The obstacles they faced when applying for a loan or disaster assistance were far worse than any drought, flood, hail or windstorm they had ever confronted. It was discrimination based on their heritage that kept them from receiving timely support from an agency whose mission is to support all of America's farmers equally.

Evidence of discriminatory practices in the U.S. Department of Agriculture is an unfortunate and shameful part of our history. On several occasions, I have joined my colleagues in the Senate and in the House to express our desire to bring this disgraceful chapter to a close. During the most recent debate on America's 2008 farm bill, we affirmed that it is the sense of Congress that all pending claims and class actions brought against the Department of Agriculture by socially disadvantaged farmers or ranchers be resolved in an expeditious and just manner.

I would like to acknowledge that Secretary of Agriculture Tom Vilsack has been courageous in this matter, and I am pleased that the administration views this as a priority. I am also pleased that the Secretary has expressed his intent to ensure that no other farmers experience the same discrimination and that he will take definitive action to improve USDA's record on civil rights. I remain ready and willing to work with the administration and my colleagues to support this policy.

I want to emphasize that this is an issue of fundamental fairness. The sooner we can resolve this, the sooner we can look forward to a USDA that serves all Americans equally. It is my hope that these cases be resolved expeditiously and fairly so that the farmers and their families who have suffered the real effects of discrimination can finally put this matter to rest.

COMMENDING ROBERT C. BYRD

The PRESIDING OFFICER. The distinguished Senator from West Virginia.

Mr. ROCKEFELLER. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 354, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

S. RES. 354

Whereas, Robert C. Byrd has served for fifty-six years in the United States Congress, making him the longest serving Member of Congress in history,

Whereas, Robert C. Byrd has served over fifty years in the United States Senate, and is the longest serving Senator in history, having been elected to nine full terms;

Whereas, Robert C. Byrd has had a long and distinguished record of public service to the people of West Virginia and the United States, having held more elective offices than any other individual in the history of West Virginia, and being the only West Virginian to have served in both Houses of the West Virginia Legislature and in both Houses of the United States Congress;

Whereas, Robert C. Byrd has served in the Senate leadership as President pro tempore, Majority Leader, Majority Whip, Minority Leader, and Secretary of the Majority Conference;

Whereas, Robert C. Byrd has served on a Senate committee, the Committee on Appropriations, which he has chaired during five Congresses, longer than any other Senator;

Whereas, Robert C. Byrd is the first Senator to have authored a comprehensive history of the United States Senate;

Whereas, Robert C. Byrd has throughout his service in the Senate vigilantly defended the Constitutional prerogatives of the Congress;

Whereas, Robert C. Byrd has played an essential role in the development and enactment of an enormous body of national legislative initiatives and policy over many decades: now, therefore be it

Resolved, That the Senate recognizes and commends Robert C. Byrd, Senator from West Virginia, for his fifty-six years of exemplary service in the Congress of the United States.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. Madam President, when Senator ROBERT C. BYRD first entered the Senate in January 1959, he shared the floor with three future Presidents: Senators Lyndon Johnson, John Kennedy, and occasionally, when a tie-breaking vote was needed, Vice President Richard Nixon. Those men now belong to history, but Senator BYRD is still making history.

It is an honor to see him make history, once again, as he becomes the longest serving Member of Congress in the history of America. He has given 56 years, 10 months, and 16 days—a total of 20,744 days—of dedicated service to the Congress, to the Constitution of the United States of America, and, of course, to his beloved West Virginia. What a remarkable achievement.

Senator BYRD's masterful, four-volume history of this body is the definitive account. His own historical records could fill nearly a volume of

history for the Senate on its own. He served in Congress with—not under—11 different Presidents. Three and a half years ago, he became the longest serving Senator in our Nation's history, and he is the only Senator ever elected nine times to the Senate. He has cast more votes—18,585—than any other Senator in history. All these records are unlikely ever to be broken.

He has also presided over both the shortest session of the Senate in history—six-tenths of a second on February 27, 1989—and the longest continuous session—21 hours, 8 minutes—on March 7 and 8, 1960. He has held more leadership positions—majority whip, minority leader, majority leader, and President pro tempore—than any other Senator in history.

During the administration of President Jimmy Carter, Senator BYRD, then the majority leader of this body, was criticized by some for not doing enough to help the President of his party. Senator BYRD replied:

I am not the President's man. I am a Senate man.

He is a passionate and unyielding defender of Senate rules and prerogatives—not as an end in themselves but as a means of preserving our Constitution and our balance of power.

I will always remember his eloquent and valiant effort which he waged in 2003 to try to persuade this Senate not to grant broad war-making authority to the executive branch. He was a true study in political and moral courage and it was not missed on the population of America. When my wife and I attended church in Chicago at Old St. Patrick's, our regular parish, after the communion, as we were kneeling in our pews, an older man came by and leaned over, obviously having followed the Senate debate on the war in Iraq, and said to me in a voice that could be heard around the church: "Stick with Bob Byrd." I told Senator BYRD that story and he loved it.

It is fitting that Senator BYRD keeps a copy of the Constitution in his breast pocket because its promises and obligations are always that close to his heart. In 2001, he was named West Virginian of the Century by his Governor and legislature. Indeed, the name "Robert C. Byrd" is nearly synonymous with West Virginia.

The story of his early life is the story of struggle and great achievement. It also is a story highlighted by his marriage to his high school sweetheart Erma Ora James Byrd, a coal miner's daughter. He married her in 1937, and she was his rock for 69 years.

He never gave up on his dream of higher education, earning his law degree from American University in 1963 after attending night school for 10 years. He earned his bachelor's degree from Marshall University in 1994, at the age of 77.

He has been winning elections for 63 years, and he has never—not once—lost a race. He was elected in 1952 to the House, where he served three terms. Before that he served in the house of delegates and the senate of his home State of West Virginia. He is the only person in the State's history to carry all 55 of the State's counties—a feat he accomplished several times—and the only person in the State's history to run unopposed to the Senate of the United States.

Eleven years ago, Senator BYRD spoke about his devotion to the Senate as part of the Leader Lecture Series. He called this Senate "the anchor of the Republic, the morning and evening star in the American constitutional constellation."

He described the great panoply of men and women who have served in this body. He has said this Senate "has had its giants and its little men, its Websters and its Bilbos, its Calhouns and its McCarthys."

I would offer as well that there has only been one ROBERT C. BYRD. He is a unique patriot, a singular Senator, a Senator's Senator.

We are honored to share this historic milestone with him today. We thank him for his lifetime devotion to America, the Senate, and his beloved Constitution. West Virginia can be proud of this great man who has served them so well for so long.

I yield the floor.

Mr. NELSON of Florida. Madam President, I hope Senator BYRD may be within the reach of my voice because I wish to add my voice to the many who have commended him for his public service, especially today as we mark a milestone in the history of this Nation because our Senate colleague, our President pro tempore, becomes the longest serving Federal lawmaker since the founding of this country.

Many this week are depicting ROBERT BYRD's long list of achievements in numbers, and it is large numbers, and there are certainly many of those achievements. The Senator from West Virginia, for instance, actually began serving in the Senate the same year that Alaska became a State, 1959. He has been elected to no fewer than nine Senate terms. Before the Senate, he served in the House for 6 years, and now in the Senate for 50 years, 10 months, and 18 days. He has cast well over 18,500 votes.

Senator BYRD has presided over the longest session of the Senate—more than 21 hours—and he has presided over the shortest. We have had no fewer than 11 Presidents since he first took office.

But the numbers don't tell all of the story because ROBERT BYRD has been one of the greatest representatives of and advocates for the folks in his beloved State of West Virginia. He is that larger-than-life, that iconic figure in our Nation's history too. He is the Senate's premier Member-observer. He is the Senate's institutional history.

I flash back to that first day—and you never forget the first event of an occurrence in your life. It was my maiden speech, my first speech on the floor of the Senate 9½ years ago. I was at one of those junior desks right over there. I gave my maiden speech. It was actually on the budget. We happened to have a surplus then. I was laying out how we ought to preserve that surplus; as a matter of fact, even use it to pay down the national debt. I happened to mention in the course of my remarks that it was my maiden speech. All of a sudden those doors swung open and in strode Senator BYRD, that white shock of hair flowing as he took his place over there on the center aisle.

As I finished my remarks, he said: Will the Senator from Florida yield? And I said: Of course, I yield to the senior Senator from West Virginia. Senator BYRD proceeded to give extemporaneously a history of the maiden speeches in the Senate.

Of course, I was spellbound, I was awestruck, as I listened to this walking American political history book recite from memory, on that particular occasion, something that had been important to this Senator on the occasion of my very first speech in this extraordinary august body.

Senator BYRD continues to be the Senate's conscience. In the spirit of Thomas Jefferson, ROBERT BYRD has always put public service ahead of personal fortune. On many of our desks—and it is certainly in my personal office in the Senate—are Senator BYRD's addresses on the history of the Senate. There were more than 100 of them delivered in the past 10-year period. They have been called the most ambitious study of the Senate that had ever been undertaken. Every day they serve to remind me of the living history of this institution and its vital role in our democracy.

Senator BYRD has been a dear personal friend to so many of us. He has been such a mentor.

Madam President, since the Vice President of the United States has just entered the Chamber, I wanted to recall for him that 9 years ago, in our freshman class of Senators, Senator BYRD took us on as a special project to teach us the protocol of how to preside. I can tell you what class a Presiding Officer comes from now, if it was a class that was under the tutelage of Senator BYRD, because there was a right way and a wrong way to preside in the Senate. The Vice President is acknowledging that is true.

By the way, I have the privilege of standing at the desk the Vice President used to occupy. I particularly chose this desk because not only has he been such a great mentor to me personally but a very dear friend.

With Senator BYRD, all of us grieved with him 3 years ago when his beloved wife Erma passed away. I know he

yearns for her and wishes she could be by his side on this historic day.

Now there is another number that is going to be important in ROBERT BYRD'S life. In just 2 days, he celebrates his 92nd birthday. We all hope we can be here with him for many more years.

Remember what President Reagan had to say about age and leadership. He said:

I believe that Moses was 80 when God first commissioned him for public service.

If the Lord is using that same commissioning for Senator BYRD, at 92, he has a long way to go. The Lord would certainly say to Senator BYRD: Well done, my good and faithful servant.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. Madam President, I congratulate Senator BYRD on this historic milestone. It has been my pleasure and a great honor to work and serve with Senator BYRD during his service to our Nation. He has served as a devoted champion to his home State of West Virginia. Senator BYRD is worthy to be part of the history of the United States, as he now becomes the longest serving Member of the Congress of the United States of America. I am pleased to join my colleagues in paying tribute to his great service and the accomplishments of this great American, Senator ROBERT BYRD of West Virginia.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. UDALL of New Mexico. Madam President, following on the heels of my colleague Senator INOUYE, I congratulate Senator BYRD on his many years of public service. Today Senator BYRD passed a landmark in the Senate. He is the longest serving Senator. He came to the Congress in my father's class of representatives in 1954. My father Stewart Udall and the entire Udall clan congratulate him on his record-setting years of public service.

Mr. BINGAMAN. Madam President, I rise today to pay tribute to Senator ROBERT C. BYRD as he becomes the longest-serving Member of Congress in American history. Senator BYRD has served 56 years and 320 days. During his time in the Senate Senator BYRD has cast more than 18,500 votes, more than any Senator in history.

Senator BYRD was elected to the U.S. House of Representatives in 1952, and he was sworn in to the U.S. Senate on Jan. 3, 1959. This was, coincidentally, the same day that Alaska became a State, and before Hawaii was admitted to the Union. He is now serving an unprecedented ninth term in the Senate.

Yet, to discuss only his longevity would do a grave disservice to the reality of what Senator BYRD has meant to the U.S. Senate and to this country. Many distinguished Members have had long careers in the Senate, but I believe it is safe to say that none have contributed more to the preservation of the history, traditions and strength of the Senate than ROBERT C. BYRD. His knowledge of and reverence for the Constitution has served over these many years to remind us time and again of the beauty, eloquence, and timelessness of that document, and the importance of relying upon it as the touchstone of our deliberations.

Senator BYRD has had many great legislative and oratorical achievements in his time in the Senate, but I wanted to refer briefly to just one today. His outspoken opposition to giving President George W. Bush the power to wage war against Iraq was an inspiration to those of us who shared his views, and he never forgot those who were with him on that vote. The eloquence and passion with which he expressed his views were extraordinarily powerful; his floor speeches exemplified the power of language to shape ideas. I believe that what has transpired in Iraq since those speeches has affirmed the courageous stance that he took.

In conclusion, it is an honor and a privilege to serve with Senator BYRD, and I congratulate him on this great milestone.

Mr. CARDIN. Madam President, I wish to pay special tribute to Senator ROBERT C. BYRD. Today, Senator BYRD becomes the longest-serving Member in the illustrious history of the U.S. Congress. What an amazing accomplishment! He already holds the distinction as the longest-serving Senator, and is the only Senator in U.S. history elected to nine full terms.

Considering that Senator BYRD won his first election, to the West Virginia House of Delegates, in 1946, it may be that he is the longest-serving elected official in history—period.

When ROBERT BYRD was elected to the Senate in 1958 after serving in the House for 6 years, he was part of a large, distinguished class that included such future giants as Hugh Scott, Gene McCarthy, Edmund Muskie, and Philip Hart (D–MI). He has surpassed them all.

According to the Senate Historical Office, ROBERT BYRD was the 1,579th person to become a U.S. Senator. Since he was elected to the Senate, another 334 individuals have become U.S. Senators. All in all, ROBERT BYRD has served with over 400 other Senators. And I am certain that all of them have held their colleague, as I do, in the highest esteem.

Senator BYRD's modest beginnings in the hard-scrabble coal fields of Appalachia are well known. Suffice it to say that his life is the quintessential American success story.

I think every young American should learn about Senator BYRD's life as an example of what hard work and persistence and devotion can accomplish in this country.

Senator BYRD married his high-school sweetheart, Erma Ora James, shortly after they both graduated from Mark Twain High School in 1937. He was too poor to afford college right away and wouldn't receive his degree from Marshall University until 60 years later when he was 77. In between, he did something no other Member of Congress has ever done: he enrolled in law school at American University and in 10 years of part-time study while serving as a Member of Congress, he completed his law degree.

Senator BYRD was married to his beloved Erma for nearly 69 years, and has been blessed with two daughters, six grandchildren, and seven great-grandchildren.

During his Senate tenure, ROBERT BYRD has been elected to more leadership positions than any other Senator in history. He has cast 18,585 rollcall votes. Only 28 other Senators in the history of the Republic have cast more than 10,000 votes; Strom Thurmond is the only other Senator to cast more than 16,000 votes. Senator BYRD's attendance record over the past five decades just under 98 percent is as impressive as the sheer number of votes cast he has cast.

Senator BYRD's legislative accomplishments, from economic development and transportation to education and health care, are legendary. It is no surprise that he has won 100 percent of the vote of West Virginians in a previous election, 1976, or carried all 55 of West Virginia's counties.

In the meantime, he has written five books, including the definitive history of the U.S. Senate.

Perhaps the highest tribute to Senator BYRD can be found in his biographical section of the ''Almanac of American Politics,'' which states: ''Robert Byrd may come closest to the kind of senator the Founding Fathers had in mind than any other.'' His fealty to the U.S. Senate and to the Constitution has served as an inspiration, a lesson, and a guiding light to all of us who have been privileged to follow him in this chamber.

Robert E. Lee said, ''Duty is the most sublime word in our language. Do your duty in all things. You cannot do more. You should never wish to do less.'' Senator ROBERT C. BYRD has done his duty in all things—to himself, to his family, to his State, to his Nation, and to God.

I am honored to join his and my colleagues here in the Senate, West Virginians, and all Americans in paying tribute to this great Senator and this great man.

Mr. GREGG. Madam President, I rise today to recognize the longest-serving lawmaker in congressional history; I rise to recognize a leader; and I rise to recognize a friend.

Senator BYRD has served in Congress for over 56 years. His tenure has traversed 9 elections, 18,000 votes, 20,000

days, and 11 Presidents. I have had the privilege of serving with Senator BYRD on the Senate Appropriations Subcommittee on Homeland Security. I am proud of our efforts to protect Americans and make our Nation more secure, especially in the area of border security and addressing the threat of weapons of mass destruction. Senator BYRD was a terrific partner, and I valued his input. And when we would give introductory remarks at the committee markup of our bill, I have never received such generous compliments from another lawmaker. I hope Senator CONRAD, my counterpart on the Budget Committee, is taking notes.

More recently, it is a testament to his character and sense of duty that after battling illness and absence earlier this year, Senator BYRD returned to once again craft our Nation's homeland security budget: a $44 billion measure that funds natural disaster response, antiterrorism efforts, and other critical programs to meet and repel the various threats facing our homeland.

Lastly, I want to recognize Senator BYRD for his dedication to the Senate as an institution and his understanding of its inner workings. No one can better recite or describe Senate rules and parliamentary procedures or better defend them. His encyclopedic knowledge of the Senate, as well as the copy of the U.S. Constitution which he always carries in his jacket pocket, is something that we can all respect and appreciate. He is a man committed to the principles and laws that founded our great Nation, and for that we should be thankful.

In closing, we have much to thank Senator BYRD for: Merit-based scholarships; teacher training programs; and the strengthening of American history curriculum in our schools. But one thing that many of us and our constituents might take for granted, Senator BYRD is responsible for the cameras in the Senate Chamber. As he often does, Senator BYRD put it eloquently when he said that proceedings should be televised to prevent the Senate from becoming the ''invisible branch'' of government. I couldn't agree more.

Before yielding the floor, let me be one of the first to wish our esteemed colleague an early Happy Birthday. He turns 92 this Friday. Happy Birthday, friend.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. LEVIN. Madam President, I will be 30 seconds because I believe we are ready to adopt a resolution. It has been a long time since I was a young Senator listening to a man who was even then a giant of the Senate. For hours, Senator ROBERT C. BYRD would speak eloquently, and usually from memory, on the history and traditions of the Senate. Even then, it was clear to me there had been few combinations more fortuitous in the history of our Nation than that of ROBERT BYRD and the Senate.

We celebrate today as he becomes the longest serving Member in the history of the Congress. There have been many beneficiaries of that long service: the people of West Virginia, whom he has served so ably; the citizens of the United States, who have been fortunate to reap the rewards of his knowledge and commitment; and, more personally for us here, the Members of the Senate, and most personally, me.

His career is even more remarkable for its depth than for its length. In addition to more than half a century in this body, ROBERT BYRD managed to work as a butcher, a ship welder, and a Member of the House of Representatives. He learned to play the fiddle, became a recognized expert on Rome's senate, and wrote or edited nine books. It says much about him as a person that he was never out of place in the coal country of West Virginia, even as he moved to the highest levels of our government.

There is seldom any doubt where Senator BYRD stands on an issue, be it the decision to go to war in Iraq or a challenge to the prerogatives of the Senate. But in those instances where history or his own reflection have shown him to be mistaken, he has shown the rare grace to accept responsibility for his own imperfections, and ask for forgiveness. In this, as in many other things, he is truly an example to emulate.

He is rightfully honored not just for his knowledge of the Senate, but for a fierce determination to protect its traditions, procedures, and its role in our system of government. I have seen this determination up close, perhaps never so clearly as in 1996, when he and I, along with Senator Moynihan, filed an amicus brief with the U.S. Supreme Court on the subject of the line-item veto. Congress's approval of the law establishing this veto occurred over Senator BYRD's powerful and learned opposition, and after it became law, he continued to oppose what he saw, and I saw, as a clear violation of the constitutionally mandated separation of powers. In this instance and many others, the Senate and the Nation have benefitted from his immense knowledge of the Constitution and his ability to focus that knowledge on the issues before us. Before party or personal preference, ROBERT BYRD places the Constitution—a document always at hand in the Senator's pocket.

More than 3 years ago, Senator BYRD reached another milestone—becoming the longest serving Member of the Senate. Let me repeat something I said then: ''That is the tribute we can all pay to Robert Byrd: to defend this institution, to stand for its procedures, and to carry, as he does, at least in our hearts, the Constitution, as he carries the Constitution on his body.''

I conclude with congratulations not just to Senator BYRD and not just on the longevity of his service, but on the depth of its quality and the love he has for the Senate, his commitment to constitutional government. We remember this day also his love for his beloved wife Erma who was a blessing to Robert, a blessing to their family, and a blessing to our Senate family.

I yield the floor.

Mr. CASEY. Madam President, I would like to commend and congratulate my colleague Senator ROBERT BYRD on the momentous accomplishment of becoming the longest serving Member of Congress.

Senator BYRD has spent 56 years and 320 days serving the people of West Virginia, in that time casting more than 18,500 votes.

He is a fierce advocate for his home State of West Virginia, a mentor and disciplinarian with new Senators. And he possesses an encyclopedic knowledge of Senate history, rules, and procedure. The current President pro tempore of the Senate, he has held more leadership positions than anyone in Senate history.

I am honored to have worked alongside a man who will go down in history as a great American public servant, and I look forward to working with Senator BYRD for years to come.

Ms. STABENOW. Madam President, how lucky we are to have the great Senator from West Virginia—20,744 days spent in this ''sanctuary,'' this Senate Chamber, which I have heard him call, on more than one occasion, ''the very temple of constitutional liberty.''

Within just a few days of my arriving here in 2001, I was instructed in no uncertain terms to go and see Senator BYRD, to listen to him, and to learn from him. And so I went and I listened and I learned. I learned about the history of this great body. I learned about the importance of the rules and decorum of the Senate.

It is such an honor to be a Member of this body but also an awesome responsibility. For 20,744 days, Senator BYRD has been fighting for the people who sent him here, for the great men and women of West Virginia, and for all the people of this country.

He is an inspiration.

I was proud to be 1 of the 22 Senators who stood with him against the Iraq war. I was proud to stand with him on so many occasions to fight for the working men and women of this country—whether they be coal miners in West Virginia or autoworkers in Detroit. And I am proud to stand here today, with so many of my colleagues, to honor Senator BYRD's remarkable service.

Right outside my office, I proudly display a print of a painting made by the Senator from West Virginia, a very beautiful scene of West Virginia tranquility. Whenever I see it, which is

every day, I am reminded of my colleague, of his extraordinary service, of his fierce dedication to liberty, and of his humble respect for the Constitution of our great country.

Madam President, I thank the Senator from West Virginia for his friendship, for his wisdom, and for his great service to our country.

Mr. KOHL. Madam President, today we honor Senator ROBERT C. BYRD for 20,744 days of service in the Congress of the United States. That feat of endurance is laudable, but certainly not surprising.

This is the man who has memorized volumes of poetry and analyzed libraries of great books, histories, legislation, and speeches. This is the man who attended law school at night while serving in the House of Representatives and then the Senate. This is the man who remembers every important date—Veterans Day, Mothers Day, the Fourth of July—with a carefully crafted, masterfully delivered oration on the Senate floor. This is the man who has held the most powerful positions in the Senate and has faced the most powerful adversaries on its floor and in Committee.

No one should be surprised, then, that this is the man who has served longest in the United States Congress.

But we are not just here to commemorate the days Senator BYRD has served. We are here to honor the service he has rendered.

Senator BYRD has served West Virginia. In those 20,744 days representing them, Senator BYRD has spent countless hours—in the Appropriations Committee, on the floor, in the offices of his colleagues—fighting for his people.

Senator BYRD has served the Senate. When I was first elected, Senator BYRD schooled me, as he has almost everyone in this body, in the nuances of Senate rules and traditions. He sat on the floor when I gave my first speech and made me understand the gravity and privilege of being a U.S. Senator. He has written the definitive, four-volume history of the Senate while earning himself a place in those pages alongside Senators Daniel Webster, Henry Clay, Robert Lafollette.

And Senator BYRD has served this country. He carries our Constitution next to his heart and wields it like a sword against those who put politics above principle. He has defended the Senate's constitutional powers in front of the Supreme Court, arguing passionately against the line item veto—and in front of the world, arguing for the Senate's proper role in issues of war and peace.

In years of working with Senator BYRD, I have had the honor of getting to know a true American patriot and call him friend. Senator BYRD has never let down the people of West Virginia and steadfastly upheld our beloved Constitution. He will forever be known not just as Congress's longest standing member but as its strongest standing member. I thank him—as he taught me, through you, Mr. President—for his friendship and his service to the Senate, to the Constitution, and to the United States of America.

Mr. DORGAN. Madam President, I would like to add my congratulations to Senator ROBERT C. BYRD on his historic achievement today. Not only is he the longest serving senator in the history of this body, but today he is the longest serving Member of Congress in the history of our Nation.

For more than 50 years, Senator BYRD has been a steadfast defender of the Constitution and the principles on which it stands. Senator BYRD is truly a statesman, a patriot, a proud son of West Virginia, and an important voice in the history of this country.

Senator BYRD has come a long way from the coal fields of West Virginia where he grew up in poverty and learned the value of hard work. He first came to Washington in January 1953—20,774 days ago—when he was elected to the U.S. House of Representatives. He served in the House for three terms before being elected to the Senate, where he has served the people of West Virginia faithfully for the last 50 years.

Over the years, Senator BYRD has never forgotten his roots and the State and the people that he loves. The people of West Virginia have recognized his achievements and hard work on their behalf in the Senate and have elected him for an unprecedented nine terms in the United States Senate. He has served with 11 Presidents. Can you believe that?

To add to his long list of achievements, Senator BYRD has also held more leadership positions than any other Senator in history. This includes Senate majority whip, chairman of the Democratic Conference, Senate minority leader, and Senate majority leader. Currently, Senator BYRD is the president pro tempore. Throughout his career, Senator BYRD has cast nearly 18,600 roll call votes in five decades of service in the Senate. I'd say that's an unprecedented record.

Senator BYRD is also the longest serving member of the esteemed Appropriations Committee. He has served as its chairman or ranking member since 1989 until stepping down earlier this year. It has been my honor to serve with him on the Appropriations Committee and I have learned a tremendous amount under his leadership.

Many of us know Senator BYRD as our resident historian. He has a wealth of knowledge about the procedures of the Senate and shares enthusiastic stories of the many interesting events that have occurred in this Chamber. He is also the author of a magisterial four-volume set about this body entitled ''The Senate, 1789–1989'', and other works.

He also had a unique talent outside the halls of Congress. Senator BYRD learned to play the fiddle at a young age and carried it with him everywhere he went. His skill with the instrument led to performances at the Kennedy Center and on a national television appearance on Hee Haw. He even recorded his own album, Mountain Fiddler.

No tribute to Senator BYRD would be complete without mentioning his life's love, Erma Ora James. For nearly 69 years, the Byrds were inseparable, traveling throughout their native West Virginia and crossing the globe together. Sadly, Mrs. Byrd passed away on March 25, 2006, but Senator BYRD speaks lovingly of her and their life together each day.

The times have changed considerably since Senator BYRD first came to Washington. We have seen a man walk on the Moon. We have mapped the human genome, and we have seen unbelievable technological advances that have changed the way we live, work and communicate. But through it all, the one constant is Senator BYRD's steadfast championing of our Constitution and the people of West Virginia.

Senator BYRD is to many the voice of the Senate, and it has been my privilege to serve with him and learn from his stories and wisdom. The Senate is a stronger institution and a better place because of the many years of service of Senator BYRD. I join my colleagues in offering my congratulations to him on this important day and wish him well as he celebrates his 92nd birthday later this week.

Mrs. FEINSTEIN. Madam President, I join my colleagues today in congratulating Senator Robert C. Byrd on reaching yet another milestone in a long and very distinguished career.

Today, Senator BYRD has served 20,774 days—that is 56 years and 10½ months in Congress—making him the longest serving Member in U.S. history.

Senator BYRD has attended 18,582 Senate rollcall votes.

He cast his first votes in the Senate, in January 1959, when Dwight Eisenhower was President. John F. Kennedy and Lyndon B. Johnson were among his Senate colleagues. And Hawaii was not yet a State.

He has served in the Senate longer than 10 of his current colleagues and President Obama have been alive—BOB CASEY, Jr., AMY KLOBUCHAR, BLANCHE LINCOLN, JOHN THUNE, DAVID VITTER, MARK PRYOR, MARK BEGICH, MICHAEL BENNET, KIRSTEN GILLIBRAND and GEORGE LEMIEUX.

He has been elected to the Senate an unprecedented nine times, and has served alongside 11 U.S. Presidents.

Senator BYRD has seen great changes in these past 56 years. Yet he has never lost sight of where he came from.

He grew up in poverty among the coalfields of Southern West Virginia.

His adoptive parents early on instilled in him a strong work ethic. He was a butcher, a gas station attendant, a grocery store clerk, and a shipyard welder before winning a seat to the West Virginia State Legislature and eventually being elected to Congress.

Senator BYRD earned a law degree from American University in 1963—the only person to have ever begun and completed law school while serving in Congress.

The ''Almanac of American Politics'' has said that Senator BYRD ''may come closer to the kind of senator the Founding Fathers had in mind than any other.''

I wholeheartedly agree. And so he has set the standard for all of us to follow.

We, of course, all know him as a great orator with a love of language. His speeches on this floor often quote poetry and the classics—Roman historian Titus Livius is a favorite.

Senator BYRD is a man of conviction. He always speaks his mind. He never minces words.

He is our fiercest defender of the U.S. Constitution—in fact, he carries a pocket version of this dynamic document wherever he goes.

There is no one who has loved this institution so dearly. He adores it so much he has authored four volumes about the history of the U.S. Senate.

In a speech he gave earlier this year when he marked 50 years in the U.S. Senate, Senator BYRD said: ''The Senate has served our country so well because great and courageous Senators have always been willing to stay the course and keep the faith. And the Senate will continue to do so as long as there are members who understand the Senate's constitutional role and who zealously guard its powers.''

He of course leads this list.

Yet Senator BYRD's highest priority has always been serving the constituents of his beloved Mountain State.

As a longtime chairman and member of the Senate Appropriations Committee he has sent home millions of dollars in needed Federal funds for economic renewal and infrastructure projects. These monies have gone to build highways, dams, educational and health institutions, and Federal agency offices throughout West Virginia.

He has long been a strong proponent of education. The valedictorian of his high school class, Senator BYRD has fought for teaching of ''traditional American history'' in the Nation's public school system. It is an issue true and dear to my heart as well.

Today, thanks to Senator BYRD, the Department of Education awards millions of dollars each year in grants to fund training programs to improve the skills of history teachers.

Senator BYRD's love of the Senate and of his fellow West Virginians knows no bounds. It is exceeded only by the love of his beloved wife Erma who passed away 3 years ago. In a statement this week marking his own milestone, Senator BYRD said ''I know that she is looking down from the heavens, smiling at me and saying congratulations my dear Robert but don't let it go to your head.''

I have had the privilege of working on the Appropriations Committee while Senator BYRD was chairman. There has been no one who has been more faithful to the Constitution, to the goals and rules of the Senate, or has served this body more honorably.

I consider myself lucky to have served alongside this great statesman for 17 years.

Again, congratulations Senator BYRD. You are a true American Patriot.

Mr. SESSIONS. Madam President, I wish to make a few remarks about one of the most remarkable men ever to serve in the Senate, ROBERT C. BYRD on this milestone of service. When I came to the Senate, he was my teacher. We went to school to him. He told all of the new Members about the rules of the Senate and we all got copies of his book on the history of the Senate. We were all mightily impressed, because he had an encyclopedic understanding of this Senate.

I have heard him over the years refer to the Senate as the great Senate or the second great Senate, the Roman Senate being the first great Senate and the U.S. Senate being the next great Senate. The pride he has in this institution, the way he respects it and reveres it, I think is second to none who has ever served here. I believe that.

I remember one night—I don't know why it was so late, but it was sometime during the debate over Afghanistan or Iraq, and I was here speaking. It was 8 or 9 o'clock at night, later than this—and Senator BYRD was the Presiding Officer. I told this fabulous story somebody had shared with me. It was a history of Rome, and it was about what the Romans did when they had terrorists and pirates. When they could stand the disgrace no longer, the Romans all got together and said we have to take action, and they selected the leading man of the country and gave him a whole fleet of ships and I think 100,000 or more soldiers. They issued a directive to every city on the Mediterranean that they would cooperate with Rome, and they set about to destroy the pirates. The pirates had captured a Roman leader or two. They raided the coast of Rome, and the disgrace was intolerable and they finally got together and crushed them in short order.

I was the last one to speak, as I am tonight, and he asked me to come up to the Chair. He said, that was Marc Antony; ''I think that was 6 AD.'' So he is a real student of history and the Roman Empire and the Roman Senate.

I also would normally preside over the Senate on Fridays, and Senator BYRD at 11 o'clock would appear through the door almost every Friday and he would make a speech. They were remarkable speeches. He had a remarkable talent for speaking. He would quote poetry at length without a single note, or quote the Scripture without notes. I still can remember some of his speeches. One of my favorites was his discussion of the failure of modern textbooks.

One of the things that irked him—and he quoted from them—is that they didn't recognize the difference between a democracy and a republic, and there is a difference. He delineated that with great clarity. Finally, at the conclusion, he referred to those books as touchy feely twaddle, and I thought that was a phrase I liked. I have remembered it ever since.

He also discussed the little school he attended. My father attended one like that and my grandmother taught in one like that. But the highlight of their day was to be selected to be the one to take the bucket and go down to the spring and get a bucket of water to put in the barrel so the kids would have something to drink. They were taught well. He made clear that they were well taught. This was not poor education; it was a good education. But, that is the way the school was conducted. He noted they had a single dipper for the class and all the students used it to dip in the barrel to get the water whenever they needed it. I guess the EPA would have them in jail today if they were to try such a thing as that.

He has been and still remains a fierce advocate of issues he considers important. We did not agree on the Iraq war, and Senator BYRD was fierce in his opposition. He articulated it aggressively and fairly and in a tough, effective manner. He was one of the most effective Senators on that matter.

We agree on a number of issues involving immigration. I strongly believe that the immigration system in this country is broken and we need to create a lawful system and that we cannot tolerate the continued lawlessness, and he agreed. He doesn't believe people have a right to just walk into the country illegally and claim they are a citizen, then just wait a little bit and get amnesty.

What kind of law is that? On many of those votes, we shared a common view. I guess I will say he is a person who answers to his own sense of right and wrong. It is a deep sense of right and wrong. He is a man who understands the Scriptures, a man of deep personal faith and there are things he believes that are right and there are things he believes are wrong and he doesn't do what he thinks is wrong. It is the kind of model that I think is a good one for all of us in the Senate.

I find Senator BYRD to be one of the most refreshing and brilliant men I know in the Senate. I say this with

some real confidence: Nobody loves the Senate more than ROBERT C. BYRD.

I thank the Chair and yield the floor.

Ms. MIKULSKI. Madam President, I rise today to pay tribute to my friend and colleague, Senator ROBERT C. BYRD from West Virginia. Today, Senator BYRD becomes the longest serving Member of the U.S. Senate, the longest serving Member of the U.S. Congress, and the longest serving Member in Congressional history. Today, Senator BYRD marks his 20,744th day in the Congress. This is an extraordinary milestone for a man who has played such an important role in the Senate.

Senator BYRD has a compelling personal story. He lost his parents as a young child and was raised by his aunt and uncle in a coal mining community. He became the first in his family to attend college and law school, working a series of jobs to support himself and his family. He was blessed with a wonderful wife, Erma Ora Byrd, who was beloved in the Senate family.

Senator BYRD never forgot where he came from. His work on behalf of the people of West Virginia is legendary. He never forgot the coal mining community he came from. He always worked to strengthen the opportunity ladder that he used to put himself through college and law school. He never forgot the people and communities that too often are left out and left behind.

When I first came to the U.S. Senate in 1987, Senator BYRD was the majority leader. He helped me get on some of the best committees, including the Appropriations Committee. Senator BYRD helped me learn the arcane Senate procedure. He helped me learn the ropes on the Appropriations Committee and how the appropriations process could be used to help communities and people in Maryland—and to create jobs.

As majority leader and as chairman, Senator BYRD set a tone of bipartisanship. He worked across the aisle to meet the day-to-day needs of his constituents and the long-range needs of our Nation.

I join my colleagues in celebrating Senator BYRD's many accomplishments—and in thanking him for his friendship.

Mr. ROCKEFELLER. Madam President, I ask unanimous consent that the resolution and preamble be agreed to en bloc, and the motions to reconsider be laid upon the table en bloc; further, that any statements with respect to Senator BYRD be printed in the RECORD.

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

The resolution (S. Res. 354) was agreed to.

The preamble was agreed to.

(Applause, Senators rising.)

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Madam President, I know Senator BYRD is about to speak, but I sat here in this row for years with my dear friend from West Virginia. We have been friends for the 35 years I have served here. In his mind I am but a junior Member of the Senate, having been here only 35 years, but they have been especially good ones because he is here. I will save something for later on.

I yield the floor.

The PRESIDING OFFICER. The very distinguished Senator from West Virginia.

Mr. BYRD. I thank the Chair. Thank you, PAT. I thank Senator REID, my leader. I thank Senator MCCONNELL, and I thank my colleague and dear friend, Senator JAY ROCKEFELLER, and all Senators, everyone, for their good words and for this outstanding resolution.

Today, Madam President, is much more than a commemoration of the length of service of one Senator. Today also celebrates the great people of the great and mighty State of West Virginia who have honored me by repeatedly placing their faith in me. Because of those wonderful people in West Virginia, this foster son of an impoverished coal miner from the great hills of southern West Virginia has had the opportunity to walk with Kings, to meet with Prime Ministers, and to debate with Presidents.

I have had the privilege not only to witness, but also to participate in, the great panorama of history. From the apex of the Cold War to the collapse—the collapse—of the Soviet Union, from my opposition to the 1964 Civil Rights Act to my part in securing the funds for the building of the memorial to Martin Luther King, from my support for the war in Vietnam to my opposition to President George W. Bush's war with Iraq, I have served with so many fine Senators in the Congress, and I have loved every precious minute of it.

I recall those days a long time ago when I walked 3 miles down a hollow in the snow in order to catch a bus to attend a two-room school in Mercer County in southern West Virginia. In Stotesbury, WV, after school, I went from house to house collecting scraps of food. I was the scrap boy, collecting scraps of food to feed the hogs of my coal miner dad, raised in a pen beside a railroad track to support the family budget.

Little could I have ever imagined or dreamed while I was feeding those hogs or walking in the snow to catch a bus to school that one day under God's great mercy I would become the longest serving Member in the history—the great history—of the U.S. Congress. I am grateful, simply grateful to an Almighty God for having had an opportunity to serve my State of West Virginia and to serve our great Nation. My only regret is that my dear wife Erma is not here to enjoy this moment with me. But I know—yes, I do—that she is smiling down from heaven and reminding me not to get a big head.

Again, I thank all Senators. I thank all West Virginians. May the great God Almighty continue to bless these United States of America, and may he keep her forever free.

Madam President, I yield the floor.

(Applause, Senators rising.)

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. BURRIS). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. AKAKA. Mr. President, I rise to honor and extend my warmest aloha to my colleague, mentor and good friend—Senator ROBERT C. BYRD—for reaching this unprecedented milestone.

My colleague from West Virginia has held the most prestigious and influential positions in this legislative body.

Today he is the Senate President Pro Tempore, but we know him as the "Dean of the Senate."

We are so lucky to have him—as he continues to maintain the highest standards in Senate decorum and constitutional procedure.

Senator BYRD has served this country for nearly a quarter of its existence—56 years, 10 months, 16 days.

His dedicated service to his State and this country—and his unrivaled knowledge of parliamentary procedure—continues to be an inspiration to me, and many others in Congress and to people around the country.

Senator BYRD's inspiring story is rooted in his modest upbringing and steadfast determination to serve his country.

Growing up, his parents' taught him the value of hard work. He worked as a butcher and grocer, won election to the West Virginia Legislature, then to Congress.

His work ethic allowed him to earn a law degree from American University—while serving in the House.

But he is not all work. Senator BYRD and I share a love for music and the arts. He is an accomplished musician. His amazing fiddle playing was even showcased at the Grand Ole Opry.

He is a man of great faith. We have attended Senate Prayer Breakfast together for many years. His favorite hymn is "Old Rugged Cross." I have enjoyed singing it with him a number of times.

He is a scholar in the history of democracy and our country. Senator BYRD often cites our founding fathers and Greek philosophers to remind us of where we have come from. He always carries a copy of the Constitution in his pocket.

When I was a freshman Senator in 1990, he generously helped me learn the ways of this great institution.

I still have the notes he gave me on how to preside—always insisting that we follow the proper, time-tested procedures—and that we give our full attention to the Senate floor.

His years of masterful legislation have become such a consistent force in this lawmaking body that he has his own procedural budget rule named after him: The Byrd Rule.

Senator BYRD is an embodiment of the democratic spirit.

We have looked to him for his steady leadership for so many years, and as our country faces new 21st century challenges, we are fortunate that we still have his wisdom today.

It is a pleasure to serve with him.

I again want to extend my aloha and my congratulations to Senator ROBERT C. BYRD for this amazing milestone. Thank you for what you do for this institution Senator BYRD. I look forward to the future together with you. God bless you, ROBERT BYRD.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I am privileged to stand here to say a few words about my friend, ROBERT C. BYRD.

When I got here in 1976—I almost said 1776. But when I got here in 1976—some people think I have been here since 1776—ROBERT C. BYRD was the majority leader in the Senate. Actually, it was 1977 when I actually took my seat here. I have to say, he was one of the finest majority leaders I have seen in all of my 33 years in the Senate. There was literally nobody who knew the rules as well as ROBERT C. BYRD. Senator BYRD was an expert on the rules, and he taught me a great deal. In my first years in the Senate, we were on opposite sides in the labor and law reform debate, but it was a time of great learning for me as a young Senator, and he was very patient. He was very kind, very decent to two young Senators, Senator LUGAR and myself, who both came at exactly the same time. I will never forget that.

In the intervening years, I have seen this man play his fiddle and do it with such joy. I have seen him love his wife the way a man ought to love his wife. I have seen him be kind to his dog. I have seen him be kind to numerous people. I have seen him go out of his way for all of us, from time to time. Yet there was no more formidable Senator on the floor of this Senate than Senator BYRD.

As he has continuously, through the years, educated us on ancient history, modern history, the Constitution, anybody who has listened to those discussions and remarks on the floor has to acknowledge this is one very bright and intelligent man.

To think he got his law degree, if I am not mistaken, while he was serving as a U.S. Senator—and I know he hardly ever missed a vote. That he went on to law school and got a law degree while he was, at the same time, a sitting U.S. Senator is pretty remarkable to me. I don't know anybody else in this body who could have done that. It is an amazing thing.

He has gone out of his way in those years for those of us who were younger and didn't know an awful lot about the procedural rules, who didn't know a lot about the Senate. He has been a stickler for the rules and made sure the Senate has always respected them as now we, the Senators, respect him—not only for his knowledge of the rules but for the way he has conducted himself all these years.

I don't know of any other Senator who has done as much for his State as Senator BYRD—unless it was Senator Stevens from Alaska. In the many years they were both on the Senate Appropriations Committee, they were towers of strength. I have been amazed at the strength, the endurance, the intelligence, and the absolute kindness and decency Senator BYRD has shown as he has evolved as a Senator from those early days when not many people knew him, to today when all of us are honoring him.

What an achievement, to be the longest-serving Member in the history of the Congress. This is a very important day to Senator BYRD and to all of us. I can truthfully say that I love and respect him. We have had our share of differences over the years, but they have always been cordial. I look forward to serving here in the Senate with Senator BYRD for many more years.

I yield the floor.

The PRESIDING OFFICER. The Republican leader.

Mr. MCCONNELL. Mr. President, I say to my good friend from West Virginia, I spoke this morning on his remarkable record of achievement.

We are all proud of your service to your State and to our country. I sent you a note including my remarks from this morning about this remarkable record you have now achieved. Of course, you broke the record of a Senator from Arizona. One of his successors is here on the floor and would like to address that matter as well.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, I prematurely congratulated Senator BYRD yesterday for breaking the record of Carl Hayden, who has up to now held the record and was in the House of Representatives the day Arizona became a State. He served all the way up until I believe 1968.

Senator BYRD reminded me: No, it is not until tomorrow, at whatever hour it was.

I said: Well, I think you will probably make it.

Of course, his response was: The Lord willing.

That has been a motto of Senator BYRD throughout his career: The Lord willing. We hope the Lord is willing for many more days so the record will be even harder to break.

We congratulate you.

RECESS SUBJECT TO THE CALL OF THE CHAIR

Mr. DORGAN. Mr. President, at the request of the majority leader, I ask unanimous consent that the Senate recess subject to the call of the Chair.

There being no objection, the Senate, at 5:18 p.m., recessed subject to the call of the Chair and reassembled at 6:28 p.m. when called to order by the Presiding Officer (Ms. CANTWELL).

The PRESIDING OFFICER. The Senator from Kansas is recognized.

ORDER OF PROCEDURE

Mr. ROBERTS. Madam President, it is my understanding that I am going to be recognized for approximately 15 minutes, and I seek unanimous consent that Senator GRASSLEY follow me for 15 minutes, so we would take approximately 30 minutes of the Senate's time at this point. I think I should probably ask unanimous consent to proceed as in morning business.

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

HEALTH CARE REFORM

Mr. ROBERTS. Madam President, I come to the floor today to join my good friend from Iowa, Senator GRASSLEY, who is our ranking member on the Senate Finance Committee, to raise concerns about a too-little-discussed aspect of the health care bill the Senate will soon debate. While much of the health reform debate to date has focused on the health care side of the bill and the $500 billion in higher taxes, fees, and fines that will be required to pay for it, very little attention has been paid to how these taxes and fines will be implemented and administered and, most importantly, enforced. I think that is a very critical discussion. We need to have that discussion, and it is one the American people fully need to understand as this debate gets underway. This is important stuff.

Senator GRASSLEY has already sounded the alarm about how the Senate Finance Committee bill expands the size and reach of the Internal Revenue Service, the IRS, further into the lives of every American. But listen up: All the health care bills we have seen so far call for reforms to be carried out to a great extent by the Internal Revenue Service—that is right, the IRS, the Nation's tax collector.

This isn't CMS, the Department of Health and Human Services; this is the IRS. So the Nation's tax collector will be in charge of implementing, administering, and enforcing a significant portion of this bill.

Under the various bills, the IRS is given unprecedented authority to obtain information about your family's health care decisions. The IRS is authorized to collect new information—information that is unrelated to an individual or a family's tax liability—in order to carry out health care reform.

This information will be used to implement, administer, and enforce several controversial provisions. For example, the IRS—again, not the Department of Health and Human Services—is the government agency that will determine whether everyone has insurance and will assess a tax penalty on anyone without insurance. The IRS will have to collect additional information from individuals and families in order to make this determination. We don't know how this information will be collected or how it may be used.

The IRS would assess taxes on employers who do not provide affordable coverage for their employees. Since affordability would be determined on an individual's total income, an employer would have to collect income information from all of his or her employees. This will require employers to provide additional information about their employees to the IRS—information I am sure that an employer would just as soon not ask about. We don't know how an employer would use this information or how it would be protected.

In addition, the IRS will have to work with the new health care exchanges to verify whether an individual is eligible for a subsidy and will have to share information about taxpayers with those exchanges. However, we still don't know if the exchange will be a State agency or a private entity, so we don't know how the IRS will collect and safeguard taxpayer information.

Yet even as the health care bill creates new responsibilities for the IRS, consider that the IRS is having a lot of trouble doing its No. 1 job—tax administration—efficiently and effectively. Two reports were issued recently that I think raise questions about the IRS's ability to carry out its new responsibilities in this bill, let alone its original responsibilities.

Last week, the Government Accountability Office, or GAO, released its annual audit of the IRS's financial statements for 2008 and 2009.

In the report, the GAO found that while the IRS has made progress in addressing internal control deficiencies, the report also states that deficiencies remain with regard to the IRS's internal control over unpaid tax assessments and over information security. The report states that ''the serious challenges IRS faces as a result of these remaining deficiencies adversely affect the IRS's ability to . . . obtain current, complete, and accurate information it needs to make well-informed decisions.''

Then, on Monday, the Treasury Inspector General for Tax Administration found that because of the way the Making Work Pay credit—the credit created in this year's stimulus bill to provide workers with a one-time tax credit of up to $400—has been implemented and administered by the IRS, more than 15 million taxpayers may actually end up having to pay back some of their credit to the IRS.

Similar administrative problems with the home buyer tax credit have led to waste and abuse of taxpayer dollars.

The IG's audit of the IRS's administration of the credit found that the IRS may have allowed thousands of taxpayers to claim millions of dollars in credits to which they were not entitled to despite recommendations made a year ago by the IG that the IRS take steps to verify eligibility for the credit.

In its audit, the inspector general found that more than 19,000 taxpayers claimed $139.4 million in credits for homes they had not yet purchased but would allegedly purchase. In addition, over 70,000 taxpayers claimed more than $479 million in credits despite indications that they were not first-time home buyers. The IG also identified 582 taxpayers under 18 years of age who claimed almost $4 million worth of credits. By the way, the youngest taxpayers receiving the credit were 4 years old.

Mr. President, the problems the IRS has encountered in administering these credits and the issues raised by the GAO about the security of taxpayer information—I will repeat that: the security of taxpayer information, your taxes—raise serious questions about whether the IRS is up to the task of implementing and enforcing the far-reaching tax proposals that are called for in the health care bill.

Wait, there is more. We know the IRS will need additional funding and employees—employees with expertise and training—if they are to implement, administer, and enforce the dozen or so new tax provisions called for in the health care bill.

How much will that cost? That is a good question. Nobody knows. These costs are not included in estimates provided by either the Congressional Budget Office or the Joint Committee on Taxation.

The bill as passed by the Senate Finance Committee—I don't know what is in the bill that will be considered, just announced by my friends across the aisle. They are doing that behind closed doors. But the bill as passed by the Finance Committee doesn't include any funding for the IRS for any administrative or personnel costs associated with this bill. We will see if the leader's bill that will be announced sometime tomorrow, which is being talked about in the hallways, contains such estimates.

Estimates of a more narrow bill by an independent group found that the IRS administration alone would cost several billion dollars—never mind the costs for the Department of Health and Human Services or CMS or other new Federal offices that will be created. We can only assume the cost to administer and enforce the taxes, fees, and fines in this bill will be significantly higher.

Americans need to understand what health care reform means for their health care, but they also need to know what the IRS's significant and intrusive new role would be in implementing and enforcing such health care reform.

All the proposals we have seen so far expand the reach of the IRS even further into the lives of ordinary Americans, allowing them to collect more information than ever before about you and your health care choices in order to tax you based on those choices.

Do Americans want the IRS to collect even more information about them and their families than it already does? I don't think so. Do they want the IRS having access to information about their health care decisions? Again, I doubt it.

Furthermore, would the IRS be able to do the job? Will they get it right? Recent reports by the IRS's own IG and the GAO cast doubt on the agency's ability to effectively administer the wide-reaching provisions in the health care bill.

Americans should be very concerned about putting the IRS in charge of administering more than $500 billion in new taxes, fees, and fines in this bill and expanding its reach further into Americans' lives.

Americans should be concerned about this path that the Senate leadership and the White House is taking us down, placing this very complex health care bill in the hands of the IRS, especially when they have not provided the resources the IRS will need to get the job done—not to the funding.

Madam President, the bottom line is that Americans need to know, need to understand, and need to question whether they want the Internal Revenue Service more involved in their daily lives and their health care decisions. Under the proposals we have seen, that is the case.

Sit up, America, and take notice. I think if we took a poll or had yet another townhall meeting, most Americans would say no to any further IRS involvement in their lives and no to IRS intrusion into their health care.

I yield the floor. I see the distinguished ranking member of the committee, a distinguished Senator who has been an expert on the IRS and basically bringing reform almost on an individual basis to that agency.

I yield to Senator GRASSLEY.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. I thank my friend, the Senator from Kansas, for his kind

remarks. I am very happy to join him in sounding an alarm about the role of the Internal Revenue Service in America's health care choices.

The various health care bills being considered before Congress would task the IRS with administering several new and very controversial provisions. This would include things such as the individual mandate—or another way to say that is a government-run insurance mandate, a government-required insurance mandate. It would also affect the employer free rider penalty. The IRS would be involved with the premium subsidy for low-income individuals. It would be involved with the small business tax credit. The IRS would be involved in working with exchanges to verify income information, and it would be involved in figuring out how to calculate and collect several new fees, which are in fact excise taxes.

Senator ROBERTS has just explained some of this. Also, during debate in the Finance Committee—when the Senate Finance Committee bill was up in that committee, some people joked that CMS stands for ''it's a mess.'' The same could be said of the IRS. As many of us know all too well, the tax gap is a very serious problem. The hundreds of billions of dollars owed that the IRS isn't collecting suggests that the IRS isn't effective at executing its primary mission: the enforcement of our revenue laws.

The IRS is just now starting to increase its enforcement efforts, which had declined significantly after the restructuring of that agency a decade ago. But just like many other Federal agencies, it is facing a human resource crisis because more than 50 percent of its workforce is expected to retire in the near future. So it doesn't have the resources it needs to do its presently described job, never mind a whole new one, such as administering health care reform—or at least helping administer health care reform.

One independent report after another highlights IRS's enforcement problems. Senator ROBERTS mentioned the recent reports on the Making Work Pay credit, home buyer tax credit, and the IRS's financial statements. In addition to those, we have problems with the earned-income tax credit and the health coverage tax credit.

In February, the Treasury Inspector General for Tax Administration issued a report on fraud in the earned-income tax credit. Then today, the administration reports that waste of taxpayer dollars from improper payments has increased from $72 billion in 2008 to $98 billion in 2009. Over $12 billion—almost 12 percent—of the $98 billion in improper payments was because of the earned-income tax credit.

In another tax inspector general report from earlier this month on the health coverage tax credit, that inspector general reviewed a valid sample of individuals who claimed this credit on their 2006 Federal tax return. The tax inspector general found that 72 percent did not have the required documentation to get that credit. In addition, the inspector general states that the IRS does not effectively identify or prevent individuals from erroneously claiming the health credit on their Federal tax return.

The inspector general identified over 1,200 individuals who appeared to have wrongly claimed $1.8 million of these credits on their Federal tax returns. This report is particularly relative since the premium subsidy in the Finance Committee health reform bill is modeled after this credit.

The earned-income tax credit, the health coverage tax credit, and the making work pay tax credit are all examples of social welfare programs that presently are being administered by the Internal Revenue Service, and this despite the fact that we have a whole separate agency—the Department of Health and Human Services—that is supposed to be concerned with social welfare.

In a recent interview with tax analysts about current health reform proposals, a former IRS Assistant Commissioner had this to say about IRS' role in the health reform issue:

> These kinds of programs require social welfare expertise. IRS agents are not recruited or trained to do that. . . . The IRS record is mixed and sometimes abysmal with regard to effectively administering these kinds of programs.

I couldn't have said it better myself.

Aside from the costs and the problems with enforcing these types of credits, there are opportunity costs associated with requiring the IRS to administer programs outside its expertise. The Government Accountability Office and the tax inspector general issued reports discussing the IRS' poor performance in providing telephone customer service during the 2009 filing season because of stimulus legislation. That was passed in February of this year. The reports state that customer service declined significantly, despite the fact that collection employees were assigned to staff the phones.

So honest and diligent taxpayers do not get the help they need when they need it, and tax cheats and tax evaders increasingly get away with not paying their fair share, and the tax gap widens.

From a tax administration perspective, the provisions in the various health reform bills will create infinite new problems for the Internal Revenue Service. The Internal Revenue Service is likely to be tasked with implementing provisions for which it actually must go out and collect new data—data that is unrelated to the taxpayer's tax liability.

In addition to the provisions Senator ROBERTS highlighted, the Internal Revenue Service would have to develop new processes and procedures for insurance companies and employers to challenge and appeal the calculations of the high-cost premiums tax and the employer free rider excise tax, both new provisions in the Senate Finance Committee bill. Both these taxes are calculated by a third party, other than the IRS or the individual taxpayer. The IRS would have to develop a method for calculating the new excise taxes on medical devices and pharmaceuticals, also a new provision in that bill, the basis for which is unprecedented.

In light of these issues, I think it is fair to consider a couple questions.

Assuming that an individual mandate is constitutional, do we want the IRS checking up on whether everyone has health insurance?

Another question: Do we want to facilitate the dissemination of tax information to third parties, such as employers or an insurance exchange? We have always been very cautious about maintaining the privacy of individual tax returns.

Another question: Shouldn't we be providing more resources to the Department of Health and Human Services to ensure that it can receive and process the necessary data if this bill is going to be implemented instead of having the IRS do it?

My Democratic colleagues in the Congress and the administration have many ideas for new and complex ways to tax individuals and, of course, tax small businesses as well, to fund all sorts of new spending. It would seem wise to make sure the IRS can enforce the tax laws before being charged with administering new social programs created because of health reform.

I ask my colleagues on the other side of the aisle to consider these questions as we debate the health care reform bill over the next several weeks.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. BEGICH). Without objection, it is so ordered.

ORDER OF PROCEDURE

Ms. CANTWELL. Mr. President, as in executive session, I ask unanimous consent that on Thursday, November 19, at 2 p.m., all postcloture time be yielded back, except for 30 minutes, and that the time be equally divided and controlled by Senators LEAHY and SESSIONS or their designees; that at 2:30 p.m., the Senate proceed to vote on confirmation of the nomination of Judge Hamilton; that upon confirmation, the motion to reconsider be laid

upon the table, no further motions be in order, the President be immediately notified of the Senate's action, and the Senate then resume legislative session.

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

Ms. CANTWELL. Mr. President, I ask unanimous consent that on Thursday, November 19, following the period of morning business, the Senate proceed to the consideration of Calendar No. 190, S. 1963, and that the bill be considered under the provisions of the order of November 17; further, that upon disposition of the Hamilton nomination and the Senate resuming legislative session, there be 2 minutes of debate prior to a vote in relation to the Coburn amendment, No. 2785; that upon the use of that time, the Senate proceed to vote in relation to the amendment; that upon disposition of the amendment, the Senate then proceed to passage as provided under the order of November 17.

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

MORNING BUSINESS

Ms. CANTWELL. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

AMERICAN UNIVERSITY OF AFGHANISTAN

Mr. INOUYE. Mr. President, I rise today to apprise my colleagues of an impressive effort in Afghanistan. I recently had the opportunity to visit with our military troops and civilian personnel serving in Afghanistan. While I was there, I had the pleasure to meet Dr. Michael Smith, president of the American University of Afghanistan. I was embarrassed to admit that until meeting Dr. Smith, I had never heard of the university. Upon learning more about the university, I am encouraged to know that while bombs are bursting and bullets are flying, there is an ongoing and successful American mission to provide educational opportunities to the men and women of Afghanistan.

Today, the American University of Afghanistan has 450 students and will graduate their first undergraduate class next spring. The student body draws from every province and ethnic group in Afghanistan and is nineteen percent female and growing. While the majority of faculty members are American, 15 other countries are represented, including Afghanistan.

The university models itself after other strong international American universities like the American University of Cairo and the American University of Beirut. Its programs focus on business and entrepreneurship, information technology, and many other professional areas.

Since over 85 percent of the student body have been immigrants at some point in their lives and 29 percent of the students graduated high school in Pakistan, one goal of creating this university is to enable Afghanis the educational opportunity to earn a degree that can be utilized for the betterment of Afghanistan.

I know many of my colleagues have plans to travel to Afghanistan to visit with our troops. I would encourage all of you to take some time to learn about this university which is one of the unsung efforts we have undertaken in Afghanistan.

I urge my colleagues to support this mission so when the military departs Afghanistan we can leave with a smile and our heads held high knowing that we have not only supported the security and stabilization of Afghanistan but have provided a sustained educational mission as well.

FINANCIAL REGULATORY REFORM AND DERIVATIVES

Mr. GREGG. Mr. President, the journalist H.L. Mencken once observed that, ''complex problems have simple, easy to understand, wrong answers.'' And, though modern history has amply demonstrated the resistance of complex political and economic systems to the easy answer of centralized control, we try time and again to apply top-down solutions to our multifaceted problems. This conflict is brought into no sharper light than by Congress' current efforts at financial services reform; particularly those directed at the labyrinthine world of the multi-trillion dollar derivatives trade.

Derivatives are a vital and complex component of modern financial markets, making it imperative that reform be done right—without damage to the twin pillars of innovation and capital formation.

The question as to how derivatives should be regulated is not easy to answer, but Congress should start with some guiding principles. First, derivatives regulation should seek to foster a robust, competitive, and liquid marketplace. Second, systemic counterparty risk exposure must be reduced by incentivizing central clearing and increasing reporting requirements to promote transparency. Third, regulation must preserve the ability to engage in bilateral customized transactions for risk management. Finally, we must coordinate our efforts with the international community to prevent global regulatory arbitrage and the flight of capital to less regulated jurisdictions.

Unfortunately, the regulatory reform proposals making their way through both chambers of Congress fail to take into account the intricacies of this dynamic financial product and expose a fundamental misunderstanding of the way in which the marketplace works. Congress must think through the significant, unintended consequences before we act to mandate that all Over-the-Counter—OTC—derivatives be centrally cleared and executed on exchanges or cash collateralized, as well as subjecting end-users to capital charges. By de-incentivizing companies to use these risk management tools, such proposals will have the perverse effect of increasing business risk and raising costs.

The proposals advocated for by the U.S. Treasury and Chairman of the Senate Banking Committee, Senator CHRISTOPHER DODD, seem to provide too many government mandates and not enough flexibility. The proposed regulatory structure for OTC derivatives is built on an inadequate foundation lacking the staff, expertise, technology, and resources needed to provide truly robust oversight. Clearing and exchange-trading requirements do not accommodate the need for customized transactions. Capital and margin requirements threaten to lock up liquidity. Lack of international coordination guarantees a flight of capital away from our shores.

Derivatives may not be part of the Main Street vernacular, they may be unfamiliar to the local car dealership, but the manufacturers that supply those dealerships know them well. Derivatives provide businesses with access to lower cost capital, enabling them to grow, invest, and retain and create new jobs. With the unemployment rate at 10.2 percent nationally, this is no time to increase uncertainty and business costs.

Congress must be mindful of the mobility of capital in the global marketplace as well. Without a proper regulatory balance, capital can and will accept higher risk for less onerous regulation. We must maintain incentives for business to participate in a large and liquid OTC derivative market, while promoting global coordination to minimize regulatory arbitrage and systemic risk.

Under current proposals, capital requirements that will be imposed on OTC dealers will pass on additional cost to end-users. Coupling these capital costs with a decreasing ability to customize transactions could result in sharply lower usage by end-users. Given that 94 percent of Fortune 500 companies utilize customized OTC derivatives to manage macro-economic risk, providing less certainty to corporate balance sheets will severely undermine confidence in the American marketplace.

Further, the proposal to mandate exchange trading makes little sense in the bespoke OTC derivatives market.

The basic assumption of exchange trading reflects the use of standard products. OTC derivates by their very nature are not always standard. In the real world, mandating use of an exchange would inhibit the use of such customized derivates that are useful financial management tools to hedge extremely specific risks. Bespoke derivatives cannot always be substituted with exchange traded or standardized OTC products. Even attempting to craft a carve-out for such derivatives raises the concern of whether the U.S. Securities and Exchange Commission and Commodities Future Trading Commission could agree on what should be traded.

Another red flag raised by the circulating proposals is the unintended consequence of segregating variation margin. The more capital a dealer has to set aside to purchase an asset, the fewer assets it can purchase. Heightened capital requirements restrict a dealer's ability to generate returns on its capital or provide loans to Main Street businesses, students heading to college, or families seeking a mortgage. It also does not protect end users or reduce systemic risk in any demonstrable way.

Corporate scandal and economic failure have provided such a regulatory catalyst many times in the past. It is alarmingly reminiscent of 2002, when Congress enacted Sarbanes-Oxley; introducing a host of new compliance requirements for accounting, corporate governance, and financial disclosure. But, in the years since the legislation took effect, the overhaul has come to be widely regarded as overly complex, unduly burdensome, and a severe disadvantage to American businesses in the global marketplace.

Congress should be instructed by the lessons of the past and not add such regulations that will impede capital formation. The simple, easy, but ultimately wrong answer is to issue a government mandate for every perceived problem. Thinking through the unintended consequences of overregulation and trusting market solutions is more difficult, but it is ultimately the only way to preserve the innovation that powers American markets.

HONORING OUR ARMED FORCES

STAFF SERGEANT JUSTIN M. DECROW

Mr. BAYH. Mr. President, I rise today with a heavy heart to honor the life of SSG Justin M. Decrow. He was a member of the 16th Signal Company, 62nd Expeditionary Signal Battalion. Justin was only 32 years old when he was killed in the tragic November 5 shooting spree at Fort Hood, TX, that took the lives of 13 Americans and left 31 others wounded.

Those who enlist in our Armed Forces make an extraordinary sacrifice, agreeing to routinely face life-threatening dangers abroad as they carry out missions on our behalf. The risks they endure to protect our freedom are never expected to follow them from the theater of war to the safety of American soil, making Justin's death all the more painful and troubling.

Today, I join Justin's family and friends in mourning his untimely death. Justin will be remembered as a loving husband, father, son and friend to many. He is survived by his wife Marikay; his daugther Kylah; and his parents Rhonda Thompson and Daniel Decrow. Justin had returned over the summer from a year's deployment in South Korea before being stationed at Fort Hood.

A native of Plymouth, IN, Justin enlisted in the Army immediately after graduating from high school. At the time of his passing, he was a resident of Evans, GA, where he lived with his high school sweetheart and 13-year-old daughter in a house he built just a few years ago. Justin was planning to become an Army contractor at nearby Fort Gordon, working within his specialty of satellite communications training. At Ford Hood, he had been training soldiers to help new veterans with paperwork. Justin is remembered by family and friends as a very loving man, who enjoyed working with his hands.

While we struggle to express our sorrow over the loss of Justin, we can take pride in the example he set as a soldier, a husband, a father, and a son. Today and always, he will be remembered by family, friends and fellow Hoosiers as a true American hero, and we cherish the legacy of his service and his life.

It is my sad duty to enter the name of Justin M. Decrow in the RECORD of the U.S. Senate for his service to this country and for his profound commitment to freedom, democracy and peace.

I pray that the Decrow family, and the families of all the victims of this incomprehensible act, can find comfort in the words of the prophet Isaiah who said, ''He will swallow up death in victory; and the Lord God will wipe away tears from off all faces.''

MILITARY AND VA APPROPRIATIONS

Mr. BOND. Mr. President, in this ever-difficult era of economic recession and troops engaged overseas, I am proud to introduce this amendment with Senators UDALL of New Mexico and BINGAMAN which addresses a dual front plaguing our country's war heroes. That dual front emerges from two troubles that exist for our veterans dealing with the horrors of war abroad and lack of affordable housing at home.

This sad duality has a dark and tragic reality. To date, one out of every three homeless men sleeping somewhere in our cities and communities is a veteran. Veterans make up a significant and disproportionate amount—over 20 percent—of our country's homeless population. The number of homeless Vietnam-era veterans is greater than the number of service persons who died during that war. Regrettably, this dark shadow cast behind our Nation's veterans is stretching because we are seeing homelessness spread to veterans returning from the ongoing conflicts in Iraq and Afghanistan. Instead of receiving the services and benefits they deserve, veterans from Iraq and Afghanistan—as well as many American families—are at greater risk of homelessness due to a number of factors, such as the economic downturn, the acute shortage of affordable housing, and lingering mental health illnesses. Further, despite the efforts of the federal government and its partners at the State and local levels and their progress in addressing homelessness, there remain too many gaps in our safety net system to prevent homelessness.

For our troops and their families to whom we owe so much, who make great contributions to defend our country, and who risk their lives; is homelessness an acceptable outcome for them? Clearly, the answer is no. That is why I am proud to support this amendment with my colleagues from New Mexico and I value the work I have been a part of with my other colleagues and friends like Senators MURRAY, MIKULSKI, REED, and HUTCHISON.

This amendment sends a clear and strong message that we cannot allow our veterans to return to their communities without providing them the support they need. This is why we introduced this amendment which combines the necessary support and housing services to help our veterans. Veterans need a comprehensive approach that begins with secure and stable housing in order to provide them the opportunity to reintegrate into society and support their families. Our amendment fully funds the Homeless Grant and Per Diem Program, which is administered by the U.S. Department of Veterans Affairs and promotes the development of supportive housing and services with the goals of helping homeless veterans achieve residential stability, increase their skill levels and income and develop greater self-determination. In closing, I thank my colleagues from New Mexico and the managers of the Military Construction and Veterans Affairs appropriations bill for their support. I sincerely believe that the passage of this amendment will be another example of our shining and unwavering commitment to our veterans.

PRESIDENTIAL CAMPAIGN

Mr. BURRIS. Mr. President, in the last century, Dr. Martin Luther King, Jr., spoke often of ''the arc of the

moral universe'' and how it bends toward justice. He held an optimistic but unvarnished view of our country and saw that America's greatness lives in the promise of expanding equality and opportunity.

Sadly, for parts of our history, the halls of civil discourse were closed to people of color, women, and other groups. Too many Americans were denied the freedom that our founding documents guaranteed to every individual, and for far too long. But here in the United States, it is inevitable that justice wins out over tyranny in the end.

Thanks to the leadership of Dr. King and countless other trailblazers—of all races, backgrounds, and walks of life—today's America is more free, more fair, and more equal than our forefathers could possibly have dreamed. And today, I come to the floor in honor of one of these real-life trailblazers.

Twenty-five years ago, it was almost inconceivable that a person of color could become President of the United States. But that did not stop the Reverend Jesse L. Jackson, Sr., from mounting a serious campaign. Some applauded the effort, and some decried it as foolishness. Some said that America was not ready. But Reverend Jackson was undeterred. He laid righteous claim to the values that define us as Americans, and he shared his vision with all those who would listen and some who would not. And under his leadership, an otherwise ordinary Presidential campaign became a movement. People across America were inspired by what they saw, what they heard, and what they read. They turned out in droves to campaign for Reverend Jackson, to hear him speak, and to offer their support.

Twenty-five years ago, Rev. Jesse Jackson decided to run for President. And his bold campaign changed American politics forever. As Dr. King would say, he and his supporters put their hands on the arc of the moral universe and caused it to bend just a bit further. He broke down barriers, he shattered prejudice, and he paved the way for all who came after. He left an indelible mark on the political and social landscape in this Nation and his contributions will be felt for many years to come.

In 2008, thanks to the leadership and vision of Jesse Jackson, Martin Luther King, Jr., and countless others, America did what was once unthinkable: we elected an African-American man named Barack Obama to the highest office in our land. It was a day I never thought I would be fortunate enough to see. But it showed the world once again that this is a nation of high ideals and higher aspirations. It proved the enduring truth of the American dream and reinforced the true character of our great country.

This Nation owes a great deal to Reverend Jackson and many like him, who continue to share their talent, their vision, and their abiding faith with the American people. So today, 25 years after his historic run for President, I rise to thank Jesse Jackson for all that he has done and for all that he continues to do. And even as we honor his accomplishments, we know that we can look to the future with optimism, secure in the certain knowledge that we are in control of our destiny.

We, the American people, have the power to determine the course of this Nation, as Reverend Jackson reminded us a quarter of a century ago. That is the legacy to which he belongs—a legacy of equality and opportunity, which he has left to each of us.

Let us honor that legacy and carry it forward, so future generations can share in the ever-expanding promise of the American dream.

CONGRESSIONAL AWARDS PROGRAM

Mr. ENZI. Mr. President, I am very pleased to have this opportunity to acknowledge one of our great success stories—the Congressional Awards—on the occasion of their 30th anniversary. This is a great milestone in the history of a program that has served to inspire and encourage countless young people across the country since it was first signed into law in 1979.

Thirty years ago, Senator Malcolm Wallop of Wyoming and Congressman James Howard of New Jersey joined forces to establish and promote the Congressional Awards and provide this great opportunity to young people all across the Nation. Today this program is achieving results throughout the United States far beyond what anyone could have ever expected. One by one, students are rolling up their sleeves and getting to work, establishing personal goals as well as goals for community service. Their dedication has made it possible for them to make a great difference in the world right where it should always start—in their own backyard.

The Congressional Awards program has deep Wyoming roots because Malcolm Wallop helped to provide the leadership that led to its creation. It has deep roots in Wyoming because it has inspired our young people to a truly remarkable degree. The popularity of this program extends from one corner of my home State to the other and it continues to spark the imagination and encourage the enthusiastic participation of another group of participants every year.

Because of the great work this program makes possible, I try to attend as many award ceremonies as I possibly can. I enjoy having the opportunity to recognize the achievements of those who have earned these awards almost as much as the award winners enjoy receiving the recognition of the Congress for their efforts. Every time I take part in one of these special ceremonies, I can see the excitement and sense of satisfaction that the award represents to each recipient because they have earned it by accomplishing what they set out to do.

The Congressional Awards are open and available to young people from about age 14 to 23. They honor those who have done something to improve themselves by expanding their horizons as to what they believe is possible for them to achieve. Working with adult mentors, they dedicate themselves to achieving a set of goals in four areas—public service, personal development, physical fitness, and the exploration of the world around them. Because of their enthusiasm, it is no surprise that they have been able to achieve such great results in their lives.

There are three levels of awards offered by the program—Bronze, Silver and Gold. The Gold Award is the most difficult of the three to earn because it requires the most in terms of both time and effort.

Over the years, the number of Wyoming Congressional Award winners at each level has been impressive. However, because of the good example Malcolm Wallop worked so hard to provide, we have had a remarkable number of Gold Medal award winners in my State. That is a remarkable achievement for a State with a comparatively small population. It underscores the determination of Wyoming's young people to always finish what they set out to do.

That is why our award winners have been getting noticed and the word has been getting around about how much it means to each award winner to have earned such a special prize. That has inspired others to try to do the same and it has kept the line of program participants going strong.

Malcolm Wallop understood the importance of that message and the need for our young people to hear it—and hear it clearly. Thanks to him and his efforts, kids in Wyoming and throughout the nation understand that there is something better for them to do than to complain about what's wrong with the world. They now know that if there is a problem in the community or down the street you can do something about it. It's more than positive thinking; it's a call to action. It's a lesson learned that will then encourage our young people to apply the same determination that helped them to earn their Congressional Award to the other goals they have set for themselves so they can achieve the same kind of success in every area of their lives.

Although Malcolm accomplished a great deal during his three terms of service in the United States Senate, I have always believed the Congressional Awards had to be one of his favorite achievements, something special that

will continue to last as part of his Senate legacy that will serve to inspire present and future generations to continue to work to make great changes in the world around them.

That will mean, in the years to come, when we look to the young people of Wyoming, the West and the United States to take their place as our leaders on the local, State and national level, thanks in part to the experience of the Congressional Awards program, they will be ready.

KOREA-U.S. FREE TRADE AGREEMENT

Mr. ISAKSON. Mr. President, I wish to express my strong support for the Korea-United States Free Trade Agreement. As you know, President Obama is in South Korea today and tomorrow meeting with South Korean President Lee Myung-bak, and I would like to take this opportunity to communicate to the President and his administration the importance of expressing support for the Korea-United States Free Trade Agreement during these meetings.

The United States and the Republic of Korea have a long history of trade. According to the Office of the U.S. Trade Representative, U.S. goods and services traded with Korea totaled $101 billion in 2007. The Republic of Korea is the seventh-largest trading partner of the United States. In my home State of Georgia alone, goods and services exported to the Republic of Korea total more than $390 million, making the Republic of Korea Georgia's 12th largest trading partner. Furthermore, trade with the Republic of Korea accounted for more than $3 billion worth of goods passing through the Port of Savannah, GA.

It is imperative that the United States build on this already strong relationship with the Republic of Korea by approving a Korea-United States Free Trade Agreement. Approving a Korea-United States Free Trade Agreement will enhance both economies by growing markets for both U.S. and Korean goods and services, creating jobs in both countries, and will strengthen an already strong relationship with one of the most important allies of the United States in the East Asian region.

I would also like to take this opportunity to highlight a new KIA automobile production facility in West Point, GA. This is a direct investment from the Republic of Korea that is having a positive impact on my State's economy. This week, the first KIA Sorrento vehicles were completed at the West Point facility, where 1,200 jobs have already been created and an estimated 1,300 additional jobs will be created in the coming years. The impact on the local economy by the West Point facility is estimated to be around $6.5 billion over the next 3 years, which is already having a transformative effect on a community that was facing very hard economic times before the KIA facility came along.

Mr. President, in closing, I would just like to emphasize how important the Korea-United States Free Trade Agreement is to the United States, and in particular to my home State of Georgia. The KIA facility in West Point, GA, is just one example of the impact that this proposed free-trade agreement could have on other communities across the United States. During these difficult economic times, it is critical that the administration and Congress look for ways to build the economy and create jobs, and approving the Korea-United States Free Trade Agreement would do just that.

ADDITIONAL STATEMENTS

TRIBUTE TO DR. JAMES R. HOUSTON

• Mr. COCHRAN. Mr. President, Dr. James R. Houston of the U.S. Army Corps of Engineers will soon retire with over 38 years of service. He is a member of the Senior Executive Service, SES, and is the First Director of the Corps' Engineer Research and Development Center, ERDC. His accomplishments and dedication to the Corps of Engineers' laboratory community and the Army are exceptional and will have a significant and long-lasting positive impact on this Nation.

After serving as a private in the U.S. Army Corps of Engineers, Dr. Houston began his Army civilian career as a physicist studying explosion-generated wave effects at the U.S. Army Engineer Waterways Experiment Station, WES, in Vicksburg, MS. At WES he calculated harbor oscillations and devised a numerical model to determine the inundation limits of tsunamis in the Hawaiian Islands. In 1978, he earned his Ph.D. from the University of Florida and in 1981 received an Army R&D Achievement Award for improved methods for numerically simulating tsunami propagation and interaction with nearshore regions. In 1983 he was promoted to chief of the research division in the Coastal Engineering Research Center where he researched numerical modeling of coastal processes and tsunami flood level predictions.

In 1986 he became the SES director of the Coastal Engineering Research Center, CERC, and with the combining of CERC and the Hydraulics Laboratory in 1997, he became the director of the Coastal and Hydraulics Laboratory, CHL. In these assignments, he oversaw research programs in coastal and hydraulic engineering, oceanography, coastal geology, dredging, and numerical modeling of hydrodynamics and sediment transport. Under his leadership, CHL became the largest coastal and hydraulics engineering laboratory in the world.

In 2000 he became the first director of ERDC and in 2006 became dual-hatted as the Director of Research and Development and Chief Scientist of the U.S. Army Corps of Engineers. In that latter capacity he advised the Commanding General of the Corps on matters of science and technology and developed research and development policy for the Corps.

The ERDC research that he led has made an enormous difference in the global war on terrorism, GWOT. He led ERDC to be the 2002 Army Research and Development Organization of the Year in recognition of successful modeling of the physics of blast/structure interaction and development of structural-hardening technology for retrofitting buildings to withstand terrorist attacks. The Pentagon wedge that was hit on September 11 had just been structurally hardened using this technology, and ERDC's technology was credited with saving hundreds of lives on that tragic day. As a result of his support of GWOT, the Secretary of the Army awarded him the Decoration for Exceptional Civilian Service, and the U.S. Army Engineer Regiment awarded him both its Bronze and Silver deFleury medals.

Under his leadership, ERDC won the Army Research and Development Organization of the Year five times: 2002, 2005, 2007, 2008, and 2009. This is an unprecedented performance accomplishment in the history of the Army's laboratory of the year competition.

Dr. Houston led countless water resources research efforts such as that for the Los Angeles County flood-control project that produced savings of over $200 million. In 2004, the ERDC won the prestigious White House Closing-the-Circle Award for research on environmental stewardship. Under his leadership, the ERDC developed integrated biological, chemical, and ecological control technologies to combat nonindigenous aquatic plants, resulting in annual savings of $50 million.

Dr. Houston has been a champion for outreach programs to foster a diverse workforce and supported educational outreach activities in civil engineering, environmental quality, and computer science. He provided research experience for college students from Historically Black Colleges and Universities/Minority Institutions, HBCU/MI. During his tenure ERDC annually led the Army in meeting its HBCU/MI contracting goal.

He has published over 130 technical reports and papers, and he has received numerous honors and awards including Phi Beta Kappa; Phi Kappa Phi; SES Distinguished Presidential Rank Award; two SES Meritorious Presidential Rank Awards; Army R&D Achievement Award; Army Decoration for Exceptional Civilian Service; Army

Commendation Medal; two Army Meritorious Civilian Service Awards; Silver Order of de Fleury Medal; Bronze Order of de Fleury Medal; Eminent Speaker for 1993 from the Institution of Engineers, Australia; 1997 National Beach Advocacy Award; and the 2003 Morrough P. O'Brien Award from the American Shore and Beach Preservation Association.

Dr. Houston's career with the Corps of Engineers has been marked with unprecedented accomplishments and is a superb legacy. His exceptional leadership qualities and technical eminence are in the best tradition of the Corps. He is a consummate professional whose performance in over 38 years of service has personified those traits of competency and integrity that our Nation has come to expect of its senior civilian leaders. We wish him and his family all the best.●

RECOGNIZING GOODRICH AEROSTRUCTURES

● Mr. SESSIONS. Mr. President, I ask my colleagues to join me in congratulating the Goodrich Aerostructures Original Equipment Manufacturer and the Alabama Service Center in Foley, AL, on their 25th anniversary. Goodrich Aerostructures became part of the Baldwin County community in 1984, originally as Rohr Industries. Twenty-two years later, Goodrich expanded significantly, and since 2005 Goodrich Aerostructures has been the second largest employer in Foley with approximately 800 people manufacturing, assembling, repairing, and servicing aircraft engine components and structures for military and commercial airplanes.

Since its inception, Goodrich Aerostructures has received numerous awards and recognition for continually providing excellent service and outstanding products. For the past 8 consecutive years, employees at Goodrich in Foley have been recognized by the Federal Aviation Administration with Aviation Maintenance Technician awards. In addition, Goodrich Aerostructures in Foley recently reached a significant milestone by delivering its 500th CF34–10 nacelle, and the company is on contract to supply the pylons and nacelle systems for the Air Force's C–5 Galaxy strategic airlifter as part of the Reliability Enhancement and Re-Engining Program to modernize the Air Force airlift fleet and improve support for our military personnel around the world.

The men and women of Goodrich have also been recognized as good corporate citizens and civic leaders in Baldwin County. The United Way of Baldwin County recognized Goodrich as the top contributing industry in the county earlier this year, and Goodrich workers actively support education, arts, and civic activities in the local community, including support for the Foley Public Library, the Center for Autism for Baldwin County, and the Baldwin County Council on Aging, and sending care packages to employees' friends and family members that are serving our country in Iraq and Afghanistan.

On behalf of my Senate colleagues and the State of Alabama, I thank the men and women of Goodrich Aerostructures in Foley.●

RECOGNIZING RICKER HILL ORCHARDS

● Ms. SNOWE. Mr. President, as we prepare to celebrate Thanksgiving next week, we should be mindful of the thousands of Americans who make possible the celebration as we know it today. Farmers of all kinds grow and harvest the sweet potatoes, turkeys, and cranberries that we enjoy on our dinner tables every fourth Thursday in November. In recognition of one such business, I rise today to honor a small family farm that has been harvesting delicious fruits in western Maine for over two centuries.

Located in the scenic town of Turner in Maine's foothills, Ricker Hill Orchards primarily grows apples of all varieties, most notably the McIntosh, a tradition the Ricker family started in 1803. The small family-owned farm, now in its ninth generation, has expanded over the years to grow other fruits, including pears and peaches, as well as other items like North American ginseng. Of course with apples comes cider, and Ricker Hill presses its own cider on the premises. Similarly, the company sells numerous apple-related products at its county store, such as apple cider donuts—a fall treat in Maine—pies, turnovers, dumplings, and other sweets. For those without the good fortune of visiting Maine during the crisp fall months, Ricker Hill has an online store where customers can order sweet cortland and gala apples, refreshing cider, and other unique gifts.

Additionally, during the early fall months, Ricker Hill adds cranberries—one of only three commercially grown fruits that are native to America—to its repertoire. The orchard dry harvests its small bright berries, as opposed to employing wet harvesting, allowing Ricker Hill to sell fresh berries at market that last longer. To produce the fruit, Ricker Hill must irrigate the bogs starting in the spring, while maintaining and repairing existing fields, and building new ones, throughout the summer. Finally, the company harvests the cranberries in early fall, using a small lawnmower-like instrument to collect the fruit.

To entertain the whole family, Ricker Hill has taken great strides towards making a visit to their farm a day-long event. Complete with a corn maze, hay barn, obstacle course, and cider making tour, the company packs a plethora of activities into its Farm Fun Day Pass. Ricker Hill also offers tours to school groups of the farm's apple picking and packing operations. And something one would not expect at a farm, Ricker Hill even has a challenging disc golf course that winds through the farm's acres of bogs and woods.

Ricker Hill Orchards excels at providing visitors with a quintessential Maine fall experience. And for over 200 years, the farm has been producing some of New England's freshest and most delectable fruits, a practice that has helped the company garner a matchless reputation. As Thanksgiving approaches, and families across the country sit down to plates of cranberry sauce and apple pie, I wish everyone at Ricker Hill Orchards many more years of successful harvests of the ingredients that make this holiday so special.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Pate, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

ENROLLED BILLS SIGNED

At 9:33 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the Speaker has signed the following enrolled bills:

S. 748. An act to redesignate the facility of the United States Postal Service located at 2777 Logan Avenue in San Diego, California, as the "Cesar E. Chavez Post Office".

S. 1211. An act to designate the facility of the United States Postal Service located at 60 School Street, Orchard Park, New York, as the "Jack F. Kemp Post Office Building".

S. 1314. An act to designate the facility of the United States Postal Service located at 630 Northeast Killingsworth Avenue in Portland, Oregon, as the "Dr. Martin Luther King, Jr. Post Office".

S. 1825. An act to extend the authority for relocation expenses tests programs for Federal employees, and for other purposes.

H.R. 955. An act to designate the facility of the United States Postal Service located at 10355 Northeast Valley Road on Rollingbay, Washington, as the "John 'Bud' Hawk Post Office".

H.R. 1516. An act to designate the facility of the United States Postal Service located

at 37926 Church Street in Dade City, Florida, as the ‘‘Sergeant Marcus Mathes Post Office’’.

H.R. 1713. An act to name the South Central Agricultural Research Laboratory of the Department of Agriculture in Lane, Oklahoma, and the facility of the United States Postal Service located at 310 North Perry Street in Bennington, Oklahoma, in honor of former Congressman Wesley ‘‘Wes’’ Watkins.

H.R. 2004. An act to designate the facility of the United States Postal Service located at 4282 Beach Street in Akron, Michigan, as the ‘‘Akron Veterans Memorial Post Office’’.

H.R. 2215. An act to designate the facility of the United States Postal Service located at 140 Merriman Road in Garden City, Michigan, as the ‘‘John J. Shivnen Post Office Building’’.

H.R. 2760. An act to designate the facility of the United States Postal Service located at 1615 North Wilcox Avenue in Los Angeles, California, as the ‘‘Johnny Grant Hollywood Post Office Building’’.

H.R. 2972. An act to designate the facility of the United States Postal Service located at 115 West Edward Street in Erath, Louisiana, as the ‘‘Conrad DeRouen, Jr. Post Office’’.

H.R. 3119. An act to designate the facility of the United States Postal Service located at 867 Stockton Street in San Francisco, California, as the ‘‘Lim Poon Lee Post Office’’.

H.R. 3386. An act to designate the facility of the United States Postal Service located at 1165 2nd Avenue in Des Moines, Iowa, as the ‘‘Iraq and Afghanistan Veterans Memorial Post Office’’.

H.R. 3547. An act to designate the facility of the United States Postal Service located at 936 South 250 East in Provo, Utah, as the ‘‘Rex E. Lee Post Office Building’’.

The enrolled bills were subsequently signed by the President pro tempore (Mr. BYRD).

At 10:35 a.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 3305. An act to designate the Federal building and United States courthouse located at 224 South Boulder Avenue in Tulsa, Oklahoma, as the ‘‘H. Dale Cook Federal Building and United States Courthouse’’.

H.R. 3360. An act to amend title 46, United States Code, to establish requirements to ensure the security and safety of passengers and crew on cruise vessels, and for other purposes.

H.R. 3618. An act to provide for implementation of the International Convention on the Control of Harmful Anti-Fouling Systems on Ships, 2001, and for other purposes.

At 1:08 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 214. Concurrent resolution providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 3305. An act to designate the Federal building and United States courthouse located at 224 South Boulder Avenue in Tulsa, Oklahoma, as the ‘‘H. Dale Cook Federal Building and United States Courthouse’’; to the Committee on Environment and Public Works.

H.R. 3618. An act to provide for implementation of the International Convention on the Control of Harmful Anti-Fouling Systems on Ships, 2001, and for other purposes; to the Committee on Commerce, Science, and Transportation.

MEASURES PLACED ON THE CALENDAR

The following bill was read the first and second times by unanimous consent, and placed on the calendar:

H.R. 3360. An act to amend title 46, United States Code, to establish requirements to ensure the security and safety of passengers and crew on cruise vessels, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3656. A communication from the Secretary of Defense, transmitting a report on the approved retirement of Vice Admiral William D. Sullivan, United States Navy, and his advancement to the grade of Vice Admiral on the retired list; to the Committee on Armed Services.

EC–3657. A communication from the Secretary of Defense, transmitting a report on the approved retirement of Lieutenant General Thomas R. Turner II, United States Army, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.

EC–3658. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled ‘‘Defense Federal Acquisition Regulation Supplement; World Trade Organization Government Procurement Agreement Designated Country’’ (DFARS Case 2009–D010) received in the Office of the President of the Senate on November 16, 2009; to the Committee on Armed Services.

EC–3659. A communication from the Chairman and President of the Export-Import Bank, transmitting, pursuant to law, a report relative to transactions involving U.S. exports to the United Kingdom; to the Committee on Banking, Housing, and Urban Affairs.

EC–3660. A communication from the Director, Financial Crimes Enforcement Network, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ‘‘Financial Crimes Enforcement Network; Amendment to the Bank Secrecy Act Regulations—Administrative Ruling System’’ (RIN1506–AB03) received in the Office of the President of the Senate on November 12, 2008; to the Committee on Banking, Housing, and Urban Affairs.

EC–3661. A communication from the Acting Director of Human Resources, Office of Administration and Resources Management, Environmental Protection Agency, transmitting, pursuant to law, (3) three reports relative to vacancies in the Environmental Protection Agency, received in the Office of the President of the Senate on November 16, 2009; to the Committee on Environment and Public Works.

EC–3662. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ‘‘Pollution Prevention Equipment’’ ((RIN1625–AA90) (Docket No. USG–2004–18939)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3663. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ‘‘Anchorages; New and Revised Anchorages in the Captain of the Port Portland, OR, Area of Responsibility’’ ((RIN1625–AA01) (Docket No. USG–2008–1232)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3664. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ‘‘Drawbridge Operation Regulations; East River, New York City, NY’’ ((RIN1625–AA09) (Docket No. USG–2009–0348)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3665. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ‘‘Drawbridge Operation Regulation; Atlantic Intracoastal Waterway (AIWW), Elizabeth River, Southern Branch, VA ‘‘ ((RIN1625–AA09) (Docket No. USG–2009–0814)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3666. A communication from the Attorney Advisor, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ‘‘Security Zone; Naval Base Point Loma; San Diego, CA’’ ((RIN1625–AA87) (Docket No. USG–2008–1016)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3667. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ‘‘Safety Zone; Catholic Church Processions, San Diego Bay, San Diego, CA’’ ((RIN1625–AA00) (Docket No. USG–2009–0812)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3668. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ‘‘Safety Zone; Waters Surrounding M/V Guilio Verne and Barge Hagar for the Transbay Cable Laying Project, San Francisco Bay, CA’’ ((RIN1625–AA00) (Docket No. USG–2009–0870)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3669. A communication from the Attorney, U.S. Coast Guard, Department of Homeland Security, transmitting, pursuant to

law, the report of a rule entitled ''Safety Zone; Beachfest Fireworks, Pacific Ocean, San Diego, CA'' ((RIN1625–AA00) (Docket No. USG–2009–0811)) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3670. A communication from the Acting Assistant Administrator of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Magnuson-Stevens Act Provisions; Fisheries Off West Coast States; Pacific Coast Groundfish Fishery; 2009 Management Measures for Petrale Sole'' (RIN0648–AY07) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3671. A communication from the Acting Assistant Administrator of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Central Gulf of Alaska Rockfish Program; Amendment 85'' (RIN0648–AX42) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3672. A communication from the Deputy Assistant Administrator for Regulatory Programs, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the United States Exclusive Economic Zone Off Alaska; Fisheries of the Arctic Management Area; Bering Sea Subarea'' (RIN0648–AX71) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3673. A communication from the Deputy Assistant Administrator for Regulatory Programs, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Pacific Halibut Fisheries; Subsistence Fishing'' (RIN0648–AX53) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3674. A communication from the Acting Director of Sustainable Fisheries, National Marine Fisheries Services, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Reallocation of Pacific Cod in the Bering Sea and Aleutian Islands Management Area'' (RIN0648–XS69) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3675. A communication from the Chief of Staff, Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Wheatland, Wyoming)'' (MB Docket No. 08–3) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3676. A communication from the Chief of Staff, Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Leupp, Arizona)'' (MB Docket No. 09–98) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3677. A communication from the Chief of Staff, Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Dubois, Wyoming)'' (MB Docket No. 09–83) received in the Office of the President of the Senate on November 12, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3678. A communication from the Assistant Chief Counsel for Hazardous Materials Safety, Pipeline and Hazardous Materials Safety Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Pipeline Safety: Incorporation by Reference Update: American Petroleum Institute (API) Standards 5L and 1104'' (RIN2137–AE42) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3679. A communication from the Senior Regulations Analyst, Office of the Secretary of Transportation, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Disadvantaged Business Enterprise Program; Inflationary Adjustment'' (RIN2105–AD79) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3680. A communication from the Program Analyst, National Highway Traffic Safety Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Federal Motor Vehicle Safety Standard No. 121; Air Brake Systems'' (RIN2127–AK44) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3681. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Pilot, Flight Instructor, and Pilot School Certification; Correction'' (RIN2120–AI86) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3682. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revision of Colored Federal Airway; Washington'' ((RIN2120–AA66)(Docket No. FAA–2009–0970)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3683. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of VOR Federal Airway V–626; UT'' ((RIN2120–AA66)(Docket No. FAA–2009–0311)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3684. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Restricted Areas and Other Special Use Airspace; Fallon, NV'' ((RIN2120–AA66)(Docket No. FAA–2009–0700)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3685. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Federal Airways V–163 and V–358 in the Lampasas, TX, Area'' ((RIN2120–AA66)(Docket No. FAA–2009–0128)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3686. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Production and Airworthiness Approvals, Part Marking, and Miscellaneous Amendments'' ((RIN2120–AJ44) (Docket No. FAA–2006–25877)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3687. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class D and E Airspace and Modification of Class E Airspace; State College, PA'' ((RIN2120–AA66)(Docket No. FAA–2009–0750)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3688. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class D and E Airspace; New Orleans NAS, LA'' ((RIN2120–AA66) (Docket No. FAA–2009–0405)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3689. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class D and Class E Airspace; Topeka, KS'' ((RIN2120–AA66)(Docket No. FAA–2009–0404)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3690. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Nantucket, MA'' ((RIN2120–AA66)(Docket No. FAA–2008–1253)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3691. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Noorvik, AK'' ((RIN2120–AA66)(Docket No. FAA–2009–0318)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3692. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Spencer, WV'' ((RIN2120–AA66)(Docket No. FAA–2009–0602)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3693. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class E Airspace; Anniston, AL'' ((RIN2120–AA66)(Docket No. FAA–2009–0653)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3694. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Modification of Class E Airspace; Beckley, WV'' ((RIN2120–AA66)(Docket No. FAA–2009–0651)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3695. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Tioga, ND'' ((RIN2120–AA66)(Docket No. FAA–2009–0504)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3696. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; St. Louis, MO'' ((RIN2120–AA66)(Docket No. FAA–2009–0541)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3697. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Peoria, IL'' ((RIN2120–AA66)(Docket No. FAA–2009–0511)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3698. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Many, LA'' ((RIN2120–AA66) (Docket No. FAA–2009–0536)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3699. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Midlothian-Waxahachie, TX'' ((RIN2120–AA66) (Docket No. FAA–2009–0513)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3700. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Winona, MN'' ((RIN2120–AA66) (Docket No. FAA–2009–0539)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3701. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Minden, NE'' ((RIN2120–AA66) (Docket No. FAA–2009–0542)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3702. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures (15); Amdt. No. 3347'' (RIN2120–AA65) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3703. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures (93); Amdt. No. 3346'' (RIN2120–AA65) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3704. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures (27); Amdt. No. 3343'' (RIN2120–AA65) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3705. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures (46); Amdt. No. 3344'' (RIN2120–AA65) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3706. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures (5); Amdt. No. 3345'' (RIN2120–AA65) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3707. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures (93); Amdt. No. 3342'' (RIN2120–AA65) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3708. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A310 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0996)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3709. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; International Aero Engines AG (IAE) V2500–A1, V2527E–A5, V2530–A5, and V2528–D5 Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0294)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3710. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 747–100, 747–100B, 747–100B SUD, 747–200B, 747–200C, 747–200F, 747–300, 747SR, 747SP Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1000)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3711. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 747–200C and 747–200F Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2008–1362)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3712. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Hawker Beechcraft Corporation Model 1900, 1900C, and 1900D Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2008–1312)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3713. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 767–200, –300, –300F, and –400ER Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0314)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3714. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Cessna Aircraft Company 150 and 152 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2007–27747)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3715. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Saab AB, Saab Aerosystems Model SAAB 340A (SAAB/SF340A) and SAAB 340B Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0910)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3716. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; ATR Model ATR42 and ATR72 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0999)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3717. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model CL–600–2C10 (Regional Jet Series 700, 701 & 702) Airplanes, Model CL–600–2D15 (Regional Jet Series 705) Airplanes, and Model CL–600–2D24 (Regional Jet Series 900) Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0998)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3718. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; EMBRAER Model EMB–120, –120ER, –120FC, –120QC, and –120RT Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1001)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3719. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model CL–600–2C10 (Regional Jet Series 700, 701 & 702), CL–600–2D15 (Regional Jet Series 705), and CL–600–2D24 (Regional Jet Series 900) Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0399)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3720. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bell Helicopter Textron Canada Model 407 and 427 Helicopters'' ((RIN2120–AA64)(Docket No. FAA–2009–1003)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3721. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Reims Aviation S.A. Model F406 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2007–0115)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3722. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Fokker Model F.27 Mark 050, 200, 300, 400, 500, 600, and 700 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1024)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3723. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; 328 Support Services GmbH Dornier Model 328–300 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1023)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. KERRY, from the Committee on Foreign Relations, without amendment and with a preamble:

H. Con. Res. 36. A concurrent resolution calling on the President and the allies of the United States to raise in all appropriate bilateral and multilateral fora the case of Robert Levinson at every opportunity, urging Iran to fulfill their promises of assistance to the family of Robert Levinson, and calling on Iran to share the results of its investigation into the disappearance of Robert Levinson with the Federal Bureau of Investigation.

S. Res. 341. A resolution supporting peace, security, and innocent civilians affected by conflict in Yemen.

S. Res. 345. A resolution deploring the rape and assault of women in Guinea and the killing of political protesters.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. HARKIN for the Committee on Health, Education, Labor, and Pensions.

*David Morris Michaels, of Maryland, to be an Assistant Secretary of Labor.

*Pamela S. Hyde, of New Mexico, to be Administrator of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. MERKLEY (for himself, Mr. BAUCUS, Mr. WYDEN, and Mr. TESTER):

S. 2791. A bill to authorize the Secretary of the Interior to grant economy-related contract extensions of a certain timber contracts between the Secretary of the Interior and timber purchasers, and for other purposes; to the Committee on Energy and Natural Resources.

By Mrs. GILLIBRAND:

S. 2792. A bill to amend the Federal Meat Inspection Act to develop an effective sampling and testing program to test for E. coli O157:H7 in boneless beef manufacturing trimmings and other raw ground beef components, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. LEAHY (for himself and Mr. VOINOVICH):

S. 2793. A bill to amend the Homeland Security Act of 2002 to provide for clarification on the use of funds relating to certain homeland security grants, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. SCHUMER:

S. 2794. A bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat; to the Committee on Finance.

By Mr. VITTER:

S. 2795. A bill to prevent terrorists and those at war with the United States from receiving the same treatment as United States citizens and to ensure that the trials of those individuals would not bring more harm or reduce national security in the United States; to the Committee on the Judiciary.

By Mr. ENZI (for himself, Mr. NELSON of Nebraska, Mr. ALEXANDER, Mr. BURR, Mr. COBURN, Mr. GREGG, Mr. HATCH, Mr. ISAKSON, Mr. MCCAIN, Ms. MURKOWSKI, and Mr. ROBERTS):

S. 2796. A bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. GREGG:

S. 2797. A bill to amend the Uniformed and Overseas Citizens Absentee Voting Act to provide an exemption from certain requirements for States that provide sufficient time to vote; to the Committee on Rules and Administration.

By Mr. UDALL of Colorado (for himself and Mr. RISCH):

S. 2798. A bill to reduce the risk of catastrophic wildfire through the facilitation of insect and disease infestation treatment of National Forest System and adjacent land, and for other purposes; to the Committee on Energy and Natural Resources.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. REID (for himself, Mr. MCCONNELL, Mr. ROCKEFELLER, Mr. AKAKA, Mr. ALEXANDER, Mr. BARRASSO, Mr. BAUCUS, Mr. BAYH, Mr. BEGICH, Mr. BENNET, Mr. BENNETT, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BROWN, Mr. BROWNBACK, Mr. BUNNING, Mr. BURR, Mr. BURRIS, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CASEY, Mr. CHAMBLISS, Mr. COBURN, Mr. COCHRAN, Ms. COLLINS, Mr. CONRAD, Mr. CORKER, Mr. CORNYN, Mr. CRAPO, Mr. DEMINT, Mr. DODD, Mr. DORGAN, Mr. DURBIN, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRANKEN, Mrs. GILLIBRAND, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mrs. HAGAN, Mr. HARKIN, Mr. HATCH, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUYE, Mr. ISAKSON, Mr. JOHANNS, Mr. JOHNSON, Mr. KAUFMAN, Mr. KERRY, Mr. KIRK, Ms. KLOBUCHAR, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEMIEUX, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LUGAR, Mr. MCCAIN, Mrs. MCCASKILL, Mr. MENENDEZ, Mr. MERKLEY, Ms. MIKULSKI, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Nebraska, Mr. NELSON of Florida, Mr. PRYOR, Mr. REED, Mr. RISCH, Mr. ROBERTS, Mr. SANDERS, Mr. SCHUMER, Mr. SESSIONS, Mrs. SHAHEEN, Mr. SHELBY, Ms. SNOWE, Mr. SPECTER, Ms. STABENOW, Mr. TESTER, Mr. THUNE, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mr. VITTER, Mr. VOINOVICH, Mr. WARNER, Mr. WEBB, Mr. WHITEHOUSE, Mr. WICKER, and Mr. WYDEN):

S. Res. 354. A resolution commending Robert C. Byrd, Senator from West Virginia; considered and agreed to.

ADDITIONAL COSPONSORS

S. 46

At the request of Mr. ENSIGN, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Minnesota (Ms. KLOBUCHAR) were added as cosponsors of S. 46, a bill to amend title XVIII of the Social Security Act to repeal the Medicare outpatient rehabilitation therapy caps.

S. 148

At the request of Mr. KOHL, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 148, a bill to restore the rule that agreements between manufacturers and retailers, distributors, or wholesalers to set the minimum price below which the manufacturer's product or service cannot be sold violates the Sherman Act.

S. 332

At the request of Mrs. FEINSTEIN, the name of the Senator from Massachusetts (Mr. KIRK) was added as a cosponsor of S. 332, a bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

S. 424

At the request of Mr. LEAHY, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 424, a bill to amend the Immigration and Nationality Act to eliminate discrimination in the immigration laws by permitting permanent partners of United States citizens and lawful permanent residents to obtain lawful permanent resident status in the same manner as spouses of citizens and lawful permanent residents and to penalize immigration fraud in connection with permanent partnerships.

S. 448

At the request of Mr. SPECTER, the name of the Senator from New Mexico (Mr. UDALL) was added as a cosponsor of S. 448, a bill to maintain the free flow of information to the public by providing conditions for the federally compelled disclosure of information by certain persons connected with the news media.

S. 510

At the request of Mr. BINGAMAN, his name was added as a cosponsor of S. 510, a bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the safety of the food supply.

S. 583

At the request of Mr. PRYOR, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 583, a bill to provide grants and loan guarantees for the development and construction of science parks to promote the clustering of innovation through high technology activities.

S. 599

At the request of Mr. CARPER, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 599, a bill to amend chapter 81 of title 5, United States Code, to create a presumption that a disability or death of a Federal employee in fire protection activities caused by any certain diseases is the result of the performance of such employee's duty.

S. 727

At the request of Ms. LANDRIEU, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 727, a bill to amend title 18, United States Code, to prohibit certain conduct relating to the use of horses for human consumption.

S. 812

At the request of Mr. UDALL of Colorado, his name was added as a cosponsor of S. 812, a bill to amend the Internal Revenue Code of 1986 to make permanent the special rule for contributions of qualified conservation contributions.

S. 825

At the request of Mrs. LINCOLN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 825, a bill to amend the Internal Revenue Code of 1986 to restore, increase, and make permanent the exclusion from gross income for amounts received under qualified group legal services plans.

S. 850

At the request of Mr. KERRY, the names of the Senator from Louisiana (Mr. VITTER) and the Senator from Maine (Ms. SNOWE) were added as cosponsors of S. 850, a bill to amend the High Seas Driftnet Fishing Moratorium Protection Act and the Magnuson-Stevens Fishery Conservation and Management Act to improve the conservation of sharks.

S. 857

At the request of Mr. SCHUMER, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 857, a bill to amend the Internal Revenue Code of 1986 to allow a $1,000 refundable credit for individuals who are bona fide volunteer members of volunteer firefighting and emergency medical service organizations.

S. 994

At the request of Ms. KLOBUCHAR, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 994, a bill to amend the Public Health Service Act to increase awareness of the risks of breast cancer in young women and provide support for young women diagnosed with breast cancer.

S. 1055

At the request of Mrs. BOXER, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1055, a bill to grant the congressional gold medal, collectively, to the 100th Infantry Battalion and the 442nd Regimental Combat Team, United States Army, in recognition of their dedicated service during World War II.

S. 1067

At the request of Mr. FEINGOLD, the names of the Senator from Illinois (Mr. DURBIN), the Senator from Washington (Mrs. MURRAY) and the Senator from Nevada (Mr. REID) were added as cosponsors of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1233

At the request of Ms. LANDRIEU, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 1233, a bill to reauthorize and improve the SBIR and STTR programs and for other purposes.

S. 1313

At the request of Mr. LUGAR, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1313, a bill to amend the Internal Revenue Code of 1986 to permanently extend and expand the charitable deduction for contributions of food inventory.

S. 1325

At the request of Mr. SPECTER, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 1325, a bill to amend the Internal Revenue Code of 1986 to permanently extend and modify the section 45 credit for refined coal from steel industry fuel, and for other purposes.

S. 1492

At the request of Ms. MIKULSKI, the name of the Senator from Missouri (Mrs. MCCASKILL) was added as a cosponsor of S. 1492, a bill to amend the Public Health Service Act to fund breakthroughs in Alzheimer's disease research while providing more help to caregivers and increasing public education about prevention.

S. 1524

At the request of Mr. KERRY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1524, a bill to strengthen the capacity, transparency, and accountability of United States foreign assistance programs to effectively adapt and respond to new challenges of the 21st century, and for other purposes.

S. 1606

At the request of Mr. WHITEHOUSE, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 1606, a bill to require foreign manufacturers of products imported into the United States to establish registered agents in the United States who are authorized to accept service of process against such manufacturers, and for other purposes.

S. 1681

At the request of Mr. LEAHY, the names of the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 1681, a bill to ensure that health insurance issuers and medical malpractice insurance issuers cannot engage in price fixing, bid rigging, or market allocations to the detriment of competition and consumers.

S. 1709

At the request of Ms. STABENOW, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 1709, a bill to amend the National Agricultural Research, Extension, and Teaching Policy Act of 1977 to establish a grant program to promote efforts to develop, implement, and sustain veterinary services, and for other purposes.

S. 1789

At the request of Mr. DURBIN, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 1789, a bill to restore fairness to Federal cocaine sentencing.

S. 1963

At the request of Mr. AKAKA, the names of the Senator from North Dakota (Mr. DORGAN), the Senator from Connecticut (Mr. DODD) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

S. 2607

At the request of Mr. REID, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 2607, a bill to amend the Department of the Interior, Environment, and Related Agencies Appropriations Act, 2010 to repeal a provision of that Act relating to geothermal energy receipts.

S. 2730

At the request of Mr. BROWN, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2747

At the request of Mr. BINGAMAN, the names of the Senator from New Mexico (Mr. UDALL) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. 2747, a bill to amend the Land and Water Conservation Fund Act of 1965 to provide consistent and reliable authority for, and for the funding of, the land and water conservation fund to maximize the effectiveness of the fund for future generations, and for other purposes.

S. 2752

At the request of Mr. VITTER, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 2752, a bill to ensure the sale and consumption of raw oysters and to direct the Food and Drug Administration to conduct an education campaign regarding the risks associated with consuming raw oysters, and for other purposes.

S. 2787

At the request of Mr. THUNE, the names of the Senator from Maine (Ms. SNOWE), the Senator from Mississippi (Mr. WICKER) and the Senator from Idaho (Mr. RISCH) were added as cosponsors of S. 2787, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. MERKLEY (for himself, Mr. BAUCUS, Mr. WYDEN, and Mr. TESTER):

S. 2791. A bill to authorize the Secretary of the Interior to grant economy-related contract extensions of certain timber contracts between the Secretary of the Interior and timber purchasers, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. MERKLEY. Mr. President, today I am pleased to be joined by my colleagues Senators RON WYDEN, MAX BAUCUS, and JON TESTER, as I introduce the Forest Harvest Opportunity Act. This legislation will provide a very simple, yet critical, solution to a significant problem currently facing timber communities across the country.

As we all know, rural communities across the country have been hit particularly hard by our current economic recession. The unemployment rate for rural counties is far greater than the national average; it surpasses 20 percent in many of the rural communities in my own home state. As my colleagues have heard me mention on numerous occasions, many of our rural communities have been doubly hurt by the current economic recession because they depend on harvests from federally-owned forest land as a major component of their economies. These communities have already been struggling because timber harvests on our Federal land have been declining, but they are facing even worse situations today because the collapse of the housing market has caused a precipitous drop in timber prices.

For some of our forestry companies, this creates an even worse situation: the contracts they have to harvest timber on Federal land are now worthless. Many of these contracts were signed with the Forest Service or the Bureau of Land Management before the recession, when timber prices were still high. However, because of the decline in timber prices, harvesting today would cost forest companies more than the wood is worth and could cause ruinous problems for some of these companies.

The solution is simple common sense: allow companies to apply for additional time to harvest wood they have contracted for in times of unique economic circumstances. This simple change would allow these companies to delay the harvest until the price of timber had returned to a point that enabled the forest companies to earn a profit on the harvest. This change is not a novel idea. In fact, the Forest Service has rules in place allowing to do exactly that. Unfortunately, the Bureau of Land Management does not have similar rules in place. So, based simply on which agency a company has a contract with—and in Oregon Forest Service and BLM lands can be side-by-side—these companies may be forced to harvest timber at a loss or walk away from a contract they have won after a fair bidding process.

The Forest Harvest Opportunity Act provides a simple solution and allows these companies—and only companies who have contracts right now during the current recession—to petition for and receive an extension so they can harvest when timber prices return to a normal rate. This bill is a simple solution to address an important problem. Enacting this legislation would provide significant economic help for communities that are already among the hardest-hit by this economic downturn. I look forward to working with my colleagues for its passage.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2791

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Forest Harvest Opportunity Act''.

SEC. 2. DEFINITIONS.

In this Act:

(1) ECONOMY-RELATED CONTRACT EXTENSION.—The term ''economy-related contract extension'' means the addition of 3 years to the expiration date of a qualifying contract for the right to cut and remove timber.

(2) QUALIFYING CONTRACT.—The term ''qualifying contract'' means a contract, executed on or before December 31, 2008, for the sale of timber from land administered by the Bureau of Land Management—

(A) for which there is unharvested volume remaining;

(B) for which, not later than 90 days after the date of enactment of this Act, the timber purchaser makes a written request to the Secretary for an economy-related contract extension; and

(C) that has not been terminated prior to the request for an economy-related contract extension under section 3(a).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior, acting through the Director of the Bureau of Land Management.

(4) TIMBER PURCHASER.—The term ''timber purchaser'' means the party to the qualifying contract for the sale of timber from land administered by the Bureau of Land Management.

SEC. 3. ECONOMY-RELATED CONTRACT EXTENSIONS.

(a) REQUEST.—Not later than 30 days after a timber purchaser requests an economy-related contract extension of a qualifying contract between the Secretary and the timber purchaser, the Secretary shall modify the qualifying contract to add 3 years to the contract expiration date.

(b) WAIVER OF CLAIMS AS OF EXTENSION.—The timber purchaser shall waive any and all claims the timber purchaser has against the United States involving the qualifying contract that exist on the date that the Secretary modifies the qualifying contract under subsection (a).

(c) CLAIMS PRIOR TO DATE OF EXTENSION.—Nothing in this Act affects any claim by the United States against any timber purchaser, including claims that arose under a qualifying contract before the date on which the Secretary extends the contract expiration date under subsection (a).

By Mr. LEAHY (for himself and Mr. VOINOVICH):

S. 2793. A bill to amend the Homeland Security Act of 2002 to provide for clarification on the use of funds relating to certain homeland security grants, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. LEAHY. Mr. President, today I am introducing the Strengthening and Updating Resources and Equipment, SURE, Act, a bill that will enable our country's first responders to maintain important equipment to protect our communities. I thank Senator VOINOVICH for his support of this important legislation. First responders across the country provide critical protection from attacks on our Nation, and we should ensure they have the tools they need to keep our communities safe and prepared.

On September 22, the Federal Emergency Management Agency announced a considerable change in their policy regarding the use of preparedness grants. The new guidelines state that recipients of Urban Area Security Initiative and State Homeland Security Grant Program SHSGP, funds may no longer use the funds for maintenance of equipment beyond the period of performance for the grant. This shifts the burden of maintenance costs for important homeland security equipment to States and communities, many of which are already struggling in the current economic downturn.

Much of the equipment purchased with these grants is complex and costly to maintain, and disallowing the use of grants to cover expensive maintenance costs means that many communities will have to forego the use of systems in which they have already invested precious resources. Also, many State and local governments may be unable to purchase essential equipment because they would be unable to cover the maintenance costs in future years.

A plan to implement a statewide communications system for first responders in my home state of Vermont is severely hampered by this policy change. State and local officials have been developing this system, known as the Lifeline System, for years and have planned for implementation by combining portions of 4 years of SHSGP grants with additional law enforcement funding. Upon completion of this important system for statewide coordination, considerable funds will be required to ensure that the system remains effective. If Vermont is unable to use preparedness grants for future maintenance, the Lifeline System may become inoperable, severely diminishing statewide coordination for homeland security and emergency management. I have heard from law enforcement officials in Vermont like Lieutenant Michael Manning of the Vermont State Police about how changes in these grant programs will affect state emergency law enforcement services.

The SURE Act would make changes to the Homeland Security Act of 2002 to clarify that the administrator of these grants may not place limitations on the use of preparedness grants for maintenance costs. This important clarification means that State and local law enforcement will be able to apply funds they receive to sustain the vital systems and equipment that have been put in place to keep our communities safe.

Our Nation's law enforcement officers deserve our commitment to provide them with the tools they need to carry out their duties. I support and respect our State and local police officers and all of our first responders, and am proud to recognize their role in upholding the rule of law and keeping our Nation safe and secure.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2793

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Strengthening and Updating Resources and Equipment Act'' or the ''SURE Act''.

SEC. 2. CLARIFICATION ON USE OF FUNDS RELATING TO CERTAIN HOMELAND SECURITY GRANTS.

(a) IN GENERAL.—Section 2008 of the Homeland Security Act of 2002 (6 U.S.C. 609) is amended—

(1) in subsection (a)(4), by inserting before the semicolon at the end the following: '', and any related maintenance agreements, user fees, or sustainment costs''; and

(2) in subsection (b)(3), by adding at the end the following:

''(C) EQUIPMENT MAINTENANCE.—With respect to the use of amounts awarded to a grant recipient under section 2003 or 2004 for equipment purchase and maintenance costs, the Administrator may not—

''(i) impose a limit on the amount of any such award that may be used to pay for such purchase and maintenance costs, including any costs referred to in subsection (a)(4); or

''(ii) impose any additional limitation, including any fiscal year limitation, beyond any limitation under this section, on the amount of any such award that may be used for a specific type, purpose, or category of equipment purchase or maintenance cost.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this section and shall apply to grants made under section 2003 or 2004 of the Homeland Security Act of 2002 (6 U.S.C. 604 and 605), in accordance with the provisions specified in section 2008 of such Act (6 U.S.C. 609), as amended by subsection (a) of this section, on or after October 1, 2008.

By Mr. ENZI (for himself, Mr. NELSON, of Nebraska, Mr. ALEXANDER, Mr. BURR, Mr. COBURN, Mr. GREGG, Mr. HATCH, Mr. ISAKSON, Mr. MCCAIN, Ms. MURKOWSKI, and Mr. ROBERTS):

S. 2796. A bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. ENZI. Mr. President, I rise today to introduce legislation to extend for 1 year the Ensuring Continued Access to Student Loans Act of 2008, ECASLA. Without this extension, hundreds of thousands of students may not have access to student loans for the 2010–2011 academic year.

Since 1965, the Federal Family Education Loan, FFEL, program has successfully helped millions of Americans realize the dream of a college education. Today, it continues to provide student loans for nearly 70 percent of America's college students at over 3,400 schools. However, during the credit crisis of 2008 many private, non-profit FFEL lenders encountered difficulty raising the necessary capital to make student loans, and others left the FFEL program. Congress responded by passing the bipartisan, cost-neutral Ensuring Continued Access to Student Loans Act of 2008. ECASLA preserved liquidity in the student loan market by giving the Secretary of Education temporary authority to purchase student loans made under the FFEL program. It has been a resounding success—it has preserved liquidity in the student loan market, it has been cost neutral, in fact it has generated revenue and, most importantly, it has maintained student access to FFEL loans.

However, while it was meant to be temporary, serious problems persist in the financial markets and many private, non-profit FFEL lenders are again considering leaving the FFEL program when ECASLA expires on July 1, 2010. The potential consequences could be catastrophic for America's college students, many of whom will be

unable to secure student loans for 2010–2011 academic year without a functioning FFEL program.

Given this predicament, the solution is simple—extend ECASLA for an additional year. Unfortunately, instead of working with Congress to pass a clean, bipartisan, one-year extension of ECASLA, the Department of Education is pursuing yet another government takeover and placing undue pressure on FFEL-participating schools to switch to the government-run Direct Loan, DL, program. Some schools will make this choice, but most do not want to because the FFEL program provides a product and services that meet individual student needs rather than the one-size-fits-all approach of the government-run DL program.

Moreover, schools begin making financial aid determinations in January—just seven weeks from now. Given that it can take 4 months to make the switch to the government-run DL program, most schools do not have the time, staff, resources or capacity to make the switch while at the same time attending to the financial aid needs of current and enrolling students. Furthermore, making the switch is not simply a matter of ''flipping a switch,'' as the Department of Education asserts. Among other things, schools must install new computer software, hire and train financial aid personnel, and receive substantial technical assistance from the Department of Education. While the Department has been able to successfully assist the several hundred schools that have made the switch over the past year, thousands will need assistance over the next 7 months. The Department simply does not have the resources to devote the necessary time and attention to all of these schools, which will frantically be trying to switch before ECASLA expires on July 1, 2010.

At this point, the only responsible course of action for Congress is to pass a clean, one-year extension of ECASLA. This will ensure that students have access to student loans, and will give Congress the time needed to have a serious and well thought discussion about the future of the Federal student loan program.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2796

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

SECTION 1. EXTENSION OF STUDENT LOAN PURCHASE AUTHORITY.

Section 459A of the Higher Education Act of 1965 (20 U.S.C. 1087i–1) is amended—

(1) in subsections (a)(1), (a)(3)(A), and (f), by striking ''July 1, 2010'' and inserting ''July 1, 2011''; and

(2) in subsection (e)—

(A) in the matter preceding clause (i) of paragraph (1)(A) and the matter preceding subparagraph (A) of paragraph (2), by striking ''September 30, 2010'' and inserting ''September 30, 2011'';

(B) in paragraph (2), by striking ''February 15, 2011'' and inserting ''February 15, 2012''; and

(C) in paragraph (3), by striking ''2010, and 2011'' and inserting ''2010, 2011, and 2012''.

SEC. 2. EXTENSION OF AUTHORITY TO DESIGNATE LENDERS FOR LENDER-OF-LAST-RESORT PROGRAM.

Section 428(j) of the Higher Education Act of 1965 (20 U.S.C. 1078(j)) is amended—

(1) in paragraph (6), by striking ''June 30, 2010'' and inserting ''June 30, 2011'';

(2) in paragraph (7), by striking ''June 30, 2010'' and inserting ''June 30, 2011''; and

(3) in paragraph (9)(A)—

(A) in the matter preceding subclause (I) of clause (ii), by striking ''June 30, 2011'' and inserting ''June 30, 2012'';

(B) in subclause (III) of clause (ii), by striking ''June 30, 2010'' and inserting ''June 30, 2011''; and

(C) in the matter preceding subclause (I) of clause (iii), by striking ''July 1, 2011'' and inserting ''July 1, 2012''.

By Mr. UDALL of Colorado (for himself and Mr. RISCH):

S. 2798. A bill to reduce the risk of catastrophic wildfire through the facilitation of insect and disease infestation treatment of National Forest System and adjacent land, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. UDALL of Colorado. Mr. President, today I am introducing, along with my colleague Senator RISCH, the National Forest Insect and Disease Emergency Act of 2009.

This bipartisan bill will provide additional tools and resources to the U.S. Forest Service to help address a serious natural disaster in many western forests—the deaths of millions of acres of trees due to insect infestations. This is an issue of long-standing concern in the West and of the utmost importance. Since my very first days in Congress nearly 11 years ago, I have been fighting for Colorado's forest health. This day has been a long time in coming for me, but it is by no means the end of the fight. We still have a long way to go in combating this problem, and it is a fight I intend to see to the end.

The bill that Senator RISCH and I are introducing today addresses any and all insect and disease outbreaks in our national forests. But this bill is in direct response to an especially pronounced epidemic of bark beetles in western States. This epidemic is creating serious concerns in our communities regarding our forested regions, the recreational economy of these areas, and water supplies and infrastructure that exist on these lands.

In essence, this bill is about securing our communities from a natural threat—a threat that is as potentially devastating and disruptive as a hurricane or an earthquake. This threat is a function of both human actions and natural processes—especially global climate change.

I recently had the chance to show one of our colleagues the devastating impact of the bark beetle epidemic. Senator JOHN MCCAIN joined me at a hearing of the National Parks Subcommittee, which I chair, in August in Estes Park, CO. Senator MCCAIN and I saw firsthand the march of the bark beetle as it is making its way through Rocky Mountain National Park. We were both struck by the extent of dead trees colored rust red by this insect.

Bark beetles and other insects that feed on trees are a natural part of the forest ecology. When present at normal levels, they provide benefits to the forest ecology by thinning dense tree stands, creating openings for wildlife, and promoting cyclical regrowth.

Today, various parts of the U.S.—but especially western States—continue to experience unnaturally large-scale infestations of bark beetles and other insects that have resulted from past policies and warming climate conditions.

Recent periods of drought have weakened the trees on Forest Service land and caused the trees to be more susceptible to fire and insects. In addition, population growth on land adjacent to Forest Service land has exacerbated the threats posed by insect-killed trees by placing large numbers of citizens, homes, and businesses at greater risk of catastrophic wildland fire.

And because hundreds of miles of power transmission lines and dozens of communication sites are surrounded by dead trees that will fall due to rotted root systems, the probability that trees will fall on power transmission lines, thereby resulting in wildfires and power transmission disruptions for long periods of time, has substantially increased.

Falling dead trees are also a hazard along hundreds of miles of roads and trails, threatening the safety of motorists and recreationists and disrupting access to, and through, Forest Service land. Hundreds of developed recreation sites, including campgrounds, picnic areas, and trailheads, contain dead trees that threaten recreationists. If these dead trees are not removed, these developed recreation sites will need to be closed to preserve public safety. We are in fact experiencing these closures in Colorado.

Moreover, parcels of Forest Service land in many locations contain headwaters of water supplies for many communities. Severe wildfires that remove vegetative cover pose a threat to the quantity and quality of water by exposing soil to erosion, thereby causing a transfer of sediment to rivers, reservoirs, and water conveyance systems. In other words, the fire threats posed by these dead trees can have serious implications to providing water not only to local communities, but also to

major cities downstream that rely upon rivers and streams flowing from forested mountain regions.

All of these concerns demand that we take action to help address these threats. That is what this bipartisan bill does.

It does so by establishing ''insect emergency areas''—that is, areas defined by the Forest Service as experiencing significant tree mortality that results in increased wildfire threats and risks to people and infrastructure from falling dead trees. These areas would be in the States from the Rocky Mountains to the Pacific coast, States that are experiencing large-scale insect outbreaks.

Within these areas, the Forest Service would be directed to provide priority treatment to reduce these threats. The Forest Service would also be allowed to apply funds from the Agricultural Credit Act program, which compensates individuals for removing biomass for productive uses, towards the removal of beetle-killed trees.

The bill also provides incentives to convert this removed vegetation into biofuels.

It allows the Forest Service to apply the streamlined National Environmental Policy Act provisions to expedite environmental analysis of the treatment work that is urgently needed in these high-priority emergency areas.

In addition to this focus on emergency areas the bill authorizes an important tool to help communities respond to wildfire threats on nearby Forest Service land. The States of Colorado and Utah have had the benefit of this tool since it was provided by Congress in 2000. This tool, called the ''Good Neighbor Authority,'' allows the Forest Service to contract with state foresters to enter Forest Service lands and implement treatments to reduce threats next to homes and private property whose owners have, in many cases, removed dead trees and performed treatments on their own property adjacent to Forest Service land. This program has been very successful, and the bill we are introducing today will allow all states to benefit from this authority and make it permanent law.

The bill also helps the Forest Service more effectively implement ''stewardship contracting'' as a tool for fuels treatment work. This contracting, which is distinct from traditional timber sale contracts, allows the Forest Service to fashion agreements to perform treatment for trees—like insect-killed trees—that may not have high commercial value. This program has also been extremely successful in helping to reduce fire threats in areas that do not possess high commercially valued timber.

However, the Forest Service has not had the funding it needs to use this tool more extensively. As a result, the bill would make this ''stewardship contracting'' program permanent, and it would eliminate the requirement that the Forest Service set aside funds in the very unlikely event that it would have to cancel these contracts and pay back the contractors. The bill would authorize the Forest Service to use other funds to cancel these contracts as well as seek appropriations to pay for any contract cancellations. In so doing, the bill will help make this tool more available and allow more funds to be applied to urgently needed, on-the-ground treatment work.

I have been working with Colorado communities, the Forest Service and stakeholders since 2000 on forest health issues and responding to this bark beetle threat. I have supported providing additional tools and resources to the Forest Service to respond to this threat, such as the Healthy Forest Restoration Act, and focusing increased funds in the high hazard wildland/urban interface near communities.

This bill is an effort to continue providing such tools and resources so that we can reduce the impacts to people and property, reduce loss of life fighting catastrophic wildfires, and promote a more healthy forest ecosystem. I am relieved that we in Colorado did not experience a serious wildfire season this year like we have experienced in years past—and like we will probably face in the years ahead. But we must be ready to respond to these fires that will inevitably come. This bill takes a step in that direction. It will not solve all issues related to forest health or stop all fires. Fire is a necessary part of our forests. But the bill will help us reduce threats and promote healthy ecosystems and economies.

I look forward to working with my colleagues from both sides of the aisle in seeing this bill passed.

Mr. President, I ask unanimous consent that the text of the bill and a bill summary be printed in the RECORD.

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

S. 2798

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Forest Insect and Disease Emergency Act of 2009''.

SEC. 2. PURPOSES.

The purposes of this Act are—

(1) to ensure that adequate emphasis is placed on the mitigation of hazards posed by large-scale infestations of bark beetles and other insects through the establishment of insect and disease emergency areas;

(2) to ensure that increased resources are available within each designated insect and disease emergency area to mitigate hazards associated with—

(A) falling trees;

(B) increased fire hazards; and

(C) the restoration of National Forest System land; and

(3) to make permanent, as of the date of enactment of this Act, existing good neighbor and stewardship contracting authorities.

SEC. 3. DEFINITIONS.

In this Act:

(1) AFFECTED STATE.—The term ''affected State'' includes each of the States of—

(A) Arizona;

(B) California;

(C) Colorado;

(D) Idaho;

(E) Montana;

(F) Nevada;

(G) New Mexico;

(H) Oregon;

(I) South Dakota;

(J) Utah;

(K) Washington; and

(L) Wyoming.

(2) INSECT AND DISEASE EMERGENCY AREA.—The term ''insect and disease emergency area'' means an area of National Forest System land—

(A) that is located in an affected State that is not—

(i) designated as wilderness; or

(ii) an area recommended for wilderness in a forest land and resource management plan;

(B) in which an insect and disease infestation emergency exists, as determined by the Secretary; and

(C) that is designated by—

(i) section 4(a); or

(ii) the Secretary under section 4(c).

(3) INSECT AND DISEASE INFESTATION EMERGENCY.—The term ''insect and disease infestation emergency'' means an insect or disease infestation that has resulted in—

(A) a current or future increased risk of catastrophic wildland fire; or

(B) an increased threat posed by hazard trees to—

(i) utility corridors;

(ii) communication sites;

(iii) roads;

(iv) recreation sites;

(v) water structures (such as reservoirs and water conveyance systems); or

(vi) other infrastructure.

(4) MAP.—The term ''map'' means the map entitled ''Insect Emergency Areas''.

(5) NATIONAL FOREST SYSTEM.—The term ''National Forest System'' has the meaning given the term in section 11(a) of the Forest and Rangeland Renewable Resources Planning Act of 1974 (16 U.S.C. 1609(a)).

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Agriculture.

SEC. 4. DESIGNATION OF INSECT AND DISEASE EMERGENCY AREAS.

(a) DESIGNATION.—Each area depicted on the map is designated as an insect and disease emergency area under this Act.

(b) MAP.—

(1) DUTY OF SECRETARY.—As soon as practicable after the date of enactment of this Act, the Secretary shall file the map for insect and disease emergency areas designated by subsection (a) with—

(A) the Committee on Energy and Natural Resources of the Senate;

(B) the Committee on Agriculture, Nutrition, and Forestry of the Senate;

(C) the Committee on Natural Resources of the House of Representatives; and

(D) the Committee on Agriculture of the House of Representatives.

(2) FORCE OF LAW.—The map filed under paragraph (1) shall have the same force and effect as if included in this subsection, except that the Secretary may correct typographical errors in the map and the legal descriptions.

(3) PUBLIC AVAILABILITY.—The map filed under paragraph (1) shall be on file and available for public inspection in the appropriate offices of the Forest Service.

(c) DESIGNATION BY SECRETARY.—

(1) IN GENERAL.—The Secretary may designate additional insect and disease emergency areas in accordance with each requirement described in this subsection.

(2) INITIATION.—The designation of an insect and disease emergency area may be made by the Secretary—

(A) on the initiative of the Secretary; or

(B) in response to a request by any Governor of an affected State.

(3) DEADLINE.—If the Governor of a State described in paragraph (2)(B) requests the Secretary to designate as an insect and disease emergency area an area located in the State, the Secretary shall accept or deny the request by a date that is not later than 90 days after the date on which the Secretary receives the request.

(4) LIMITATION ON DELEGATION.—With respect to National Forest System land, the Secretary, acting through the Chief of the Forest Service, may delegate the authority to make a designation under this subsection only to a Regional Forester of the National Forest System land.

(5) PROCEDURE.—If the Secretary designates an additional insect and disease emergency area under paragraph (1), the Secretary shall—

(A) publish a notice of the designation of the insect and disease emergency area (including a map of the insect and disease emergency area) in the Federal Register; and

(B) notify—

(i) each appropriate State; and

(ii) the appropriate committees of Congress.

(6) APPLICABILITY.—A designation made by the Secretary under paragraph (1) shall not be subject to—

(A) the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.);

(B) section 322 of the Department of the Interior and Related Agencies Appropriations Act, 1999 (Public Law 105–277; 112 Stat. 2681–289); or

(C) any other applicable law (including regulations).

SEC. 5. RESPONSE TO EMERGENCY DESIGNATION.

(a) PRIORITY TREATMENTS.—In carrying out the management of an insect and disease emergency area, the Secretary shall give priority consideration to—

(1) the removal of hazardous fuels and hazard trees on, and the restoration of the health of, National Forest System land located in the insect and disease emergency area; and

(2) the provision of assistance to State and local governments, Indian tribes, and private landowners for the removal of hazardous fuels and hazard trees on, and the restoration of the health of, each parcel of land located in the insect and disease emergency area—

(A) that is under the jurisdiction of the State or local government or Indian tribe; or

(B) the title of which is held by a private landowner; and

(3) the making of payments under section 9011(d)(1)(B) of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 8111(d)(1)(B)) to each individual or entity that collects or harvests renewable biomass from a parcel of National Forest System land located in an insect and disease emergency area.

(b) EMERGENCY FOREST RESTORATION.—In implementing the emergency forest restoration program under section 407 of the Agricultural Credit Act of 1978 (16 U.S.C. 2206), the Secretary may make payments to an owner of a parcel of nonindustrial private forest land that is located in an insect and disease emergency area to carry out emergency measures in response to an insect and disease infestation emergency under this Act.

(c) BIOMASS.—Any biomass removed from a parcel of land located in an insect and disease emergency area shall be considered to be renewable biomass for purposes of the renewable fuel standard under section 211(o) of the Clean Air Act (42 U.S.C. 7545(o)).

(d) HEALTHY FOREST RESTORATION.—

(1) AUTHORITY OF SECRETARY.—The Secretary may apply each requirement described in sections 104 and 105 of the Healthy Forests Restoration Act of 2003 (16 U.S.C. 6514, 6515) to projects that are carried out to remove hazardous fuels and hazard trees on, and to restore the health of, National Forest System land that is located in an insect and disease emergency area.

(2) JUDICIAL REVIEW.—Section 106 of the Healthy Forests Restoration Act of 2003 (16 U.S.C. 6516) shall apply to each project described in paragraph (1).

SEC. 6. GOOD NEIGHBOR AUTHORITY.

(a) STATE FOREST SERVICES.—

(1) AUTHORITY OF SECRETARY.—Notwithstanding chapter 63 of title 31, United States Code, and any provisions of law related to competition, the Secretary may enter into a contract (including a sole source contract) or agreement (including an agreement for the mutual benefit of the Secretary and the State), as appropriate and consistent with all applicable general and specific operating procedures established by the Forest Service for such contracts and agreements (including labor and wage requirements), with a State to permit the State to perform watershed restoration and protection services on National Forest System land located in the State if the State is carrying out similar and complementary watershed restoration and protection services on adjacent State or private land.

(2) AUTHORIZED SERVICES.—Watershed restoration and protection services described in paragraph (1) include—

(A) the treatment of insect-infested trees;

(B) the reduction of hazardous fuels; and

(C) any other activity that is carried out to restore or improve watersheds or fish and wildlife habitat across ownership boundaries.

(b) ADMINISTRATIVE PROVISIONS.—

(1) NATIONAL FOREST MANAGEMENT ACT OF 1976.—Subsections (d) and (g) of section 14 of the National Forest Management Act of 1976 (16 U.S.C. 472a) shall not apply to services performed under a contract or other agreement under subsection (a)(1).

(2) ASSUMPTION OF LIABILITY.—The State shall assume liability, to the extent allowed by Federal, State, and local law, for the actions or omissions of employees or subcontractors of the State in preparing or implementing a contract or agreement under this title.

(3) SUBCONTRACTS.—A State may subcontract, to the extent allowed by State and local law, to prepare or implement a contract or agreement under this title.

(4) DISPUTE RESOLUTION.—Any dispute under a contract or agreement under subsection (a)(1) shall be resolved in accordance with, as applicable—

(A) the dispute clause of the contract or agreement;

(B) the Contract Disputes Act of 1978 (41 U.S.C. 601 et seq.); or

(C) section 1491 of title 28, United States Code.

(c) RETENTION OF RESPONSIBILITIES UNDER NATIONAL ENVIRONMENTAL POLICY ACT OF 1969.—With respect to any watershed restoration and protection service on National Forest System land that is proposed to be carried out by a State under subsection (a), any decision required to be made under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.) may not be delegated to the State or any officer or employee of the State.

(d) APPLICABILITY.—

(1) IN GENERAL.—Subject to paragraph (2), the authority provided by this section applies only to National Forest System land located in affected States.

(2) SECRETARY OF THE INTERIOR.—With respect to public land that is located in an affected State and administered by the Secretary of the Interior (acting through the Bureau of Land Management), the Secretary of the Interior may carry out activities under this section on the public land.

SEC. 7. STEWARDSHIP CONTRACTING.

(a) CANCELLATION COSTS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, including section 304B of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 254c), the Secretary may not obligate funds to cover the cost of canceling a Forest Service multiyear stewardship contract under section 347 of the Department of the Interior and Related Agencies Appropriations Act, 1999 (16 U.S.C. 2104 note; Public Law 105–277) until the date on which the multiyear stewardship contract is cancelled.

(2) COSTS OF CANCELLATION OR TERMINATION.—The costs of any cancellation or termination of a multiyear stewardship contract described in paragraph (1) may be paid from any appropriations that are made available to the Forest Service.

(3) ANTI-DEFICIENCY ACT.—In the case in which the appropriations described in paragraph (2) are exhausted—

(A) the exhaustion shall not be considered to be a violation of section 1341 of title 31, United States Code; and

(B) the Secretary shall seek a supplemental appropriation.

(b) PERMANENT AUTHORITY.—Section 347(a) of the Department of the Interior and Related Agencies Appropriations Act, 1999 (16 U.S.C. 2104 note; Public Law 105–277) is amended by striking ''Until September 30, 2013, the'' and inserting ''The''.

SEC. 8. EFFECT.

Nothing in this Act affects or diminishes the rights of any owner of private property.

NATIONAL FOREST INSECT AND DISEASE EMERGENCY ACT OF 2009 SECTION BY SECTION SUMMARY

SEC. 1 SHORT TITLE

The National Forest Insect and Disease Emergency Act of 2009

SEC. 2 PURPOSES

(1) To ensure adequate emphasis is placed on the mitigation of hazards posed by large-scale infestation of bark beetles and other insects through the establishment of insect and disease emergency area;

(2) To ensure increased resources are available within each designated insect and disease emergency area to mitigate hazards associated with falling trees, increased fire hazards and the restoration of national forest system land, and;

(3) To make permanent, as of the date of enactment of this Act, existing good neighbor and stewardship contracting authorities.

SEC. 3 DEFINITIONS

This section describes which states are included in the provisions of this bill, as well as what constitutes an emergency area.

(1) Affected State: Those States that this bill includes. AZ, CA, CO, ID, MT, NV, NM, OR, SD, UT, WA, WY.

(2) Insect and Disease Emergency Area: Where the action mechanisms of this bill can be used.

(3) Insect and Disease Infestation Emergency: This section gives direction on what constitutes an emergency for action as described in this bill.

(4) Map: self descriptive.

(5) National Forest System: self descriptive.

(6) Secretary: of Agriculture

SEC. 4 DESIGNATION OF INSECT AND DISEASE EMERGENCY AREAS

This section describes how the 'map' is determined—either by the Secretary or by a request to the Secretary from the affected states' Governors. It also describes the public notification process and outlines how NEPA and any other applicable laws apply. This section essentially says the insect and disease emergency areas are lines on a map—without effect. The analysis of effects occurs when an action on the ground is proposed.

SEC. 5 RESPONSE TO EMERGENCY DESIGNATION

(a) Priority Treatments: This section describes priorities for treatment—not in order of preference. The intent is for the agency to treat the identified areas before general forest.

The section also allows for assistance to State and local governments, Indian tribes and private landowners for the removal of hazardous trees and restoration of the health of land located in the insect and disease emergency area.

(b) Biomass Use: This provision states priority should be given to those areas that are in the insect and disease emergency areas when determining BCAP funded areas. BCAP is to assist with the collection, harvest, storage, and transportation of biomass material. 'The Secretary shall make a payment for the delivery of eligible material to a biomass conversion facility to (1) a producer of an eligible crop that is produced on BCAP contract acreage; or (2) a person with the right to collect or harvest eligible material' The Biomass Crop Assistance Program (BCAP) provides financial assistance to producers or entities that deliver eligible biomass material to designated biomass conversion facilities for use as heat, power, biobased products or biofuels. Initial assistance will be for the collection, harvest, storage and transportation costs associated with the delivery of eligible materials.

(c) Emergency Forest Restoration: This section provides funding assistance through grants for people who remove biomass from private property. 'The Secretary may make payments to an owner of nonindustrial private forest land who carries out emergency measures to restore the land after the land is damaged by a natural disaster.' This section adds the emergency areas described by this bill under this authority.

(d) Biomass: This amends the definition of the renewable fuels standard. The RFS specifically excludes material from NFS lands—this would include those lands in the insect and disease emergency area.

(e) Healthy Forest Restoration: This section allows the Forest Service to apply the streamlined NEPA provisions of the Healthy Forest Restoration Act to hazardous fuels removal, hazard tree removal and restoration of the health of National Forest land in the insect and disease emergency areas.

SEC. 6 GOOD NEIGHBOR AUTHORITY

This provision makes the Good Neighbor authority permanent for all states.

SEC. 7 STEWARDSHIP CONTRACTING

This provision makes Stewardship contracting permanent. It also changes the current requirement of the Federal Acquisition Regulation to fund costs of cancelling a contract at the time of award for a multi-year stewardship contract to a requirement for payment of contract cancellation at the time such cancellation may occur.

SEC. 8 EFFECT

This section says that nothing in this act diminishes the right of private property owners.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 354—COMMENDING ROBERT C. BYRD, SENATOR FROM WEST VIRGINIA

Mr. REID (for himself, Mr. MCCONNELL, Mr. ROCKEFELLER, Mr. AKAKA, Mr. ALEXANDER, Mr. BARRASSO, Mr. BAUCUS, Mr. BAYH, Mr. BEGICH, Mr. BENNET, Mr. BENNETT, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BROWN, Mr. BROWNBACK, Mr. BUNNING, Mr. BURR, Mr. BURRIS, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CASEY, Mr. CHAMBLISS, Mr. COBURN, Mr. COCHRAN, Ms. COLLINS, Mr. CONRAD, Mr. CORKER, Mr. CORNYN, Mr. CRAPO, Mr. DEMINT, Mr. DODD, Mr. DORGAN, Mr. DURBIN, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRANKEN, Mrs. GILLIBRAND, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mrs. HAGAN, Mr. HARKIN, Mr. HATCH, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUYE, Mr. ISAKSON, Mr. JOHANNS, Mr. JOHNSON, Mr. KAUFMAN, Mr. KERRY, Mr. KIRK, Ms. KLOBUCHAR, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEMIEUX, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LUGAR, Mr. MCCAIN, Mrs. MCCASKILL, Mr. MENENDEZ, Mr. MERKLEY, Ms. MIKULSKI, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Nebraska, Mr. NELSON of Florida, Mr. PRYOR, Mr. REED, Mr. RISCH, Mr. ROBERTS, Mr. SANDERS, Mr. SCHUMER, Mr. SESSIONS, Mrs. SHAHEEN, Mr. SHELBY, Ms. SNOWE, Mr. SPECTER, Ms. STABENOW, Mr. TESTER, Mr. THUNE, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mr. VITTER, Mr. VOINOVICH, Mr. WARNER, Mr. WEBB, Mr. WHITEHOUSE, Mr. WICKER, and Mr. WYDEN) submitted the following resolution; which was considered and agreed to:

S. RES. 354

Whereas, Robert C. Byrd has served for fifty-six years in the United States Congress, making him the longest serving Member of Congress in history,

Whereas, Robert C. Byrd has served over fifty years in the United States Senate, and is the longest serving Senator in history, having been elected to nine full terms;

Whereas, Robert C. Byrd has had a long and distinguished record of public service to the people of West Virginia and the United States, having held more elective offices than any other individual in the history of West Virginia, and being the only West Virginian to have served in both Houses of the West Virginia Legislature and in both Houses of the United States Congress;

Whereas, Robert C. Byrd has served in the Senate leadership as President pro tempore, Majority Leader, Majority Whip, Minority Leader, and Secretary of the Majority Conference;

Whereas, Robert C. Byrd has served on a Senate committee, the Committee on Appropriations, which he has chaired during five Congresses, longer than any other Senator;

Whereas, Robert C. Byrd is the first Senator to have authored a comprehensive history of the United States Senate;

Whereas, Robert C. Byrd has throughout his service in the Senate vigilantly defended the Constitutional prerogatives of the Congress;

Whereas, Robert C. Byrd has played an essential role in the development and enactment of an enormous body of national legislative initiatives and policy over many decades: now, therefore be it

Resolved, That the Senate recognizes and commends Robert C. Byrd, Senator from West Virginia, for his fifty-six years of exemplary service in the Congress of the United States.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS

Mr. DORGAN. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, November 19, 2009, at 2:15 p.m. in Room 628 of the Dirksen Senate Office Building to conduct a business meeting on S. 1635, the 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009, and S. 1790, a bill to amend the Indian Health Care Improvement Act to revise and extend that act, and for other purposes, to be followed immediately by an oversight hearing to examine drug smuggling and gang activity in Indian country.

Those wishing additional information may contact the Indian Affairs Committee at 202–224–2251.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. REED. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on November 18, 2009, at 9:30 a.m. in room 106 of the Russell Senate Office Building.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. REED. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on November 18, 2009, at 2:30 p.m. in room 253 of the Russell Senate Office Building.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. REED. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet during the session of the Senate on November 18, 2009, at 9:30 a.m. in room 406 of the Dirksen Senate Office Building.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. REED. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on November 18, 2009, at 10:15 a.m.

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

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. REED. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet during the session of the Senate on November 18, 2009, at 10 a.m., in room 430 of the Dirksen Senate Office Building.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. REED. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 18, 2009.

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

COMMITTEE ON THE JUDICIARY

Mr. REED. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on November 18, 2009, at 9:30 a.m., in room SD–G50 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Oversight of the U.S. Department of Justice.''

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

COMMITTEE ON THE JUDICIARY

Mr. REED. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on November 18, 2009, at 2:30 p.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Nominations.''

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

COMMITTEE ON VETERANS' AFFAIRS

Mr. REED. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on November 18, 2009. The Committee will meet in room 418 of the Russell Senate Office Building beginning at 9:30 a.m.

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

AD HOC SUBCOMMITTEE ON CONTRACTING OVERSIGHT

Mr. REED. Mr. President, I ask unanimous consent that the Ad Hoc Subcommittee on Contracting Oversight of the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 18, 2009, at 2:30 p.m., to conduct a hearing entitled, ''Accountability for Foreign Contractors: The Lieutenant Colonel Dominic 'Rocky' Baragona Justice for American Heroes Harmed by Contractors Act.''

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

SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS

Mr. REED. Mr. President, I ask unanimous consent that the Subcommittee on Public Lands and Forests be authorized to meet during the session of the Senate to conduct a hearing on November 18, 2009, at 2:30 p.m., in room SD–366 of the Dirksen Senate Office Building.

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

MILITARY CONSTRUCTION, VETERANS AFFAIRS AND RELATED AGENCIES APPROPRIATIONS ACT, 2010

On Tuesday, November 17, 2009, the Senate passed H.R. 3082, as amended, as follows:

H.R. 3082

Resolved, That the bill from the House of Representatives (H.R. 3082) entitled ''An Act making appropriations for military construction, the Department of Veterans Affairs, and related agencies for the fiscal year ending September 30, 2010, and for other purposes.'', do pass with the following amendments:

Strike out all after the enacting clause and insert:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for military construction, the Department of Veterans Affairs, and related agencies for the fiscal year ending September 30, 2010, and for other purposes, namely:

TITLE I

DEPARTMENT OF DEFENSE

MILITARY CONSTRUCTION, ARMY

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Army as currently authorized by law, including personnel in the Army Corps of Engineers and other personal services necessary for the purposes of this appropriation, and for construction and operation of facilities in support of the functions of the Commander in Chief, $3,477,673,000, to remain available until September 30, 2014: Provided, That of this amount, not to exceed $191,573,000 shall be available for study, planning, design, architect and engineer services, and host nation support, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of the determination and the reasons therefor: Provided further, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, NAVY AND MARINE CORPS

For acquisition, construction, installation, and equipment of temporary or permanent public works, naval installations, facilities, and real property for the Navy and Marine Corps as currently authorized by law, including personnel in the Naval Facilities Engineering Command and other personal services necessary for the purposes of this appropriation, $3,548,771,000, to remain available until September 30, 2014: Provided, That of this amount, not to exceed $176,896,000 shall be available for study, planning, design, and architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of the determination and the reasons therefor: Provided further, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, AIR FORCE

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Air Force as currently authorized by law, $1,213,539,000, to remain available until September 30, 2014, of which $9,800,000 shall be for an Aircraft Fuel Systems Maintenance Dock at Columbus AFB, Mississippi: Provided, That of this amount, not to exceed $106,918,000 shall be available for study, planning, design, and architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of the determination and the reasons therefor: Provided further, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, DEFENSE-WIDE

(INCLUDING TRANSFER OF FUNDS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, installations, facilities, and real property for activities and agencies of the Department of Defense (other than the military departments), as currently authorized by law, $3,069,114,000, to remain available until September 30, 2014: Provided, That such amounts of this appropriation as may be determined by the Secretary of Defense may be transferred to such appropriations of the Department of Defense available for military construction or family housing as the Secretary may designate, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation or fund to which transferred: Provided further, That of the amount appropriated, not to exceed $142,942,000 shall be available for study, planning, design, and architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of the determination and the reasons therefor: Provided

further, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $497,210,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, AIR NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $297,661,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, ARMY RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $379,012,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, NAVY RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the reserve components of the Navy and Marine Corps as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $64,124,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

MILITARY CONSTRUCTION, AIR FORCE RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air Force Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $47,376,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

NORTH ATLANTIC TREATY ORGANIZATION SECURITY INVESTMENT PROGRAM

For the United States share of the cost of the North Atlantic Treaty Organization Security Investment Program for the acquisition and construction of military facilities and installations (including international military headquarters) and for related expenses for the collective defense of the North Atlantic Treaty Area as authorized by section 2806 of title 10, United States Code, and Military Construction Authorization Acts, $276,314,000, to remain available until expended: Provided, That of the amount appropriated, not to exceed $41,400,000 shall be available for the United States share of the planning, design and construction of a new North Atlantic Treaty Organization headquarters.

FAMILY HOUSING CONSTRUCTION, ARMY

For expenses of family housing for the Army for construction, including acquisition, replacement, addition, expansion, extension, and alteration, as authorized by law, $273,236,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

FAMILY HOUSING OPERATION AND MAINTENANCE, ARMY

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $523,418,000.

FAMILY HOUSING CONSTRUCTION, NAVY AND MARINE CORPS

For expenses of family housing for the Navy and Marine Corps for construction, including acquisition, replacement, addition, expansion, extension, and alteration, as authorized by law, $146,569,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

FAMILY HOUSING OPERATION AND MAINTENANCE, NAVY AND MARINE CORPS

For expenses of family housing for the Navy and Marine Corps for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $368,540,000.

FAMILY HOUSING CONSTRUCTION, AIR FORCE

For expenses of family housing for the Air Force for construction, including acquisition, replacement, addition, expansion, extension, and alteration, as authorized by law, $66,101,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

FAMILY HOUSING OPERATION AND MAINTENANCE, AIR FORCE

For expenses of family housing for the Air Force for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $502,936,000.

FAMILY HOUSING CONSTRUCTION, DEFENSE-WIDE

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $2,859,000, to remain available until September 30, 2014: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

FAMILY HOUSING OPERATION AND MAINTENANCE, DEFENSE-WIDE

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for operation and maintenance, leasing, and minor construction, as authorized by law, $49,214,000.

DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND

For the Department of Defense Family Housing Improvement Fund, $2,600,000, to remain available until expended, for family housing initiatives undertaken pursuant to section 2883 of title 10, United States Code, providing alternative means of acquiring and improving military family housing and supporting facilities.

HOMEOWNERS ASSISTANCE FUND

For the Homeowners Assistance Fund established by section 1013 of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3374), as amended by section 1001 of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat. 194), $373,225,000, to remain available until expended.

CHEMICAL DEMILITARIZATION CONSTRUCTION, DEFENSE-WIDE

For expenses of construction, not otherwise provided for, necessary for the destruction of the United States stockpile of lethal chemical agents and munitions in accordance with section 1412 of the Department of Defense Authorization Act, 1986 (50 U.S.C. 1521), and for the destruction of other chemical warfare materials that are not in the chemical weapon stockpile, as currently authorized by law, $151,541,000, to remain available until September 30, 2014, which shall be only for the Assembled Chemical Weapons Alternatives program: Provided, That the amounts made available under this heading shall be expended for the projects and activities, and in the amounts specified, under this heading in the Committee recommendations and detail tables, including the table entitled ''Military Construction Projects Listing by Location'' in the report accompanying this Act.

DEPARTMENT OF DEFENSE BASE CLOSURE ACCOUNT 1990

For deposit into the Department of Defense Base Closure Account 1990, established by section 2906(a)(1) of the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. 2687 note), $421,768,000, to remain available until expended.

DEPARTMENT OF DEFENSE BASE CLOSURE ACCOUNT 2005

For deposit into the Department of Defense Base Closure Account 2005, established by section 2906A(a)(1) of the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. 2687

note), $7,479,498,000, to remain available until expended: Provided, That the Department of Defense shall notify the Committees on Appropriations of both Houses of Congress 14 days prior to obligating an amount for a construction project that exceeds or reduces the amount identified for that project in the most recently submitted budget request for this account by 20 percent or $2,000,000, whichever is less: Provided further, That the previous proviso shall not apply to projects costing less than $5,000,000, except for those projects not previously identified in any budget submission for this account and exceeding the minor construction threshold under 10 U.S.C. 2805.

ADMINISTRATIVE PROVISIONS

SEC. 101. None of the funds made available in this title shall be expended for payments under a cost-plus-a-fixed-fee contract for construction, where cost estimates exceed $25,000, to be performed within the United States, except Alaska, without the specific approval in writing of the Secretary of Defense setting forth the reasons therefor.

SEC. 102. Funds made available in this title for construction shall be available for hire of passenger motor vehicles.

SEC. 103. Funds made available in this title for construction may be used for advances to the Federal Highway Administration, Department of Transportation, for the construction of access roads as authorized by section 210 of title 23, United States Code, when projects authorized therein are certified as important to the national defense by the Secretary of Defense.

SEC. 104. None of the funds made available in this title may be used to begin construction of new bases in the United States for which specific appropriations have not been made.

SEC. 105. None of the funds made available in this title shall be used for purchase of land or land easements in excess of 100 percent of the value as determined by the Army Corps of Engineers or the Naval Facilities Engineering Command, except: (1) where there is a determination of value by a Federal court; (2) purchases negotiated by the Attorney General or the designee of the Attorney General; (3) where the estimated value is less than $25,000; or (4) as otherwise determined by the Secretary of Defense to be in the public interest.

SEC. 106. None of the funds made available in this title shall be used to: (1) acquire land; (2) provide for site preparation; or (3) install utilities for any family housing, except housing for which funds have been made available in annual Acts making appropriations for military construction.

SEC. 107. None of the funds made available in this title for minor construction may be used to transfer or relocate any activity from one base or installation to another, without prior notification to the Committees on Appropriations of both Houses of Congress.

SEC. 108. None of the funds made available in this title may be used for the procurement of steel for any construction project or activity for which American steel producers, fabricators, and manufacturers have been denied the opportunity to compete for such steel procurement.

SEC. 109. None of the funds available to the Department of Defense for military construction or family housing during the current fiscal year may be used to pay real property taxes in any foreign nation.

SEC. 110. None of the funds made available in this title may be used to initiate a new installation overseas without prior notification to the Committees on Appropriations of both Houses of Congress.

SEC. 111. None of the funds made available in this title may be obligated for architect and engineer contracts estimated by the Government to exceed $500,000 for projects to be accomplished in Japan, in any North Atlantic Treaty Organization member country, or in countries bordering the Arabian Sea, unless such contracts are awarded to United States firms or United States firms in joint venture with host nation firms.

SEC. 112. None of the funds made available in this title for military construction in the United States territories and possessions in the Pacific and on Kwajalein Atoll, or in countries bordering the Arabian Sea, may be used to award any contract estimated by the Government to exceed $1,000,000 to a foreign contractor: Provided, That this section shall not be applicable to contract awards for which the lowest responsive and responsible bid of a United States contractor exceeds the lowest responsive and responsible bid of a foreign contractor by greater than 20 percent: Provided furtherThat this section shall not apply to contract awards for military construction on Kwajalein Atoll for which the lowest responsive and responsible bid is submitted by a Marshallese contractor.

SEC. 113. The Secretary of Defense is to inform the appropriate committees of both Houses of Congress, including the Committees on Appropriations, of the plans and scope of any proposed military exercise involving United States personnel 30 days prior to its occurring, if amounts expended for construction, either temporary or permanent, are anticipated to exceed $100,000.

SEC. 114. Not more than 20 percent of the funds made available in this title which are limited for obligation during the current fiscal year shall be obligated during the last two months of the fiscal year.

(INCLUDING TRANSFER OF FUNDS)

SEC. 115. Funds appropriated to the Department of Defense for construction in prior years shall be available for construction authorized for each such military department by the authorizations enacted into law during the current session of Congress.

SEC. 116. For military construction or family housing projects that are being completed with funds otherwise expired or lapsed for obligation, expired or lapsed funds may be used to pay the cost of associated supervision, inspection, overhead, engineering and design on those projects and on subsequent claims, if any.

SEC. 117. Notwithstanding any other provision of law, any funds made available to a military department or defense agency for the construction of military projects may be obligated for a military construction project or contract, or for any portion of such a project or contract, at any time before the end of the fourth fiscal year after the fiscal year for which funds for such project were made available, if the funds obligated for such project: (1) are obligated from funds available for military construction projects; and (2) do not exceed the amount appropriated for such project, plus any amount by which the cost of such project is increased pursuant to law.

SEC. 118. (a) The Secretary of Defense, in consultation with the Secretary of State, shall submit to the Committees on Appropriations of both Houses of Congress, by February 15 of each year, an annual report in unclassified and, if necessary, classified form, on actions taken by the Department of Defense and the Department of State during the previous fiscal year to encourage host countries to assume a greater share of the common defense burden of such countries and the United States.

(b) The report under subsection (a) shall include a description of—

(1) attempts to secure cash and in-kind contributions from host countries for military construction projects;

(2) attempts to achieve economic incentives offered by host countries to encourage private investment for the benefit of the United States Armed Forces;

(3) attempts to recover funds due to be paid to the United States by host countries for assets deeded or otherwise imparted to host countries upon the cessation of United States operations at military installations;

(4) the amount spent by host countries on defense, in dollars and in terms of the percent of gross domestic product (GDP) of the host country; and

(5) for host countries that are members of the North Atlantic Treaty Organization (NATO), the amount contributed to NATO by host countries, in dollars and in terms of the percent of the total NATO budget.

(c) In this section, the term ''host country'' means other member countries of NATO, Japan, South Korea, and United States allies bordering the Arabian Sea.

(INCLUDING TRANSFER OF FUNDS)

SEC. 119. In addition to any other transfer authority available to the Department of Defense, proceeds deposited to the Department of Defense Base Closure Account established by section 207(a)(1) of the Defense Authorization Amendments and Base Closure and Realignment Act (10 U.S.C. 2687 note) pursuant to section 207(a)(2)(C) of such Act, may be transferred to the account established by section 2906(a)(1) of the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. 2687 note), to be merged with, and to be available for the same purposes and the same time period as that account.

(INCLUDING TRANSFER OF FUNDS)

SEC. 120. Subject to 30 days prior notification to the Committees on Appropriations of both Houses of Congress, such additional amounts as may be determined by the Secretary of Defense may be transferred to: (1) the Department of Defense Family Housing Improvement Fund from amounts appropriated for construction in ''Family Housing'' accounts, to be merged with and to be available for the same purposes and for the same period of time as amounts appropriated directly to the Fund; or (2) the Department of Defense Military Unaccompanied Housing Improvement Fund from amounts appropriated for construction of military unaccompanied housing in ''Military Construction'' accounts, to be merged with and to be available for the same purposes and for the same period of time as amounts appropriated directly to the Fund: Provided, That appropriations made available to the Funds shall be available to cover the costs, as defined in section 502(5) of the Congressional Budget Act of 1974, of direct loans or loan guarantees issued by the Department of Defense pursuant to the provisions of subchapter IV of chapter 169 of title 10, United States Code, pertaining to alternative means of acquiring and improving military family housing, military unaccompanied housing, and supporting facilities.

SEC. 121. (a) Not later than 60 days before issuing any solicitation for a contract with the private sector for military family housing the Secretary of the military department concerned shall submit to the Committees on Appropriations of both Houses of Congress the notice described in subsection (b).

(b)(1) A notice referred to in subsection (a) is a notice of any guarantee (including the making of mortgage or rental payments) proposed to be made by the Secretary to the private party under the contract involved in the event of—

(A) the closure or realignment of the installation for which housing is provided under the contract;

(B) a reduction in force of units stationed at such installation; or

(C) the extended deployment overseas of units stationed at such installation.

(2) Each notice under this subsection shall specify the nature of the guarantee involved

and assess the extent and likelihood, if any, of the liability of the Federal Government with respect to the guarantee.

(INCLUDING TRANSFER OF FUNDS)

SEC. 122. In addition to any other transfer authority available to the Department of Defense, amounts may be transferred from the accounts established by sections 2906(a)(1) and 2906A(a)(1) of the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. 2687 note), to the fund established by section 1013(d) of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3374) to pay for expenses associated with the Homeowners Assistance Program incurred under 42 U.S.C. 3374(a)(1)(A). Any amounts transferred shall be merged with and be available for the same purposes and for the same time period as the fund to which transferred.

SEC. 123. Funds made available in this title for operation and maintenance of family housing shall be the exclusive source of funds for repair and maintenance of all family housing units, including general or flag officer quarters: Provided, That not more than $35,000 per unit may be spent annually for the maintenance and repair of any general or flag officer quarters without 30 days prior notification to the Committees on Appropriations of both Houses of Congress, except that an after-the-fact notification shall be submitted if the limitation is exceeded solely due to costs associated with environmental remediation that could not be reasonably anticipated at the time of the budget submission: Provided further, That the Under Secretary of Defense (Comptroller) is to report annually to the Committees on Appropriations of both Houses of Congress all operation and maintenance expenditures for each individual general or flag officer quarters for the prior fiscal year.

SEC. 124. Amounts contained in the Ford Island Improvement Account established by subsection (h) of section 2814 of title 10, United States Code, are appropriated and shall be available until expended for the purposes specified in subsection (i)(1) of such section or until transferred pursuant to subsection (i)(3) of such section.

(INCLUDING TRANSFER OF FUNDS)

SEC. 125. None of the funds made available in this title, or in any Act making appropriations for military construction which remain available for obligation, may be obligated or expended to carry out a military construction, land acquisition, or family housing project at or for a military installation approved for closure, or at a military installation for the purposes of supporting a function that has been approved for realignment to another installation, in 2005 under the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510; 10 U.S.C. 2687 note), unless such a project at a military installation approved for realignment will support a continuing mission or function at that installation or a new mission or function that is planned for that installation, or unless the Secretary of Defense certifies that the cost to the United States of carrying out such project would be less than the cost to the United States of cancelling such project, or if the project is at an active component base that shall be established as an enclave or in the case of projects having multi-agency use, that another Government agency has indicated it will assume ownership of the completed project. The Secretary of Defense may not transfer funds made available as a result of this limitation from any military construction project, land acquisition, or family housing project to another account or use such funds for another purpose or project without the prior approval of the Committees on Appropriations of both Houses of Congress. This section shall not apply to military construction projects, land acquisition, or family housing projects for which the project is vital to the national security or the protection of health, safety, or environmental quality: Provided, That the Secretary of Defense shall notify the congressional defense committees within seven days of a decision to carry out such a military construction project.

(INCLUDING TRANSFER OF FUNDS)

SEC. 126. During the 5-year period after appropriations available in this Act to the Department of Defense for military construction and family housing operation and maintenance and construction have expired for obligation, upon a determination that such appropriations will not be necessary for the liquidation of obligations or for making authorized adjustments to such appropriations for obligations incurred during the period of availability of such appropriations, unobligated balances of such appropriations may be transferred into the appropriation ''Foreign Currency Fluctuations, Construction, Defense'', to be merged with and to be available for the same time period and for the same purposes as the appropriation to which transferred.

SEC. 127. Amounts appropriated or otherwise made available in an account funded under the headings in this title may be transferred among projects and activities within that account in accordance with the reprogramming guidelines for military construction and family housing construction contained in the report accompanying this Act, and in the guidance for military construction reprogrammings and notifications contained in Department of Defense Financial Management Regulation 7000.14–R, Volume 3, Chapter 7, of December 1996, as in effect on the date of enactment of this Act.

SEC. 128. (a) During each of fiscal years 2010 through 2014, the Secretary of Defense shall submit to the congressional defense committees a report analyzing alternative designs for any major construction projects requested in that fiscal year related to the security of strategic nuclear weapons facilities.

(b) The report shall examine, with regard to each alternative—

(1) the costs, including full life cycle costs; and

(2) the benefits, including security enhancements.

SEC. 129. Not later than each of April 15, 2010, July 15, 2010, and October 15, 2010, the Secretary of Defense shall submit to the congressional defense committees a consolidated report from each of the military departments and Defense agencies identifying, by project and dollar amount, bid savings resulting from cost and scope variations pursuant to section 2853 of title 10, United States Code, exceeding 25 percent of the appropriated amount for military construction projects funded by this Act, the Supplemental Appropriations Act, 2009 (Public Law 111–32), and the Military Construction and Veterans Affairs Appropriations Act, 2009 (division E of Public Law 110–329), including projects funded through the regular military construction accounts, the Department of Defense Base Closure Account 2005, and the overseas contingency operations military construction accounts.

SEC. 130. (a) Of the funds appropriated or otherwise made available by this title under the heading ''DEPARTMENT OF DEFENSE BASE CLOSURE ACCOUNT, 2005'', $450,000 shall be available for the Secretary of Defense to enter into an arrangement with the National Academy of Sciences to conduct a study through the Transportation Research Board of Federal funding of transportation improvements to accommodate installation growth associated with the 2005 Defense Base Closure and Realignment (BRAC) program.

(b) The study conducted pursuant to subsection (a) shall—

(1) examine case studies of congestion caused on metropolitan road and transit facilities when BRAC requirements cause shifts in personnel to occur faster than facilities can be improved through the usual State and local processes;

(2) review the criteria used by the Defense Access Roads (DAR) program for determining the eligibility of transportation projects and the appropriate Department of Defense share of public highway and transit improvements in BRAC cases;

(3) assess the adequacy of current Federal surface transportation and Department of Defense programs that fund highway and transit improvements in BRAC cases to mitigate transportation impacts in urban areas with preexisting traffic congestion and saturated roads;

(4) identify promising approaches for funding road and transit improvements and streamlining transportation project approvals in BRAC cases; and

(5) provide recommendations for modifications of current policy for the DAR and Office of Economic Adjustment programs, including funding strategies, road capacity assessments, eligibility criteria, and other government policies and programs the National Academy of Sciences may identify, to mitigate the impact of BRAC-related installation growth on preexisting urban congestion.

(c) The Secretary of Defense shall enter into an arrangement with the National Academy of Sciences to provide the study conducted pursuant to subsection (a) by not later than 45 days after the date of the enactment of the Act.

(d)(1) Not later than May 15, 2010, the National Academy of Sciences shall provide an interim report of its findings to the Secretary of Defense and the Committees on Armed Services and Appropriations of the Senate and the House of Representatives.

(2) Not later than January 31, 2011, the National Academy of Sciences shall provide a final report of its findings to the Secretary of Defense and the Committees on Armed Services and Appropriations of the Senate and the House of Representatives.

SEC. 131. (a)(1) The amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, AIR FORCE'' is hereby increased by $37,500,000.

(2) Of the amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, AIR FORCE'', as increased by paragraph (1), $37,500,000 shall be available for construction of an Unmanned Aerial System Field Training Complex at Holloman Air Force Base, New Mexico.

(b) Of the amount appropriated or otherwise made available by title I of the Military Construction and Veterans Affairs Appropriations Act, 2009 (division E of Public Law 110–329; 122 Stat. 3692) under the heading ''MILITARY CONSTRUCTION, AIR FORCE'' and available for the purpose of Unmanned Aerial System Field Training facilities construction, $38,500,000 is hereby rescinded.

SEC. 132. (a)(1) The amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, DEFENSE-WIDE'' is hereby increased by $68,500,000, with the amount of such increase to remain available until September 30, 2014.

(2) Of the amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, DEFENSE-WIDE'', as increased by paragraph (1), $68,500,000 shall be available for the construction of an Aegis Ashore Test Facility at the Pacific Missile Range Facility, Hawaii.

(b) Of the amount appropriated or otherwise made available by title I of the Military Construction and Veterans Affairs Appropriations Act, 2009 (division E of Public Law 110–329; 122

Stat. 3692) under the heading ''MILITARY CONSTRUCTION, DEFENSE-WIDE'' and available for the purpose of European Ballistic Missile Defense program construction, $69,500,000 is hereby rescinded.

TITLE II

DEPARTMENT OF VETERANS AFFAIRS

VETERANS BENEFITS ADMINISTRATION

COMPENSATION AND PENSIONS

(INCLUDING TRANSFER OF FUNDS)

For the payment of compensation benefits to or on behalf of veterans and a pilot program for disability examinations as authorized by section 107 and chapters 11, 13, 18, 51, 53, 55, and 61 of title 38, United States Code; pension benefits to or on behalf of veterans as authorized by chapters 15, 51, 53, 55, and 61 of title 38, United States Code; and burial benefits, the Reinstated Entitlement Program for Survivors, emergency and other officers' retirement pay, adjusted-service credits and certificates, payment of premiums due on commercial life insurance policies guaranteed under the provisions of title IV of the Servicemembers Civil Relief Act (50 U.S.C. App. 541 et seq.) and for other benefits as authorized by sections 107, 1312, 1977, and 2106, and chapters 23, 51, 53, 55, and 61 of title 38, United States Code, $47,218,207,000, to remain available until expended: Provided, That not to exceed $29,283,000 of the amount appropriated under this heading shall be reimbursed to ''General operating expenses'', ''Medical support and compliance'', and ''Information technology systems'' for necessary expenses in implementing the provisions of chapters 51, 53, and 55 of title 38, United States Code, the funding source for which is specifically provided as the ''Compensation and pensions'' appropriation: Provided further, That such sums as may be earned on an actual qualifying patient basis, shall be reimbursed to ''Medical care collections fund'' to augment the funding of individual medical facilities for nursing home care provided to pensioners as authorized.

READJUSTMENT BENEFITS

For the payment of readjustment and rehabilitation benefits to or on behalf of veterans as authorized by chapters 21, 30, 31, 33, 34, 35, 36, 39, 51, 53, 55, and 61 of title 38, United States Code, $8,663,624,000, to remain available until expended: Provided, That expenses for rehabilitation program services and assistance which the Secretary is authorized to provide under subsection (a) of section 3104 of title 38, United States Code, other than under paragraphs (1), (2), (5), and (11) of that subsection, shall be charged to this account.

VETERANS INSURANCE AND INDEMNITIES

For military and naval insurance, national service life insurance, servicemen's indemnities, service-disabled veterans insurance, and veterans mortgage life insurance as authorized by title 38, United States Code, chapters 19 and 21, $49,288,000, to remain available until expended.

VETERANS HOUSING BENEFIT PROGRAM FUND

For the cost of direct and guaranteed loans, such sums as may be necessary to carry out the program, as authorized by subchapters I through III of chapter 37 of title 38, United States Code: Provided, That such costs, including the cost of modifying such loans, shall be as defined in section 502 of the Congressional Budget Act of 1974: Provided further, That during fiscal year 2010, within the resources available, not to exceed $500,000 in gross obligations for direct loans are authorized for specially adapted housing loans.

In addition, for administrative expenses to carry out the direct and guaranteed loan programs, $165,082,000.

VOCATIONAL REHABILITATION LOANS PROGRAM ACCOUNT

(INCLUDING TRANSFER OF FUNDS)

For the cost of direct loans, $29,000, as authorized by chapter 31 of title 38, United States Code: Provided, That such costs, including the cost of modifying such loans, shall be as defined in section 502 of the Congressional Budget Act of 1974: Provided further, That funds made available under this heading are available to subsidize gross obligations for the principal amount of direct loans not to exceed $2,298,000.

In addition, for administrative expenses necessary to carry out the direct loan program, $328,000, which may be paid to the appropriation for ''General operating expenses''.

NATIVE AMERICAN VETERAN HOUSING LOAN PROGRAM ACCOUNT

For administrative expenses to carry out the direct loan program authorized by subchapter V of chapter 37 of title 38, United States Code, $664,000.

GUARANTEED TRANSITIONAL HOUSING LOANS FOR HOMELESS VETERANS PROGRAM ACCOUNT

For the administrative expenses to carry out the guaranteed transitional housing loan program authorized by subchapter VI of chapter 20 of title 38, United States Code, not to exceed $750,000 of the amounts appropriated by this Act for ''General operating expenses'' and ''Medical support and compliance'' may be expended.

VETERANS HEALTH ADMINISTRATION

MEDICAL SERVICES

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, food services, and salaries and expenses of healthcare employees hired under title 38, United States Code, and aid to State homes as authorized by section 1741 of title 38, United States Code; $34,704,500,000, plus reimbursements: Provided, That of the funds made available under this heading, not to exceed $1,600,000,000 shall be available until September 30, 2011: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs: Provided further, That for the Department of Defense/Department of Veterans Affairs Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, a minimum of $15,000,000, to remain available until expended, for any purpose authorized by section 8111 of title 38, United States Code.

MEDICAL SUPPORT AND COMPLIANCE

For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.); $5,100,000,000, plus reimbursements, of which $250,000,000 shall be available until September 30, 2011.

MEDICAL FACILITIES

For necessary expenses for the maintenance and operation of hospitals, nursing homes, and domiciliary facilities and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services, $4,849,883,000, plus reimbursements, of which $250,000,000 shall be available until September 30, 2011: Provided, That $100,000,000 for non-recurring maintenance provided under this heading shall be allocated in a manner not subject to the Veterans Equitable Resource Allocation.

MEDICAL AND PROSTHETIC RESEARCH

For necessary expenses in carrying out programs of medical and prosthetic research and development as authorized by chapter 73 of title 38, United States Code, $580,000,000, plus reimbursements, to remain available until September 30, 2011.

NATIONAL CEMETERY ADMINISTRATION

For necessary expenses of the National Cemetery Administration for operations and maintenance, not otherwise provided for, including uniforms or allowances therefor; cemeterial expenses as authorized by law; purchase of one passenger motor vehicle for use in cemeterial operations; hire of passenger motor vehicles; and repair, alteration or improvement of facilities under the jurisdiction of the National Cemetery Administration, $250,000,000, of which not to exceed $24,200,000 shall be available until September 30, 2011.

DEPARTMENTAL ADMINISTRATION

GENERAL OPERATING EXPENSES

For necessary operating expenses of the Department of Veterans Affairs, not otherwise provided for, including administrative expenses in support of Department-Wide capital planning, management and policy activities, uniforms, or allowances therefor; not to exceed $25,000 for official reception and representation expenses; hire of passenger motor vehicles; and reimbursement of the General Services Administration for security guard services, and the Department of Defense for the cost of overseas employee mail, $2,086,251,000: Provided, That expenses for services and assistance authorized under paragraphs (1), (2), (5), and (11) of section 3104(a) of title 38, United States Code, that the Secretary of Veterans Affairs determines are necessary to enable entitled veterans: (1) to the maximum extent feasible, to become employable and to obtain and maintain suitable employment; or (2) to achieve maximum independence in daily living, shall be charged to this account: Provided further, That the Veterans Benefits Administration shall be funded at not less than $1,689,207,000: Provided further, That of the funds made available under this heading, not to exceed

$111,000,000 shall be available for obligation until September 30, 2011: Provided further, That from the funds made available under this heading, the Veterans Benefits Administration may purchase (on a one-for-one replacement basis only) up to two passenger motor vehicles for use in operations of that Administration in Manila, Philippines.

INFORMATION TECHNOLOGY SYSTEMS

For necessary expenses for information technology systems and telecommunications support, including developmental information systems and operational information systems; for pay and associated costs; and for the capital asset acquisition of information technology systems, including management and related contractual costs of said acquisitions, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, $3,307,000,000, plus reimbursements, to be available until September 30, 2011: Provided, That not later than 30 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Appropriations of both Houses of Congress a reprogramming base letter which sets forth, by project, the Operations and Maintenance and Salaries and Expenses costs to be carried out utilizing amounts made available by this heading: Provided further, That of the amounts appropriated, $800,485,000 may not be obligated or expended until the Secretary of Veterans Affairs or the Chief Information Officer of the Department of Veterans Affairs submits to the Committees on Appropriations of both Houses of Congress a certification of the amounts, in parts or in full, to be obligated and expended for each development project: Provided further, That amounts specified in the certification with respect to development projects under the preceding proviso shall be incorporated into the reprogramming base letter with respect to development projects funded using amounts appropriated by this heading.

OFFICE OF INSPECTOR GENERAL

For necessary expenses of the Office of Inspector General, to include information technology, in carrying out the provisions of the Inspector General Act of 1978 (5 U.S.C. App.), $109,000,000, of which $6,000,000 shall be available until September 30, 2011.

CONSTRUCTION, MAJOR PROJECTS

For constructing, altering, extending, and improving any of the facilities, including parking projects, under the jurisdiction or for the use of the Department of Veterans Affairs, or for any of the purposes set forth in sections 316, 2404, 2406, 8102, 8103, 8106, 8108, 8109, 8110, and 8122 of title 38, United States Code, including planning, architectural and engineering services, construction management services, maintenance or guarantee period services costs associated with equipment guarantees provided under the project, services of claims analysts, offsite utility and storm drainage system construction costs, and site acquisition, where the estimated cost of a project is more than the amount set forth in section 8104(a)(3)(A) of title 38, United States Code, or where funds for a project were made available in a previous major project appropriation, $1,194,000,000, to remain available until expended, of which $16,000,000 shall be to make reimbursements as provided in section 13 of the Contract Disputes Act of 1978 (41 U.S.C. 612) for claims paid for contract disputes: Provided, That except for advance planning activities, including needs assessments which may or may not lead to capital investments, and other capital asset management related activities, including portfolio development and management activities, and investment strategy studies funded through the advance planning fund and the planning and design activities funded through the design fund, including needs assessments which may or may not lead to capital investments, and funds provided for the purchase of land for the National Cemetery Administration through the land acquisition line item, none of the funds appropriated under this heading shall be used for any project which has not been approved by the Congress in the budgetary process: Provided further, That funds provided in this appropriation for fiscal year 2010, for each approved project shall be obligated: (1) by the awarding of a construction documents contract by September 30, 2010; and (2) by the awarding of a construction contract by September 30, 2011: Provided further, That the Secretary of Veterans Affairs shall promptly submit to the Committees on Appropriations of both Houses of Congress a written report on any approved major construction project for which obligations are not incurred within the time limitations established above.

CONSTRUCTION, MINOR PROJECTS

For constructing, altering, extending, and improving any of the facilities, including parking projects, under the jurisdiction or for the use of the Department of Veterans Affairs, including planning and assessments of needs which may lead to capital investments, architectural and engineering services, maintenance or guarantee period services costs associated with equipment guarantees provided under the project, services of claims analysts, offsite utility and storm drainage system construction costs, and site acquisition, or for any of the purposes set forth in sections 316, 2404, 2406, 8102, 8103, 8106, 8108, 8109, 8110, 8122, and 8162 of title 38, United States Code, where the estimated cost of a project is equal to or less than the amount set forth in section 8104(a)(3)(A) of title 38, United States Code, $685,000,000, to remain available until expended, along with unobligated balances of previous ''Construction, minor projects'' appropriations which are hereby made available for any project where the estimated cost is equal to or less than the amount set forth in such section: Provided, That funds in this account shall be available for: (1) repairs to any of the nonmedical facilities under the jurisdiction or for the use of the Department which are necessary because of loss or damage caused by any natural disaster or catastrophe; and (2) temporary measures necessary to prevent or to minimize further loss by such causes.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

For grants to assist States to acquire or construct State nursing home and domiciliary facilities and to remodel, modify, or alter existing hospital, nursing home, and domiciliary facilities in State homes, for furnishing care to veterans as authorized by sections 8131 through 8137 of title 38, United States Code, $115,000,000, to remain available until expended.

GRANTS FOR CONSTRUCTION OF STATE VETERANS CEMETERIES

For grants to assist States in establishing, expanding, or improving State veterans cemeteries as authorized by section 2408 of title 38, United States Code, $42,000,000, to remain available until expended.

ADMINISTRATIVE PROVISIONS

(INCLUDING TRANSFER OF FUNDS)

SEC. 201. Any appropriation for fiscal year 2010 for ''Compensation and pensions'', ''Readjustment benefits'', and ''Veterans insurance and indemnities'' may be transferred as necessary to any other of the mentioned appropriations: Provided, That before a transfer may take place, the Secretary of Veterans Affairs shall request from the Committees on Appropriations of both Houses of Congress the authority to make the transfer and such Committees issue an approval, or absent a response, a period of 30 days has elapsed.

(INCLUDING TRANSFER OF FUNDS)

SEC. 202. Amounts made available for the Department of Veterans Affairs for fiscal year 2010, in this Act or any other Act, under the ''Medical services'', ''Medical support and compliance'' and ''Medical facilities'' accounts may be transferred between the accounts to the extent necessary to implement the restructuring of the Veterans Health Administration accounts: Provided, That any transfers between the ''Medical services'' and ''Medical support and compliance'' accounts of 1 percent or less of the total amount appropriated to the account in this or any other Act may take place subject to notification from the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress of the amount and purpose of the transfer: Provided further, That any transfers between the ''Medical services'' and ''Medical support and compliance'' accounts in excess of 1 percent, or exceeding the cumulative 1 percent for the fiscal year, may take place only after the Secretary requests from the Committees on Appropriations of both Houses of Congress the authority to make the transfer and an approval is issued: Provided further, That any transfer to or from the ''Medical facilities'' account may take place only after the Secretary requests from the Committees on Appropriations of both Houses of Congress the authority to make the transfer and an approval is issued.

SEC. 203. Appropriations available in this title for salaries and expenses shall be available for services authorized by section 3109 of title 5, United States Code, hire of passenger motor vehicles; lease of a facility or land or both; and uniforms or allowances therefore, as authorized by sections 5901 through 5902 of title 5, United States Code.

SEC. 204. No appropriations in this title (except the appropriations for ''Construction, major projects'', and ''Construction, minor projects'') shall be available for the purchase of any site for or toward the construction of any new hospital or home.

SEC. 205. No appropriations in this title shall be available for hospitalization or examination of any persons (except beneficiaries entitled to such hospitalization or examination under the laws providing such benefits to veterans, and persons receiving such treatment under sections 7901 through 7904 of title 5, United States Code, or the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.)), unless reimbursement of the cost of such hospitalization or examination is made to the ''Medical services'' account at such rates as may be fixed by the Secretary of Veterans Affairs.

SEC. 206. Appropriations available in this title for ''Compensation and pensions'', ''Readjustment benefits'', and ''Veterans insurance and indemnities'' shall be available for payment of prior year accrued obligations required to be recorded by law against the corresponding prior year accounts within the last quarter of fiscal year 2009.

SEC. 207. Appropriations available in this title shall be available to pay prior year obligations of corresponding prior year appropriations accounts resulting from sections 3328(a), 3334, and 3712(a) of title 31, United States Code, except that if such obligations are from trust fund accounts they shall be payable only from ''Compensation and pensions''.

(INCLUDING TRANSFER OF FUNDS)

SEC. 208. Notwithstanding any other provision of law, during fiscal year 2010, the Secretary of Veterans Affairs shall, from the National Service Life Insurance Fund (38 U.S.C. 1920), the Veterans' Special Life Insurance Fund (38

U.S.C. 1923), and the United States Government Life Insurance Fund (38 U.S.C. 1955), reimburse the ''General operating expenses'' and ''Information technology systems'' accounts for the cost of administration of the insurance programs financed through those accounts: Provided, That reimbursement shall be made only from the surplus earnings accumulated in such an insurance program during fiscal year 2010 that are available for dividends in that program after claims have been paid and actuarially determined reserves have been set aside: Provided further, That if the cost of administration of such an insurance program exceeds the amount of surplus earnings accumulated in that program, reimbursement shall be made only to the extent of such surplus earnings: Provided further, That the Secretary shall determine the cost of administration for fiscal year 2010 which is properly allocable to the provision of each such insurance program and to the provision of any total disability income insurance included in that insurance program.

SEC. 209. Amounts deducted from enhanced-use lease proceeds to reimburse an account for expenses incurred by that account during a prior fiscal year for providing enhanced-use lease services, may be obligated during the fiscal year in which the proceeds are received.

(INCLUDING TRANSFER OF FUNDS)

SEC. 210. Funds available in this title or funds for salaries and other administrative expenses shall also be available to reimburse the Office of Resolution Management of the Department of Veterans Affairs and the Office of Employment Discrimination Complaint Adjudication under section 319 of title 38, United States Code, for all services provided at rates which will recover actual costs but not exceed $34,158,000 for the Office of Resolution Management and $3,278,000 for the Office of Employment and Discrimination Complaint Adjudication: Provided, That payments may be made in advance for services to be furnished based on estimated costs: Provided further, That amounts received shall be credited to the ''General operating expenses'' and ''Information technology systems'' accounts for use by the office that provided the service.

SEC. 211. No appropriations in this title shall be available to enter into any new lease of real property if the estimated annual rental is more than $1,000,000 unless the Secretary submits a report which the Committees on Appropriations of both Houses of Congress approve within 30 days following the date on which the report is received.

SEC. 212. No funds of the Department of Veterans Affairs shall be available for hospital care, nursing home care, or medical services provided to any person under chapter 17 of title 38, United States Code, for a non-service-connected disability described in section 1729(a)(2) of such title, unless that person has disclosed to the Secretary of Veterans Affairs, in such form as the Secretary may require, current, accurate third-party reimbursement information for purposes of section 1729 of such title: Provided, That the Secretary may recover, in the same manner as any other debt due the United States, the reasonable charges for such care or services from any person who does not make such disclosure as required: Provided further, That any amounts so recovered for care or services provided in a prior fiscal year may be obligated by the Secretary during the fiscal year in which amounts are received.

(INCLUDING TRANSFER OF FUNDS)

SEC. 213. Notwithstanding any other provision of law, proceeds or revenues derived from enhanced-use leasing activities (including disposal) may be deposited into the ''Construction, major projects'' and ''Construction, minor projects'' accounts and be used for construction (including site acquisition and disposition), alterations, and improvements of any medical facility under the jurisdiction or for the use of the Department of Veterans Affairs. Such sums as realized are in addition to the amount provided for in ''Construction, major projects'' and ''Construction, minor projects''.

SEC. 214. Amounts made available under ''Medical services'' are available—

(1) for furnishing recreational facilities, supplies, and equipment; and

(2) for funeral expenses, burial expenses, and other expenses incidental to funerals and burials for beneficiaries receiving care in the Department.

(INCLUDING TRANSFER OF FUNDS)

SEC. 215. Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, may be transferred to ''Medical services'', to remain available until expended for the purposes of that account: Provided, That, for fiscal year 2010, $200,000,000 deposited in the Department of Veterans Affairs Medical Care Collections Fund shall be transferred to ''Medical Facilities'', to remain available until expended, for non-recurring maintenance at existing Veterans Health Administration medical facilities: Provided further, That the allocation of amounts transferred to ''Medical Facilities'' under the preceding proviso shall not be subject to the Veterans Equitable Resource Allocation formula.

SEC. 216. The Secretary of Veterans Affairs may enter into agreements with Community Health Centers in rural Alaska, Indian tribes and tribal organizations which are party to the Alaska Native Health Compact with the Indian Health Service, and Indian tribes and tribal organizations serving rural Alaska which have entered into contracts with the Indian Health Service under the Indian Self Determination and Educational Assistance Act, to provide healthcare, including behavioral health and dental care. The Secretary shall require participating veterans and facilities to comply with all appropriate rules and regulations, as established by the Secretary. The term ''rural Alaska'' shall mean those lands sited within the external boundaries of the Alaska Native regions specified in sections 7(a)(1)–(4) and (7)–(12) of the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1606), and those lands within the Alaska Native regions specified in sections 7(a)(5) and 7(a)(6) of the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1606), which are not within the boundaries of the Municipality of Anchorage, the Fairbanks North Star Borough, the Kenai Peninsula Borough or the Matanuska Susitna Borough.

(INCLUDING TRANSFER OF FUNDS)

SEC. 217. Such sums as may be deposited to the Department of Veterans Affairs Capital Asset Fund pursuant to section 8118 of title 38, United States Code, may be transferred to the ''Construction, major projects'' and ''Construction, minor projects'' accounts, to remain available until expended for the purposes of these accounts.

SEC. 218. None of the funds made available in this title may be used to implement any policy prohibiting the Directors of the Veterans Integrated Services Networks from conducting outreach or marketing to enroll new veterans within their respective Networks.

SEC. 219. The Secretary of Veterans Affairs shall submit to the Committees on Appropriations of both Houses of Congress a quarterly report on the financial status of the Veterans Health Administration.

(INCLUDING TRANSFER OF FUNDS)

SEC. 220. Amounts made available under the ''Medical services'', ''Medical support and compliance'', ''Medical facilities'', ''General operating expenses'', and ''National Cemetery Administration'' accounts for fiscal year 2010, may be transferred to or from the ''Information technology systems'' account: Provided, That before a transfer may take place, the Secretary of Veterans Affairs shall request from the Committees on Appropriations of both Houses of Congress the authority to make the transfer and an approval is issued.

SEC. 221. Amounts made available for the ''Information technology systems'' account may be transferred between projects: Provided, That no project may be increased or decreased by more than $1,000,000 of cost prior to submitting a request to the Committees on Appropriations of both Houses of Congress to make the transfer and an approval is issued, or absent a response, a period of 30 days has elapsed.

(INCLUDING TRANSFER OF FUNDS)

SEC. 222. Any balances in prior year accounts established for the payment of benefits under the Reinstated Entitlement Program for Survivors shall be transferred to and merged with amounts available under the ''Compensation and pensions'' account, and receipts that would otherwise be credited to the accounts established for the payment of benefits under the Reinstated Entitlement Program for Survivors program shall be credited to amounts available under the ''Compensation and pensions'' account.

SEC. 223. The Department shall continue research into Gulf War illness at levels not less than those made available in fiscal year 2009, within available funds contained in this Act.

SEC. 224. (a) Upon a determination by the Secretary of Veterans Affairs that such action is in the national interest, and will have a direct benefit for veterans through increased access to treatment, the Secretary of Veterans Affairs may transfer not more than $5,000,000 to the Secretary of Health and Human Services for the Graduate Psychology Education Program, which includes treatment of veterans, to support increased training of psychologists skilled in the treatment of post-traumatic stress disorder, traumatic brain injury, and related disorders.

(b) The Secretary of Health and Human Services may only use funds transferred under this section for the purposes described in subsection (a).

(c) The Secretary of Veterans Affairs shall notify Congress of any such transfer of funds under this section.

SEC. 225. None of the funds appropriated or otherwise made available by this Act or any other Act for the Department of Veterans Affairs may be used in a manner that is inconsistent with—

(1) section 842 of the Transportation, Treasury, Housing and Urban Development, the Judiciary, and Independent Agencies Appropriations Act, 2006 (Public Law 109–115; 119 Stat. 2506); or

(2) section 8110(a)(5) of title 38, United States Code.

SEC. 226. Of the amounts made available to the Department of Veterans Affairs for fiscal year 2010, in this Act or any other Act, under the ''Medical Facilities'' account for non-recurring maintenance, not more than 20 percent of the funds made available shall be obligated during the last 2 months of the fiscal year: Provided, That the Secretary may waive this requirement after providing written notice to the Committees on Appropriations of both Houses of Congress.

SEC. 227. Section 1925(d)(3) of title 38, United States Code, is amended by striking ''appropriation 'General Operating Expenses, Department of Veterans Affairs' '', and inserting ''appropriations for 'General Operating Expenses and Information Technology Systems, Department of Veterans Affairs' ''.

SEC. 228. Section 1922(a) of title 38, United States Code, is amended by striking ''(5) administrative costs to the Government for the costs

of'', and inserting ''(5) administrative support performed by General Operating Expenses and Information Technology Systems, Department of Veterans Affairs, for''.

SEC. 229. (a) ADDITIONAL AMOUNT FOR STATE VETERANS CEMETERIES.—The amount appropriated by this title under the heading ''GRANTS FOR CONSTRUCTION OF STATE VETERANS CEMETERIES'' is hereby increased by $4,000,000.

(b) OFFSET.—The amount appropriated or otherwise made available by this title under the heading ''GENERAL OPERATING EXPENSES'' is hereby decreased by $4,000,000.

SEC. 230. (a)(1)(A) Of the amount made available by this title for the Veterans Health Administration under the heading ''MEDICAL SERVICES'', $1,500,000 shall be available to allow the Secretary of Veterans Affairs to offer incentives to qualified health care providers working in underserved rural areas designated by the Veterans Health Administration, in addition to amounts otherwise available for other pay and incentives.

(B) Health care providers shall be eligible for incentives pursuant to this paragraph only for the period of time that they serve in designated areas.

(2)(A) Of the amount made available by this title for the Veterans Health Administration under the heading ''MEDICAL SUPPORT AND COMPLIANCE'', $1,500,000 shall be available to allow the Secretary of Veterans Affairs to offer incentives to qualified health care administrators working in underserved rural areas designated by the Veterans Health Administration, in addition to amounts otherwise available for other pay and incentives.

(B) Health care administrators shall be eligible for incentives pursuant to this paragraph only for the period of time that they serve in designated areas.

(b) Not later than March 31, 2010, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs and Appropriations of the Senate and the House of Representatives a report detailing the number of new employees receiving incentives under the pilot program established pursuant to this section, describing the potential for retaining those employees, and explaining the structure of the program.

SEC. 231. (a) NAMING OF HEALTH CARE CENTER.—Effective October 1, 2010, the North Chicago Veterans Affairs Medical Center located in Lake County, Illinois, shall be known and designated as the ''Captain James A. Lovell Federal Health Care Center''.

(b) REFERENCES.—Any reference to the medical center referred to in subsection (a) in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the Captain James A. Lovell Federal Health Care Center.

SEC. 232. Section 315(b) of title 38, United States Code, is amended by striking ''December 31, 2009'' and inserting ''December 31, 2010''.

SEC. 233. Of the amount appropriated or otherwise made available by this title under the heading ''MEDICAL SERVICES'', $150,000,000 may be available for the grant program under section 2011 of title 38, United States Code, and per diem payments under section 2012 of such title.

SEC. 234. Of the amounts appropriated or otherwise made available by this title for the Department of Veterans Affairs, up to $5,000,000 may be available for the study required by section 1077 of the National Defense Authorization Act for Fiscal Year 2010.

SEC. 235. (a) CAMPUS OUTREACH AND SERVICES FOR MENTAL HEALTH AND NEUROLOGICAL CONDITIONS.—Of the amounts appropriated or otherwise made available by this title, $5,000,000 may be available to conduct outreach to and provide services at institutions of higher education to ensure that veterans enrolled in programs of education at such institutions have information on and access to care and services for neurological and psychological issues.

(b) SUPPLEMENT NOT SUPPLANT.—The amount described in subsection (a) for the purposes described in such subsection is in addition to amounts otherwise appropriated or made available for readjustment counseling and related mental health services.

SEC. 236. In administering section 51.210(d) of title 38, Code of Federal Regulations, the Secretary of Veterans Affairs may permit a State home to provide services to, in addition to non-veterans described in such section, a non-veteran any of whose children died while serving in the Armed Forces, as long as such services are not denied to a qualified veteran seeking such services.

SEC. 237. (a) DESIGNATION OF ROBLEY REX DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.—The Department of Veterans Affairs Medical Center in Louisville, Kentucky, and any successor to such medical center, shall after the date of the enactment of this Act be known and designated as the ''Robley Rex Department of Veterans Affairs Medical Center''.

(b) REFERENCES.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the medical center referred to in subsection (a) shall be considered to be a reference to the Robley Rex Department of Veterans Affairs Medical Center.

SEC. 238. (a) ADDITIONAL AMOUNT FOR HOMELESS VETERANS COMPREHENSIVE SERVICE PROGRAMS AND HOUSING ASSISTANCE AND SUPPORTIVE SERVICES.—The amount appropriated by this title under the heading ''MEDICAL SERVICES'' under the heading ''VETERANS HEALTH ADMINISTRATION'' is increased by $750,000, with the amount of the increase to be available for the following:

(1) The grant program under section 2011 of title 38, United States Code.

(2) Per diem payments under section 2012 of such title.

(3) Housing assistance and supportive services under subchapter V of chapter 20 of such title.

(b) OFFSET.—The amount appropriated or otherwise made available by this title under the heading ''GENERAL OPERATING EXPENSES'' under the heading ''DEPARTMENTAL ADMINISTRATION'' is decreased by $750,000.

SEC. 239. (a) MODIFICATION ON RESTRICTION OF ALIENATION OF CERTAIN REAL PROPERTY IN GULFPORT, MISSISSIPPI.—Section 2703(b) of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (Public Law 109–234; 120 Stat. 469), as amended by section 231 of the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2009 (division E of Public Law 110–329; 122 Stat. 3713), is further amended by inserting after ''the City of Gulfport'' the following: '', or its urban renewal agency,''.

(b) MEMORIALIZATION OF MODIFICATION.—The Secretary of Veterans Affairs shall take appropriate actions to modify the quitclaim deeds executed to effectuate the conveyance authorized by section 2703 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 in order to accurately reflect and memorialize the amendment made by subsection (a).

SEC. 240. (a)(1) The amount appropriated or otherwise made available by this title under the heading ''CONSTRUCTION, MINOR PROJECTS'' is hereby increased by $50,000,000.

(2) Of the amount appropriated or otherwise made available by this title under the heading ''CONSTRUCTION, MINOR PROJECTS'', as increased by paragraph (1), $50,000,000 shall be available for renovation of Department of Veterans Affairs buildings for the purpose of converting unused structures into housing with supportive services for homeless veterans.

(b) The amount appropriated or otherwise made available by title I under the heading ''HOMEOWNERS ASSISTANCE FUND'' is hereby reduced by $50,000,000.

SEC. 241. Of the amounts appropriated or otherwise made available by this title, the Secretary shall award $5,000,000 in competitively-awarded grants to State and local government entities or their designees with a demonstrated record of serving veterans to conduct outreach to ensure that veterans in under-served areas receive the care and benefits for which they are eligible.

SEC. 242. (a) STUDY ON CAPACITY OF DEPARTMENT OF VETERANS AFFAIRS TO ADDRESS COMBAT STRESS IN WOMEN VETERANS.—The Inspector General of the Department of Veterans Affairs shall carry out a study to assess the capacity of the Department of Veterans Affairs to address combat stress in women veterans.

(b) ELEMENTS.—In carrying out the study required by subsection (a), the Inspector General shall consider the following:

(1) Whether women veterans are properly evaluated by the Department for post-traumatic stress disorder (PTSD), military-related sexual trauma, traumatic brain injury (TBI), and other combat-related conditions.

(2) Whether women veterans with combat stress are being properly adjudicated as service-connected disabled by the Department for purposes of veterans disability benefits for combat stress.

(3) Whether the Veterans Benefits Administration has developed and disseminated to personnel who adjudicate disability claims reference materials that thoroughly and effectively address the management of claims of women veterans involving military-related sexual trauma.

(4) The feasibility and advisability of requiring training and testing on military-related sexual trauma matters as part of a certification of Veterans Benefits Administration personnel who adjudicate disability claims involving post-traumatic stress disorder.

(5) Such other matters as the Inspector General considers appropriate.

(c) REPORTS.—

(1) INTERIM REPORT.—Not later than 180 days after the date of the enactment of this Act, the Inspector General shall submit to the Secretary of Veterans Affairs, and to the appropriate committees of Congress, a report setting forth the plan of the Inspector General for the study required by subsection (a), together with such interim findings as the Inspector General has made as of the date of the report as a result of the study.

(2) FINAL REPORT.—Not later than one year after the date of the enactment of this Act, the Inspector General shall submit to the Secretary, and Congress, then the Secretary shall make recommendations for legislative or administrative action.

(3) APPROPRIATE COMMITTEES OF CONGRESS DEFINED.—In this subsection, the term ''appropriate committees of Congress'' means—

(A) the Committees on Appropriations and Veterans' Affairs of the Senate; and

(B) the Committees on Appropriations and Veterans' Affairs of the House of Representatives.

SEC. 243. (a) STUDY ON IMPROVEMENTS TO INFORMATION TECHNOLOGY INFRASTRUCTURE NEEDED TO FURNISH HEALTH CARE SERVICES TO VETERANS USING TELEHEALTH PLATFORMS.—The Secretary of Veterans Affairs shall carry out a study to identify the improvements to the infrastructure of the Department of Veterans Affairs that are required to furnish health care services to veterans using telehealth platforms.

(b) AVAILABILITY OF FUNDS.—The amounts appropriated or otherwise made available by

this title under the headings ''DEPARTMENTAL ADMINISTRATION'' and ''INFORMATION TECHNOLOGY SYSTEMS'' shall be available to the Secretary of Veterans Affairs to carry out the study required by subsection (a).

SEC. 244. Of the amounts appropriated or otherwise made available by this title under the headings ''VETERANS HEALTH ADMINISTRATION'' and ''MEDICAL SERVICES'', $1,000,000 may be available for education debt reduction under subchapter VII of chapter 76 of title 38, United States Code, for mental health care professionals who agree to employment at the Department of Veterans Affairs.

TITLE III

RELATED AGENCIES

AMERICAN BATTLE MONUMENTS COMMISSION

SALARIES AND EXPENSES

For necessary expenses, not otherwise provided for, of the American Battle Monuments Commission, including the acquisition of land or interest in land in foreign countries; purchases and repair of uniforms for caretakers of national cemeteries and monuments outside of the United States and its territories and possessions; rent of office and garage space in foreign countries; purchase (one-for-one replacement basis only) and hire of passenger motor vehicles; not to exceed $7,500 for official reception and representation expenses; and insurance of official motor vehicles in foreign countries, when required by law of such countries, $63,549,000, to remain available until expended.

FOREIGN CURRENCY FLUCTUATIONS ACCOUNT

For necessary expenses, not otherwise provided for, of the American Battle Monuments Commission, such sums as may be necessary, to remain available until expended, for purposes authorized by section 2109 of title 36, United States Code.

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

SALARIES AND EXPENSES

For necessary expenses for the operation of the United States Court of Appeals for Veterans Claims as authorized by sections 7251 through 7298 of title 38, United States Code, $27,115,000, of which $1,820,000 shall be available for the purpose of providing financial assistance as described, and in accordance with the process and reporting procedures set forth, under this heading in Public Law 102–229.

DEPARTMENT OF DEFENSE—CIVIL

CEMETERIAL EXPENSES, ARMY

SALARIES AND EXPENSES

For necessary expenses, as authorized by law, for maintenance, operation, and improvement of Arlington National Cemetery and Soldiers' and Airmen's Home National Cemetery, including the purchase of two passenger motor vehicles for replacement only, and not to exceed $1,000 for official reception and representation expenses, $37,200,000, to remain available until expended. In addition, such sums as may be necessary for parking maintenance, repairs and replacement, to be derived from the Lease of Department of Defense Real Property for Defense Agencies account.

Funds appropriated under this Act may be provided to Arlington County, Virginia, for the relocation of the federally owned water main at Arlington National Cemetery making additional land available for ground burials.

ARMED FORCES RETIREMENT HOME

TRUST FUND

For expenses necessary for the Armed Forces Retirement Home to operate and maintain the Armed Forces Retirement Home—Washington, District of Columbia, and the Armed Forces Retirement Home—Gulfport, Mississippi, to be paid from funds available in the Armed Forces Retirement Home Trust Fund, $134,000,000, of which $72,000,000 shall remain available until expended for construction and renovation of the physical plants at the Armed Forces Retirement Home—Washington, District of Columbia, and the Armed Forces Retirement Home—Gulfport, Mississippi.

TITLE IV

OVERSEAS CONTINGENCIES OPERATIONS

MILITARY CONSTRUCTION

MILITARY CONSTRUCTION, ARMY

For an additional amount for ''Military Construction, Army'', $924,484,000, to remain available until September 30, 2012: Provided, That notwithstanding any other provision of law, such funds may be obligated and expended to carry out planning and design and military construction projects not otherwise authorized by law.

MILITARY CONSTRUCTION, AIR FORCE

For an additional amount for ''Military Construction, Air Force'', $474,500,000, to remain available until September 30, 2012: Provided, That notwithstanding any other provision of law, such funds may be obligated and expended to carry out planning and design and military construction projects not otherwise authorized by law.

ADMINISTRATIVE PROVISION

SEC. 401. (a)(1) The amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, ARMY'' and available for a dining hall project at Forward Operating Base Dwyer is hereby increased by $4,400,000.

(2) The amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, ARMY'' and available for a dining hall project at Forward Operating Base Maywand is hereby reduced by $4,400,000.

(b)(1) The amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, ARMY'' and available for a dining hall project at Forward Operating Base Wolverine is hereby increased by $2,150,000.

(2) The amount appropriated or otherwise made available by this title under the heading ''MILITARY CONSTRUCTION, ARMY'' and available for a dining hall project at Forward Operating Base Tarin Kowt is hereby reduced by $2,150,000.

SEC. 402. Amounts appropriated or otherwise made available by this title are designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

TITLE V

DEPARTMENT OF VETERANS AFFAIRS

VETERANS HEALTH ADMINISTRATION

MEDICAL SERVICES

For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, food services, and salaries and expenses of healthcare employees hired under title 38, United States Code, and aid to State homes as authorized by section 1741 of title 38, United States Code; $37,136,000,000, plus reimbursements, which shall become available on October 1, 2010, and shall remain available through September 30, 2011: Provided, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs: Provided further, That for the Department of Defense/Department of Veterans Affairs Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, a minimum of $15,000,000, to remain available until expended, for any purpose authorized by section 8111 of title 38, United States Code.

MEDICAL SUPPORT AND COMPLIANCE

For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.); $5,307,000,000, plus reimbursements, which shall become available on October 1, 2010, and shall remain available through September 30, 2011.

MEDICAL FACILITIES

For necessary expenses for the maintenance and operation of hospitals, nursing homes, and domiciliary facilities and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services, $5,740,000,000, plus reimbursements, which shall become available on October 1, 2010, and shall remain available through September 30, 2011.

TITLE VI

GENERAL PROVISIONS

SEC. 601. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 602. Such sums as may be necessary for fiscal year 2010 for pay raises for programs funded by this Act shall be absorbed within the levels appropriated in this Act.

SEC. 603. None of the funds made available in this Act may be used for any program, project, or activity, when it is made known to the Federal entity or official to which the funds are made available that the program, project, or activity is not in compliance with any Federal law relating to risk assessment, the protection of private property rights, or unfunded mandates.

SEC. 604. No part of any funds appropriated in this Act shall be used by an agency of the executive branch, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, and for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or film presentation designed to support or defeat legislation pending before Congress, except in presentation to Congress itself.

SEC. 605. All departments and agencies funded under this Act are encouraged, within the limits of the existing statutory authorities and funding, to expand their use of ''E-Commerce'' technologies and procedures in the conduct of their business practices and public service activities.

SEC. 606. None of the funds made available in this Act may be transferred to any department, agency, or instrumentality of the United States Government except pursuant to a transfer made by, or transfer authority provided in, this or any other appropriations Act.

SEC. 607. Unless stated otherwise, all reports and notifications required by this Act shall be submitted to the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies of the Committee on Appropriations of the House of Representatives and the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies of the Committee on Appropriations of the Senate.

SEC. 608. (a) Notwithstanding any other provision of this Act and except as provided in subsection (b), any report required to be submitted by a Federal agency or department to the Committee on Appropriations of either the Senate or the House of Representatives in this Act shall be posted on the public website of that agency upon receipt by the committee.

(b) Subsection (a) shall not apply to a report if—

(1) the public posting of the report compromises national security; or

(2) the report contains proprietary information.

SEC. 609. None of the funds made available under this Act may be distributed to the Association of Community Organizations for Reform Now (ACORN) or its subsidiaries.

This Act may be cited as the ''Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010''.

AMERICAN EDUCATION WEEK

Ms. CANTWELL. Mr. President, I ask unanimous consent that the HELP Committee be discharged from further consideration of S. Res. 353 and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 353) supporting the goals and ideals of ''American Education Week.''

There being no objection, the Senate proceeded to consider the resolution.

Ms. CANTWELL. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statement related to the resolution be printed in the RECORD.

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

The resolution (S. Res. 353) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 353

Whereas the National Education Association has designated November 15 through November 21, 2009, as the 88th annual observance of ''American Education Week'';

Whereas public schools are the backbone of democracy in the United States, providing young people with the tools needed to maintain the precious values of freedom, civility, and equality in our Nation;

Whereas by equipping young people in the United States with both practical skills and broader intellectual abilities, public schools give young people hope for, and access to, a productive future;

Whereas people working in the field of public education, including teachers, higher education faculty and staff, custodians, substitute educators, bus drivers, clerical workers, food service professionals, workers in skilled trades, health and student service workers, security guards, technical employees, and librarians, work tirelessly to serve children and communities throughout the Nation with care and professionalism; and

Whereas public schools are community linchpins, bringing together adults, children, educators, volunteers, business leaders, and elected officials in a common enterprise: Now, therefore, be it

Resolved, That the Senate—

(1) supports the goals and ideals of ''American Education Week''; and

(2) encourages the people of the United States to observe ''American Education Week'' by reflecting on the positive impact of all those who work together to educate children.

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the majority leader, pursuant to Public Law 105–83, announces the appointment of the following individual to serve as a member of the National Council of the Arts: the Honorable CLAIRE MCCASKILL of Missouri.

ORDERS FOR THURSDAY, NOVEMBER 19, 2009

Ms. CANTWELL. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m. tomorrow, Thursday, November 19; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate proceed to a period of morning business for 1 hour, with Senators permitted to speak therein for up to 10 minutes each, with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first half and the Republicans controlling the final half; that following morning business, the Senate proceed to the consideration of Calendar No. 190, S. 1963, the Caregivers and Veterans Omnibus Health Services Act Of 2009, as provided for under the previous order.

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

PROGRAM

Ms. CANTWELL. Mr. President, at 2:30 p.m. tomorrow the Senate will proceed to a series of three rollcall votes. The votes will be on the confirmation of the nomination of David Hamilton to be a U.S. circuit judge for the Seventh Circuit; in relation to the Coburn amendment No. 2785, relating to spending priorities; and passage of S. 1963, the Caregivers and Veterans Omnibus Health Services Act, as amended, if amended.

Finally, I ask unanimous consent that following the remarks of Senator SESSIONS, Senator HARKIN, and Senator ALEXANDER, the Senate adjourn under the previous order.

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

The Senator from Alabama is recognized.

NOMINATION OF DAVID HAMILTON

Mr. SESSIONS. Mr. President, I thank Senator CANTWELL. I appreciate her courtesy. I just want to share a few remarks tonight.

We are now postcloture on the nomination of Judge David Hamilton to the circuit court of appeals. Cloture is a procedure in the Senate generally used to end a prolonged debate. The majority leader, Senator REID, filed cloture on Judge Hamilton, however, before there had been even 1 hour of debate on the nomination. The cloture motion was filed before I or any of my colleagues had time set aside and had the opportunity to debate this matter.

Judge Hamilton's judicial philosophy and record as a district judge were problematic. There are important matters involved considering the fact that President Obama has nominated him to serve on the Court of Appeals for the Seventh Circuit. It is worthy of serious consideration, this lifetime appointment.

Yesterday, 28 Senators joined me in voting against cloture. I believe they voted no on cloture for a number of reasons. The first is the one I have just mentioned. Cloture is generally reserved to end a prolonged debate, and Senator REID filed cloture without any debate, before debate had really begun.

The second is that Judge Hamilton's judicial philosophy is outside the mainstream—I think well outside the mainstream. As I have said before, if a judge is not committed to following the law whether they like it or not, then that person is not qualified to be a judge. They may be a good advocate, but a judge must, by definition, be impartial.

I think there will be more people voting against Judge Hamilton's nomination than voted against cloture—the 29

who voted yesterday. I think we need to spend some time talking about his record and his judicial philosophy.

I do not have anything against Judge Hamilton. I understand he may be a fine person, and I really mean that. But there is afoot in this country a philosophy of judging, an approach to law that I think is dangerous and strikes at the very heart of the classical American judicial philosophy and legal system that has served us so well. So that is what this is about. If judges have the wrong philosophy as they approach the bench about how they should go about deciding cases, then that can disqualify them.

As Senators, we each have a right to express our opinion on whether we believe a nominee is qualified and should be confirmed or not elevated to a higher court, but the American people expect we will not misrepresent the facts. Let's be fair to this nominee, and let's not in any way misrepresent who he is and what he did and what his philosophy is. I intend to be fair to him. I think any nominee is entitled to that. Even though I might be a critic, I should not be inaccurate in what I say.

In this case, I think the facts have been misrepresented by others, and I want to correct the record on some of the issues, where it has been suggested that I or others have been incorrect or unfair in our criticism. Accuracy goes both ways. If you are for a judge and want to move him forward, OK, let's be accurate. Those who are opposed to him, you must be restrained and accurate also.

Yesterday on the floor of the Senate, the majority leader, Senator REID, invoked the Golden Rule. He said that when he became majority leader, he sought to ''treat [President Bush's] judicial nominees the way they would want them treated if the roles were reversed.''

Let's take a look at the way President Bush's judicial nominees were treated by the Democratic majority. Senator REID complained that Judge Hamilton, the judge before us tonight—tomorrow—waited 166 days for this vote. If Republicans followed Senator REID's version of the Golden Rule, would he have been confirmed earlier? No. Judge Hamilton would have waited at least another year and a half before he received consideration on the Senate floor. That is exactly how President Bush's nominees were treated for the first group of nominees he submitted to the circuit courts.

Priscilla Owen, a fabulous judge at the Supreme Court of Texas, John Roberts, now on the Supreme Court of the United States, and Deborah Cook all waited 2 years before receiving a confirmation vote.

Yesterday Senator REID said:

> It's really unfortunate we have to file cloture on a judge.

Really unfortunate that we have to file cloture on a judge? As if this was something that had never been done before. Indeed, during the Bush administration, cloture had to be filed on at least 17 different judicial nominees because Senator REID was leading filibusters himself. The majority leader complains he could not get a time agreement. But he never offered a reasonable amount of time. I believe there were discussions about 30 hours of debate, which was rejected. Senator REID said he was stunned that some people believed there was not enough time to debate the nomination when no debate had been had.

He accused Republicans of not entering into a time agreement. But as I said Monday, Senator REID has a short memory. When Senator REID was in the middle of filibustering Priscilla Owen, Senator BENNETT made a unanimous consent request that the Senate spend 10 hours more debating the nomination and then vote. Senator REID objected. When Senator BENNETT asked how much time would be sufficient to debate the Priscilla Owen nomination, Senator REID responded by saying:

> [T]here is not a number of [hours] in the universe that would be sufficient.

Later Senator MCCONNELL sought a time agreement on Judge Owen. Senator REID responded by saying:

> We would not agree to a time agreement . . . of any duration.

Yesterday Senator REID said:

> The Democratic majority in the Senate confirmed three times as many nominees [under President Bush] as we have been able to confirm in the same amount of time under President Obama.

Senator REID left out the fact that Democrats filibustered more than three times as many nominees under President Bush. Indeed, there were 30 cloture votes on 17 different judicial nominations during the Bush administration. There were 1,044 total votes against 30 filibustered President Bush's nominees. The Democrats, under Senator REID's leadership, cast 99.9 percent of those votes.

Yesterday Senator REID talked about the Senate and the legal precedent and advocated that Republicans follow Senate precedent in judicial confirmations. Ironically, that is exactly what Senate Republicans asked Senator REID to do during the Bush administration. There had been 214 years of precedent of not filibustering judges. Yet Senator REID voted more than 20 times to filibuster President Bush's judges. Everyone knows that in a court of law, you follow the most recent precedent, and the most recent precedent was established last time in the Bush administration by the Democrats in this body.

Yesterday Senator REID also said the following:

> I want to reiterate that every Senator may vote for or against Judge Hamilton's nomination as he or she sees fit. That's what we do here, but that is not the issue before us today. The question before us is whether the President of the United States deserves to have his nomination reviewed by the Senate as the Constitution demands he does.

The fact is that Senator REID did not feel that way about Terrence Boyle who was nominated by President Bush for the Fourth Circuit Court of Appeals and languished for close to 8 years without ever receiving a confirmation vote, even though he passed out of the Senate Judiciary Committee with a majority vote. He did not feel that way about President Bush's nominee, the superb legal mind of Miguel Estrada, unanimously voted well qualified by the American Bar Association. He was filibustered through seven cloture votes and was never confirmed, a fabulous nominee to the court of appeals and one capable of being on any short list for the Supreme Court. Or what about Charles Pickering who was filibustered and never confirmed; Carolyn Kuhl who was filibustered and never confirmed; William Myers who was filibustered and never confirmed; Henry Saad who was filibustered and never confirmed; William Haynes who was filibustered and never confirmed?

What Senator REID meant to say was: Do not do unto me as I have done unto you. You get it? Do not do unto me as I did to you.

I don't believe Senator REID or President Obama would wish for us to return to the Democratic version of the Golden Rule. I don't believe we intend to do that. Republicans have not held a private retreat to figure out how to change the ground rules and to block President Obama's nominations. That is what the Democrats did. It was reported in the New York Times. We have not taken orders from outside groups to block nominees. We have not blocked nominees because we do not want them to sit on a specific case, and we had some of that in the past. We have not attempted to filibuster a nominee in the Judiciary Committee. We let them go through. That is how President Bush's nominees were treated. I am not exaggerating. I was there. Those are the facts.

I will express my opinion in more detail when I vote against Judge Hamilton. I have a right to do that, as does every Member. But I do not have a right to misrepresent the facts, and I try to be accurate in what I say. If I am in error, I look forward to being corrected. I hope my colleagues will start making an effort to do that.

The way this happened was this: After President Bush was elected, the Democrats met with Marcia Greenberg and Lawrence Tribe and Cass Sunstein. They came up with a new idea. They said: We are going to change the ground rules. We no longer are not going to filibuster, as has been done in the history of the Senate. We are going to do anything we can to block in committee and on the floor good nominees.

We had some fabulous nominees, such as Priscilla Owen, Bill Pryor. These are brilliant lawyers, proven people. They were rated highly by the American Bar Association. There was strong support in their home States and communities. They were blocked for months, even years before they could get a vote. Some got through, and some did not.

My personal view is that the President deserves deference in his nominees. I fully expect and hope to be able to vote for 90 percent of President Obama's nominees. I voted for well over 90 percent of President Clinton's nominees. But I am not a rubberstamp. I am not going to vote for a judge who I believe, by virtue of their stated judicial philosophy, thinks a judge has the right to write footnotes to the Constitution, as Judge Hamilton has said, who blocks legislation for 7 years and has to be finally slapped down hard by the court of appeals because apparently he didn't appreciate the State of Indiana's passage of a law on informed consent. He kept that bottled up for 7 years. And how much Indiana had to spend on legal fees, and how much of the will of the people was frustrated by one unelected, lifetime-appointed judge I do not know, but it was significant.

So those are the issues we will talk about in more detail. But I did want to set the record straight that I do not like not moving forward with a judge and giving them an up-or-down vote, but after the 8 years of President Bush and the repeated filibusters that occurred then, I have to agree with a number of my colleagues that, indeed, the Democrats did successfully change the standard in the Senate. We have to be careful about it. But they changed it to say that a filibuster is legitimate if you believe, according to the Gang of 14, there are extraordinary circumstances.

To me, a person can be honest and have integrity, but if they believe, as a philosophical approach to the law, they have the ability to write footnotes to the Constitution, they have an ability to actually amend the Constitution through their decisions, when the Constitution itself provides only one method to amend the Constitution, then that makes the person one who is not qualified to be on the bench.

So it is a big deal. We love the American legal system. I so truly admire it. It is based on a firm commitment to the rule of law. The oath judges take that they will impartially apply the law—not allow their personal views but impartially do it—that they will do equal justice to the poor and to the rich, that they will serve under the Constitution and laws of the United States—and not above them—that is the essence of it.

I think a judge who cannot follow that oath they must take, one whose philosophy indicates they are not committed to that oath, is not qualified.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

CONGRATULATING SENATOR ROBERT C. BYRD

Mr. HARKIN. Mr. President, this body often finds itself divided. But today we are united in our respect and affection for the senior Senator from West Virginia, ROBERT BYRD. I join with my colleagues in congratulating him on yet another historic milestone: becoming the longest serving Member of Congress.

But I hasten to add that to salute Senator BYRD only for his remarkable longevity is to really kind of miss the point. The measure of a Senator is not just how many years he or she serves but the quality and the consequences of that service. That is where Senator BYRD has truly distinguished himself in Congress over the last 20,774 days.

The ''Almanac of American Politics'' says, ROBERT BYRD ''may come closer to the kind of Senator the Founding Fathers had in mind than any other.'' I could not agree more. He is a person of wise and mature judgment, a patriot with a deep love of country. He is passionately loyal to the Constitution, and a fierce defender of the role and prerogatives of Congress, the Senate in particular.

Senator BYRD was once asked how many Presidents he has served under. He answered he had not served ''under'' any President, but he has served ''with'' 11 Presidents, as a proud Member of a separate and coequal branch of government.

During his more than 56 years in Congress, Senator BYRD has witnessed many changes. Our population has grown by more than 125 million. There has been an explosion of new technologies. America has grown more prosperous, more diverse, more powerful.

But across those nearly six decades of rapid change, there has been one constant: Senator BYRD's tireless service to his country, his passion for bringing new opportunities to the people of West Virginia, and his dedication to this branch of government, the U.S. Congress, and especially to this House of Congress, the U.S. Senate.

Senator BYRD is a person of many accomplishments and a rich legacy. But, above all, in my brief time today I want to focus on his commitment to improving K through 12 public education in the United States and expanding access to higher education, especially for those of modest means.

As my colleagues know, ROBERT C. BYRD was raised in the hardscrabble coal fields of West Virginia. His family was poor but rich in faith and values. And his parents nurtured in young ROBERT BYRD a lifelong passion for education and learning.

He was valedictorian of his high school class but too poor to go to college right away. Of course, that was in the days before Pell grants and loans and Byrd Scholarships. So he worked as a shipyard welder and later as a butcher in a coal company town. It took him 12 years to save enough money to even start college.

He was a U.S. Senator when he later earned his law degree. No other Member of Congress before or since has started and completed law school while serving in the Congress.

But degrees do not begin to tell the story of the education of ROBERT BYRD. He is the ultimate lifetime learner. It is like for the last seven decades he has been enrolled in the Robert C. Byrd School of Continuing Education.

Senator BYRD's erudition has borne fruit in no less than nine books he has written and published over the last two decades. We all know that he literally wrote the book on the U.S. Senate—a masterful four-volume history of this institution that was an instant classic that will bear the burdens of time. What my colleagues may not know is that he also authored a highly respected history of the Roman Senate. Now, there are some who think ROBERT BYRD served in the Roman Senate, but that part of the Byrd legend just is not so.

I have talked at length about Senator BYRD's education because this explains why he is so passionate about ensuring every American has access to a quality public education—both K through 12 and higher education.

One thing Senator BYRD and I have in common—and we always kind of talk about it when we get together—is we are the only two Senators whose fathers were actually coal miners. We are both the sons of coal miners, neither of whom had very much formal education. My father only went to the 8th grade. Actually, he only went to the 6th grade, but we will not get into that. But, anyway, he said he went to the 8th grade, but, like I said, I will not get into that. But coming from a poor background, Senator BYRD believes, as I do, that a cardinal responsibility of government is to provide a ladder of opportunity so everyone, no matter how humble their background, has a shot at the American dream.

Obviously, the most important rungs of that ladder of opportunity involve education—beginning with quality K through 12 public schools, and including access to college, vocational education, and other forms of higher education.

During my 25 years in this body, no one has fought harder for public education than Senator ROBERT BYRD. As the longtime chairman and still the senior member of the Appropriations Committee, he has been the champion of education at every turn—fighting to reduce class sizes, improving teacher

training, bringing new technologies into the classroom, boosting access to higher education.

In 1985, he created the only national merit-based college scholarship program funded through the U.S. Department of Education. Congress later named them in his honor. Originally, the Byrd Scholarships consisted of a 1-year $1,500 award to outstanding students. Today, Byrd Scholarships provide grants of up to $6,000 over 4 years.

Senator BYRD is a great student of literature, and I am sure he knows The Canterbury Tales—a lot of it, probably, by heart. Describing the Clerk of Oxford, Chaucer might just as well have been describing ROBERT C. BYRD. Chaucer wrote:

Filled with moral virtue was his speech;
And gladly would he learn and gladly teach.

Senator BYRD is a great Senator and a great American. He has both written our Nation's history and left his mark on it. It has been an honor to serve with my friend, my longtime chairman, Senator BYRD, for the last 25 years.

Today, as he reaches yet another historic milestone that no other Member of Congress has ever achieved—and I daresay probably no one ever will—we honor his service. And we express our respect and our love for this remarkable U.S. Senator.

I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I am glad I had the opportunity to hear the comments of the Senator from Iowa on Senator BYRD. We all have enormous respect for Senator BYRD. I had a chance this morning to say a word about him and to reflect on, among other things, that when I first came here as a young aide 42 years ago to Senator Baker, Senator BYRD had already been here for 10 years as a Senator.

So it is quite a span of history, and all of us have many stories, including the instructions he would give us to stand behind our desk when we vote, and not work at the table when we preside. He kept order in the Senate, and we are grateful to him for that.

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, I would like to say a word about health care. The Democratic leader, Senator REID, today announced that he has completed work on a health care bill. We have been waiting for that. It has been written behind closed doors in Senator REID's office for the last several weeks, so we have not known exactly what might be in it.

We have had two pieces of legislation from the Senate, one written by the HELP Committee, upon which I serve, another one from the Finance Committee. Now a bill has come from the House of Representatives. It has actually been passed there. Now the Democratic majority leader will be bringing forward his version of the bill. The bill seems to grow each time we have a new one—a little faster than the Federal debt grows even. This one seems to be another 2,000-page, trillion-dollar bill.

But the point I want to make tonight is that the American people's response to this work will be what all of ours should be: We want to read the bill. We want to know what it costs. And we want to make sure we have time to understand exactly how it affects the health of each American.

This is the most personal kind of debate we could have about the health of every single American. It affects 17 percent of our economy. It is a dramatic proposal, an enormous amount of money, at a time when our debt has reached $12 trillion. A great many Americans are concerned about Washington, DC, because we do not seem to have a check and a balance on the various proposals for Washington takeovers, more debt, more spending, more taxes. Tonight I would like to do a simple thing, which is not to make a Republican speech but to read a letter, or parts of a letter, and insert it in the RECORD, that was written by eight Democratic Senators on October 6 to Senator REID.

I think their words say a great deal about this bill and about how we should proceed on it. The letter is dated October 6, from eight Democratic Senators. It says, in part:

Dear Leader REID:

. . . .Whether or not our constituents agree with the direction of the debate, many are frustrated and lacking accurate information on the emerging [health care] proposals in Congress. Without a doubt—

Say these eight Democratic Senators——

reforming health care in America is one of the most monumental and far-reaching undertakings considered by this body in decades. We believe the American public's participation in this process is critical to our overall success of creating a bill that lowers health care costs and offers access to quality and affordable health care for all Americans.

And then, if I may read a couple more paragraphs from the letter from these eight Democratic Senators to the Democratic leader:

Every step of the process needs to be transparent, and information regarding the bill needs to be readily available to our constituents before the Senate starts to vote—

''to vote''——

on legislation that will affect the lives of every American.

The eight Democratic Senators continue:

The legislative text and complete budget scores from the Congressional Budget Office of the health care legislation considered on the Senate floor should be made available on a website the public can access for at least 72 hours prior to the first vote to proceed to the legislation.

Let me read that again. That is not 40 Republicans—although all 40 of us agree with it—this is eight Democratic Senators to the Democratic leader: ''The legislative text,'' No. 1, the ''complete budget scores,'' No. 2, ''from the Congressional Budget Office,'' posted on ''a website,'' No. 3, for ''72 hours'' before ''the first vote to proceed on the legislation.''

The distinguished Democratic leader's announcement was only made a few minutes ago, but my understanding is we do not yet have a complete legislative text. Hopefully, that will come tonight or in the morning.

Second, I understand the estimates from the Congressional Budget Office are preliminary estimates. This letter says: ''complete budget scores.'' We know what a ''complete budget score'' is around here. It was talked about in the Finance Committee debate. The Director of the Congressional Budget Office said a complete estimate of the health care bill would take about 2 weeks to do. So the question is, Do they have it? And then: ''72 hours'' before ''the first vote to proceed.''

So I think the eight Democratic Senators, along with all 40 Republican Senators, have a bipartisan agreement here on how we should start this debate. We want to be able to read it, we want to know what it costs, and we want to see how it affects every American. That means, No. 1, a complete text. No holes, no ''We will get back to you later'' a complete text. No. 2, a complete estimate. Those are these words here: A complete estimate of the cost and how it affects every American. And third, for 72 hours on the Web site so not only we in the Senate but our constituents, the people who expect us to weigh in on this, have a chance to read it before we have our first vote, which I don't think is scheduled.

There is other language here, but I ask unanimous consent that this letter from the eight Democratic Senators of October 6 to the Honorable HARRY REID be included in the RECORD following my remarks.

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

(See exhibit 1.)

Mr. ALEXANDER. Mr. President, the last thing I would say is this: I think it is pretty obvious why we want to read the bill and know what it costs and understand how it affects the health care of every American, which it will, but in case anyone is wondering why we want to read the bill, it is because the bills we have already seen increase insurance premiums, raise taxes, and cut Medicare. That is what we have seen from the two Senate bills and the House bill. We on the Republican side think this ought to be about reducing costs, reducing premiums, but the Democrats' proposals increase premiums, increase taxes, and cut Medicare. Not only does it cut Medicare in the bills we have seen so far by $400 billion or $500 billion; it doesn't spend it

on grandma, it spends it on somebody else, even though the Medicare Program, the trustees tell us, will begin to go broke by 2015.

There are some other problems with the bills we have seen before, so we would want to be able to ask these same questions about the new bill we haven't yet seen but we are about to see.

On Medicare, how big are the cuts? Then we hear in this new bill there are Medicare taxes, new Medicare payroll taxes. On which employees or which employers? And if their taxes are raised, are they spent to make Medicare solvent or are they spent on a new program? It is inconceivable to me that we could be even thinking about having savings in Medicare and spending it on something else when Medicare is about to go broke.

Then there are some other questions. The Democratic leader said it doesn't add to the debt. I hope he is right, but we have questions to ask about that. Does his proposal include a full dealing with the issue of physician reimbursement? What we mean by that is when we create these big government programs, then some agency in Washington tells how much we can pay doctors for different services and how much we pay hospitals. Right now, in the government programs we have—Medicare, for example—doctors are only paid about 80 percent of what they are paid for serving the roughly 200 million of us who have private plans. And for those who are in Medicaid—low income; that is the largest government program—it is about 60 percent. Doctors are paid about 60 percent of what they were paid if they saw private physicians. Then, as a result, 50 percent of doctors won't see new people in that Medicaid Program, which is why so many people think: I am not so sure a new government-run program of insurance is such a good idea, because I might end up in it and it might be like Medicaid and 50 percent of the doctors won't see new Medicaid patients.

Why might you end up in a government program if you are not there now? Well, in the other bills we have seen—and this would be a question we have about Senator REID's bill—the combination of sections means that a great many employers are going to look at the bill and the requirements that are placed on them and they are going to write a letter to their employees and say: Congratulations, there is a new government plan. I have sent a check to the government, and instead of having employer insurance, you are in the government plan. Well, you may not have been thinking that was the kind of health reform you wanted.

There is the matter of the States. I will admit that as a former Governor I may be more worried about this than some people, but I see a former mayor in the Presiding Officer's chair today. I won't speak for him, but I know I used to sit back there in Nashville and nothing would make me madder than some Member of Congress coming up with a big idea, pass it into law, issue a press release, take credit for it, and send me the bill when I was Governor. So all of the other bills we have seen say, It is a great idea to expand Medicaid. We are going to dump about 14 million more Americans in this program for low-income Americans and we are going to send the bill for part of it to the State.

Well, our Democratic Governor thinks that is a bad idea, because our State, which is fiscally well managed—Tennessee—and virtually every other State is having the worst time they have had since the Great Depression in managing their resources. Here they have the Medicaid Program going up at 8 percent a year, and they are cutting higher education and other programs. That is what is going on in the States. So we will have to ask the question: How much does this new bill transfer costs to the States?

There are a great many questions we will need to ask, and they are appropriate questions. The Republican leader pointed out that when we did the farm bill, we talked for 4 weeks. We debated, we had amendments, we came to a conclusion, and we had a bipartisan result. When we did No Child Left Behind, it was 7 weeks. I remember on the Energy bill of 2005, which put us on a new direction, Senator BINGAMAN and Senator Domenici and others worked very hard on it, but on the floor it took 8 or 9 weeks. We need to have a full discussion of whatever bill finally comes to the floor, and this may be the bill. It is at least 2,000 pages. It is at least $1 trillion. Maybe it is a good bill. But the American people will have a lot of questions about whether their premiums are going up instead of down, their taxes are going up instead of down; how much are the Medicare cuts—why are they being spent on somebody else instead of the people in Medicare? What about these Medicare payroll taxes? What about new State taxes? Will I lose my insurance? These are big questions and they deserve to be answered.

A good way to start is to take the advice of the eight Democratic Senators who wrote the Democratic leader and said: Before we have our first vote, Mr. Leader, No. 1, we want to see the complete text which we don't yet have; we want to see a complete estimate by the Congressional Budget Office; and we want it to be on the Internet for at least 72 hours—the words were very strong—because we have a duty to the American people that they know how this affects them, because it is a very personal matter.

I thank the President.

EXHIBIT 1

U.S. SENATE,
Washington, DC, October 6, 2009.

Hon. LARRY REID,
Senate Majority Leader, U.S. Capitol, Washington, DC.

DEAR LEADER REID: As you know, Americans across our country have been actively engaged in the debate on health care reform. Whether or not our constituents agree with the direction of the debate, many are frustrated and lacking accurate information on the emerging proposals in Congress. Without a doubt, reforming health care in America is one of the most monumental and far-reaching undertakings considered by this body in decades. We believe the American public's participation in this process is critical to our overall success of creating a bill that lowers health care costs and offers access to quality and affordable health care for all Americans.

Every step of the process needs to be transparent, and information regarding the bill needs to be readily available to our constituents before the Senate starts to vote on legislation that will affect the lives of every American. The legislative text and complete budget scores from the Congressional Budget Office (CBO) of the health care legislation considered on the Senate floor should be made available on a website the public can access for at least 72 hours prior to the first vote to proceed to the legislation. Likewise, the legislative text and complete CBO scores of the health care legislation as amended should be made available to the public for 72 hours prior to the vote on final passage of the bill in the Senate. Further, the legislative text of all amendments filed and offered for debate on the Senate floor should be posted on a public website prior to beginning debate on the amendment on the Senate floor. Lastly, upon a final agreement between the House of Representatives and the Senate, a formal conference report detailing the agreement and complete CBO scores of the agreement should be made available to the public for 72 hours prior to the vote on final passage of the conference report in the Senate.

By publically posting the legislation and its CBO scores 72 hours before it is brought to a vote in the Senate and by publishing the text of amendments before they are debated, our constituents will have the opportunity to evaluate these policies and communicate their concerns or their message of support to their Members of Congress. As their democratically-elected representatives in Washington, DC, it is our duty to listen to their concerns and to provide them with the chance to respond to proposals that will impact their lives. At a time when trust in Congress and the U.S. government is unprecedentedly low, we can begin to rebuild the American people's faith in their federal government through transparency and by actively inviting Americans to participate in the legislative process.

We respectfully request that you agree to these principles before moving forward with floor debate of this legislation. We appreciate your serious consideration and look forward to working with you on health care reform legislation in the weeks ahead.

Sincerely,

BLANCHE L. LINCOLN.
MARY L. LANDRIEU.
CLAIRE MCCASKILL.
MARK L. PRYOR.
EVAN BAYH.
JOSEPH I. LIEBERMAN.
BEN NELSON.
JIM WEBB.

The PRESIDING OFFICER. The Senator from Alabama.

Mr. SESSIONS. Mr. President, I ask unanimous consent to speak as in morning business.

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

Mr. SESSIONS. Mr. President, I wish to thank Senator ALEXANDER for his remarks because I think I have heard it said that this new health care bill, don't worry about it, it is going to be revenue neutral. But if you create a bill that is revenue neutral by taking hundreds of billions of dollars out of Medicare, which we already know is heading into default in the next 5 or 6 years, and you do it by raising taxes, both of which are to fund a new program that we don't have the money for, then that is not, in my mind, what the average person would say in commonsense thought is revenue neutral.

I think that is what we are talking about. We need to be able to see the details of it. I appreciate Senator ALEXANDER for that fine summary of where we are. I hope our Members will take it to heart.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. The Senate will stand adjourned until Thursday, November 19, at 9:30 a.m.

There being no objection, the Senate, at 7:51 p.m., adjourned until Thursday, November 19, 2009, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF COMMERCE

NICOLE YVETTE LAMB-HALE, OF MICHIGAN, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE WILLIAM G. SUTTON, RESIGNED.

ENVIRONMENTAL PROTECTION AGENCY

ARTHUR ALLEN ELKINS, JR., OF MARYLAND, TO BE INSPECTOR GENERAL, ENVIRONMENTAL PROTECTION AGENCY, VICE NIKKI RUSH TINSLEY, RESIGNED

DEPARTMENT OF VETERANS AFFAIRS

ROBERT A. PETZEL, OF MINNESOTA, TO BE UNDER SECRETARY FOR HEALTH OF THE DEPARTMENT OF VETERANS AFFAIRS, VICE MICHAEL J. KUSSMAN, RESIGNED.

HOUSE OF REPRESENTATIVES—*Wednesday, November 18, 2009*

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

PRAYER

Reverend Matthew Southall Brown, Sr., St. John Baptist Church, Savannah, Georgia, offered the following prayer:

Our Father, we are confident that You are here in the midst of all of us, so as we gather here this morning, we ask for Your wisdom and courage for the Members of this august body as they face the challenges of this day.

Lord, I pray, lead them and guide them in matters facing this Nation and indeed the world. We live, my Father, in a time when "men are trying to war their way to peace, spend their way to wealth and enjoy their way to Heaven."

Lord, it is our prayer that each Member of this House of Representatives be sensitive to Your voice, the needs of the people of America and indeed throughout the world. May the decisions made here be for the good of America and the world.

Hasten the day, Father, when men will "beat their war tools into pruning hooks and study war no more." Finally, my Father, we pray for our President, Barack Obama, his family, and all leaders of this great Nation.

May this Nation once again hear the words of the Lord Himself saying, "If My people who are called by My name will humble themselves and pray and seek My face and turn from their wicked ways, then I will hear from heaven and will forgive their sins and heal their land."

It is in the name of Him Who said, "If I be lifted up from the Earth, I will draw all men unto Me."

It is in His name we pray. Let the people of the Lord say amen.

THE JOURNAL

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

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

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) come forward and lead the House in the Pledge of Allegiance.

Mrs. CHRISTENSEN led the Pledge of Allegiance as follows:

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

WELCOMING REV. MATTHEW SOUTHALL BROWN, SR.

The SPEAKER. Without objection, the gentleman from Georgia (Mr. BARROW) is recognized for 1 minute.

There was no objection.

Mr. BARROW. Madam Speaker, I rise to pay tribute to my friend, Rev. Matthew Southall Brown, Sr., who delivered the invocation for the House this morning.

If history is biography, then the history of the civil rights movement in my home of Savannah, Georgia, is the biography of Matthew Southall Brown. He got involved in the movement before there was a movement helping to bring about the end of one era and the birth of another.

During World War II, Rev. Brown was serving as an Army non-com in Europe when the Battle of the Bulge broke out. In those days, blacks were confined to supporting units. But when men were needed to fight, General Eisenhower called for black soldiers to volunteer infantry duty. Rev. Brown was one of the 2,221 who answered that call, even though he had to give up his rank to do so.

Later, answering a different call, Rev. Brown was chosen to lead Savannah's historic St. John Baptist Church. For over 35 years, Pastor Brown not only led his church family; he was a leader in the movement to secure equal rights and equal opportunity for everyone in our community.

Rev. Brown, thank you for being there with my father in Europe and for your willingness to give your life to help us win that war, even when it was unfair. But more importantly, thank you for spending your life to help us win the peace. Sometimes it's an awful lot easier to fight for your country than it is to live for your country. You've done both, and for that we salute you.

ANNOUNCEMENT BY THE SPEAKER

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

TRIBUTE TO THE 25TH ANNIVERSARY OF REV. JESSE JACKSON'S RUN FOR THE PRESIDENCY

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

Ms. LEE of California. Madam Speaker, I rise today to recognize and honor the contributions of a truly great American who is with us today, the Reverend Jesse Louis Jackson.

Twenty-five years ago, Rev. Jackson embarked on a trailblazing run for the Presidency which really did energize our Nation and was an inspiration to millions. Many Members of this body are here today as a result of the movement Rev. Jackson led.

Rev. Jackson's run for the White House gave us more than hope. He showed us how to build a serious grassroots movement that cut across race and class. We learned how to empower and engage our communities so that our voices would be heard and our issues addressed.

In the 25 years since Rev. Jackson's historic run for the Presidency, America has witnessed monumental changes culminating in our Nation electing the first African American President. Much remains to be done in this great Nation to achieve the American Dream, but Rev. Jackson's example of perseverance and coalition-building continues to inspire hope and change and provide for the participation of all of those in our great democracy.

Rev. Jackson, you have shown us that if the dream can be conceived, it can be achieved. And we honor you today.

RECOVERY.GOV REPORTS FAKE JOBS

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

Mr. WILSON of South Carolina. Mr. Speaker, last night, I learned that the government's own official Web site that was designed to report waste, fraud and abuse of the misnamed stimulus funds has produced a fake report.

Recovery.gov, the official administration Web site, shows that $6 million was to create six jobs in South Carolina's fake 16th Congressional District. It shows that $3 million couldn't even produce a single job in South Carolina's fake 43rd District.

Somehow, $1.8 million was spent for 1.4 jobs in the fake 00 district. This would be funny, but the money belongs

☐This symbol represents the time of day during the House proceedings, e.g., ☐1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

to the taxpayers, not the government. The administration is mocking people looking for jobs.

Americans are faced with fake districts and fake jobs. Democrats and Republicans should work together to jump-start America's economy by promoting real jobs for real, hardworking American families.

In conclusion, God bless our troops and we will never forget September the 11th in the global war on terrorism.

Congratulations, Jesse Jackson of Greenville, South Carolina.

HONORING AND RECOGNIZING THE REVEREND JESSE JACKSON

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

Mrs. CHRISTENSEN. Mr. Speaker, I proudly rise today in honor of the Reverend Jesse Jackson, Sr., and to recognize his landmark and barrier-breaking run for the Presidency of the United States of America 25 years ago. I was his campaign Chair in the U.S. Virgin Islands and a committed delegate during both campaigns and conventions.

Although I recall those days on the platform committee, fighting for every vote on the floor and the tears of admiration from people from every corner and segment of U.S. society when he spoke to us, what I remember most was his coming to the aid of an often cast-aside, forgotten or ignored, misunderstood territory of our great Nation in our time of need.

After the devastation of Hurricane Hugo in 1989 and the ensuing negative media portrayal that our community endured in its wake, I contacted him through my DNC Black Caucus Chair, Dr. C. Delores Tucker, and Rev. Jackson came to St. Croix with an entourage that included Cicely Tyson to bolster our spirits, inspire our recovery efforts, and stave off an ill-informed Presidential declaration of martial law.

Jesse, there is so much for which we are grateful to you, but for me and the people of the U.S. Virgin Islands, we love you for always coming to the aid of those whom many look upon as the ''least of these,'' God's people. You are doing God's work.

□ 1015

CONGRATULATING ST. AGNES SCHOOL IN FORT WRIGHT, KENTUCKY

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

Mr. DAVIS of Kentucky. Mr. Speaker, I rise today to recognize the students, faculty, and staff at St. Agnes School in Fort Wright, Kentucky. St. Agnes was recently named a 2009 Blue Ribbon School. The Blue Ribbon Schools Program honors schools that are either academically superior or that demonstrate dramatic gains in student achievement to high levels. These schools serve as models for others throughout the Nation.

I recently had the opportunity to meet the students and faculty at St. Agnes and speak with them about their efforts to improve their school. Students and staff are unable to be here today in Washington with us because they're back in Kentucky working hard in the classroom to uphold their high standards. However, the students in Ms. Patti Conway's first-grade class sent a distinguished visitor to represent them in Washington, D.C.

Mr. Speaker, I ask my colleagues to join me in welcoming Teddy to the House of Representatives and extend our congratulations to all of the students of the St. Agnes community for their outstanding achievement.

CELEBRATING THE LIFE OF REV. JESSE JACKSON

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

Mr. KUCINICH. We feel the presence of Rev. Jesse Jackson not only in this Chamber but in this Nation. Through nearly a half century commitment to social and economic justice, Rev. Jackson heard the call of Dr. King and marched for civil rights and helped to make civil rights for millions of Americans a reality.

He heard the call of the prophet Isaiah early in his life and made justice the measuring line—not just social justice, but economic justice, political justice. He heard the call of Matthew and made his life about a commitment to doing for the least of the brethren; asked the question, When I was hungry, did you feed me? When I was homeless, did you shelter me?

He has been and continues to be a powerful force for economic justice in America. He has and continues to be a person who points the way—a way-shower—for jobs, for health care, for housing, for education. Let us celebrate Rev. Jesse Jackson by continuing to support his work.

THE AMTRAK SECURE TRANSPORTATION OF FIREARMS ACT OF 2009

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

Mr. FLEMING. Mr. Speaker, last month, I introduced H.R. 3789, the Amtrak Secure Transportation of Firearms Act of 2009. The bipartisan legislation will permit law-abiding gun owners to legally transport firearms on Amtrak trains—just as Americans have been able to do for years on our Nation's airlines.

Currently, sportsmen who choose to travel by rail for a hunting trip are left in an impossible situation because of Amtrak's prohibitions against checking unloaded firearms in the secure baggage car. Conversely, these same gun owners are legally allowed to check guns in their luggage on our Nation's airlines, of all places. Why the double standard? Should our federally subsidized passenger rail line have more restrictive regulations than air carriers?

The Amtrak Secure Transportation of Firearms Act would require Amtrak to enact regulations similar to those the U.S. airline industry uses to regulate the secure transport of firearms on airplanes. The requirements would apply for any year that Amtrak receives a federal subsidy.

I ask my colleagues here to support this bill.

TRIBUTE TO REV. JESSE JACKSON

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

Mr. CONYERS. Mr. Speaker, as I look over the House, no one has known Jesse Jackson longer than I. I remember him coming to Detroit, I remember going to Chicago, and I remember the work that he was doing even before Dr. Martin Luther King added him to the top of his staff as a valuable assistant.

The quest that he pursued then is still the quest that he pursues now. Over the 25 years, he hasn't changed. As a matter of fact, he has become international. I'm so proud that in our State we nominated him for President in one of his runs. Obviously, now the connection is clear—from Jackson to Obama. Rev. Jackson, we owe you this victory that we celebrate today.

GOVERNMENT TAKEOVER OF HEALTH CARE

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

Mr. GINGREY of Georgia. Mr. Speaker, I oppose a government takeover of our Nation's health care system, like the one the House passed late in the night on Saturday, November 7. The Democratic legislation—a 1,990-page, $1 trillion bill—will raise taxes, it will increase our national debt, and, worse, it will put government bureaucrats between patients and doctors.

I agree it's important to reform our health care system, Mr. Speaker, but this is not the way to do it. I've spent the last 10 months trying to share my perspective as a physician for over 30 years with my colleagues. This legislation that the Democrats put on the floor of the House proves that the Speaker doesn't care what practicing physicians or indeed the American public think.

This legislation is the wrong direction for America, and it is a death knell for quality care for American patients, and I'm disappointed in my colleagues who voted to pass that measure.

Mr. Speaker, I reject any government takeover of our Nation's health care system.

REV. JESSE JACKSON: A GOOD SAMARITAN

(Ms. JACKSON-LEE of Texas asked and was given permission to address the House for 1 minute.)

Ms. JACKSON-LEE of Texas. I am privileged to join my colleagues this morning to celebrate a man who I call a Good Samaritan—who battled for the impoverished, those without voices, those who cannot speak for themselves. Rev. Jesse Jackson, who is with us here today, is a man of all seasons. He rescues, he discovers, he challenges. And there is no doubt in my mind that as Martin Luther King rests in peace, he is proud of Rev. Jesse Jackson. Jesse is the reason that we now can celebrate the election of President Barack Obama. But I know that he is also a man that finds problems and solves problems.

I thank him for coming to Houston, Texas, in the midst of the debacle of the Enron Company, and giving empowerment to the employee victims. As we stood outside that building and employees cried, Jackson was there with me to empower them and to give them, for the first time in history, a stakeholder position in receiving benefits that they would not have gotten. I thank him for coming to Galveston, Texas, and announcing and analyzing that insurance companies benefited from the work of slaves, and derived their wealth from unpaid labor—he demanded reparation for the people who were taken advantage of.

This is a man who goes and seeks those who, again, cannot speak for themselves. We are gratified that he is a Good Samaritan on the battlefield, fighting for those who, again, are voiceless. We're gratified that he received the Presidential Medal of Freedom in 2000 and was the third largest Democratic vote-getter when he ran for President in 1984.

Rev. Jackson, thank you, the Good Samaritan, our Rev. Jesse L. Jackson.

TERRORIST IN NEW YORK

(Mr. DANIEL E. LUNGREN of California asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DANIEL E. LUNGREN of California. Mr. Speaker, can anything top this last week's lesson in absurdity and perversity? I'm talking about the administration's decision to bring Khalid Sheikh Mohammed and three other terrorist suspects from Guantanamo to New York. Absurd, because they have been charged before military tribunals, where they ought to be. Absurd, because it serves no purpose to bring them to the site of their worst action, just a stone's throw from Ground Zero. Perverse, because now, if you kill Americans on the battlefield, you will see justice done when you are captured by a military tribunal. But if instead of being a soldier on the battlefield, you attack Americans in their own home, you attack innocent Americans, you will now be privileged to get constitutional rights. The worse the terrorist, the greater the constitutional rights given to them. What a perverse action by this administration.

RECOGNIZING THE WORKS OF JESSE JACKSON

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

Ms. WATERS. Mr. Speaker and Members, 1984 and 1988 were the proudest and most productive periods of my life. Jesse Jackson ran for President both in 1984 and 1988, and I served as the national co-Chair and the Chair of the California campaign. I was so pleased to be a part of the Rainbow Coalition he formed that included African Americans, Hispanics, Arab Americans, Asian Americans, Native Americans, family farmers, the poor and working class, homosexuals, as well as white progressives. It truly was a Rainbow Coalition.

Listen to Jesse Jackson's campaign platform. Jobs. Creating a Works Progress Administration-style program to rebuild America's infrastructure; reversing Reaganomics-inspired tax cuts; cutting the budget of the Department of Defense by as much as 15 percent over the course of his administration; supporting family farmers by reviving many of Roosevelt's New Deal-era platforms; creating a single-payer system of universal health care; and applying stricter enforcement of the Voting Rights Act.

Jesse Jackson, thank you for the leadership that you provided. It is because of you and the hope that you created that has caused Barack Obama to be the President today.

NET NEUTRALITY VS. FREE SPEECH

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

Mr. POE of Texas. Mr. Speaker, the different ways we get our information in America have changed dramatically over the last few decades. We've gone from rabbit ears on our TV sets to cable satellite dishes and broadband. In the next decades, everything—radio, television, Internet, telephones—everything will use broadband.

''Net neutrality'' is a new legislative scheme cooked up by the government fairness police to ration broadband access. It's not about keeping the Internet ''neutral''—it's about government control. Anybody who's ever downloaded pictures over a slow Internet connection knows that some things use more Internet bandwidth than others. Under net neutrality, a plan disguised to make Internet access fair to everybody, the government actually rations how much bandwidth people can use. No one gets more than anyone else.

If the fairness police control broadband, they limit the amount of information people receive and how they receive it. This is the newest threat to free speech in modern times. It's yet more government control over all communication and information.

And that's just the way it is.

HONORING REV. JESSE JACKSON

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

Ms. KILPATRICK of Michigan. Today, I rise to recognize 25 years ago one of our leaders of this world, Rev. Jesse Jackson, ran for President. I was honored in 1988 to be a delegate when he ran again. Rev. Jackson, as was mentioned earlier, 25 years ago called for single-payer health care. Unfortunately, we weren't able to get it last week, but we're on the way to new health care competition.

He also called for increased funding for public education. Public education. Just what we need today. The Equal Rights Amendment—thank you, Rev. Jackson—has now become law. He called for a work program, an employee program, 25 years ago.

The things that you called for then, Rev. Jackson, in your leadership, still exist today. Thank you for standing up, for speaking out, for being the man that God intended that you be. We love you.

HONORING MIAMI-DADE COUNTY POLICE DEPARTMENT DIRECTOR BOBBY PARKER

(Mr. LINCOLN DIAZ-BALART of Florida asked and was given permission to address the House for 1 minute.)

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I rise today to honor a leader in my community, Miami-Dade County Police Department Director Bobby Parker. After serving honorably in the Army, Director Parker joined the Miami-Dade Police Department in 1976 and worked his way up the ranks, culminating in his promotion to director in April, 2004.

The Miami-Dade Police Department is the eighth-largest in the Nation, with over 4,700 personnel, serving almost 2.5 million residents and countless visitors to our community. Under

Director Parker's leadership, the department has been at the forefront of effective law enforcement, and he's implemented numerous programs that have had a major effect in ensuring the safety and quality of life of our citizens.

Director Parker retired from the department earlier this month. His leadership and vision will be sorely missed, but his standard of excellence will surely carry on. On behalf of a grateful community, I wish to thank Director Parker for his outstanding service and wish him well in his future endeavors. May you long enjoy your retirement with family and friends, Director Bobby Parker.

RECOGNIZING PLEASANTON MILITARY FAMILIES

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

Mr. McNERNEY. I rise today to commend the tireless efforts of the Pleasanton Military Families on behalf of the brave men and women in our Armed Forces. Created in 2004, the Pleasanton Military Families is a support group for active military personnel and their families based in my hometown of Pleasanton, California. The Pleasanton Military Families leads a public recognition program for our servicemembers by hanging yellow streamers along Main Street marked with the names of residents serving in our Armed Forces.

My family was honored that the Pleasanton Military Families hung a yellow pennant for my son, Michael, when he was serving in the Air Force. In addition, the Pleasanton Military Families hold warm welcome home ceremonies and sends packages to troops overseas.

All of these efforts to support our active duty personnel and their families give due honor to the sacrifice and service of these young men and women. I urge my colleagues to join me in recognizing the Pleasanton Military Families for their dedication and commitment to our men and women in uniform.

□ 1030

NETWORKS IGNORE PRESIDENT'S REVERSAL

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

Mr. SMITH of Texas. Mr. Speaker, during the Presidential campaign, then-Senator Obama made a ''firm pledge'' that he would not raise taxes on any family ''making less than $250,000 a year.'' President Obama reversed himself on that pledge by supporting a health care bill that imposes, ''new taxes on people who don't buy qualified health insurance, including those making (much) less than $250,000 a year,'' according to the Associated Press.

Not a single network news report mentioned the President's flip-flop in the days following his reversal, according to an analysis by the Business and Media Institute, and BMI found that less than one-third of the health care stories on the three networks even mentioned the $550 million in new taxes in the health care bill.

The national media should give Americans the facts, not ignore the truth. And, Mr. Speaker, if you'll indulge me for a second more, I have noticed that several individuals today have rightfully made speeches honoring the Reverend Jesse Jackson. I think it is very appropriate and fitting that his son, a Member of Congress, is presiding over the Chamber right now as temporary Speaker. I appreciate both his presence and his father's contributions.

THE REVEREND JESSE JACKSON, OUR CAPTAIN

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

Mr. CLEAVER. Mr. Speaker, back during the time when I played football in high school and college, I ended up on the corner. And it was at that time that most teams ran what was called ''student body right'' and ''student body left,'' which meant that there would be a sweep around the end and you would have a pulling guard, a pulling tackle, a wide receiver who was in motion, a fullback all leading a running back. The only people who could play that position were those who were willing to run into this interference. Now, the person who ran into the interference would rarely ever make a tackle, and only people who understood football would understand the job that this cornerback played. So playing that position, I never led my team in tackles, but my team elected me as its captain. They understood football.

And so, on the 25th anniversary of the Presidential run of the Reverend Jesse Jackson, Mr. Speaker, I nominate him as our captain. He is our captain because he was willing to go in and knock down the interference so that somebody else would make the tackle and get the recognition.

RECOVERY.ORG

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

Mr. PITTS. Mr. Speaker, I represent the 16th Congressional District of Pennsylvania. I'm not quite sure who represents the 23rd District or the 65th District, since these districts don't actually exist. They only exist in the fictional world created by recovery.gov, the administration's Web site that shows how many jobs were ''saved or created'' by the billions of dollars in so-called stimulus money.

For $18 million, the Treasury Department has produced a Web site that creates new congressional districts and then places saved jobs in those fictional districts. In one case, the purchase of a single riding lawnmower supposedly saved 50 jobs. Some companies have claimed that they have saved and created more jobs than the number of employees that they actually have. Now the leaders are talking about yet another stimulus package. We are about to spend our way into a fiscal tsunami, not economic recovery.

HONORING THE 25TH ANNIVERSARY OF THE REVEREND JESSE JACKSON'S PRESIDENTIAL CAMPAIGN

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

Ms. EDWARDS of Maryland. Mr. Speaker, I rise today to join my colleagues in recognizing the 25th anniversary of Rev. Jackson's candidacy for President. He is a strong iconic voice for civil rights and social justice. It was his unwavering determination and leadership that inspired me to take action, first volunteering in 1984 and then again in those cold, snowy days in New Hampshire 4 years later.

Rev. Jackson's historic campaigns forever changed the political and social landscape of this country. He brought people together across the rainbow, regardless of social and economic status, race or religion, who shared a common vision for this country where everyone could achieve the American dream. Without question, Rev. Jackson's run 25 years ago laid the foundation for us to realize the rainbow in 2008 by electing Barack Obama.

Mr. Speaker, I rise today to honor Rev. Jackson. And I salute his efforts that continue to this day for the least among us.

Rev. Jackson, today we are reminded that no trail is blazed alone.

HONORING THE REVEREND JESSE JACKSON

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

Ms. FUDGE. Mr. Speaker, I rise today to commemorate Rev. Jesse Jackson's historic run for President of these United States 25 years ago. Main Street pundits then underestimated his ability to draw Americans to the polls,

but his passionate devotion to the advancement of the disenfranchised resonated with so many Americans. In fact, in his 1988 Presidential bid, he won 11 contests, 7 primaries, and 4 Democratic caucuses.

His current activism moves our Nation towards the true inclusion of diverse ideas, of classes, races, and ethnicities. In his words, he said, ''At the end of the day, we must go forward with hope and not backward by fear and division.''

As an agent of social, political, and economic change, Rev. Jackson has positively impacted the lives of many. I celebrate Rev. Jackson's achievements and applaud him for continuing his advocacy for economic parity and minority inclusion.

Mr. Speaker, I thank you so much for this opportunity, and I thank Mr. JACKSON for being in our midst today.

25TH ANNIVERSARY OF THE REVEREND JESSE JACKSON'S RUN FOR PRESIDENT

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

Mr. DAVIS of Illinois. Mr. Speaker, today marks the 25-year anniversary of the Jesse Jackson run for President of the United States.

As a resident of Chicago, I have been privileged to be up front and close to the Jesse Jackson phenomenon. I have seen his positive impact on Chicago as he globalized a world vision for change. I know how he has helped the Democratic Party to become more democratic and the Republican Party to focus more on the Republic.

He has advanced the causes of all minorities, helped Illinois become a State where African Americans and other minorities can be elected to the highest of public offices, and he laid the groundwork for the election of the Nation's first African American President, Barack Obama.

Rev. Jackson, we salute you.

THANKING THE REVEREND JESSE JACKSON FOR HIS 1984 RUN FOR PRESIDENCY

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

Mr. RUSH. Mr. Speaker, I am here to congratulate and thank Rev. Jesse Jackson, Sr. Thank you, Rev. Jackson, for your historic run for President in 1984.

But I really want to thank you for what you did for me back in the summer of 1969. My friend and fellow member on the Illinois chapter of the Black Panther party was assassinated while he slept in his bed at 4 a.m. by the Chicago Police Department and Cook County State's Attorney's Office. The very next morning, at 5 a.m., they came to my apartment, seeking to kill me. I was not there. I was running for my life over the next few days, until Saturday, December 8, 1969, I turned myself in to Operation PUSH and the Reverend Jesse Louis Jackson.

Mr. Speaker, if it had not been for Rev. Jesse Louis Jackson, I would have been killed. If it had not been for Rev. Jesse Louis Jackson, I would not be here today. If it had not been for Rev. Jesse Louis Jackson, I would not be representing the people of the First Congressional District.

Thank you, Rev. Jackson. I love you, and you can't do nothing about it.

LOAN MODIFICATION SCAM AWARENESS MONTH

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

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I will not be speaking on Rev. Jackson this morning, but I will be submitting something for the RECORD, as I know that my good colleague Mr. COHEN of Tennessee will also.

Actually, today I rise to talk about something I think is very important, and I think that Jesse Jackson and others who have worked so hard for the community would care about. I rise to recognize National Loan Modification Scam Awareness Month which was established to stop predators around the country from taking advantage of our constituents who are at risk of foreclosure.

Currently, in California, the foreclosure rate is 10.8 percent. Experts predict that nationwide there will be 8.1 million foreclosures by the year 2012, and given this environment, loan modification scams are proliferating at a rapid pace. Every day, more homeowners are falling prey to slick advertising that promises to help them stay in their homes if they pay a third party.

NeighborWorks America and their affiliates around the country are working to combat loan modification scams. To do so, they have launched a national public education campaign to help homeowners protect themselves against loan modification scams, find trusted help, and report illegal activity to authorities.

I urge my colleagues to support National Loan Modification Scam Awareness Month.

HONORING THE REVEREND JESSE JACKSON

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

Mr. CARSON of Indiana. Mr. Speaker, in the year of 1984, a young man 9 years old, myself with my grandmother, had the chance to tag along with Rev. Jackson as he visited Indianapolis multiple times, and I got a chance to go out to San Francisco. Rev. Jackson, we commend you and love you not only because you are a great civil rights leader, but you are an oratorical genius. ''Up with hope, down with dope,'' ''Keep hope alive,'' bringing multiple races together, but also breaking down racial, psychological barriers that existed at that time. You led the way for our beloved President. We owe you. Back then as a 9-year-old young man, he reminded me of the lyrical greats, the MellyMels, the Run-DMCs, the James Baldwins.

He was a leader. He is a leader. We deserve to honor him, and we will continue to honor him.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Record votes on postponed questions will be taken later.

AUTHORIZING THE SCORE PROGRAM

Ms. VELÁZQUEZ. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1839) to amend the Small Business Act to improve SCORE, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1839

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

SECTION 1. EXPANSION OF VOLUNTEER REPRESENTATION AND BENCHMARK REPORTS.

(a) EXPANSION OF VOLUNTEER REPRESENTATION.—Section 8(b)(1)(B) of the Small Business Act (15 U.S.C. 637(b)(1)(B)) is amended—

(1) by inserting ''(i)'' after ''(B)''; and

(2) by adding at the end the following:

''(ii) The Administrator shall ensure that SCORE, established under this subparagraph, carries out a plan to increase the proportion of mentors who are from socially or economically disadvantaged backgrounds and, on an annual basis, reports to the Administrator on the implementation of this subparagraph.''.

(b) BENCHMARK REPORTS.—Section 8(b)(1)(B) of the Small Business Act (15 U.S.C. 637(b)(1)(B)), as amended, is further amended by adding at the end the following:

''(iii) The Administrator shall ensure that SCORE, established under this subparagraph, establishes benchmarks for use in evaluating the performance of its activities and of its volunteers. The benchmarks shall include benchmarks relating to the demographic characteristics and the geographic characteristics of persons assisted by SCORE,

benchmarks related to the hours spent mentoring by volunteers, and benchmarks relating to the performance of the persons assisted by SCORE. SCORE shall report, on an annual basis, to the Administrator the extent to which the benchmarks established under this clause are being attained.''.

SEC. 2. MENTORING AND NETWORKING.

Section 8(b)(1)(B) of the Small Business Act (15 U.S.C. 637(b)(1)(B)), as amended, is further amended by adding at the end the following:

''(iv) The Administrator shall ensure that SCORE, established under this subparagraph, establishes a mentoring program for small business concerns that provides one-on-one advice to small business concerns from qualified counselors. For purposes of this clause, qualified counselors are counselors with at least 10 years experience in the industry sector or area of responsibility of the small business concern seeking advice.

''(v) The Administrator shall carry out a networking program through SCORE, established under this subparagraph, that provides small business concerns with the opportunity to make business contacts in their industry or geographic region.''.

SEC. 3. NAME OF PROGRAM CHANGED TO SCORE.

(a) NAME CHANGE.—The Small Business Act is amended as follows:

(1) In section 8(b)(1)(B) (15 U.S.C. 637(b)(1)(B)), by striking ''Executives (SCORE)'' and inserting ''Executives (in this Act referred to as 'SCORE')''.

(2) In section 7(m)(3)(A)(i)(VIII) (15 U.S.C. 636(m)(3)(A)(i)(VIII)), by striking ''the Service Corps of Retired Executives'' and inserting ''SCORE''.

(3) In section 20 (15 U.S.C. 631 note)—

(A) in subsection (d)(1)(E), by striking ''the Service Corps of Retired Executives program'' and inserting ''SCORE''; and

(B) in subsection (e)(1)(E), by striking ''the Service Corps of Retired Executives program'' and inserting ''SCORE''.

(4) In section 33(b)(2) (15 U.S.C. 657c(b)(2)), by striking ''Service Corps of Retired Executives'' and inserting ''SCORE''.

(b) ELIMINATION OF ACE.—Section 8(b)(1)(B) of the Small Business Act (15 U.S.C. 637(b)(1)(B)), as amended, is further amended by striking ''and an Active Corps of Executive (ACE)''.

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

Section 20 of the Small Business Act (15 U.S.C. 631 note) is amended by inserting the following new subsection after subsection (e):

''(f) AUTHORIZATION OF APPROPRIATIONS FOR SCORE.—There is authorized to be appropriated $7,000,000 for SCORE under section 8(b)(1) for each of the fiscal years 2010 and 2011.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Ms. VELÁZQUEZ) and the gentleman from Florida (Mr. BUCHANAN) each will control 20 minutes.

The Chair recognizes the gentlewoman from New York.

GENERAL LEAVE

Ms. VELÁZQUEZ. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

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

There was no objection.

Ms. VELÁZQUEZ. Mr. Speaker, when first starting out, entrepreneurs often struggled with basics, like marketing their services, accessing capital, and learning to navigate the tax code. In the earliest stages of development, mistakes in these areas can mean the difference between a venture's success and its failure. That is why the SCORE program was established to help fledgling business owners learn the ropes of entrepreneurship.

By matching new business owners with practiced hands, SCORE helps entrepreneurs trade best practices and learn from the mistakes of their forerunners. The program functions as a mentoring service, one that allows retired business owners to continue giving back to their communities. This is a laudable goal to be sure. But unfortunately, SCORE has not kept pace with the shifting marketplace. H.R. 1839 will update and enhance the program, tailoring it to meet the needs of today's entrepreneurs.

With the economy in flux, small firms require specialized training in areas not previously offered. To begin, technology plays a vastly more important role in entrepreneurship than it has in the past.

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This bill recognizes that fact and modernizes the SCORE to deliver the kind of training that is critical to doing business in the information age.

Just as the business world is changing, so, too, is the face of entrepreneurship. In recent years, we have seen a surge in the number of women and minorities starting their own firms; and yet for some reason, SCORE has failed to reflect that trend.

Mr. BUCHANAN's bill will promote greater diversity within the program. That way, we can better match small business owners with mentors and be sure every entrepreneur, regardless of race, gender, industry or region, has access to the specialized resources they need to be successful.

This bill helps train the next generation's small business innovators. It allows them to sidestep the pitfalls of early entrepreneurship and get straight to work doing what they do best: creating jobs and growing our economy.

H.R. 1839 is an important piece of legislation, and I thank Representative BUCHANAN for his contribution.

I urge support and reserve the balance of my time.

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

I rise today in strong support of my legislation to modernize the Small Business Administration's small business counseling program. The Service Corps of Retired Executives program, also known as SCORE, provides entrepreneurs with the small business advice of working and retired executive volunteers.

For years, SCORE has been providing entrepreneurship with free, confidential, and valued small business advice. With double-digit unemployment rates, more people will be trying to start their own business today. Their success is vital to an economic recovery. This bill will help ensure that qualified volunteers are available to provide one-on-one advice and counsel to small businesses.

Research shows that small businesses are five times more likely to start if they get assistance from a government-supported program such as SCORE. This bill will require SCORE administrators to actively recruit and maintain volunteer mentors and track their success. Counselors will be required to have at least 10 years of similar experience.

Earlier this year, the chairwoman from the Manasota SCORE chapter, Jeannette Mills, testified in support of my bill before the small business Subcommittee on Rural Development, Entrepreneurship and Trade. She said, ''SCORE fulfills a vital role for America's small business owners and aspiring entrepreneurs by providing much needed technical assistance. As you know, many small businesses continue to struggle with layoffs, access to capital, cash flow and overall management issues advise. SCORE has a proven track record of both being creative and saving jobs by improving business survival rates as well as accelerating small business formation.''

Here are some facts about SCORE for people that aren't aware. They have assisted in more than 523,000 people in the last year; they provided counseling to more than 8.5 million business owners; they've conducted more than 322,000 counseling sessions; they've received 3.2 million visitors to their Web site in just the last year; they have helped create more than 20,000 new small businesses.

I know from my own experience in the 1980s, I remember the U.S. Chamber came out with a statistic, as I remember today, 92 percent that start up small businesses fail in 5 years. But the IFA had a statistic during that time, the International Franchise Association, that 80 percent of businesses succeed. Because of that partnership, they could be in business for themselves, but not by themselves. That's what SCORE provides. We want a much higher probability of success, not a 92 percent failure rate. We want an 80 percent or better-type success rate for small businesses that will create jobs.

Also, currently SCORE has 389 chapter locations throughout the United States with over 10,000 volunteers nationwide.

I'd like to close by thanking my good friend, and her incredible leadership on small business, Chairwoman VELÁZQUEZ, as well as Ranking Member GRAVES for their support and assistance with this important bill.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise before you today in support of H.R. 1839, "to amend the small business act to improve SCORE, and for other purposes." I would like to thank my colleague, Congressman VERN BUCHANAN, for his leadership on this important legislation. The SCORE (Service Corps of Retired Executives) program provides entrepreneurs with the business advice of working and retired executive volunteers.

This legislation will modernize the Small Business Administration's (SBA) small business counseling program. This legislation requires the Administrator of the Small Business Administration (SBA) to ensure that SCORE carries out a plan to increase the proportion of small business mentors from socially or economically disadvantaged backgrounds, and reports annually to the Administrator on plan implementation, establishes benchmarks for evaluating its activities and volunteers and establishes a mentoring program of one-on-one advice to small businesses from qualified counselors.

Over the years SCORE has been providing entrepreneurs with free, confidential, and valuable small business advice. With unprecedented unemployment rates, more people will be trying to start their own business. Their success is vital to our economic recovery. This bill will help ensure that qualified volunteers are available to provide one-on-one advice and counsel to small businesses.

Research shows that small businesses are five times more likely to start if they get assistance from a government supported program such as SCORE. The "Retired Executives Building Better Businesses Act of 2009" would require SCORE administrators to actively recruit and maintain volunteer mentors and track their success. Counselors would be required to have at least ten years of similar experience.

My district is the perfect example of why small businesses are so vital to the nation's economy. Houston's newer and growing economic sub-centers have relied more on small business as their cornerstone than the older Central Business District. According to a report issued by the Office of Advocacy of the U.S. Small Business Administration findings suggest that while small firms support urban economic growth, as development proceeds they grow substantially. In turn, small firm growth plays an important role in urban economic development which is likely to lead to economic growth for the entire local economy. Moreover, small businesses—including minority- and women-owned companies—are the leading employers in the Houston area and provide nearly half of all jobs in Texas.

Many small businesses continue to struggle with layoffs, access to capital, cash flow and overall management issues. SCORE has a proven track record of both creating and saving jobs by improving business survival rates as well as accelerating small business formation which is why this legislation is so important. SCORE fulfills a vital role for America's small business owners and aspiring entrepreneurs by providing much needed technical assistance. In 2007 SCORE volunteers assisted in the creation of almost 20,000 new small businesses and help create more than 25,000 new jobs each year. Currently, SCORE has 389 chapters in locations throughout the United States with 10,500 volunteers nationwide.

I urge my colleagues to support small business by voting in favor of this vital legislation.

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

Ms. VELÁZQUEZ. I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Ms. VELÁZQUEZ) that the House suspend the rules and pass the bill, H.R. 1839, as amended.

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

A motion to reconsider was laid on the table.

NATIVE AMERICAN BUSINESS DEVELOPMENT ENHANCEMENT ACT OF 2009

Ms. VELÁZQUEZ. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1834) to amend the Small Business Act to expand and improve the assistance provided to Indian tribe members, Alaska Natives, and Native Hawaiians, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1834

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Native American Business Development Enhancement Act of 2009''.

SEC. 2. OFFICE OF NATIVE AMERICAN AFFAIRS; TRIBAL BUSINESS INFORMATION CENTERS PROGRAM.

(a) ASSOCIATE ADMINISTRATOR.—Section 4(b)(1) of the Small Business Act (15 U.S.C. 633(b)(1)) is amended—

(1) by striking ''five Associate Administrators'' and inserting ''six Associate Administrators''; and

(2) by inserting after ''vested in the Administration.'' the following: ''One such Associate Administrator shall be the Associate Administrator for Native American Affairs, who shall administer the Office of Native American Affairs established under section 44.''.

(b) ESTABLISHMENT.—The Small Business Act (15 U.S.C. 631 et seq.) is amended—

(1) by redesignating section 44 as section 45; and

(2) by inserting after section 43 the following:

"SEC. 44. OFFICE OF NATIVE AMERICAN AFFAIRS AND TRIBAL BUSINESS INFORMATION CENTERS PROGRAM.

''(a) OFFICE OF NATIVE AMERICAN AFFAIRS.—

''(1) ESTABLISHMENT.—There is established in the Administration an Office of Native American Affairs (hereinafter referred to in this subsection as the 'Office').

''(2) ASSOCIATE ADMINISTRATOR.—The Office shall be administered by an Associate Administrator appointed under section 4(b)(1).

''(3) RESPONSIBILITIES.—The Office shall have the following responsibilities:

''(A) Developing and implementing tools and strategies to increase Native American entrepreneurship.

''(B) Expanding the access of Native American entrepreneurs to business training, financing, and Federal small business contracts.

''(C) Expanding outreach to Native American communities and marketing entrepreneurial development services to such communities.

''(D) Representing the Administration with respect to Native American economic development matters.

''(4) COORDINATION AND OVERSIGHT FUNCTION.—The Office shall provide oversight with respect to and assist the implementation of all Administration initiatives relating to Native American entrepreneurial development.

''(5) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated to the Administrator $2,000,000 for each of fiscal years 2010 and 2011.

''(b) TRIBAL BUSINESS INFORMATION CENTERS PROGRAM.—

''(1) ESTABLISHMENT.—The Administrator is authorized to operate, alone or in coordination with other Federal departments and agencies, a Tribal Business Information Centers program that provides Native American populations with business training and entrepreneurial development assistance.

''(2) DESIGNATION OF CENTERS.—The Administrator shall designate entities as centers under the Tribal Business Information Centers program.

''(3) ADMINISTRATION SUPPORT.—The Administrator may contribute agency personnel and resources to the centers designated under paragraph (2) to carry out this subsection.

''(4) GRANT PROGRAM.—The Administrator is authorized to make grants of not more than $300,000 to centers designated under paragraph (2) for the purpose of providing Native Americans the following:

''(A) Business workshops.

''(B) Individualized business counseling.

''(C) Entrepreneurial development training.

''(D) Access to computer technology and other resources to start or expand a business.

''(5) REGULATIONS.—The Administrator shall by regulation establish a process for designating centers under paragraph (2) and making the grants authorized under paragraph (4).

''(6) DEFINITION OF ADMINISTRATOR.—In this subsection, the term 'Administrator' means the Administrator, acting through the Associate Administrator administering the Office of Native American Affairs.

''(7) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated to the Administrator $15,000,000 for fiscal year 2010 and $17,000,000 for fiscal year 2011.

''(c) DEFINITION OF NATIVE AMERICAN.—The term 'Native American' means an Indian tribe member, Alaska Native, or Native Hawaiian as such are defined in section 21(a)(8) of this Act.''.

SEC. 3. SMALL BUSINESS DEVELOPMENT CENTER ASSISTANCE TO INDIAN TRIBE MEMBERS, ALASKA NATIVES, AND NATIVE HAWAIIANS.

(a) IN GENERAL.—Section 21(a) of the Small Business Act (15 U.S.C. 648(a)) is amended by adding at the end the following:

''(8) ADDITIONAL GRANT TO ASSIST INDIAN TRIBE MEMBERS, ALASKA NATIVES, AND NATIVE HAWAIIANS.—

''(A) IN GENERAL.—Any applicant in an eligible State that is funded by the Administration as a Small Business Development Center may apply for an additional grant to be used solely to provide services described in subsection (c)(3) to assist with outreach, development, and enhancement on Indian lands of small business startups and expansions owned by Indian tribe members, Alaska Natives, and Native Hawaiians.

''(B) ELIGIBLE STATES.—For purposes of subparagraph (A), an eligible State is a State that has a combined population of Indian tribe members, Alaska Natives, and Native Hawaiians that comprises at least 1 percent of the State's total population, as shown by the latest available census.

''(C) GRANT APPLICATIONS.—An applicant for a grant under subparagraph (A) shall submit to the Administration an application that is in such form as the Administration may require. The application shall include information regarding the applicant's goals and objectives for the services to be provided using the grant, including—

''(i) the capability of the applicant to provide training and services to a representative number of Indian tribe members, Alaska Natives, and Native Hawaiians;

''(ii) the location of the Small Business Development Center site proposed by the applicant;

''(iii) the required amount of grant funding needed by the applicant to implement the program; and

''(iv) the extent to which the applicant has consulted with local tribal councils.

''(D) APPLICABILITY OF GRANT REQUIREMENTS.—An applicant for a grant under subparagraph (A) shall comply with all of the requirements of this section, except that the matching funds requirements under paragraph (4)(A) shall not apply.

''(E) MAXIMUM AMOUNT OF GRANTS.—No applicant may receive more than $300,000 in grants under this paragraph for any fiscal year.

''(F) REGULATIONS.—After providing notice and an opportunity for comment and after consulting with the Association recognized by the Administration pursuant to paragraph (3)(A) (but not later than 180 days after the date of enactment of this paragraph), the Administration shall issue final regulations to carry out this paragraph, including regulations that establish—

''(i) standards relating to educational, technical, and support services to be provided by Small Business Development Centers receiving assistance under this paragraph; and

''(ii) standards relating to any work plan that the Administration may require a Small Business Development Center receiving assistance under this paragraph to develop.

''(G) ADVICE OF LOCAL TRIBAL ORGANIZATIONS.—A Small Business Development Center receiving a grant under this paragraph shall request the advice of a tribal organization on how best to provide assistance to Indian tribe members, Alaska Natives, and Native Hawaiians and where to locate satellite centers to provide such assistance.

''(H) DEFINITIONS.—In this paragraph, the following definitions apply:

''(i) INDIAN LANDS.—The term 'Indian lands' has the meaning given the term 'Indian country' in section 1151 of title 18, United States Code, the meaning given the term 'Indian reservation' in section 151.2 of title 25, Code of Federal Regulations (as in effect on the date of enactment of this paragraph), and the meaning given the term 'reservation' in section 4 of the Indian Child Welfare Act of 1978 (25 U.S.C. 1903).

''(ii) INDIAN TRIBE.—The term 'Indian tribe' means any band, nation, or organized group or community of Indians located in the contiguous United States, and the Metlakatla Indian Community, whose members are recognized as eligible for the services provided to Indians by the Secretary of the Interior because of their status as Indians.

''(iii) INDIAN TRIBE MEMBER.—The term 'Indian tribe member' means a member of an Indian tribe (other than an Alaska Native).

''(iv) ALASKA NATIVE.—The term 'Alaska Native' has the meaning given the term 'Native' in section 3(b) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b)).

''(v) NATIVE HAWAIIAN.—The term 'Native Hawaiian' means any individual who is—

''(I) a citizen of the United States; and

''(II) a descendant of the aboriginal people, who prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawaii.

''(vi) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given that term in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).

''(I) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this paragraph $7,000,000 for each of fiscal years 2010 and 2011.

''(J) FUNDING LIMITATIONS.—

''(i) NONAPPLICABILITY OF CERTAIN LIMITATIONS.—Funding under this paragraph shall be in addition to the dollar program limitations specified in paragraph (4).

''(ii) LIMITATION ON USE OF FUNDS.—The Administration may carry out this paragraph only with amounts appropriated in advance specifically to carry out this paragraph.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Ms. VELÁZQUEZ) and the gentleman from Missouri (Mr. LUETKEMEYER) each will control 20 minutes.

The Chair recognizes the gentlewoman from New York.

GENERAL LEAVE

Ms. VELÁZQUEZ. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

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

There was no objection.

Ms. VELÁZQUEZ. Mr. Speaker, the Small Business Administration has always worked to promote entrepreneurship amongst underrepresented groups and within underserved parts of the country. For this community, small business growth means more than just new jobs; it means economic development. That is why SBA offers a number of programs designed to encourage women and minorities to start their own ventures. H.R. 1834, the Native American Business Development Enhancement Act, builds on that tradition of growth through diversity.

As our economy continues to struggle, we need to be creating jobs everywhere we can. This rings especially true amongst underserved groups like Native Americans. After all, few segments of the population are in greater need of job creation. Within the Navajo tribe, the largest in the Native American community, unemployment has long hovered at 50 percent. On certain tribal reservations, it has reached a staggering 80 percent.

In a recent speech to various tribal leaders, President Obama stressed the need for Native Americans to become ''a full partner in the American economy.'' Mr. Speaker, what better way to forge that kind of partnership than through entrepreneurship? While their community faces significant challenges, Native Americans have never shied away from starting their own ventures. In recent years, entrepreneurship among Native Americans and Alaska Native women has soared by 69 percent. With this bill, we can build on that growth, supporting the kind of job creation that the Native American community so sorely needs.

As of 2002, there were over 200,000 Native American firms nationwide. While those businesses span a broad range of tribes and industries, they are unified in their need for resources like technical assistance and affordable capital. This bill helps them access those tools. Importantly, it establishes an office focused solely on Native American small businesses, one that can address their unique needs head on.

Like many small business owners, Native American entrepreneurs have been battered by the recession. As a result, many of these men and women are struggling with obstacles like access to capital. For these business owners, entrepreneurial development programs, such as those that provide training for loan applications, can go a long way in easing challenges. H.R. 1834 puts critical training resources within reach, and tailors them to the specific strengths of the Native American firms. By better customizing these programs, we can give Native American entrepreneurs the tools they need to grow and the resources they need to create jobs.

This is an important piece of legislation, and I thank Representative KIRKPATRICK for her work in helping it come together.

I urge its support, and I reserve the balance of my time.

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

Mr. Speaker, I rise in support of the request to suspend the rules and pass H.R. 1834, a bill to provide additional small business development center resources focused on Native Americans, Alaska Natives, and Native Hawaiians.

I'd like to thank Chairwoman VELÁZQUEZ for working in a cooperative and bipartisan manner to bring this bill to the House floor.

The majority of Indian tribe members and Alaska Natives live on or in

the immediate vicinity of Indian lands. These lands are generally in remote locations far from access to resources that most Americans take for granted. Due to the remoteness and lack of economic development, it is not surprising that Native Americans suffer from unemployment averages in excess of twice that faced by the rest of the American population.

Enactment of H.R. 1834 is not designed to immediately relieve the harsh circumstances facing many Native Americans. Instead, it is an effort to bring greater technical assistance to Native Americans so they can create new businesses that will spur economic development.

The committee has heard testimony from Native Americans about the value of the technical assistance provided by SBA's entrepreneurial outreach programs. These programs enable them to navigate the complexities of starting a business. H.R. 1834 recognizes the value of this assistance by codifying the Small Business Administration's Tribal Business Center program. In addition, the bill improves access to Small Business Development Centers by providing the grantees with increased incentives to perform outreach to Native Americans without undermining the core funding provided to Small Business Development Centers.

Finally, the bill requires better coordination between the SBA and tribal organizations in providing technical programs. By providing the technical resources needed to start and manage businesses, H.R. 1834 will challenge the entrepreneurial spirit of Native Americans, increase economic development on Indian lands, reduce poverty, and create a healthier living environment for future generations of the first Americans.

I reserve the balance of my time.

Ms. VELÁZQUEZ. Mr. Speaker, I yield as much time as she may consume to the lead sponsor of the bill, the gentlelady from Arizona (Mrs. KIRKPATRICK).

Mrs. KIRKPATRICK of Arizona. Thank you for the opportunity to consider my legislation, the Native American Business Development Enhancement Act. The resources in this bill will greatly assist tribal communities develop their economic potential.

I was born and grew up in the White Mountain Apache communities where my father ran a small business. I have seen our Native communities make due with less even when times are good. And in these tough economic times, we can do more to help build communities and bolster local economies on tribal lands.

Like most entrepreneurs, Native small business owners require help with planning, capitalizing, and turning their businesses into thriving businesses. This bill will strengthen economies and create new jobs by expanding the assistance available to Indian, Alaska Native, and Native Hawaiian small business entrepreneurs under the Small Business Act.

By providing essential training and assistance and helping to capitalize small businesses in Indian Country, Native communities will benefit as their businesses prosper, opportunities for economic development multiply, and new jobs are created. This legislation was included in a House-passed package of policies to encourage entrepreneurship.

Thank you to Chairwoman VELÁZQUEZ and to Ranking Member LUETKEMEYER for working with me on this important issue. I am very pleased this legislation is moving forward, and I urge its passage.

Ms. RICHARDSON. Mr. Speaker, as a member of the Native American Caucus, I rise today in strong support of H.R. 1834, the Native American Business Development Enhancement Act of 2009, which will promote entrepreneurship within the Native American community. This is the kind of legislation we need to lift us out of this economic downturn. H.R. 1834 will serve as a vehicle to create jobs, support small businesses, and help people get back to work in the communities that need it most.

I acknowledge Chairwoman VELÁZQUEZ for her leadership in bringing this important bill to the floor. I would also like to thank my colleague Congresswoman KILPATRICK, the author of this legislation, who worked so hard to help such an underserved community get the opportunities they need to succeed.

Mr. Speaker, the Native American Business Development Enhancement Act establishes the Office of Native American Affairs in the Small Business Administration, SBA, to increase Native American entrepreneurship. H.R. 1834 will enable SBA's administrator to operate a Tribal Business Information Centers program to provide Native American populations with business training and entrepreneurial development assistance. The SBA will contribute agency personnel and resources to the centers, as well as make grants to the centers. In addition, Indian tribe members, Alaska Natives, and Native Hawaiians can apply for grants to assist with outreach, development, and enhancement of small business startups and expansions.

In California, the State I represent, there are over 100 tribes, many of varying levels of economic success. As a long time friend and supporter of the Native American community, I am so pleased to champion a bill such as H.R. 1834, which provides economic opportunities that have been denied to this community for so long. But more must be done, and I look forward to working with my colleagues to ensure that Native Americans receive the full equal range of opportunities in this country.

In conclusion, Mr. Speaker, I support this bill because it will provide job training and opportunities to the areas and populations that need the most assistance. The communities served by H.R. 1834 represent some of the most traditionally disadvantaged, isolated, and underserved populations in America. This legislation is yet another example of how Congress is taking the action necessary to respond to the current economic situation with innovative solutions.

Mr. Speaker, I urge my colleagues to join me in supporting H.R. 1834.

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

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

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Ms. VELÁZQUEZ) that the House suspend the rules and pass the bill, H.R. 1834, as amended.

The question was taken.

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

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

The yeas and nays were ordered.

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

☐ 1100

EXPANDING ENTREPRENEURSHIP ACT OF 2009

Ms. VELÁZQUEZ. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1842) to amend the Small Business Act to improve the Small Business Administration's entrepreneurial development programs, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1842

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Expanding Entrepreneurship Act of 2009''.

SEC. 2. EXPANDING ENTREPRENEURSHIP.

Section 4 of the Small Business Act (15 U.S.C. 633) is amended by adding at the end the following:

''(g) MANAGEMENT AND DIRECTION.—

''(1) PLAN FOR ENTREPRENEURIAL DEVELOPMENT AND JOB CREATION STRATEGY.—The Administrator shall develop and submit to Congress a plan, in consultation with a representative from each of the agency's entrepreneurial development programs, for using the Small Business Administration's entrepreneurial development programs to create jobs during fiscal years 2010 and 2011. The plan shall include the Administration's plan for drawing on existing programs, including Small Business Development Centers, Women's Business Centers, SCORE, Veterans Business Centers, Native American Outreach, and other appropriate programs. The Administrator shall identify a strategy for each Administration region to create or retain jobs through Administration programs. The Administrator shall identify, in consultation with appropriate personnel from entrepreneurial development programs, performance measures and criteria, including job creation, job retention, and job retraining goals, to evaluate the success of the Administration's actions regarding these efforts.

''(2) DATA COLLECTION PROCESS.—The Administrator shall, after notice and opportunity for comment, promulgate a rule to develop and implement a consistent data collection process to cover all entrepreneurial development programs. Such data collection process shall include data relating to job creation, performance, and any other data determined appropriate by the Administrator with respect to the Administration's entrepreneurial development programs.

''(3) COORDINATION AND ALIGNMENT OF SBA ENTREPRENEURIAL DEVELOPMENT PROGRAMS.—The Administrator shall submit annually to Congress, in consultation with other Federal departments and agencies as appropriate, a report on opportunities to foster coordination, limit duplication, and improve program delivery for Federal entrepreneurial development programs.

''(4) DATABASE OF ENTREPRENEURIAL DEVELOPMENT SERVICE PROVIDERS.—The Administrator shall, after a period of 60 days for public comment, establish a database of providers of entrepreneurial development services and, make such database available through the Administration's Web site. The database shall be searchable by industry, geography, and service required.

''(5) COMMUNITY SPECIALIST.—The Administrator shall designate not less than one staff member in each Administration district office as a community specialist who has as their full-time responsibility working with local entrepreneurial development service providers to increase coordination with Federal resources. The Administrator shall develop benchmarks for measuring the performance of community specialists under this subsection.

''(6) ENTREPRENEURIAL DEVELOPMENT PORTAL.—The Administrator shall publish a design for a Web-based portal to provide comprehensive information on the Administration's entrepreneurial development programs. After a period of 60 days for public comment, the Administrator shall establish such portal and—

''(A) integrate under one Web portal, Small Business Development Centers, Women's Business Centers, SCORE, Veterans Business Centers, the Administration's distance learning program, and other programs as appropriate;

''(B) revise the Administration's primary Web site so that the Web portal described in subparagraph (A) is available as a link on the main Web page of the Web site;

''(C) increase consumer-oriented content on the Administration's Web site and focus on promoting access to business solutions, including marketing, financing, and human resources planning;

''(D) establish relevant Web content aggregated by industry segment, stage of business development, level of need, and include referral links to appropriate Administration services, including financing, training and counseling, and procurement assistance; and

''(E) provide style guidelines and links for visitors to the Administration's Web site to be able to comment on and evaluate the materials in terms of their usefulness.

''(7) PILOT PROGRAMS.—The Administrator may not conduct any pilot program for a period of greater than 3 years if the program conflicts with, or uses the resources of, any of the entrepreneurial development programs authorized under section 8(b)(1)(B), 21, 29, 32, or any other provision of this Act.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Ms. VELÁZQUEZ) and the gentleman from Missouri (Mr. LUETKEMEYER) each will control 20 minutes.

The Chair recognizes the gentlewoman from New York.

GENERAL LEAVE

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

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

There was no objection.

Ms. VELÁZQUEZ. Mr. Speaker, entrepreneurial development initiatives, or ED programs, provide critical services for aspiring entrepreneurs seeking to launch a new enterprise. These programs also help established businesses that are trying to expand and create new jobs.

By helping small firms flourish, the SBA's ED services will be vital to sustaining our economic recovery. But for this to happen, the SBA must use its resources effectively. This is especially true during economic downturns. After all, when money is scarce, we want to make sure the taxpayer gets the most job-creating bang for their buck.

We already know that ED initiatives are a wise investment. Every dollar put into these programs returns $2.87 to the U.S. Treasury. The legislation that we are considering today will make these programs even more responsive, so that they better meet the needs of small business owners.

H.R. 1842 will bring enhanced coordination to the SBA's portfolio of ED services. In order for these initiatives to perform at their full potential, we have to know what is working and what could function better. This bill takes important steps in that direction. Requiring the SBA to collect data will provide important insights into the strengths of the ED program and highlight where there is room for improvement.

The bill also instructs the SBA to develop a plan outlining how to use ED initiatives to create new jobs over the next 2 years. Given the current state of the economy, it make sense that the agency focus on using ED to expand employment options. The bill will also reduce duplication between different ED initiatives. By verifying that the SBA's right hand knows what the left hand is doing, we will further leverage the agency's resources and channel more support to small businesses.

Mr. Speaker, this is a good bill. It puts in place some commonsense steps that are badly needed at SBA. Most importantly, this bill will ensure the SBA's programs do a better job of helping businesses. I think all of us can stand behind that goal. I urge my colleagues to vote ''yes.''

I reserve the balance of my time.

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

Mr. Speaker, first I would like to recognize Chairman VELÁZQUEZ for her great leadership and bipartisan fashion on this committee which has a myriad of issues that we address on a daily basis, and I want to thank her for her excellent leadership and providing us a forum to debate these ideas in a fair fashion.

I am proud to support H.R. 1842, the Expanding Entrepreneurship Act of 2009, to assist many fellow small business owners and employees throughout my district in Missouri and throughout the country. Small businesses have generated up to 80 percent of net new jobs annually over the last decade and continue to contribute 38 percent to the gross domestic product. As we try to jumpstart the slumping economy and put people back to work, it only makes sense to provide relief and not more onerous tax hikes to our Nation's most productive job creators.

While this logic has underpinned alternative plans supported by myself and many of my colleagues to boost the economy and ensure growth in the future, it has been all but ignored by the administration and the majority in Congress. At a time when small businesses are struggling to keep their doors open, we must remain ever vigilant in improving the efficacy of entrepreneurial and technical assistance programs. We also need to ensure our small businesses are able to adequately utilize all available resources.

My bill beefs up support services in key entrepreneurial development programs, making these programs more effective and responsive to the needs of small businesses and ensuring that existing programs are being used effectively and duplicative government programs are done away with.

To make these widely used programs more responsive to the needs of small businesses and at no cost to the taxpayers, H.R. 1842 establishes planning standards within these programs, requires maintenance of an entrepreneurial development database, and ensures that someone is available to assist small businesses at all SBA district offices. The bill also requires the SBA to develop a job-creation strategy for 2009–2010.

The bill also expands specific programs, such as small business development centers, women's business centers, and the Service Corps of Retired Executive, or SCORE. These widely used programs are intended to assist entrepreneurs with practical and technical skills needed to help start and sustain a business.

In addition, the bill creates new support programs for veteran-owned and Native American-owned small businesses, improves cross-program coordination to maximize use of program resources, and creates 21st-century online learning initiatives for entrepreneurs.

An investment in entrepreneurial development programs yields strong returns. In 2008, the SBA entrepreneurial development programs helped to generate 73,000 new jobs and bring $7.2 billion into the economy. Some economists have estimated that every dollar invested in these initiatives returns $2.87 to our economy and helps these small businesses thrive.

Since the onset of the credit crisis over 2 years ago, available credit to small businesses and consumers has contracted by trillions of dollars. Without access to credit, small businesses can't grow, can't hire, and too often end up going out of business. That is why I am particularly pleased to support a bill that strengthens small business development centers, one-stop assistance centers for current and prospective small business owners designed to assist small firms in securing capital and credit.

As Louis Celli, CEO of the Northeast Veterans Business Resource Center in Boston, put it at a recent hearing on this same subject, we have the right focus by wanting ''to interweave these programs together and really force everybody to play in the same sandbox.'' And by making entrepreneurial development programs more effective, we can be not only more responsive to small businesses but also be better stewards of taxpayers' dollars.

I urge my colleagues to support the legislation.

I yield back the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise before you today in support of H.R. 1842, the "Expanding Entrepreneurship Act of 2009." I would like thank my colleague, Representative LUETKEMEYER, for introducing this act of solidarity, as well as the cosponsors.

When people think of the American Dream, there are few things they are more likely to think of than opening a small business. Our President called them the dreamers who built this country. In his words, "They're the workers who took a chance on their desire to be their own boss, the part-time inventors who became the full-time entrepreneurs, the men and women who have helped build the American middle class, keeping alive that most American of ideals." My home city is very much a part of this dream—according to Fortune Small Business magazine, Houston, Texas, is one of the five best cities in which to start a small business.

That is what makes the Expanding Entrepreneurship Act such an important bill. It would make several changes to the Small Business Administration's, SBA, entrepreneurial development programs including establishment of planning standards, greater coordination of SBA programs, maintenance of an entrepreneurial development database, creation of an entrepreneurial development portal, and the introduction of community specialists to the program.

Under this legislation, the Administrator of the SBA would be required to develop a job creation strategy for 2009–2010. This plan would include the agency's intent for using existing programs, including Small Business Development Centers, SBDCs, Women's Business Centers, WBCs, Service Corps for Retired Executives, SCORE, Veterans' Business Outreach Centers, Native American Outreach, and other appropriate initiatives, to create and retain jobs throughout the United States. The SBA Administrator would establish performance measures and criteria including job creation, job retention and job retaining goals, to evaluate the agency's progress in this effort.

Also, under this act the Administrator would be required to oversee the coordination of SBA's Entrepreneurial Development Programs with other Federal agencies when it's appropriate. The Administrator would be required to report to Congress annually on opportunities to foster coordination, limit duplication, and improve Federal entrepreneurial development programs, without regard to the agency that houses an entrepreneurial outreach effort.

To ensure easy access for entrepreneurs, a portal will be designed on the SBA website with links to all of the SBA's entrepreneurial development programs. This portal will also have links to relevant web content organized by industry type, stage of business, and level of need. A separate database of providers of entrepreneurial development services will also be established on the SBA's website.

A community specialist would also be recruited to serve in every SBA District office. Their sole purpose would be working with local entrepreneurial development service providers to improve coordination with Federal resources. This will make the bill especially helpful for minority owned businesses.

This legislation is particularly efficient because it develops a cost effective way to reach a larger number of entrepreneurs in need and coordinates all entrepreneurial development programs eliminating duplication and government waste.

That is why I am supporting this legislation—because of what it will do to help women, minorities, and veterans who gave the ultimate service to our great country to be a part of its great dream.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Ms. VELÁZQUEZ) that the House suspend the rules and pass the bill, H.R. 1842, as amended.

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

A motion to reconsider was laid on the table.

SMALL BUSINESS EARLY-STAGE INVESTMENT ACT OF 2009

Ms. VELÁZQUEZ. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3738) to amend the Small Business Investment Act of 1958 to establish a program for the Small Business Administration to provide financing to support early stage small businesses in targeted industries, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3738

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Early-Stage Investment Act of 2009''.

SEC. 2. SMALL BUSINESS EARLY-STAGE INVESTMENT PROGRAM.

Title III of the Small Business Investment Act of 1958 (15 U.S.C. 681 et seq.) is amended by adding at the end the following:

''PART D—SMALL BUSINESS EARLY-STAGE INVESTMENT PROGRAM

''SEC. 399A. ESTABLISHMENT OF PROGRAM.

''The Administrator shall establish and carry out an early-stage investment program (hereinafter referred to in this part as the 'program') to provide equity investment financing to support early-stage small businesses in targeted industries in accordance with this part.

''SEC. 399B. ADMINISTRATION OF PROGRAM.

''The program shall be administered by the Administrator acting through the Associate Administrator described under section 201.

''SEC. 399C. APPLICATIONS.

''(a) IN GENERAL.—Any incorporated body, limited liability company, or limited partnership organized and chartered or otherwise existing under Federal or State law for the purpose of performing the functions and conducting the activities contemplated under the program and any small business investment company may submit to the Administrator an application to participate in the program.

''(b) REQUIREMENTS FOR APPLICATION.—An application to participate in the program shall include the following:

''(1) A business plan describing how the applicant intends to make successful venture capital investments in early-stage small businesses in targeted industries.

''(2) Information regarding the relevant venture capital investment qualifications and backgrounds of the individuals responsible for the management of the applicant.

''(3) A description of the extent to which the applicant meets the selection criteria under section 399D.

''(c) APPLICATIONS FROM SMALL BUSINESS INVESTMENT COMPANIES.—The Administrator shall establish an abbreviated application process for small business investment companies that have received a license under section 301 and that are applying to participate in the program. Such abbreviated process shall incorporate a presumption that such small business investment companies satisfactorily meet the selection criteria under paragraphs (3) and (5) of section 399D(b).

''SEC. 399D. SELECTION OF PARTICIPATING INVESTMENT COMPANIES.

''(a) IN GENERAL.—Not later than 90 days after the date on which the Administrator receives an application from an applicant under section 399C, the Administrator shall make a final determination to approve or disapprove such applicant to participate in the program and shall transmit such determination to the applicant in writing.

''(b) SELECTION CRITERIA.—In making a determination under subsection (a), the Administrator shall consider each of the following:

''(1) The likelihood that the applicant will meet the goals specified in the business plan of the applicant.

''(2) The likelihood that the investments of the applicant will create or preserve jobs, both directly and indirectly.

''(3) The character and fitness of the management of the applicant.

''(4) The experience and background of the management of the applicant.

''(5) The extent to which the applicant will concentrate investment activities on early-stage small businesses in targeted industries.

''(6) The likelihood that the applicant will achieve profitability.

''(7) The experience of the management of the applicant with respect to establishing a profitable investment track record.

''SEC. 399E. GRANTS.

''(a) IN GENERAL.—The Administrator may make one or more grants to a participating investment company.

''(b) GRANT AMOUNTS.—

''(1) NON-FEDERAL CAPITAL.—A grant made to a participating investment company under the program may not be in an amount that exceeds the amount of the capital of such company that is not from a Federal source and that is available for investment on or before the date on which a grant is drawn upon. Such capital may include legally binding commitments with respect to capital for investment.

''(2) LIMITATION ON AGGREGATE AMOUNT.—The aggregate amount of all grants made to a participating investment company under the program may not exceed $100,000,000.

''(c) GRANT PROCESS.—In making a grant under the program, the Administrator shall commit a grant amount to a participating investment company and the amount of each such commitment shall remain available to be drawn upon by such company—

''(1) for new-named investments during the 5-year period beginning on the date on which each such commitment is first drawn upon; and

''(2) for follow-on investments and management fees during the 10-year period beginning on the date on which each such commitment is first drawn upon, with not more than 2 additional 1-year periods available at the discretion of the Administrator.

''SEC. 399F. INVESTMENTS IN EARLY-STAGE SMALL BUSINESSES IN TARGETED INDUSTRIES.

''(a) IN GENERAL.—As a condition of receiving a grant under the program, a participating investment company shall make all of the investments of such company in small business concerns, of which at least 50 percent shall be early-stage small businesses in targeted industries.

''(b) EVALUATION OF COMPLIANCE.—With respect to a grant amount committed to a participating investment company under section 399E, the Administrator shall evaluate the compliance of such company with the requirements under this section if such company has drawn upon 50 percent of such commitment.

''SEC. 399G. PRO RATA INVESTMENT SHARES.

''Each investment made by a participating investment company under the program shall be treated as comprised of capital from grants under the program according to the ratio that capital from grants under the program bears to all capital available to such company for investment.

''SEC. 399H. GRANT INTEREST.

''(a) GRANT INTEREST.—

''(1) IN GENERAL.—As a condition of receiving a grant under the program, a participating investment company shall convey a grant interest to the Administrator in accordance with paragraph (2).

''(2) EFFECT OF CONVEYANCE.—The grant interest conveyed under paragraph (1) shall have all the rights and attributes of other investors attributable to their interests in the participating investment company, but shall not denote control or voting rights to the Administrator. The grant interest shall entitle the Administrator to a pro rata portion of any distributions made by the participating investment company equal to the percentage of capital in the participating investment company that the grant comprises. The Administrator shall receive distributions from the participating investment company at the same times and in the same amounts as any other investor in the company with a similar interest. The investment company shall make allocations of income, gain, loss, deduction, and credit to the Administrator with respect to the grant interest as if the Administrator were an investor.

''(b) MANAGER PROFITS.—As a condition of receiving a grant under the program, the manager profits interest payable to the managers of a participating investment company under the program shall not exceed 20 percent of profits, exclusive of any profits that may accrue as a result of the capital contributions of any such managers with respect to such company. Any excess of this amount, less taxes payable thereon, shall be returned by the managers and paid to the investors and the Administrator in proportion to the capital contributions and grants paid in. No manager profits interest (other than a tax distribution) shall be paid prior to the repayment to the investors and the Administrator of all contributed capital and grants made.

''(c) DISTRIBUTION REQUIREMENTS.—As a condition of receiving a grant under the program, a participating investment company shall make all distributions to all investors in cash and shall make distributions within a reasonable time after exiting investments, including following a public offering or market sale of underlying investments.

''SEC. 399I. FUND.

''There is hereby created within the Treasury a separate fund for grants which shall be available to the Administrator subject to annual appropriations as a revolving fund to be used for the purposes of the program. All amounts received by the Administrator, including any moneys, property, or assets derived by the Administrator from operations in connection with the program, shall be deposited in the fund. All expenses and payments, excluding administrative expenses, pursuant to the operations of the Administrator under the program shall be paid from the fund.

''SEC. 399J. APPLICATION OF OTHER SECTIONS.

''To the extent not inconsistent with requirements under this part, the Administrator may apply sections 309, 311, 312, 313, and 314 to activities under this part and an officer, director, employee, agent, or other participant in a participating investment company shall be subject to the requirements under such sections.

''SEC. 399K. DEFINITIONS.

''In this part, the following definitions apply:

''(1) EARLY-STAGE SMALL BUSINESS IN A TARGETED INDUSTRY.—The term 'early-stage small business in a targeted industry' means a small business concern that—

''(A) is domiciled in a State;

''(B) has not generated gross annual sales revenues exceeding $15,000,000 in any of the previous 3 years; and

''(C) is engaged primarily in researching, developing, manufacturing, producing, or bringing to market goods, products, or services with respect to any of the following business sectors:

''(i) Agricultural technology.

''(ii) Energy technology.

''(iii) Environmental technology.

''(iv) Life science.

''(v) Information technology.

''(vi) Digital media.

''(vii) Clean technology.

''(viii) Defense technology.

''(ix) Photonics technology.

''(2) PARTICIPATING INVESTMENT COMPANY.—The term 'participating investment company' means an applicant approved under section 399D to participate in the program.

''(3) SMALL BUSINESS CONCERN.—The term 'small business concern' has the same meaning given such term under section 3(a) of the Small Business Act (15 U.S.C. 632(a)).

''SEC. 399L. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out the program $200,000,000 for the first full fiscal year beginning after the date of the enactment of this part.''.

SEC. 3. PROHIBITIONS ON EARMARKS.

None of the funds appropriated for the program established under part D of title III of the Small Business Investment Act of 1958, as added by this Act, may be used for a Congressional earmark as defined in clause 9(d) of rule XXI of the Rules of the House of Representatives.

SEC. 4. REGULATIONS.

Except as otherwise provided in this Act or in amendments made by this Act, after an opportunity for notice and comment, but not later than 180 days after the date of the enactment of this Act, the Administrator shall issue regulations to carry out this Act and the amendments made by this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Ms. VELÁZQUEZ) and the gentleman from Missouri (Mr. GRAVES) each will control 20 minutes.

The Chair recognizes the gentlewoman from New York.

GENERAL LEAVE

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

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

There was no objection.

Ms. VELÁZQUEZ. Mr. Speaker, like the credit markets, the pipeline for equity financing has become clogged. For many entrepreneurs who are looking to turn a good idea into a profitable, job-creating business, venture capital has traditionally been an important source of financing. In today's economy, that funding often isn't there.

Venture capital funds are on track to invest between $15 billion and $20 billion in new companies this year. That is between $15 billion and $20 billion less than the previous 2 years. This simply means fewer firms are finding the funds they need to get off the ground. Between January and October of this year, there were 1,100 fewer venture capital deals compared to the same period last year.

The legislation offered by Mr. NYE, H.R. 3738, will reverse this troubling

trend. Under this bill, the Small Business Administration could begin to act as a partner to private venture capital firms, offering them incentives to help small business startups get off the ground.

Through the creation of this new public-private partnership, the SBA can encourage more venture capital firms to begin investing again. The program will also mean larger blocks of funding will be available to businesses in their early growth stages. Helping early stage startups launch is one of our most powerful tools for generating job opportunities. During economic downturns, when larger companies contract and engage in layoffs, startups go in the opposite direction by growing and creating jobs. These early stage businesses also engage in some of the most promising research areas—like defense, medicine, and renewable energy. Advances in these fields mean new products and new jobs.

Mr. Speaker, after every previous recession, we have found our way back to prosperity thanks to the risk-takers that do not wait around for the economy to bounce back but go out and start creating a new product or new service. That can only happen when investors are ready to help move new ideas from the drawing board to the marketplace.

With this bill, we will help new small businesses launch and start creating new jobs in the short term. I commend the gentleman from Virginia for his work on this legislation. I urge my colleagues to vote ''yes.''

I reserve the balance of my time.

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

Mr. Speaker, today I rise in support of the request to suspend the rules and pass H.R. 3738, a bill to provide early stage seed-capital financing for small businesses, and I would like to thank Chairwoman VELÁZQUEZ for working in a cooperative and bipartisan manner to bring this bill to the House floor today.

As I mentioned in a recent floor statement, America needs to stop exporting risk and restart making products that the world desires. Those products are most likely to come from the minds of America's entrepreneurs in such fields as value-added agriculture, biotechnology, renewable energy, and computer software. Nevertheless, startups in these fields are finding it increasingly difficult to find financing. If these enterprises have to rely on expensive debt capital, it will detract from their ability to expand their businesses.

The SBA used to have a program designed to help provide long-term equity capital to start up small businesses. However, this program was overly complex and forced potential participants to wade through a lengthy, maze-like application process.

The bill before us today, H.R. 3738, provides a streamlined process to enable qualified venture capitalists to bootstrap their investment with additional Federal moneys to provide needed equity capital to small businesses. Successful operators will pay back the Federal Government before they take their own profits.

While there is a modest cost to the program, the potential benefits to the economy are quite significant. Some of the best known names in American businesses, including companies like Federal Express, Dell, Intel, Nike, Callaway Golf and Build-A-Bear received assistance through the use of long term equity capital. If H.R. 3738 creates a new Intel, it would certainly pay for itself. More importantly, the program will help America's entrepreneurs, the individual risk-takers who had an idea, and that is what made this country great.

Mr. Speaker, I reserve the balance of my time.

Ms. VELÁZQUEZ. Mr. Speaker, I yield such time as he may consume to the lead sponsor of this bill, the gentleman from Virginia (Mr. NYE).

Mr. NYE. Mr. Speaker, the financial crisis that led to the current economic downturn has caused our small business credit markets to dry up. There has been much discussion in recent weeks about the difficulty that small firms face in securing affordable credit. Somewhat less attention has been paid to the other side of the capital equation, namely investment.

For early stage businesses, investment from venture capital firms makes more sense than taking out a loan. After all, fledgling businesses typically do not have the cash flow to make regular payments on debt. For these enterprises, investment from venture capital firms is usually a better way to raise capital. These early stage businesses engage in some of the most promising research areas like defense, medicine, and renewable energy. Breakthroughs in these fields mean new products, and more importantly, they mean new jobs.

In my home State of Virginia, we have seen the importance of venture funding to job growth. Virginia ranks ninth in the Nation for jobs created or saved by venture capital, and over the past 6 years, we have been able to trace the creation of 13,000 Virginia jobs to venture capital investments.

If our economic recovery is going to be sustained, we will need high growth, high-risk firms that will spawn nascent innovative products, break new ground, and hire out-of-work Americans.

□ 1115

That kind of progress will require investment from venture capital communities.

My bill, the Small Business Early Investment Act of 2009, will help promote a new wave of venture capital investments by creating a new Small Business Early Stage Investment program at the SBA. Under the program, carefully screened companies that invest in new enterprises will be eligible for SBA grants. These grants will match the capital that investors have already raised from the private market.

Once these investments mature and the venture capital companies exit their investments, the SBA will be paid back at the same rate as traditional investors. These grants will go to those who invest in early-stage companies that are doing work in some of our most promising sectors, like alternative energies, biotechnology, and defense technology. These are fields in which we want the United States to maintain its competitive edge. So these grants will not only stimulate growth but will also advance our national priorities.

Mr. Speaker, we all know that entrepreneurs will be central to our economic recovery; however, for these firms to perform their traditional job-creating role, they need capital. The legislation before us would, for the first time, create a program at the SBA that is dedicated to ensuring America's small businesses can access venture capital. This will help new companies get off the ground and early-stage companies fully develop. Most of all, this bill will invest taxpayer dollars wisely by creating new jobs, sparking technological progress, and fostering entrepreneurship.

I want to thank Chairwoman VELÁZQUEZ and Ranking Member GRAVES for their leadership on the committee and for working with me on this important initiative.

I urge my colleagues to support and pass this bill for our small businesses and for the recovery of our economy.

Mr. GRAVES. Mr. Speaker, I yield such time as he may consume to the gentleman from Arizona (Mr. FLAKE).

Mr. FLAKE. I thank the gentleman for yielding.

I rise in opposition to the legislation. This bill is one of many we're considering under suspension of the rules that were part of broader pieces of legislation we passed just a few weeks ago.

Members may recall that I offered an amendment to clarify that the grant program established under this program remain free of earmarks. That amendment was hardly controversial. It's passed a number of times, a similar amendment on similar bills. In fact, I think it's been by voice vote six times in the 111th Congress, twice by recorded vote, once in the 110th and again just a few weeks ago. This amendment on this bill earlier passed by a margin of 370–55, yet that language does not appear in the legislation that we're considering today.

Ms. VELÁZQUEZ. Will the gentleman yield?

Mr. FLAKE. I yield to the gentlewoman from New York.

Ms. VELÁZQUEZ. I don't know what bill you read, but your amendment is part of the bill, so I would invite the gentleman to go back and read the bill.

Mr. FLAKE. I hope I'm mistaken. I hope that it is.

Ms. VELÁZQUEZ. The gentleman is mistaken.

Mr. FLAKE. Thank you. I appreciate that.

On to the broader piece of legislation, this Early Stage Investment program would allow the SBA to provide matching grants to private investment firms when they will use the money to invest in small business. I have to wonder, have to question——

Ms. VELÁZQUEZ. Will the gentleman yield again?

Mr. FLAKE. Yes, I yield.

Ms. VELÁZQUEZ. Page 11, section 3, ''Prohibitions on Earmarks. None of the funds appropriated for the program established under part D of title III of the Small Business Investment Act of 1958, as added by this act, may be used for a congressional earmark as defined in clause 9(d) of rule XXI of the rules of the House of Representatives.''

Thank you for yielding.

Mr. FLAKE. I thank the gentlewoman and I apologize.

Ms. VELÁZQUEZ. Is it correct that this is your language?

Mr. FLAKE. Yes, that is correct.

Ms. VELÁZQUEZ. Thank you.

Mr. FLAKE. That is my language. I'm pleased to see it is part of the legislation. However, as to the broader bill, I still remain opposed, but I thank the gentlewoman, and I hope that that language remains in all the legislation. Sometimes we have a habit of putting it in, then it goes to conference and the language is removed and it comes back. So I'm glad to be surprised and I'm very happy to be wrong in this case.

As to the broader bill, I think that when we are running a deficit of $1.4 trillion this year and have a debt of somewhere around $11 trillion, it behooves us to look at programs like this and wonder why we are taking taxpayer money. I know the sponsor of the legislation says that it will be invested wisely.

We are basically, as I understand it, using taxpayer money to give to or combine with venture capital money to invest in small business. By definition, if we are moving in with Federal taxpayer money, it's because venture capitalists and others don't see a profit being generated in the future or don't see the need or don't agree that this business model is sound. Yet we are taking taxpayer money and saying we're going to invest it because we know better than the venture capitalists, that somehow Congress, in all of our wisdom, in all of our small business wisdom and business acumen, we know better than venture capitalists which businesses are going to succeed and which ones are not. I think that that thinking is folly.

We in Congress don't have a stellar record when it comes to investing. You could name a number of things starting decades and decades ago where we haven't exactly picked the best winners and losers in the economy. But in this case with the kind of deficit we're running, with the kind of debt that we have, with the unfunded obligations totaling more than $50 trillion out there, to come with new authorization for new money, to invest where venture capitalists dare not tread, with taxpayer money, I think it should frighten us all. And to the extent that this legislation does that, we should reject it.

I should mention, as well, that this is talked about with early investment, but under the legislation only 50 percent of the funding is required to be invested early. Now, I think it would be folly to invest early, late, or anytime with Federal taxpayer money in private business in this fashion, but I think it's a bit of a misnomer even to call it ''early investment'' when only half of the money is required to be invested early in this case.

I hope that we reconsider this. Between now and the end of the year, we're going to be passing a lot of authorization bills like this, and a lot of people will say, well, it's not appropriation. It's not real money. We're just authorizing it. We're just stating goals and ideals. But then come next year or later when we haven't funded this, people will say, hey, we're cutting back or we're cutting funding that has been authorized. The Congress authorized it by a big margin, and this will probably pass by a big margin, and yet when we don't fund it, people will come back and say we haven't funded what we've authorized.

So it is important to make a statement here that it's not the right time, now or anytime, frankly, to use taxpayer money to invest in small business in this fashion, to go where venture capitalists dare not tread, where they will not invest their own money, but we're going to put Federal taxpayer money in this venture.

So with that, I appreciate the gentleman for yielding, and I thank the gentlewoman again. And I appreciate the diligence that you've worked with to keep the language in the legislation. That hasn't always happened, and I appreciate that it is here.

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

Mr. Speaker, I know that he didn't read his language in the bill, but perhaps I might help him understand the bill.

SBA doesn't do any investing in this bill. It doesn't pick winners and losers.

I reserve the balance of my time.

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I stand here today in support of H.R. 3738, the Small Business Early-Stage Investment Act of 2009, which establishes the Small Business Early-Stage Investment program to provide equity investment finance to small businesses. I support this resolution because I believe that encouraging small business investment is crucial as the United States emerges from the recent economic downturn.

I would like to first thank my colleague, Congressman GLENN NYE, for introducing this valuable legislation. According to the National Bureau of Economic Research (NBER), the United States economy experienced the longest recession since World War II. As described by the Congressional Research Service (CRS), "this recession features the largest decline in output, consumption, and investment . . . of any post-war recession." The tightened credit markets have caused nonresidential investment to decline by 1.7% in the third quarter of 2008, by 21.7% in the fourth quarter of 2008, and by an estimated 37.9% in the first quarter of 2009, as reported by CRS. The impacts of the tightened credit markets and decline in business investment include the possibility of lenders declining to make loans to small businesses that they otherwise would in a more robust economy and small businesses possibly becoming more risk averse, thereby delaying or aborting projects. The difficulty obtaining investment that small businesses face today could lead to delays in new business ventures.

There are certain business sectors that we rely upon for innovation in order to transform our society. The United States is looking to innovation from the energy technology, environmental technology, and clean technology sectors to lead the way in developing technology that will reduce or eliminate climate change factors while maintaining our standard of living. We are looking to the information technology and digital media sectors to help level the educational playing field and open up the world to all students. If we allow these sectors to recover on their own, we could lose precious time for solving these problems.

H.R. 3738 seeks to reverse the negative impacts of the recession and the subsequent decline in investment opportunities for small businesses in critical economic sectors. While there currently exists a Small Business Innovation Research program established to provide small businesses with venture capital for projects in late stages of development, there does not currently exist a program to provide grant funding for early state research. Particularly, the biotechnology and defense technology business sectors require early stage investment to develop innovative technology. H.R. 3738 will help those and other critical sectors gain access to capital in order to drive innovation.

H.R. 3738 will establish a new program to provide equity financing to small businesses in targeted industries with early stage projects. The Small Business Administration (SBA) will be authorized to provide grants to qualified investment companies, determined by the SBA Administrator, under certain criteria. Any firm that applies for funds must have a 1-to-1 match of private funds. Equity firms that apply for these funds must return the funds in full

plus 20 percent. While there is a $250 million initial appropriation, the program is predicted to be self-sustaining from the profits of the loan program.

My district is the perfect example of why small businesses are so vital to the nation's economy. Houston's newer and growing economic sub-centers have relied more on small business as their cornerstone than the older Central Business District. According to a report issued by the SBA Office of Advocacy, findings suggest that while small firms support urban economic growth, as development proceeds they grow substantially. In turn, small firm growth plays an important role in urban economic development which is likely to lead to economic growth for the entire local economy. I believe that H.R. 3738 will support the small businesses that sustain Houston's economy.

Ms. VELÁZQUEZ. Mr. Speaker, I urge adoption of this bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Ms. VELÁZQUEZ) that the House suspend the rules and pass the bill, H.R. 3738, as amended.

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

A motion to reconsider was laid on the table.

MESSAGE FROM THE SENATE

A message from the Senate by Ms. Byrd, one of its clerks, announced that the Senate has passed with an amendment in which the concurrence of the House is requested, a bill of the House of the following title:

H.R. 3082. An act making appropriations for military construction, the Department of Veterans Affairs, and related agencies for the fiscal year ending September 30, 2010, and for other purposes.

The message also announced that the Senate insists upon its amendment to the bill (H.R. 3082) ''An Act making appropriations for military construction, the Department of Veterans Affairs, and related agencies for the fiscal year ending September 30, 2010, and for other purposes,'' requests a conference with the House on the disagreeing votes of the two Houses thereon, and appoints Mr. JOHNSON, Mr. INOUYE, Ms. LANDRIEU, Mr. BYRD, Mrs. MURRAY, Mr. REED, Mr. NELSON, Mr. PRYOR, Mr. LEAHY, Mrs. HUTCHISON, Mr. BROWNBACK, Mr. MCCONNELL, Ms. COLLINS, Ms. MURKOWSKI, and Mr. COCHRAN, to be conferees on the part of the Senate.

The message also announced that pursuant to Public Law 106–398, as amended by Public Law 108–7, in accordance with the qualifications specified under section 1238(b)(3)(E) of Public Law 106–398, and upon the recommendations of the Majority Leader, in consultation with the Chairmen of the Senate Committee on Armed Services and the Senate Committee on Finance, the Chair, on behalf of the President pro tempore, appoints the following individuals to the United States-China Economic Security Review Commission:

Patrick A. Mulloy of Virginia, for a term beginning January 1, 2010 and expiring December 31, 2011.

William A. Reinsch of Maryland, for a term beginning January 1, 2010 and expiring December 31, 2011.

The message also announced that pursuant to Public Law 95–277, as amended by Public Law 102–246, the Chair, on behalf of the Majority Leader, in consultation with the Republican Leader, appoints the following individuals as members of the Library of Congress Trust Fund Board for five year terms:

Elaine Wynn of Nevada, vice Bernard Rapoport.

Tom Girardi of California, vice Leo Hindery.

SMALL BUSINESS HEALTH INFORMATION TECHNOLOGY FINANCING ACT

Ms. VELÁZQUEZ. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3014) to amend the Small Business Act to provide loan guarantees for the acquisition of health information technology by eligible professionals in solo and small group practices, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3014

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Health Information Technology Financing Act''.

SEC. 2. SMALL BUSINESS HEALTH INFORMATION TECHNOLOGY FINANCING PROGRAM.

The Small Business Act (15 U.S.C. 631 et seq.) is amended by redesignating section 44 as section 45 and by inserting the following new section after section 43:

''SEC. 44. LOAN GUARANTEES FOR HEALTH INFORMATION TECHNOLOGY.

''(a) DEFINITIONS.—As used in this section:

''(1) The term 'health information technology' means computer hardware, software, and related technology that supports the meaningful EHR use requirements set forth in section 1848(o)(2)(A) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)) and is purchased by an eligible professional to aid in the provision of health care in a health care setting, including, but not limited to, electronic medical records, and that provides for—

''(A) enhancement of continuity of care for patients through electronic storage, transmission, and exchange of relevant personal health data and information, such that this information is accessible at the times and places where clinical decisions will be or are likely to be made;

''(B) enhancement of communication between patients and health care providers;

''(C) improvement of quality measurement by eligible professionals enabling them to collect, store, measure, and report on the processes and outcomes of individual and population performance and quality of care;

''(D) improvement of evidence-based decision support; or

''(E) enhancement of consumer and patient empowerment.

Such term shall not include information technology whose sole use is financial management, maintenance of inventory of basic supplies, or appointment scheduling.

''(2) The term 'eligible professional' means any of the following:

''(A) A physician (as defined in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))).

''(B) A practitioner described in section 1842(b)(18)(C) of that Act.

''(C) A physical or occupational therapist or a qualified speech-language pathologist.

''(D) A qualified audiologist (as defined in section 1861(ll)(3)(B)) of that Act.

''(E) A qualified medical transcriptionist who is either certified by or registered with the Association for Healthcare Documentation Integrity, or a successor association thereto.

''(F) A State-licensed pharmacist.

''(G) A State-licensed supplier of durable medical equipment, prosthetics, orthotics, or supplies.

''(H) A State-licensed, a State-certified, or a nationally accredited home health care provider.

''(3) The term 'qualified eligible professional' means an eligible professional whose office can be classified as a small business concern by the Administrator for purposes of this Act under size standards established under section 3 of this Act.

''(4) The term 'qualified medical transcriptionist' means a specialist in medical language and the healthcare documentation process who interprets and transcribes dictation by physicians and other healthcare professionals to ensure accurate, complete, and consistent documentation of healthcare encounters.

''(b) LOAN GUARANTEES FOR QUALIFIED ELIGIBLE PROFESSIONALS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator may guarantee up to 90 percent of the amount of a loan made to a qualified eligible professional to be used for the acquisition of health information technology for use in such eligible professional's medical practice and for the costs associated with the installation of such technology. Except as otherwise provided in this section, the terms and conditions that apply to loans made under section 7(a) of this Act shall apply to loan guarantees made under this section.

''(2) LIMITATIONS ON GUARANTEE AMOUNTS.—The maximum amount of loan principal guaranteed under this subsection may not exceed—

''(A) $350,000 with respect to any single qualified eligible professional; and

''(B) $2,000,000 with respect to a single group of affiliated qualified eligible professionals.

''(c) FEES.—(1) The Administrator may impose a guarantee fee on the borrower for the purpose of reducing the cost (as defined in section 502(5) of the Federal Credit Reform Act of 1990) of the guarantee to zero in an amount not to exceed 2 percent of the total guaranteed portion of any loan guaranteed under this section. The Administrator may also impose annual servicing fees on lenders not to exceed 0.5 percent of the outstanding balance of the guarantees on lenders' books.

''(2) No service fees, processing fees, origination fees, application fees, points, brokerage fees, bonus points, or other fees may be charged to a loan applicant or recipient by a lender in the case of a loan guaranteed under this section.

''(d) DEFERRAL PERIOD.—Loans guaranteed under this section shall carry a deferral period of not less than 1 year and not more than 3 years. The Administrator shall have the authority to subsidize interest during the deferral period.

''(e) EFFECTIVE DATE.—No loan may be guaranteed under this section until the meaningful EHR use requirements have been determined by the Secretary of Health and Human Services.

''(f) SUNSET.—No loan may be guaranteed under this section after the date that is 7 years after meaningful EHR use requirements have been determined by the Secretary of Health and Human Services.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the cost (as defined in section 502(5) of the Federal Credit Reform Act of 1990) of guaranteeing $10,000,000,000 in loans under this section. The Administrator shall determine such program cost separately and distinctly from other programs operated by the Administrator.''.

SEC. 3. REGULATIONS.

Except as otherwise provided in this Act or in amendments made by this Act, after an opportunity for notice and comment, but not later than 180 days after the date of the enactment of this Act, the Administrator shall issue regulations to carry out this Act and the amendments made by this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Ms. VELÁZQUEZ) and the gentleman from Missouri (Mr. GRAVES) each will control 20 minutes.

The Chair recognizes the gentlewoman from New York.

GENERAL LEAVE

Ms. VELÁZQUEZ. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

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

There was no objection.

Ms. VELÁZQUEZ. Mr. Speaker, I rise in support of H.R. 3014, important legislation authored by Mrs. DAHLKEMPER to assist our Nation's small health care providers.

The passage of America's Affordable Health Choices Act earlier this month marked a turning point in our journey toward lasting health care reform. That legislation promises to break from the status quo, delivering solutions that not only reduce costs but also increase efficiency. These are changes our current system sorely needs. And, Mr. Speaker, reduced costs and enhanced efficiency are two benefits that health information technology already offers.

In big hospitals across the country, electronic medical records are revolutionizing health care. They are streamlining the flow of data, minimizing errors, and improving communication between medical professionals, and they are doing it all with a click of a mouse. But while HIT offers a myriad of obvious benefits, small medical practices have struggled to adopt this technology. This is because the technology, like most groundbreaking new products, is extraordinarily expensive.

For your average small practice, implementation of HIT runs close to $100,000. As a result, only 13 percent of single-doctor practices have chosen to purchase technology. This bill ensures all medical practices, regardless of size, can afford HIT. To begin, it blunts product and installation costs by making capital more affordable. It also allows small practices to defer loan payments. That way, these practitioners have the flexibility to bring this system online and reap the benefits before having to shoulder the implementation costs.

Access to capital has always been a key concern for small firms even during the best of times. The current trend in tightening credit and restricting lending has compounded that challenge. Like all small businesses, small health practitioners are feeling the pinch of these tightening credit conditions. This is why this bill is so important. Without it, small practices will be unable to afford HIT. And because the vast majority of Americans patronize small practices, countless patients will miss out on the benefits of a streamlined system.

Only days ago, this body took historic action to overhaul our broken health care system. As we continue to work towards lasting reform, HIT will play a critical role. With this bill, we can increase adoption within the small business community, reducing costs and improving quality for all Americans.

Mr. Speaker, this is an important piece of legislation. It is supported by 23 of the most prominent medical organizations, including the American Medical Association, the American Academy of Pediatrics, the American Osteopathic Association, and the American College of Surgeons.

I thank Representative DAHLKEMPER for her work on this bill. I urge my colleagues to vote ''yes.''

Mr. Speaker, I reserve the balance of my time.

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

Mr. Speaker, I rise today in support of the request to suspend the rules and pass H.R. 3014, a bill to provide financial assistance in the form of loans to install health information technology systems.

Two weeks ago, there was significant disagreement about the health care reform bill offered by the Democrats. Those concerns included the cost impact on small businesses and whether the bill actually will improve the efficiency and efficacy of the health care system at a time of skyrocketing health insurance premiums. One way to improve the efficiency of the health care system is for physicians and other providers of health care, such as pharmacists, physical therapists, and providers of durable medical equipment, to install health information technology systems.

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Electronic medical records have proven to be an effective tool in reducing medical errors and eliminating unnecessary medical procedures. However, health information technology systems are extremely expensive, particularly for the numerous small businesses such as solo physician practitioners in rural areas to purchase and install such systems.

H.R. 3014 addresses this issue by providing loan guarantees by the Small Business Administration to health care providers that install health information technology systems. The loan process will operate in a manner identical to that of the SBA's 7(a) loan guarantee program. Thus, fees will be charged to borrowers and lenders as they are in the 7(a) loan program.

Testimony before the committee revealed that it takes anywhere from 1 to 3 years for physicians and other health care providers to reach the level of efficiency that they operated with under handwritten systems. Recognizing this, H.R. 3014 authorizes a deferral period in repayment of 1 to 3 years. While there is an additional cost associated with such deferral, this small incentive will pay for itself many times through an increase in efficiency of the health care system without undertaking a government capture of the health care market.

Mr. Speaker, I reserve the balance of my time.

Ms. VELÁZQUEZ. Mr. Speaker, I yield as much time as she may consume to the lead sponsor of this bill, the gentlelady from Pennsylvania (Mrs. DAHLKEMPER).

Mrs. DAHLKEMPER. Mr. Speaker, I rise today in support of the Small Business Health Information Technology Financing Act. This legislation is a vital piece to lowering the health care costs of our country, and a key to making health technology accessible to small business health companies.

While we talk about the high price of health care to hospitals and consumers, we often forget that most doctors and pharmacists work in small groups or as individual health care providers. These small medical businesses are dramatically affected by administrative burdens, which can translate to higher health care costs for their patients.

My legislation creates an affordable path for these providers to make the investment in health information technologies that lower the cost of health

care for their patients and for their businesses.

Rural communities, like many of those in my district, often rely on only a few health care providers in the area. These providers—independent pharmacists, doctors and allied health professionals—struggle to continue providing their services when they do not have the infrastructure and support of bigger hospitals or other facilities. Doctors and practitioners with small practices work tirelessly to keep communities healthy at the most basic level, but the costs to do so can be overwhelming.

The Small Business Health Information Technology Financing Act creates a new loan guarantee program at the SBA that would allow these small pharmacies, small doctors and allied professional offices to purchase health information technology that would drastically improve their businesses and potentially lower the costs to patients. The loan guarantee programs provides a 90 percent guarantee on loan amounts up to $350,000 for an individual practitioner and $2 million for a group to purchase cost-saving information technologies which are often too expensive an investment for a small business.

Mr. Speaker, the Small Business Health Information Technology Financing Act will not only lower the administrative costs of health care, it will help bolster small businesses by allowing them access to modern and efficient technologies. My legislation creates an affordable loan program for these providers to make the investment in health information technologies that lower the cost of health care for everyone and improve the health of all. I urge my colleagues on both sides of the aisle to support this small business legislation.

Mr. GRAVES. Mr. Speaker, I don't have any other speakers. I would just like to say that I appreciate the chairwoman's work on this bill and incorporating ideas from our side into this bill. As always, the bipartisan work of the committee is very much noticed and I appreciate that.

I would yield back the balance of my time.

Ms. VELÁZQUEZ. I have an additional speaker. I will yield as much time as he may consume to the gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I thank the gentlelady for yielding, and I want to commend the sponsor of this act before us today.

Mr. Speaker, I rise in strong support of H.R. 3014, the Small Business Health Information Technology Financing Act. As this Congress is moving aggressively to solve our Nation's health care crisis by establishing universal health care, we are going to have to move aggressively also to look at ways of controlling costs. That really is one of the vital reasons why we have to overhaul our Nation's health care system. Health information technology will be a vital part of the effort to both improve quality and cut costs.

But, of course, with this there will be an up-front cost that many doctors, in particular, are going to have to absorb. We have to work aggressively, I believe, to try to support them in this transition to adopt these new health information technologies. Again, many of these doctors are just, if you will, small businesses themselves. Today, the Congress is debating several bills supporting small business.

In order to create jobs we absolutely have to look to small businesses. In many ways they are the backbone of our economy. Certainly in my home State of Rhode Island that's true, with 96 percent of employers being small businesses. My constituents right now are struggling with a heavy burden of 13 percent unemployment in a State whose recession began almost a year earlier than most of its neighbors, and the need for job creation could not be more urgent.

Many of the new jobs we need will be created through new business endeavors, and that's why this legislation and other pieces of small business legislation that we're debating today are so important. By looking at new business models, we will better target the needs of our communities. We need to help our small businesses grow, keep people employed, and train them for new, sustainable jobs. American prosperity clearly depends on the success of small businesses and the innovative spirit of the American people. I'm certainly committed to bringing relief to Main Street and small businesses that are struggling in our State. Certainly, doctors, as I said, many of them are small businesses themselves, and helping them with the up-front cost of adopting this health information technology will assist them to stay in business. And particularly, as we try to grow our primary care system, this will become more and more important.

I commend the gentlelady for introducing the legislation. I am proud to support it, as I am proud to support all of our small businesses and helping them to stay in business and grow jobs.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Ms. VELÁZQUEZ) that the House suspend the rules and pass the bill, H.R. 3014, as amended.

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

A motion to reconsider was laid on the table.

PROVIDING FOR CONSIDERATION OF H.R. 3791, FIRE GRANTS REAUTHORIZATION ACT OF 2009

Ms. PINGREE of Maine. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 909 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 909

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 3791) to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived except those arising under clause 9 or 10 of rule XXI. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chair and ranking minority member of the Committee on Science and Technology. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute recommended by the Committee on Science and Technology now printed in the bill modified by the amendment printed in part A of the report of the Committee on Rules accompanying this resolution. That amendment in the nature of a substitute shall be considered as read. All points of order against that amendment in the nature of a substitute are waived except those arising under clause 10 of rule XXI. Notwithstanding clause 11 of rule XVIII, no amendment to that amendment in the nature of a substitute shall be in order except those printed in part B of the report of the Committee on Rules. Each such amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question. All points of order against such amendments are waived except those arising under clause 9 or 10 of rule XXI. At the conclusion of consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

SEC. 2. The Chair may entertain a motion that the Committee rise only if offered by the chair of the Committee on Science and Technology or his designee. The Chair may not entertain a motion to strike out the enacting words of the bill (as described in clause 9 of rule XVIII).

The SPEAKER pro tempore. The gentlewoman from Maine is recognized for 1 hour.

Ms. PINGREE of Maine. Mr. Speaker, for the purposes of debate only, I yield the customary 30 minutes to the gentleman from California (Mr. DREIER).

All time yielded during consideration of the rule is for debate only. I yield myself such time as I may consume.

GENERAL LEAVE

Ms. PINGREE of Maine. I also ask unanimous consent that all Members be given 5 legislative days in which to revise and extend their remarks on House Resolution 909.

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

There was no objection.

Ms. PINGREE of Maine. Mr. Speaker, House Resolution 909 provides a structured rule for consideration of H.R. 3791, the Fire Grants Reauthorization Act of 2009. The rules waive all points of order against consideration of the bill except those arising under clause 9 or 10 of rule XXI. The rule provides 1 hour of general debate equally divided and controlled by the Committee on Science and Technology. The rule provides that the amendment in the nature of a substitute recommended by the Science and Technology Committee modified by the amendment printed in part A of the Rules Committee report shall be considered as adopted and shall be considered as read. The rule waives all points of order against the substitute amendment, except those arising under clause 10 of rule XXI. The rule makes in order the amendments printed in part B of the Rules Committee report and waives all points of order against such amendments except those arising under clause 9 or 10 of rule XXI. The rule makes in order all five of the amendments submitted for consideration. The Chair may not entertain a motion to rise unless offered by the Chair of the Committee on Science and Technology or his designee, and may not entertain a motion to strike the enacting clause.

Mr. Speaker, H.R. 3791 reauthorizes funding for two vital programs that support our local firefighters and our communities: the Assistance to Firefighters Grant (AFG) program and the Staffing for Adequate Fire and Emergency Response (SAFER) grant program. These two programs go hand in hand by providing assistance that keeps local fire departments prepared and able to respond, while assuring that each department is adequately staffed to meet the needs of the community. The AFG program provides funding for local fire departments to purchase equipment, vehicles and training, and the SAFER grants program helps local departments maintain and hire firefighters.

The success of both programs has been indisputable and their impacts have been felt in each of our districts. Since 2001, the AFG program has provided over $4.8 billion in funding to local fire departments to purchase emergency response training and equipment. Since 2004, the SAFER program has competitively awarded $700 million to local departments for hiring, recruitment and retention of fire fighters. The effect of both programs can be simply stated. Each dollar saves lives and jobs.

While this funding has been essential, the unmet needs of our local departments remain staggering. In fiscal year 2008, the Federal Emergency Management Agency received over 20,000 applications from fire departments requesting over $3 billion. In the same fiscal year, FEMA also received over 1,000 applications for SAFER grants, requesting over $500 million. The National Fire Protection Association estimates that 65 percent of fire departments in the United States do not have enough portable radios to equip all firefighters, and that 36 percent of all fire departments involved in emergency medical responses do not have enough adequately trained personnel to respond to these emergencies.

The numbers speak for themselves. During these tough economic times, the needs of our local fire departments have been exacerbated and local resources have been stretched to the breaking point. Communities in rural areas, which have always been strapped for resources and struggled to compete for Federal funds, have been hit exceptionally hard by this economic downturn.

□ 1145

In Portland, Maine, one of the more urban areas that I represent, nine firefighters in the Portland region were recently laid off due to significant budget cuts. But the local unions stepped up and unanimously stood up to support their laid-off colleagues out of their own pay checks.

While this is a great example of people pulling together during tough times, and it may exemplify part of what we admire about first responders, this is simply an unacceptable solution. The Federal Government has no higher charge than to provide for the common protection and the common good of its citizens and to support this work at the local level. It is time to reinvest in our emergency responders and renew our commitment to these critical programs.

This funding is also critical in rural towns across the country. Raymond, Maine, in my district, for example, is a town of less than 5,000 residents and a fire department that is mostly made up of volunteers. In 2008 when they realized that their SCBAs, self-contained breathing apparatus, on all of their trucks were outdated and didn't meet the current requirements, they turned to this program. And thanks to a $150,000 grant, Raymond, Maine, was able to purchase the equipment they so desperately needed. Stories like this are now more common because of the SAFER program.

The safety of our homes and our neighborhoods has never been a partisan issue, and the bravery and service of our local fire departments has never been in question. This is clearly demonstrated by the broad bipartisan support for this bill and the strong endorsements from the International Association of Firefighters and the National Volunteer Fire Council.

I look forward to the passage of this important legislation, and I reserve the balance of my time.

Mr. DREIER. Mr. Speaker, I thank my friend from North Haven for yielding me the customary 30 minutes, and I yield myself such time as I might consume.

Mr. Speaker, my Rules Committee colleague has pointed at the fact that this is a bipartisan measure. Dealing with issues of firefighting obviously transcend partisanship in every way. And this is a very, very important measure that will, in fact, have, I suspect, unanimous support here on the House floor. She has outlined appropriately the two grant programs, the Assistance to Firefighters program which will provide $12.2 billion, and the SAFER program which will provide $1 billion in assistance. And I believe that this is a measure which is critically important as we look at the challenges of the Federal Government's role in dealing with firefighting.

Mr. Speaker, this past August 26 was a devastating day in southern California history. We saw the largest fire in Los Angeles County history burn 160,000 acres. It was a horrible, horrible time, because above all of it, we lost two courageous firefighters, Captain Ted Hall and Specialist Arnie Quinones. And when one thinks about where it is that we are going on this issue, it is critical that we do every single thing that we can for the brave men and women who are firefighters.

And, Mr. Speaker, I think it's important for us to never forget what it is that happened in Los Angeles or in other fires. There was a memorial service that was held at Dodgers Stadium several weeks ago. And I was struck at that service with the fact that firefighters stood up and said that the one thing that continues to happen is that while the populace at large may have a tendency to forget these things, firefighters never, ever forget their own. And that is why there is a redoubling of the commitment to the spouses, the children and other family members of Captain Ted Hall and Specialist Arnie Quinones.

This program is important, and it has a Federal component, I believe, in large part due to the fact that the area that burned just above La Canada, California, is an area that consists of the Angeles National Forest, which is Federal land. So I hope very much that we are able to proceed in a bipartisan way in dealing with this issue.

If you think about the sacrifice that is made, on average 75,000 firefighters

are injured every single year, and on average 100 firefighters are killed every single year as they are proceeding with their very, very important work. That is why this program will, I believe, go a long way towards diminishing the loss of life and the threat to those people and at the same time diminish the threat of fire overall.

Now, Mr. Speaker, as important as this issue is, and my friend from North Haven has pointed to the fact that it is bipartisan, I believe this measure should be considered under either suspension of the rules, because while the five amendments that were offered were made in order, I'm convinced that under the able leadership of the committee of jurisdiction, there could have been an agreement that would have allowed this to come up with 20 minutes of debate. Just as the last measures that we have considered were considered under suspension of the rules, this very easily could have. But since it's not, it obviously should be considered under an open amendment process.

Now it's very sad that we have gone through this entire Congress, this entire Congress without a single open rule. And that is, I think, a very, very unfortunate thing. It is a step forward that every amendment submitted upstairs to the Rules Committee was made in order. But why not consider it under an open amendment process which would allow any rank-and-file Member to stand up and offer an amendment to this legislation?

So I also have to say that the amount of time that we are expending on this is, I believe, not necessary in light of the fact that as important as it is, it enjoys strong bipartisan support, as both of us have said.

I believe what the American people want us to be doing here, Mr. Speaker, is focusing on jobs, jobs, jobs. We all know that when the stimulus package, the $787 billion stimulus package passed, President Obama said that its passage would ensure that we would not see an unemployment rate that would exceed 8 percent.

We all know that today, tragically, the unemployment rate is at 10.2 percent. In my State of California, it's 12.2 percent. In some of the areas that I represent around Los Angeles, it's up over 14 percent. And that's why what we should be doing is focusing on issues that will create jobs so that those individuals who are losing their homes and losing their small businesses are not going to continue to suffer.

Now what should we be doing? At this moment, President Obama is in Seoul, South Korea. And we know that denuclearizing the Korean peninsula is obviously a high priority. But just as was discussed when President Obama was in Beijing, similarly in Seoul, the priority issue being discussed is the U.S.-Korea free trade agreement.

Now there are a lot of people, Mr. Speaker, who say, why, when you're dealing with economic difficulties would you possibly consider embarking on a free-trade agreement? Well, guess what? There are very important reasons. The main reason is that it's one of the most important ways that we can create jobs right here in the United States of America.

Let's take just a moment, and I wish we were debating this agreement which has been completed, similarly the Colombia and the Panama agreements have been completed which would be job creators right here in the United States. Automobiles, the automobile industry is hurting in the United States, and we know that there is this massive disparity between the number of automobiles going from the United States of America being sold in Korea, that number is actually just under 10,000, and the number of Korean automobiles that are sold in the United States; 700,000 Korean automobiles are purchased by Americans.

Now I think everyone should have a right to buy the best quality product at the lowest possible price, but I believe we should do everything that we can to have an opportunity to create more jobs here in the United States of America in the automobile industry and every other industry that is tied to that, by creating a market opening, a market-opening vehicle for us in South Korea.

Now, people ask, well, why would you want to do an agreement that would make that happen? The reason is very simple. The tariff is higher on U.S. automobiles going into South Korea than it is on Korean vehicles coming into the United States by and large. And even more important than that, Mr. Speaker, there is a tax and regulatory structure that exists in South Korea that prevents us from being able to sell those cars. So, again, fewer than 10,000 American-made automobiles are sold in South Korea today; and we purchase 700,000 cars and trucks from there.

So what should we do? We should pass this free-trade agreement, pass this free-trade agreement which will create jobs right here in the United States of America and, I believe, go a long way towards dealing with the devastating 10.2 percent unemployment rate that we have. We can, we can implement job-creating economic growth policies. Unfortunately, based on the track record that we've seen over this past year, we haven't. So people are hurting. It's very important for us to pass this legislation which could be considered either under suspension of the rules or under an open amendment process, which unfortunately it isn't; and we could spend our time passing policies that will help the American worker.

With that, I reserve the balance of my time.

Ms. PINGREE of Maine. Mr. Speaker, I want to thank my colleague for all of the many topics he brought up this morning. I'm sure he and I will have another time when we get to discuss the trade issues in this country. And I also appreciate that there will be time in our committee to talk about the issues around amendments and open rules.

I will say that there are job components, particularly in this bill when I brought up the firefighters in Portland, Maine, who had recently lost their jobs and are now helping some of their brethren with their own paychecks. I know that funding through this helps many of our firefighters to maintain their service. I do want to also say, I know we all extended our sympathy at the time, but I appreciated that you spoke to us about the extreme fire issues in your district. And I also want to send my sympathies to those firefighters who are lost and their families. And I know that was a perilous time.

I appreciate the fact that while I represent a very rural district, even in your urban district, we have very many similarities of issues that we have to deal with.

I would now like to yield 3 minutes to the gentlewoman from Ohio (Ms. SUTTON).

Ms. SUTTON. I thank the gentlewoman for the time, and I thank her for her leadership on behalf of our firefighters and on behalf of all those out there who are fighting for jobs and for her leadership in taking us to a place today to bring this bill to the floor.

I rise today in support of H.R. 3791, the Fire Grants Reauthorization Act. Our communities desperately need this bill. We need to be able to keep our firefighters on the job and keep our constituents and communities safe. So this is all about jobs and the safety and well-being of those whom we are so honored to represent.

I'm pleased, too, with many of the changes that have been made to the Firefighters Grant programs, that H.R. 3791 sets aside specific percentages of the assistance to firefighter grants for career fire departments, combination departments and volunteer fire departments.

Currently, there is no statutory language guaranteeing professional fire departments a minimum percentage of funding. So I'm also pleased that we are including economic hardship waiver language in this bill. This language will, for the first time, work to address some of the devastating effects we have seen in this recession. It will allow that the local matching fund requirements be waived also. It allows the requirement that departments use the SAFER grants to supplement, rather than replace, local funds to be waived. It allows use the requirement that departments use the funds to hire additional firefighters rather than retain existing personnel to be waived.

That's what we're passing today, and that is what we passed earlier in the year. However, I'm deeply concerned that the SAFER grant guidance recently released by the Department of Homeland Security does not reflect congressional intent or the sacrifices made by local fire departments in some significant ways.

This bill makes it clear that our intent is to allow SAFER grants to be used to retain firefighters, as well, during the worst recession since the Great Depression. Many firefighters in my congressional district and across the country have made very difficult decisions to take pay cuts and make other sacrifices to avoid layoffs—for now. But their shared sacrifice may work against them when applying for these grants under the current guidelines. And it's my opinion and it is our intent, congressional intent, that they should not be penalized from accessing these grants that can keep them working.

□ 1200

Our firefighters sacrifice so much for our safety and should not be punished for sacrificing during the recession to stay on the job to protect our communities and one another.

Mr. DREIER. Mr. Speaker, I yield myself such time as I may consume. I was sorry my friend from North Haven didn't want to yield to me. I was simply going to tell her that I completely concurred with her argument that the job creation that will focus on firefighters is a very, very important thing, and I support that.

Ms. PINGREE of Maine. Will the gentleman yield?

Mr. DREIER. Of course. I'm always happy to yield to my friend.

Ms. PINGREE of Maine. I just want to say to my good friend from California, I apologize for not yielding earlier, and I appreciate your comments.

Mr. DREIER. Let me say that the notion of discussing a wide range of issues as I did, talking about the critical importance of the Assistance to Firefighters Grant Program of $1.2 billion and the SAFER Program of an additional billion dollars, is critical—and we support that. We support that very enthusiastically. But President Obama is at this point in Korea, and that is what led me to talk about the importance of our dealing with job creation.

As I talk to my constituents, Mr. Speaker—jobs, jobs, jobs—that is the message that continues to come through loudly and clearly. And the notion of expanding private-sector jobs is something that I believe we should be encouraging through improved tax and regulatory policy, bringing about marginal rate reduction, decreasing the regulatory burden and, Mr. Speaker, opening up new opportunities for U.S. workers here in the United States of America, which is exactly what is being said to President Obama as he meets in Korea at this moment with their leadership, with President Lee and others. And so I think that we need to have our attention in this Congress focused on the priority that the American people have.

Firefighting is very, very important. But, again, this measure will pass—if not unanimously, nearly unanimously—and it will do so, and I hope get the resources to ensure that we never have the loss of life, as I said, of Captain Hall and Specialist Quinones, and others. But I know from having spoken to their families, Mr. Speaker, that they believe that it's absolutely essential for us to encourage private-sector job creation and economic growth, and that's why I'm talking about this priority that needs to be addressed here.

Mr. Speaker, I'm going to urge my colleagues to defeat the previous question as we move ahead. Why? Because the issue of reading legislation is another very, very important one that is before us. There is a bipartisan proposal launched by Messrs. BAIRD and CULBERSON, supported by Mr. DENT and others, a bipartisan measure which will allow us to, if we defeat the previous question and debate that measure, which calls for 72 hours for the reading of legislation before we bring it to the floor.

I suspect that my colleague from North Haven has heard, just as I, that the American people believe that we should read legislation before it comes to the House floor. Right now, we regularly waive the 72-hour, 3-day layover requirement.

So, Mr. Speaker, I'm going to urge my colleagues to defeat the previous question. It will not in any way impinge on our ability to move ahead and pass this very important legislation dealing with firefighting. At the same time, it will do something else that the American people have been asking us, and that is to read, review, and consider legislation in a very deliberative manner, which is exactly what the framers of our Constitution wanted us to do.

With that, I reserve the balance of my time.

Ms. PINGREE of Maine. At this moment I have no other speakers. I would inquire whether the gentleman is ready to yield back his time.

Mr. DREIER. Let me yield myself such time as I might consume to close by simply saying this is very good and important legislation. It needs to pass. It's being considered, unbelievably, under a structured amendment process. It enjoys strong bipartisan support and should pass with that.

I think we should be focusing our attention, as I said, on job creation and economic growth, which is what the American people want us to be spending our time doing here rather than taking a long period of time to debate an issue on which we all agree.

So I urge my colleagues to vote "no" on the previous question so that we can consider the bipartisan Baird-Culberson language that would allow us to read legislation before it's considered here over the 72-hour period of time.

If by chance—if by chance—the previous question is not defeated and we don't have an opportunity to debate that very important legislation that will allow us to have the 3-day layover, I will urge my colleagues to vote "no" on the rule so that we can come back with an open amendment process, which is another very, very important part of the transparency message which should be coming through.

AMENDMENT TO H. RES. 909 OFFERED BY MR. DREIER

At the end of the resolution, insert the following new section:

SEC. 3. On the third legislative day after the adoption of this resolution, immediately after the third daily order of business under clause 1 of rule XIV and without intervention of any point of order, the House shall proceed to the consideration of the resolution (H. Res. 554) amending the Rules of the House of Representatives to require that legislation and conference reports be available on the Internet for 72 hours before consideration by the House, and for other purposes. The resolution shall be considered as read. The previous question shall be considered as ordered on the resolution and any amendment thereto to final adoption without intervening motion or demand for division of the question except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Rules; (2) an amendment, if offered by the Minority Leader or his designee and if printed in that portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII at least one legislative day prior to its consideration, which shall be in order without intervention of any point of order or demand for division of the question, shall be considered as read and shall be separately debatable for twenty minutes equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit which shall not contain instructions. Clause 1(c) of rule XIX shall not apply to the consideration of House Resolution 554.

(The information contained herein was provided by Democratic Minority on multiple occasions throughout the 109th Congress.)

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not merely a procedural vote. A vote against ordering the previous question is a vote against the Democratic majority agenda and a vote to allow the opposition, at least for the moment, to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's Precedents of the House of Representatives, (VI, 308–311) describes the vote on the previous question on the rule as "a motion to direct or control the consideration of the subject before the House being made by the Member in charge." To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's

ruling of January 13, 1920, to the effect that ''the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition'' in order to offer an amendment. On March 15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R–Illinois) said: ''The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition.''

Because the vote today may look bad for the Democratic majority they will say ''the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever.'' But that is not what they have always said. Listen to the definition of the previous question used in the Floor Procedures Manual published by the Rules Committee in the 109th Congress, (page 56). Here's how the Rules Committee described the rule using information from Congressional Quarterly's ''American Congressional Dictionary'': ''If the previous question is defeated, control of debate shifts to the leading opposition member (usually the minority Floor Manager) who then manages an hour of debate and may offer a germane amendment to the pending business.''

Deschler's Procedure in the U.S. House of Representatives, the subchapter titled ''Amending Special Rules'' states: ''a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate.'' (Chapter 21, section 21.2) Section 21.3 continues: Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon.''

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Democratic majority's agenda and allows those with alternative views the opportunity to offer an alternative plan.

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

Ms. PINGREE of Maine. I thank my colleague for co-managing this rule. I appreciate his concerns about jobs. I know it's a top priority for our caucus and one we will be talking about in the coming weeks and days. I want to finish my remarks by focusing on the important contribution of firefighters.

Mr. Speaker, the fire service in this country is being asked to do more than ever before—from hazmat response and safety planning for schools to EMT duties and homeland security responsibilities. These days, fire departments do much more than spray water on burning buildings. Or, as one of my firefighter friends says, much more than ''putting the wet stuff on the red stuff.'' These increased responsibilities are why these programs are so vitally important.

My home State of Maine has used these programs to great success. During fiscal year 2008, Maine received almost $5 million in AFG funding and close to $1 million in SAFER grants. But these numbers alone do not tell the whole story. The real success of these programs is told through the stories of those whose lives have been saved and those whose jobs have been preserved.

In 2005, a Maine fire department received an AFG grant to purchase smoke alarms and install those in homes that did not meet the level of protection recommended by the National Fire Protection Association. Just 2 months after the local fire department began installing the smoke alarms, firefighters were called to a house where smoke had been detected in the basement. The family of six living in the home was awakened by a smoke alarm and they were able to escape before any of them suffered a serious injury. The smoke alarm had been bought and installed with funding from the AFG program.

The town of Saco, Maine, recently used these programs to install an exhaust system for the fire station so the building doesn't fill up with diesel exhaust every time the fire trucks start up. And the town of Brunswick, a community facing the challenges of a Navy base closure, the department was able to hire critically needed firefighters thanks to a SAFER grant.

But, Mr. Speaker, I think some of the real success stories lie in our rural communities, communities often staffed by volunteer fire departments. Just like bigger communities, those small-town fire departments are being asked to do more, but acquiring the equipment they need is often beyond the scope of small-town municipal budgets. Through these programs, small-town volunteer fire departments in my State have been able to acquire the turnout coats, the breathing apparatus, and the hazmat suits to do the job effectively and safely.

Mr. Speaker, I am a proud cosponsor of this bill and I will continue to be a strong supporter of the men and women who put their lives on the line to keep our businesses, our homes, and our communities safe.

I urge a ''yes'' vote on the previous question and on the rule.

I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. JACKSON of Illinois). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

PROVIDING FOR AN ADJOURNMENT OR RECESS OF THE TWO HOUSES

Ms. PINGREE of Maine. Mr. Speaker, I send to the desk a privileged concurrent resolution and ask for its immediate consideration.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 214

Resolved by the House or Representatives (the Senate concurring), That when the House adjourns on the legislative day of Thursday, November 19, 2009, or Friday, November 20, 2009, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Tuesday, December 1, 2009, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on any day from Friday, November 20, 2009, through Wednesday, November 25, 2009, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Monday, November 30, 2009, or such other time on that day as may be specified in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate if, in their opinion, the public interest shall warrant it.

The SPEAKER pro tempore. The question is on the concurrent resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on adoption of House Concurrent Resolution 214 will be followed by 5-minute votes on ordering the previous question on House Resolution 909; and adoption of House Resolution 909, if ordered.

The vote was taken by electronic device, and there were—yeas 243, nays 166, not voting 25, as follows:

[Roll No. 896]

YEAS—243

Abercrombie	Berman	Braley (IA)
Ackerman	Berry	Brown, Corrine
Andrews	Bilbray	Butterfield
Baca	Bishop (GA)	Capps
Baird	Bishop (NY)	Cardoza
Baldwin	Blumenauer	Carnahan
Barrow	Boccieri	Carson (IN)
Bartlett	Boswell	Castor (FL)
Bean	Boucher	Chaffetz
Becerra	Boyd	Chandler
Berkley	Brady (PA)	Childers

Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Costello
Courtney
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Dicks
Doggett
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garrett (NJ)
Gohmert
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Heller
Herseth Sandlin
Higgins
Hill
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Linder
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lummis
Lynch
Maffei
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Platts
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Taylor
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wilson (OH)
Woolsey
Wu
Young (AK)
Young (FL)

NAYS—166

Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Arcuri
Austria
Bachmann
Bachus
Barton (TX)
Biggert
Bishop (UT)
Blackburn
Boehner
Bonner
Bono Mack
Boozman
Boren
Boustany
Brady (TX)
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cao
Capito
Carney
Carter
Cassidy
Castle
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Diaz-Balart, L.
Diaz-Balart, M.
Donnelly (IN)
Dreier
Duncan
Ellsworth
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Giffords
Gingrey (GA)
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Hensarling
Herger
Himes
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Kosmas
Kratovil
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
LoBiondo
Lucas
Luetkemeyer
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Mitchell
Moran (KS)
Murphy (NY)
Myrick
Neugebauer
Nunes
Paulsen
Pence
Petri
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schauer
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuler
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf

NOT VOTING—25

Barrett (SC)
Bilirakis
Blunt
Bright
Brown (SC)
Cantor
Capuano
Cooper
Costa
Crowley
Deal (GA)
Dingell
Garamendi
Gerlach
Gutierrez
Honda
Maloney
Murphy, Tim
Pitts
Rothman (NJ)
Salazar
Sullivan
Tanner
Wexler
Yarmuth

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1237

Messrs. WITTMAN, CAMPBELL, Mrs. CAPITO, Ms. KOSMAS, Messrs. ARCURI, and CASSIDY changed their vote from ''yea'' to ''nay.''

Mr. GOHMERT changed his vote from ''nay'' to ''yea.''

So the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. BRIGHT. Mr. Speaker, on rollcall No. 896, had I been present, I would have voted "yea."

PROVIDING FOR CONSIDERATION OF H.R. 3791, FIRE GRANTS REAUTHORIZATION ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the vote on ordering the previous question on House Resolution 909, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 242, nays 174, not voting 18, as follows:

[Roll No. 897]

YEAS—242

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Brown, Corrine
Butterfield
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Costello
Courtney
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Reyes
Richardson
Rodriguez
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wilson (OH)
Woolsey
Wu

NAYS—174

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Baird
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis

Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Bright
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Capito
Carter
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Kucinich
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOT VOTING—18

Barrett (SC)
Brown (SC)
Cao
Capuano
Cooper
Costa
Crowley
Deal (GA)
Dingell
Gerlach
Murphy, Tim
Pitts
Rangel
Rothman (NJ)
Sullivan
Tanner
Wexler
Yarmuth

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised they have 2 minutes left to vote.

□ 1244

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

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

The yeas and nays were ordered.

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

The vote was taken by electronic device, and there were—yeas 245, nays 173, not voting 16, as follows:

[Roll No. 898]

YEAS—245

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Butterfield
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costello
Courtney
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sestak
Shea-Porter
Sherman
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wilson (OH)
Woolsey
Wu

NAYS—173

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Carter
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gingrey (GA)
Gohmert
Goodlatte
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuler
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOT VOTING—16

Barrett (SC)
Brown (SC)
Capuano
Costa
Crowley
Deal (GA)
Dingell
Gerlach
Gordon (TN)
Granger
Murphy, Tim
Rothman (NJ)
Serrano
Tanner
Wexler
Yarmuth

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Two minutes remain in this vote.

□ 1251

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. CROWLEY. Mr. Speaker, on November 18th, 2009, I was absent for three rollcall votes because I was attending the funeral of a family member. If I had been here, I would have voted: "yes" on rollcall vote 896; "yes" on rollcall vote 897; and "yes" on rollcall vote 898.

PERSONAL EXPLANATION

Mr. TIM MURPHY of Pennsylvania. Mr. Speaker, on rollcall Nos. 896, 897, and 898 I was unavoidably detained.

Had I been present I would have voted "nay" on rollcall No. 896; "nay" on rollcall No. 897; and "nay" on rollcall No. 898.

PRIVILEGED REPORT ON RESOLUTION OF INQUIRY TO THE ATTORNEY GENERAL

Mr. CONYERS, from the Committee on the Judiciary, submitted a privileged report (Rept. No. 111–341) on the resolution (H. Res. 871) directing the Attorney General to transmit to the House of Representatives certain documents, records, memos, correspondence, and other communications regarding medical malpractice reform, which was referred to the House Calendar and ordered to be printed.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 874

Mr. LATOURETTE. Mr. Speaker, I ask unanimous consent that my name be removed as a cosponsor of H.R. 874.

The SPEAKER pro tempore (Mr. DRIEHAUS). Is there objection to the request of the gentleman from Ohio?

There was no objection.

GENERAL LEAVE

Mr. GORDON of Tennessee. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the bill, H.R. 3791.

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

There was no objection.

FIRE GRANTS REAUTHORIZATION ACT OF 2009

The SPEAKER pro tempore. Pursuant to House Resolution 909 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 3791.

□ 1254

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 3791) to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes, with Mr. JACKSON of Illinois in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

The gentleman from Tennessee (Mr. GORDON) and the gentleman from Nebraska (Mr. SMITH) each will control 30 minutes.

The Chair recognizes the gentleman from Tennessee.

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

Mr. Chairman, I rise today in support of H.R. 3791, the Fire Grants Reauthorization Act of 2009. This bill reauthorizes the Assistance to Firefighters Grant (AFG) program and the Staffing for Adequate Fire and Emergency Response (SAFER) program. Over the past 9 years, these programs have provided over $5 billion to purchase firefighting equipment and training, and for communities to hire additional firefighters. This Federal support for public safety is even more important in this tough economy as local officials struggle to provide services in the face of decreasing budgets.

The provisions in this bill make several changes to the program to enable more fire departments to apply for grants, and to ensure that the programs can benefit all types of communities, from small towns to our largest cities.

As part of this, the bill apportions the AFG funding between the career, volunteer, and combination fire departments according to a formula that authorizes a minimum of 25 percent of each year's total AFG dollars for each type of department.

The bill also authorizes the director to waive matching funds, budget maintenance requirements and other requirements for fire departments facing exceptional economic hardships. It further lowers the matching requirement for AFG and modifies the matching structure of SAFER to make it easier for communities to plan for the commitment of a SAFER grant.

The Science Committee heard testimony from fire service experts in July that, particularly in this economy, the current matching requirements dissuaded some departments from applying. These provisions enable those fire departments with the most need to apply.

Finally, H.R. 3791 also increases the amount of money larger jurisdictions may apply for under the AFG program. These amounts better reflect the needs of larger metropolitan areas as well as fire departments that have been consolidated to provide unified coverage to a large area.

H.R. 3791 is the product of much hard work by the International Association of Fire Chiefs, the International Association of Fire Fighters, the National Volunteer Fire Council, the National Fire Protection Association, and the Congressional Fire Services Institute. It has been endorsed by all of these groups. This bill has bipartisan support and passed out of the Science and Technology Committee by voice vote.

I would like to once again thank Mr. MITCHELL for sponsoring this important legislation. I would also like to recognize the efforts of our subcommittee chairman, Mr. WU, in getting the policy right in this bill and working to get a consensus piece of legislation. I also want to thank Mr. PASCRELL of New Jersey for being the father of the origination of these bills, as well as Majority Leader STENY HOYER for bringing all of the parties together and working together to get a good bill out.

Finally, I would like to recognize the staff who have been integral in crafting this legislation: Meghan Housewright and Mike Quear on the majority staff, and Dan Byers on the minority staff.

We have some amendments today. I look forward to working with my colleagues today to make a good bill better.

Mr. Chairman, I reserve the balance of my time.

Mr. SMITH of Nebraska. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise today in support of H.R. 3791, the Fire Grants Reauthorization Act of 2009. This bill reauthorizes both the Assistance to Firefighters Grant (AFG) program and the Staffing for Adequate Fire and Emergency Response (SAFER) program, which both provide much-needed assistance to fire departments across the Nation.

As we learned through our committee work on this bill, and as I have heard firsthand in discussions with fire chiefs and firefighters in my district, the AFG program is frequently cited as a ''life safer'' and the only means by which many departments can acquire up-to-date equipment and training—which requires a significant portion of their budget—for their firefighters.

This is particularly true in rural areas such as my district in rural Nebraska, where many communities rely upon all-volunteer departments to respond to fires and other emergencies. The equipment needed to fight fires and save lives and property is costly, and required for departments to meet certain minimum response capabilities regardless of whether they are protecting a community of a few hundred people or a large city of a few hundred thousand people. As such, firefighter grants have proven absolutely vital for rural and volunteer fire departments, which have small tax bases and the least ability to acquire such equipment.

□ 1300

The bill before us today makes several modest changes to the AFG and SAFER programs, reflecting a compromise reached by the leading national fire service organizations who worked closely with the Science and Technology Committee to develop this legislation. I support these changes and the underlying reauthorization effort, and I want to call attention to two in particular which I offered as amendments during committee consideration of this bill. They are intended to support the ability of smaller combination and volunteer departments to successfully compete for and receive AFG

grants and to emphasize the AFG program should be a funding priority generally.

The first amendment added language to the bill clarifying in awarding grants competitively, FEMA must consider a broad range of factors related to a fire department's ability to respond to hazards, not just the size of the population a department protects but also other factors such as its geographic response area, hazard vulnerability, or financial situation. This addition does not make any changes to the underlying AFG program but, rather, explicitly codifies FEMA's existing practice.

Second, I was pleased to incorporate amendment language in committee calling attention to the dramatic decline in funding for the AFG program over the last 5 years and emphasize restoring it should be a priority.

The AFG program is authorized in this legislation at $1 billion a year; however, its actual appropriated funding has never reached that amount and, in fact, has steadily declined in recent years. In fiscal year 2003, $750 million was appropriated for AFG. Since this time, funding has steadily declined. Last year it was $565 million, and this year the Obama administration requested only $390 million. This represents a 48 percent decline since fiscal year 2003. Given the importance of AFG to helping fire departments around the country meet minimum response requirements, especially those in rural areas with limited tax bases, this trend is troubling and should be reversed.

I was pleased our colleagues in the majority accepted these amendments, and I appreciate the chairman's work. I thank them for working closely with me and the leading national fire service organizations to develop an agreeable compromise under which we could move this reauthorization forward.

I urge Members to support passage of this bill, and I hope for and expect a continued smooth process as we do go forward.

Mr. GORDON of Tennessee. Mr. Chairman, I yield 4 minutes to the author of the bill, the gentleman from Arizona (Mr. MITCHELL).

Mr. MITCHELL. Mr. Chairman, I rise today in strong support of H.R. 3791, the Fire Grants Reauthorization Act of 2009.

Firefighters are often the first and the last to leave an emergency scene. Whether it's putting out a house fire or wildfire or responding to terrorist attacks or a car accident, we depend upon firefighters every day.

But firefighters also depend on us. They depend on the public and their elected officials to make sure they have the resources, equipment, and training they need for their jobs. Without those tools, we put them and all of us at unnecessary risk.

H.R. 3791 reauthorizes the Assistance to Firefighters Grant program, or AFG, and the Staffing for Adequate Fire and Emergency Response program, or SAFER. This bill also makes several key improvements to those programs to assist the cities and towns in Arizona and across the country which are facing major budget shortfalls and cuts in services.

Since the AFG program was established in 2000, this program has provided more than $5 billion directly to fire departments through competitive award grants. These FIRE grants have also provided critical support to Arizona's fire departments. Between 2005 and 2008, Arizona received 165 AFG grants for a total of approximately $22.5 million. These grants are made available to local fire departments to purchase response equipment, training, and fire trucks. The AFG program also supports fire prevention and safety grants, which are used for smoke detectors, fire prevention education, and research to reduce the causes of fire-related injuries and death. The SAFER program provides competitively awarded funds for the hiring, recruiting, and retention of firefighting personnel.

Over the past 4 years, this program has provided nearly $700 million to local fire departments nationally, and Arizona has received 26 SAFER grants for a total of approximately $16 million. This funding is especially critical during these difficult economic times.

Based on testimony that the Science and Technology Committee heard from fire service representatives, H.R. 3791 makes several key improvements to this legislation.

First of all, this bill will change the matching requirements to enable fire departments with the greatest need to take advantage of the programs. The bill sets the matching requirement for the Assistance to Firefighters Grant program from 20 percent to 10 percent, with fire departments serving populations under 20,000 paying a 5 percent match. This greatly benefits rural and less urban areas.

H.R. 3791 also modifies the matching requirements for the SAFER program. Based on the recommendations of fire service organizations, reflecting the hardships faced by our State and local governments, SAFER will require instead a 20 percent match for each of 3 years.

This bill also gives the administrator the authority to waive the matching requirements for both programs in case of exceptional economic hardship. Such waivers may also be given for the programs' budget maintenance requirements and SAFER provisions that restrict the funding to hiring only additional firefighters, rather than retaining current firefighters. This is a necessary step at a time when fire departments in many areas of the country are confronted with the prospect of laying off firefighters.

This bill is the result of a consensus among the fire service organizations, including the International Association of Fire Chiefs, the International Association of Fire Fighters, the National Fire Protection Association, the National Volunteer Fire Council, and the Congressional Fire Services Institute.

I would like to take a moment to thank Chairman GORDON, Chairman WU, and the Science and Technology Committee for their tireless work on this legislation. In particular, I would like to thank Meghan Housewright, Mike Quear, Louis Finkel, and Lori Pepper for their hard work. I would also like to thank the majority leader, Mr. HOYER, and Congressman PASCRELL for their leadership on this important issue.

I urge my colleagues to support this legislation that provides vital resources to our Nation's firefighters. During these tough economic times, this support is crucial to our public safety.

Mr. SMITH of Nebraska. Mr. Chairman, I yield 2 minutes to the gentlewoman from Illinois (Mrs. BIGGERT).

Mrs. BIGGERT. Mr. Chairman, I rise in support of H.R. 3791, the Fire Grants Reauthorization bill.

As a longtime supporter of firefighters and a cosponsor of this bill, I'm very happy we are considering this important and timely legislation to help our firefighters and our fire departments across the country.

Whether it's a fire, a vehicle crash, a dangerous spill, or even a terrorist attack, our firefighters, men and women, put their lives on the line in almost every emergency situation they come across. The least we can do is to ensure that they have the equipment needed to do their jobs without exposing themselves to unnecessary risk.

Today we have the opportunity to improve two FIRE grant programs: the Assistance to Firefighters Grant program, which provides the departments access to proper training and equipment; and the SAFER program that helps fire departments hire new firefighters.

No time is more important than now to reauthorize the FIRE grant programs. It should be no surprise when I say that the economic downturn that has adversely affected everyone has also hit our fire departments hard. With local tax revenue on a steady decline, fire stations across the country and at home in Illinois are feeling far greater pressure to do more with less. H.R. 3791 will help our frontline responders meet their basic firefighting and emergency medical responsibilities with additional resources for staffing, training, and equipment. In passing this important legislation today, we improve the safety of our communities and that of the men and women who keep us safe.

Mr. Chairman, I urge our colleagues to support H.R. 3791.

Mr. GORDON of Tennessee. Mr. Chairman, I yield 1 minute to the majority leader, as I said earlier, the person who really was the sheriff in bringing everybody together for this bill, and we thank him for it.

Mr. HOYER. I thank the gentleman from Tennessee (Mr. GORDON), who does such an extraordinary job of leading the committee. I thank Mr. SMITH for his leadership. I also want to thank DAVID WU, the chairman of the subcommittee, for his leadership. All of them have joined together to get this bill to the floor. And I would be remiss if I did not acknowledge their contribution, because this bill, the genesis of it, was really with Mr. PASCRELL of New Jersey, who worked so many years ago to work with the Senate in generating this idea so that it came back to the House, but he was the godfather, if you will, of this piece of legislation. I want to acknowledge his presence here and thank him for his leadership. And I certainly want to thank Mr. MITCHELL, Congressman MITCHELL, who has been so critical in getting this bill to this point in time. He is an extraordinarily able Member of the Congress, and the firefighters throughout our country I know are appreciative of his efforts on this bill.

Every day, Mr. Chairman, we and our families live under the blanket of protection provided by America's firefighters, both career and volunteer, men and women who are willing to risk their lives to safeguard us, our loved ones, and our property. We may not often think about those sacrifices but every firefighter does.

Last year, more than 100 of them died in the line of duty, and tens of thousands more sustained injuries. To honor those sacrifices and to make our communities safer places to live, Congress has worked to become a partner with the fire departments across the Nation. Today we can reaffirm that commitment by reauthorizing two successful grant programs for firefighters: FIRE and SAFER.

I also want to mention a former fire chief from Pennsylvania who was also critically important in working on this legislation. He's no longer a Member of this body, Curt Weldon, a Member of the other side of the aisle. He and I cochaired the Fire Service Caucus for over 15 years. His leadership was critical in moving us towards the partnership of which I have just spoken between the Congress and the emergency responders throughout our country, career and volunteer.

This bill reauthorizes both programs through fiscal year 2014, pledging a total of $2.2 billion per year to our firefighters. The FIRE grant program authorizes $1 billion per year for state-of-the-art fire equipment, up-to-date training, and fire prevention programs. These competitive grants will benefit career, volunteer, and combination fire departments throughout the country. I know the chairman and subcommittee Chair have already spoken of what it will do, but I wanted to add as well State training academies and volunteer EMS departments, so critical to our emergency response strategies and team.

The SAFER grant program ensures that our community firehouses never have to sit empty: Its $1.2 billion per year will ensure 24-hour staffing at eligible departments so that there are always firefighters on duty in case of emergency. In fact, of course, it is the firefighters and emergency medical response teams that are usually the first on the scene at almost any disaster. It is therefore critical that they be available during a 24-hour, 7-day-a-week schedule. It also commits money each year to help volunteer departments recruit and retain new members.

Since FIRE's inception in 2000 and SAFER's in 2004, these programs have won support from Democrats and Republicans alike. This is truly a bipartisan effort on behalf of our communities. Our respect for firefighters and our commitment to get them the tools and training they need has transcended party lines, as it should have, and I hope today it will be no different and I know it will be no different.

I want to commend my colleagues HARRY MITCHELL and BILL PASCRELL, as I said, the father of the FIRE grants program, for their leadership on this issue, as well as Chairman GORDON and Chairman WU and my fellow Fire Caucus co-Chairs PETER KING, ROB ANDREWS, and JO ANN EMERSON.

I urge all of my colleagues to vote to reauthorize these grants and carry forward this successful and vital partnership.

Mr. SMITH of Nebraska. Mr. Chairman, I yield 1 minute to the gentleman from Indiana (Mr. BURTON).

Mr. BURTON of Indiana. I thank the gentleman from Nebraska for yielding this time.

I agree with everything the majority leader just said. You know, the firefighters of this country are not only protectors of us from a domestic standpoint; they are leaders in the war against terrorism.

We all remember what happened at 9/11 when so many firefighters gave their lives to try to protect those people who died in the Twin Towers in New York City. And we should not forget that because there is the threat of terrorism every single day in this country, and the frontline fighters, in addition to the policemen, are the firefighters. They're the ones that are going to have to rush in to protect people and save lives in the event that we have another tragedy like 9/11.

So I'd just like to say in the short time I have here today we need to give them every single tool they need. This is one area of government that's absolutely essential, and the firefighters of this country need to know the Congress of the United States is behind them 100 percent.

☐ 1315

Mr. GORDON of Tennessee. Mr. Chairman, I yield 1 minute to the gentlelady from Texas, a former member of the Science and Technology Committee, Ms. JACKSON-LEE.

Ms. JACKSON-LEE of Texas. I thank the distinguished chairman, and I thank him for his leadership. I rise to support H.R. 3791 and the $1 billion for the AFG per year, and the $1.2 billion for the SAFER. In my community, over the last 3 months we've had 17 fires in Heights and Shady Acres, putting firefighters in jeopardy and threatening lives. This legislation is enormously important, in that it allows cities over 2.5 million to get grants up to $9 million. I would be looking forward or like to look forward to work with the chairman to establish a study to determine the propensity of serial fire instigators, if you will, threatening the lives of firefighters, and I'd like to be able to work with the chairman on this crucial issue of providing a study so that we can emphasize these grants going to fight against serial fires.

I yield to the gentleman from Tennessee.

Mr. GORDON of Tennessee. My friend from Texas raises a valid point and an excellent point. You can be well assured that we will continue to work with you through this, through the conference process to bring your legitimate points to light.

Ms. JACKSON-LEE of Texas. Our community is in jeopardy, and this will be an important step for them. As a member of the Fire Caucus and Homeland Security, I rise to support the bill and thank you for working with me to help those in need in Houston, Texas.

Mr. SMITH of Nebraska. I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I yield 5 minutes to the gentleman from Oregon (Mr. WU), the chairman of the subcommittee.

Mr. WU. Mr. Chairman, I rise in strong support of this legislation, which reauthorizes the AFG and SAFER grant programs. These important programs help keep firefighters and the public safe, and I want to commend Chairman GORDON's leadership in bringing this crucial legislation to the floor today, Mr. MITCHELL's contributions to this legislation, Mr. HOYER for his crucial role in bringing this legislation to the floor, and Mr. PASCRELL for originating the legislation 9 years ago and carrying this bill for many years.

Over the past 9 years, the AFG program has provided nearly $5 billion in competitive awards to help local fire departments purchase equipment, training and other crucial resources.

This program has played a vital role in improving the readiness and capabilities of fire departments across the country.

Despite the program's success so far, an alarming number of local fire departments remain without adequate training and equipment. The AFG program helps address crucial shortfalls, and this bill will further empower the Federal Government to assist local fire departments as they improve their capabilities. AFG also supports fire prevention and safety grants, which help provide smoke detectors, fire prevention education, and research to reduce the causes of fire and fire-related injury and death. Three thousand Americans die every year in fires. We have made progress, and I'm proud of the progress the Science and Technology Committee has made in advancing the goals of the FIRE grant program.

This bill also reauthorizes the SAFER program, which provides funding to help fire departments maintain adequate staffing levels. Through the SAFER program, the Federal Government has provided nearly $700 million to local fire departments in the past 4 years, funding that is especially crucial during the current economic downturn. And I have to note that the changes in matching requirements are especially helpful in these hard economic times.

At a time when many local governments are facing major budget shortfalls and cuts in services, Federal support to fire departments is crucial to public safety. It is particularly important in Oregon, where the unemployment rate is at about 11½ percent. The bill is an important step forward in our efforts to protect communities across the country and the firefighters who serve them. I'm particularly proud of my subcommittee's work on this very important piece of legislation.

For more than 6 months it has worked with multiple fire service organizations to identify opportunities to improve the AFG and SAFER grant programs, culminating in hearings held earlier this year. In that context, I want to especially thank Meghan Housewright for her hard work in this field. The bill addresses the needs and priorities identified by fire service experts, and I'm grateful for the cooperation of the International Association of Fire Chiefs, the International Association of Fire Fighters, the National Volunteer Fire Council and the National Fire Protection Association and the Congressional Fire Services Institute. Your ability to come together on this legislation made our job much, much easier.

This bill improves both the SAFER and the AFG programs by ensuring that fire departments with the greatest need will be able to apply for funding. The bill also provides for an equitable balance in the distribution of grant funding, ensuring that funding will benefit communities, both large and small.

I would like to thank the ranking member of the Technology and Innovation Subcommittee, Mr. SMITH, for working closely with me. I would also like to thank the fire service organizations for their hard work in crafting this bill. I urge my colleagues to support this important legislation.

Mr. SMITH of Nebraska. I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I want to thank Chairman THOMPSON and Chairman OBERSTAR for working with me to get this important bill to the floor.

I would like to insert an exchange of committee correspondence in the RECORD at this time.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC, November 7, 2009.

Hon. BART GORDON,
Chairman, Committee on Science and Technology, House of Representatives, Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: I am writing you regarding H.R. 3791, the "Fire Grants Reauthorization Act of 2009," introduced on October 13, 2009. This legislation was initially referred to the Committee on Science and Technology and sequentially referred to the Committee on Homeland Security on November 6, 2009.

In the interest of permitting this important legislation to proceed expeditiously to floor consideration, I am willing to waive further consideration of H.R. 3791. I do so with the understanding that waiving further consideration of the bill should not be construed as the Committee on Homeland Security waiving, altering, or otherwise affecting its jurisdiction over subject matters contained in the bill which fall within its Rule X jurisdiction.

Further, I request your support for the appointment of Homeland Security conferees during any House-Senate conference convened on this or similar legislation. I also ask that a copy of this letter and your response be placed in the Congressional Record during floor consideration of this bill.

I look forward to working with you on this legislation and other matters of great importance to this nation.

Sincerely,

BENNIE G. THOMPSON,
Chairman.

HOUSE OF REPRESENTATIVES, COMMITTEE ON SCIENCE AND TECHNOLOGY,
Washington, DC, November 7, 2009.

Hon. BENNIE G. THOMPSON,
Chairman, Committee on Homeland Security, House of Representatives, Ford House Office Building, Washington, DC.

DEAR CHAIRMAN THOMPSON: Thank you for your letter regarding H.R. 3791, the Fire Grants Reauthorization Act of 2009. Your support for this legislation and your assistance in ensuring its timely consideration are greatly appreciated.

I agree that provisions in the bill are within the jurisdiction of the Committee on Homeland Security. I acknowledge that by waiving rights to further consideration of H.R. 3791, your Committee is not relinquishing its jurisdiction and I will fully support your request to be represented in a House-Senate conference on those provisions over which the Committee on Homeland Security has jurisdiction in H.R. 3791. A copy of our letters will be placed in the Congressional Record during consideration of the bill on the House floor.

I value your cooperation and look forward to working with you as we move ahead with this important legislation.

Sincerely,

BART GORDON,
Chairman.

HOUSE OF REPRESENTATIVES, COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC, November 12, 2009.

Hon. BART GORDON,
Chairman, Committee on Science and Technology, House of Representatives, Rayburn House Office Building, Washington, DC.

DEAR CHAIRMAN GORDON: I write to you regarding H.R. 3791, the "Fire Grants Reauthorization Act of 2009".

H.R. 3791 contains provisions that fall within the jurisdiction of the Committee on Transportation and Infrastructure. I recognize and appreciate your desire to bring this legislation before the House in an expeditious manner and, accordingly, I will not seek a sequential referral of the bill. However, I agree to waive consideration of this bill with the mutual understanding that my decision to forgo a sequential referral of the bill does not waive, reduce, or otherwise affect the jurisdiction of the Committee on Transportation and Infrastructure over H.R. 3791.

Further, the Committee on Transportation and Infrastructure reserves the right to seek the appointment of conferees during any House-Senate conference convened on this legislation on provisions of the bill that are within the Committee's jurisdiction. I ask for your commitment to support any request by the Committee on Transportation and Infrastructure for the appointment of conferees on H.R. 3791 or similar legislation.

Please place a copy of this letter and your response acknowledging the Committee on Transportation and Infrastructure's jurisdictional interest in the Committee Report on H.R. 3791 and in the Congressional Record during consideration of the measure in the House.

I look forward to working with you as we prepare to pass this important legislation.

Sincerely,

JAMES L. OBERSTAR, M.C.
Chairiman.

HOUSE OF REPRESENTATIVES, COMMITTEE ON SCIENCE AND TECHNOLOGY,
Washington, DC, November 12, 2009.

Hon. JAMES L. OBERSTAR,
Chairman, Committee on Transportation and Infrastructure, House of Representatives, Rayburn House Office Building, Washington, DC.

DEAR CHAIRMAN OBERSTAR: Thank you for your November 12, 2009 letter regarding H.R. 3791, the Fire Grants Reauthorization Act of 2009. Your support for this legislation and your assistance in ensuring its timely consideration are greatly appreciated.

I agree that provisions in the bill are of jurisdictional interest to the Committee on Transportation and Infrastructure. I acknowledge that by forgoing a sequential referral, your Committee is not relinquishing its jurisdiction and I will fully support your request to be represented in a House-Senate conference on those provisions over which the Committee on Transportation and Infrastructure has jurisdiction in H.R. 3791. A

copy of our letters will be placed in the Committee report on H.R. 3791 and in the Congressional Record during consideration of the bill on the House floor.

I value your cooperation and look forward to working with you as we move ahead with this important legislation.

Sincerely,

BART GORDON,
Chairman.

I would like to now yield 3 minutes to the gentleman from Mississippi and chairman of the Homeland Security Committee, Mr. THOMPSON.

Mr. THOMPSON of Mississippi. Mr. Chairman, I'd like to thank Chairman GORDON, Chairman WU and Mr. MITCHELL for working to move this important legislation. Every Member of this body represents a community that is secured by a firehouse. But in recent times, too many fire stations have had to short change their own training or community fire awareness programs just to stay operational.

Today, we have the opportunity to reaffirm our support for our hometown first responders by supporting H.R. 3791, the Fire Grants Reauthorization Act of 2009. This legislation seeks to enhance and improve two of FEMA's programs that directly award grants on a competitive basis to local fire stations and departments. This critical reauthorization will help ensure that departments large and small, volunteer and career, can continue to provide lifesaving services, including fire prevention and safety programs.

As a former volunteer firefighter, I'd like to thank Mr. PASCRELL, the gentleman from New Jersey, the father of the Assistance to Firefighter Grants program, for working to help pioneer the original program and working diligently to help produce this legislation. The so-called AFG grant and the SAFER grant programs provide funding directly to local fire departments so they can purchase needed equipment, conduct fire awareness and prevention service activities, insure that personnel are well trained for all of the duties, assignments as required for certification. And, in the case of SAFER, recruit and hire and retain firefighters without bureaucratic delays.

This bill also authorizes an additional $9.8 billion in funding for these vital programs. Mr. Chairman, within the AFG program, this bill revises grant allocations so that career volunteer and combination fire departments will have access to equal slices of the available grant dollar pie.

Mr. Chairman, I'd also like to say that during these tough economic times, many communities across America are being forced to cut back on public service. Cutbacks to public services should be avoided at all costs. Again, Mr. Chairman, the International Association of Fire Chiefs, Congressional Fire Service Institute, International Association of Volunteer Fire Fighters, National Volunteer Fire Council, National Fire Protection Association, all these organizations support this legislation.

Mr. Chairman, I urge my colleagues to support this bill.

Mr. SMITH of Nebraska. I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I now yield 2 minutes to the Chairman of the Transportation Committee, the gentleman from Minnesota, Chairman OBERSTAR, and I want to once again thank him for helping bring this bill to the floor.

Mr. OBERSTAR. Mr. Chairman, I do thank Chairman GORDON for the splendid work that his committee has done and the cooperation that we've had with the Committee on Science and Technology and that of the Committee on Homeland Security with the gentleman from Mississippi (Mr. THOMPSON). We've worked very well together and very diligently to bring this very important Fire Grants Reauthorization Act to the House floor.

Many fire departments in my district point with great pride and with gratitude to the fire trucks, the breathing equipment, the protective clothing, the radios, the other technology they have received through this valuable program. These are small grants, often just $2,500 to maybe a quarter of a million dollars for a new fire truck, but desperately needed in small communities and rural areas, replacing equipment, often more than 40 years old, or new gear to combat new issues such as fires at meth labs in the countryside or as we call it, the back woods of Northern Minnesota. The fire department needs that equipment, whether to combat a house fire or a chemical spill or a fire in the center of small communities.

The FIRE grants program goes back to the year 2000 and predates the horrific events of September 11. It was never intended to be a terrorism preparedness program, but the Department of Homeland Security made it one. And in recent years, I've been concerned by reports, and I've met with the small fire departments that didn't receive a grant because they could not show a specific connection to terrorism.

Our terror in Northern Minnesota is fire. Our terror is blizzards, tornados, floods. Those are the things that we need, and we need to be prepared for.

The CHAIR. The time of the gentleman has expired.

Mr. GORDON of Tennessee. I yield the gentleman 30 additional seconds.

Mr. OBERSTAR. There are a lot of organizations that support this legislation. I just want to mention Pete Makowski, my district staff person in Northern Minnesota who is a volunteer firefighter who has introduced me to these issues and to these concerns, has brought me together with the volunteer fire departments in my district. And I just want to say, the pleasure, the joy, the pride that those volunteer firefighters have in getting this small bit of assistance is overwhelming to me. I am so pleased that we have in this legislation very clear language that these small firefighting organizations do not have to show that they're combating weapons of mass destruction.

The CHAIR. The time of the gentleman has again expired.

Mr. SMITH of Nebraska. I would yield 30 seconds more to the Chairman of the Transportation Committee if he wishes to continue.

Mr. OBERSTAR. I thank the gentleman for the time.

I'm sure that the gentleman has the same experience with small volunteer firefighters who have to hire a grant application writer to fill out forms this thick. That's absurd. I think we changed that in this legislation and we take away this need to show a connection with terrorism. Our terror is fire. That's all we need to be prepared for.

Mr. SMITH of Nebraska. Mr. Chairman, I would also add briefly that, for right now, that the demands on volunteer fire departments are far greater than the population might reflect, especially when we talk about public lands and the susceptibility to fire in the midst of drought and other things as well.

I reserve the balance of my time.

Mr. GORDON of Tennessee. I thank my friend from Nebraska for his courtesy to Mr. OBERSTAR. I would request of the Chairman, what time is left for each side?

The CHAIR. The gentleman from Tennessee has 11½ minutes remaining. The gentleman from Nebraska has 22½ minutes remaining.

Mr. SMITH of Nebraska. I reserve the balance of my time.

□ 1330

Mr. GORDON of Tennessee. Mr. Chairman, as has been pointed out earlier, I'm not sure whether it's the godfather or the grandfather of the FIRE Grants program, Mr. PASCRELL from New Jersey. He is here, and he is recognized for 3 minutes.

Mr. PASCRELL. I want to thank Chairman BART GORDON; Subcommittee Chairman DAVE WU; Mr. MITCHELL; Chairman THOMPSON; and my friend who is not here today on the other side, PETER KING. They all deserve recognition as partners in this quest to get people's attention on the most neglected side of the public safety equation, our firefighters.

This legislation, we think, is unique. We had a difficult time in the beginning when were writing this legislation. It took about 2½ years. We had about enough people to fit in a telephone booth. And then we brought the firefighters to Washington, and all of a sudden, we had over 280 sponsors.

In the 106th Congress, prior to, the former speaker just pointed out, 9/11, that FIRE Act passed. It had bipartisan support. There was no Federal support for our brave firefighters, be they career or volunteer. They were working with outdated equipment. In some places in the country, they had to push the equipment to the fire, literally. They couldn't get the necessary training in order to provide the best protection for their local communities.

The one thing we made sure we took care of is that there would not be a differential, there would not be a firewall, so to speak, between the volunteers and the career. If you look at the grants of the first 5 or 6 years, there is an over-preponderance of volunteer departments, because we did not want to make this what so many bills in the past had been.

And I might add, Mr. Chairman, this money goes directly to the communities, no skimming, no nonsense: $6.5 billion, both of these bills, the SAFER bill, which deals with our personnel, in 9 years, over $15 billion requested. We are far from even close to responding to the needs that existed before 9/11.

This legislation, in its ranking and review, the FIRE Grants program itself received the second highest rating of any program in the Department of Homeland Security. The only agency that beat it out by one percentage point was the Secret Service.

Since the inception of the FIRE and SAFER grants, the programs have provided over, as I said, $6.5 billion for our local communities. And the point I want to make here is that the FIRE Grants programs are as vital and necessary today as they were in 2000.

The CHAIR. The time of the gentleman has expired.

Mr. GORDON of Tennessee. I yield the gentleman 1 additional minute.

Mr. PASCRELL. I have always said that real homeland security starts on the streets of our local towns and not in the hallways of Washington. I truly believe these FIRE grants awarded to local municipalities are key to our homeland security infrastructure. Today we move a great step toward furthering that commitment.

And just today, Mr. Chairman, on the west lawn outside the Capitol, firefighters, police officers and construction workers who responded at 9/11 gathered to hear what the Congress was going to do to respond to what had happened at 9/11. We salute them. We've had two major studies from Mount Sinai Hospital in New York. The ''all clear'' should not have been given to these people who worked in hazardous situations. We can again down the road to pass legislation to help these guys and gals that have suffered the consequences of their responding mostly, voluntarily.

I thank all of those who participated today.

Mr. SMITH of Nebraska. I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I yield 2 minutes to the gentlewoman from Colorado (Ms. MARKEY).

Ms. MARKEY of Colorado. Mr. Chairman, I rise today in support of the Fire Grants Reauthorization Act of 2009. From cities on Colorado's front range to small towns on the eastern plains, firefighters and other emergency personnel are the first to respond to everything from traffic accidents to wildfires. These brave men and women dedicate their lives to helping people and protecting their communities.

More than three-quarters of the fire departments in Colorado's Fourth District are mostly or entirely volunteer run. In addition to full-time jobs and families, these men and women devote their time and energy to help the small rural communities in which they live, often at great risk to themselves. In my district, last year, three brave volunteers lost their lives in the line of duty. Captain Shane Stewart, Fire Chief Terry DeVore and Firefighter John Schwartz, Jr., lost their lives while fighting to keep their rural communities safe.

Mr. Chairman, it is with the memory of these men who gave everything to defend their neighbors and communities that I am proud to stand here today as a cosponsor of the Fire Grants Reauthorization Act. I encourage all of my colleagues to support this important reauthorization, because these grant programs help support the operations of all fire departments, urban and rural, career and volunteer, and protect the lives of the men and women who selflessly serve to protect their communities.

The CHAIR. The gentleman from Tennessee has 6 minutes remaining. The gentleman from Nebraska has 22½ minutes remaining.

Mr. SMITH of Nebraska. I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I yield 2 minutes to the gentlewoman from Arizona (Mrs. KIRKPATRICK).

Mrs. KIRKPATRICK of Arizona. Mr. Chairman, this spring my office was approached by two fire chiefs with the same problem. Chief Casson of the Cottonwood Fire Department and Chief Moore of the Clarkdale Fire Department both explained that for their small departments, SAFER grants can make all the difference in whether they have the number of firefighters on staff required to keep their communities safe.

With the economic downturn, SAFER has become more important than ever, but falling tax revenues make meeting the matching requirement difficult. This has happened to small fire departments across the Nation. Many have even returned the grants they were awarded.

This is why I introduced H.R. 2759, which would waive the cost-sharing requirement for the most recent grant cycle, helping departments hire the staff they need during this tough time. While my legislation is not specifically contained within this act, I am glad that this bill significantly improves the SAFER program to help departments with these conditions.

This act reduces the overall cost-share requirement for departments and, more importantly, allows the director to waive this requirement in the case of economic hardship. Therefore, in the future, the departments with the greatest need should be able to take advantage of this program.

Mr. Chairman, will you work with me to ensure that the SAFER works as intended, helps the departments most in need, and addresses the concerns of small, rural fire departments?

Mr. GORDON of Tennessee. Will the gentlewoman yield?

Mrs. KIRKPATRICK of Arizona. I yield to the chairman.

Mr. GORDON of Tennessee. I would like to thank the gentlewoman for her efforts with the SAFER program and her support for the bill.

You raise a very good point that fire departments in many communities are struggling with shrinking budgets. Some of these struggling communities do have SAFER grants. I would be happy to work with you on this issue as we work to enact this legislation into law.

Mr. SMITH of Nebraska. Mr. Chairman, I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I yield 2 minutes to a very active member of our committee, the gentleman from New Mexico (Mr. LUJÁN).

Mr. LUJÁN. Mr. Chairman, I rise in strong support of the Fire Grants Reauthorization Act of 2009.

It has been almost 10 years since the Cerro Grande fire ripped through thousands of acres in my district in northern New Mexico with devastating effect for the wildlife, the environment and the people in its path. Drought conditions and high temperatures contributed to the size of this fire, while dry winds accelerated its path through Los Alamos. Each year, fires plague our communities. They hurt people. They devastate communities. They devastate families. But when we can come together and make sure that we are working to provide support for our local fire departments, for our first responders and for those that put their lives on the line every day, we are able to make a difference.

These FIRE grants will provide volunteer and career fire departments across the country with vital funding to increase firefighting capabilities, better respond to medical emergencies, handle natural disasters and operate more effectively.

Supporting local fire departments is more important now than ever before. Now that States are facing many budgetary shortfalls, it has become increasingly difficult for local governments to maintain the equipment and training necessary.

Mr. Chairman, as we came down today, I was reminded of a chief in New Mexico who lost his life responding to a fire about a week after he had just gotten word that he had received a grant for the fire district to replace the truck that broke down in the midst of a range fire that he lost his life in. These grants make a difference in people's lives. To his wife, to his spouse, that fought so hard with us in New Mexico to get a fire fund in place to be able to help us out locally, I commend my colleagues here, the chairman, Mr. PASCRELL for making this happen, and for believing in firefighters and for making sure that we in Congress are doing our part to get funding to them.

The CHAIR. The gentleman from Tennessee has 2 minutes remaining and has the right to close.

Mr. SMITH of Nebraska. Mr. Chairman, I would inquire of the committee chairman how much time he is looking to need, perhaps.

Mr. GORDON of Tennessee. You are courteous to ask. I think we have marshaled it just right. We have 2 more minutes and one speaker.

Mr. SMITH of Nebraska. I would yield 2 minutes to the chairman if he would wish to use that.

Mr. GORDON of Tennessee. Again, I thank you for the courtesy. I believe we are going to be able to do it, but thank you very much.

Mr. SMITH of Nebraska. I would reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I would yield 1½ minutes to my friend from St. Louis, Missouri (Mr. CARNAHAN).

Mr. CARNAHAN. Thank you, Mr. Chairman, and the gentleman from Nebraska for managing this today.

On behalf of the firefighters, the amazing firefighters that serve my constituents in Missouri, I rise today in strong support of the Fire Grants Reauthorization Act of 2009. H.R. 3791 reauthorizes and improves the FIRE and SAFER Grant programs which assist firefighters, first responders and local communities in my home State of Missouri and nationwide with the equipment, training, and personnel needed to protect the public.

In these difficult economic times, it is imperative that we provide local fire departments around the country the needed equipment, training and staffing for both full-time and volunteer firefighters, urban and rural, to quickly respond to emergencies.

This legislation will reduce the grantee matching requirement at a time when many jurisdictions are finding it increasingly difficult or impossible to maintain equipment, training, and personnel. FIRE grants will provide funding to hire additional personnel, modify facilities, and obtain protective gear and other resources to respond to fire and related hazards.

I'm pleased to be a cosponsor of this legislation and to have joined my colleagues on the Science and Technology Committee to bring it to the floor. I now urge the full House to support and pass the Fire Grants Reauthorization Act of 2009.

Mr. SMITH of Nebraska. I would reserve the balance of my time.

Mr. GORDON of Tennessee. I will use the remainder of my time to close, so if the gentleman would like to close.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman. I will be very brief. We were expecting some other Members here. But I will say that I appreciate the process that we have gone through this. It involved quite a bit of discussion early on at the subcommittee level and full committee level. I'm grateful that the chairman considered amendments from our side so that we can meet the public safety needs of our country. It's not just about my district, it's not just about certain districts, but the entire country. I'm grateful to be a part of this process, and I will say it does work.

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

Mr. GORDON of Tennessee. Mr. Chairman, in quick closing, I want to concur with Mr. SMITH's remarks, thanking him for his cooperation. This has been a good subcommittee, committee process. It has been bipartisan. And because of that, we have a good bill.

Ms. RICHARDSON. Mr. Chair, as a member of the Committee on Homeland Security and an original co-sponsor, I rise in strong support of H.R. 3791, the Fire Grants Reauthorization Act of 2009, which reauthorizes for five years $1 billion per year for FEMA's Assistance to Firefighters Grants (AFG) program and reauthorizes $1.2 billion for the Staffing for Adequate Fire and Emergency Response (SAFER) program.

This increase in federal support for the nation's fire departments is especially important in this tough economy as local officials struggle to provide critical services—including public safety services—in the face of declining revenues and decreasing budgets.

I thank Chairman GORDON and my colleague, Congressman MITCHELL of Arizona, for their hard work in shepherding this critical legislation to the floor today.

We all remember the wildfires from this summer that hit my home state of California especially hard. Over 160,000 acres were destroyed in the "Station Fire," the most in the history of Los Angeles County. But not only did people lose their homes in this terrible tragedy, two firefighters lost their lives as well. Incidents like these underscore the importance of providing firefighters with the best possible equipment and training to perform their dangerous jobs. And that is probably the most important reason of all for passing H.R. 3791, the Fire Grants Reauthorization Act of 2009.

Mr. Chair, I support H.R. 3791 because it:

Provides a fairer distribution of FIRE Grant funding among fire departments by setting a 25 percent distribution of the appropriated funds among the categories of career, volunteer and combination fire departments;

Lowers matching and maintenance of expenditure requirements and authorizes the FEMA Administrator to waive or reduce such requirements for applicants facing demonstrated economic hardship;

Raises the limit on FIRE Grant awards to $9 million for jurisdictions based on population so that large urban areas with population more than 2.5 million like the one I represent.

Makes the SAFER Grant program more accessible to fire departments by making it a three-year program with a 20 percent match.

Raises the maximum amount for individual Fire Prevention and Safety Grants to $1.5 million.

Mr. Chair, in the last nine years the Assistance to Firefighters Grant (AFG) program, or FIRE grant program, has aided thousands of fire departments nationwide by providing more than $5 billion in federal aid for critically-needed training, equipment, health and wellness programs and other fire service needs.

The Staffing for Adequate Fire and Emergency Response or "SAFER" program has provided nearly $700 million to fire departments to help hire and retain firefighters since its creation in 2004.

Yet, despite the success of the programs, effectiveness has been curtailed by the uneven distribution of grants among jurisdictions of varying sizes. Statutory restrictions have inadvertently hampered larger fire departments that protect the majority of the population from receiving much-needed federal assistance. As a result, the majority of FIRE Grant funds currently are being spent to protect a relatively small portion of the population. H.R. 3791 corrects this imbalance by targeting more funding to larger fire departments in the more populous jurisdictions.

Mr. Chair, H.R. 3791 is the product of bipartisan cooperation and is broadly supported by the firefighting community because it strikes an equitable balance in the distribution of the grants so that the funding can benefit all types of communities and ensures that fire departments with the greatest need can apply for and receive funding in amounts sufficient to address their real needs. That is why this legislation is broadly supported by the firefighting and fire prevention community, including the following major organizations: the International Association of Fire Chiefs, the National Fire Protection Association, the National Volunteer Fire Council, the International Association of Fire Fighters, the International Association of Arson Investigators, and the Congressional Fire Services Institute.

Mr. Chair, H.R. 3791 is good for our firefighters. It is good for our local governments. It is good for the nation and good for my district. I am proud to be an original co-sponsor of the critical legislation and urge my colleagues to join me in voting for its passage.

Mr. DINGELL. Mr. Chair, I rise today to support H.R. 3791, the Fire Grants Reauthorization Act. This act reauthorizes the Assistance

to Firefighters Grant, AFG, program and the Staffing for Adequate Fire and Emergency Response, SAFER, grant program. These two successful programs provide critical support for our Nation's fire departments and Emergency Medical Services, EMS, organizations, thus enabling our firefighters and emergency personnel to adequately respond to fire emergencies in our communities.

H.R. 3791 authorizes $1 billion per year for the AFG program for fiscal years, FY, 2010 through 2014 and $1.2 billion per year for the SAFER program for FY 2010 through FY 2014. The AFG program, created in 2000, provides grants to local fire departments and related EMS organizations to provide them needed equipment, training, vehicles and other resources. The SAFER, created in 2004, program provides grants to local fire departments to increase their staffing and deployment capabilities.

Both programs have proven highly successful. In 2003, the U.S. Department of Agriculture's Leadership Development Academy Execptive Potential Program independent assessment of the AFG program concluded it was "highly effective in improving the readiness and capabilities of firefighters across the nation." Since that time, the program has received high marks from Department of Homeland Security, DHS, Inspector General as well as the Bush Administration's budgetary program evaluation tool. And since 2004, the SAFER program has been ensuring that our local fire departments can provide 24-hour staffing to so that they can respond to our communities during emergencies.

Unfortunately, during times of economic hardship, public safety budgets are often hard hit. Thus, the importance of continued Federal support for these programs cannot be underestimated. That is why this legislation lowers the matching requirement from 20 percent to 10 percent for the AFG program and allows the DHS to waive cost share requirements for the SAFER program in times of economic hardship.

In addition, H.R. 3791 ensures that funding to our career and volunteer fire departments is equitable by requiring that AFG funds are apportioned in the following way: 25 percent to career fire departments, 25 percent to combination fire departments, and 25 percent to volunteer fire departments, 10 percent for open competition among all types of fire departments, and the remaining 15 percent for certain other important functions, including ire prevention and safety grants.

Mr. Chair, the fire grants program has directly benefited the 15th Congressional District of Michigan, including Frenchtown Township, Ypsilanti, Monroe, Woodhaven, Flat Rock, Romulus, and many other communities I have the honor of representing. Clearly, these programs are a boon to other communities across our country. That is why I strongly urge my colleagues to join me in voting "yes" on H.R. 3791.

Mr. KING of New York. Mr. Chair, I rise to express my support for H.R. 3791, the Fire Grants Reauthorization Act of 2009. The Fire and SAFER grant programs reauthorized by this bill are highly effective and vitally important programs which provide much-needed support to fire departments and emergency responders across the country.

As chairman of the Congressional Fire Services Caucus and ranking member of the Homeland Security Committee, I strongly support reauthorization of these two grant programs. First responders rely on Fire grants for the training, vehicles, and equipment that are necessary to keep our communities safe, while SAFER grants provide the necessary funds to hire and train new firefighters and to help recruit and train volunteer firefighters.

In 2008 alone, the Fire grant program received $3.2 billion in requests for grants, which highlights a serious need in the firefighter and first responder community for more resources. I continue to support strong funding for both the Fire and SAFER programs. I am pleased that H.R. 3791 authorizes $1 billion annually for the Fire program and approximately $1.2 billion annually for the SAFER program over the next 5 years.

The Fiscal Year 2010 Homeland Security Appropriations Act that passed the House in June provided double the amount of funding for the SAFER program over last year. However, I am disappointed that the final funding level approved by Congress for the Fire grant program in Fiscal Year 2010 is $175 million less than last year's funding for that program. Both of these programs merit robust funding.

The bill under consideration today incorporates the unified recommendations of the major fire service organizations that represent volunteer, career, and combination fire departments across the country.

For example, this bill adds an "economic hardship waiver" for the Fire grant program for fire departments that are unable to meet certain matching requirements or budget requirements. In addition, the bill adds an economic hardship waiver to allow fire departments to retain staff with SAFER grant funds whom they would otherwise have to lay off in these difficult economic times. This bill also allots 10 percent of Fire grants to the Fire Prevention and Safety program, which is up from 5 percent in previous years.

I hope that both the Fire and SAFER grant programs will see continued support from this administration and the Democratic leadership.

I urge my colleagues to support passage of this important bill.

Mr. GENE GREEN of Texas. Mr. Chair, I rise today in support for H.R. 3791, the Fire Grants Reauthorization Act of 2009, introduced by my good friend Representative HARRY MITCHELL.

H.R. 3791 will reauthorize the FIRE Grants programs—comprised of the Assistance to Firefighter Grant, AFG, program and the Staffing for Adequate Fire and Emergency Response, SAFER, grant program—to ensure that our local firefighters have the tools and resources they need to keep us safe and secure.

Since 2001, the Fire Grants Programs have provided more than $5 billion in support to local fire departments across the Nation, $190 million of which has gone to support Texas fire departments. H.R. 3791 provides a 5-year reauthorization of $1 billion per year for the AFG and $1.194 billion for the SAFER programs.

The AFG program was created to address concerns that local budgets were unable to handle the mounting responsibilities allocated to the fire service by providing funds to local fire departments to purchase equipment, vehicles, and training. The SAFER program assists fire departments in hiring quality personnel and ensuring that volunteers meet the required safety standards. Funding through these programs has been a valuable tools in helping local fire departments provide emergency response services to their communities.

The changes made to the AFG and SAFER programs in H.R. 3791 will improve these programs by allowing funding to be used for certain volunteer emergency medical services organizations and for building inspector certifications.

I want to thank Representative MITCHELL for his hard work in crafting this legislation which reflects bipartisan cooperation and is supported by the International Association of Fire Chiefs, the International Association of Fire Fighters, the National Volunteer Fire Council, the National Fire Protection Association, and the Congressional Fire Services Institute.

All fire departments, including those in our congressional district in Texas, strive to provide a superior level of emergency service that continually improves the quality of life, health and safety of our residents, and I am proud to support legislation that will ensure that they can achieve those goals.

Mr. VAN HOLLEN. Mr. Chair, I rise in support of H.R. 3791, the Fire Grants Reauthorization Act.

The economic downturn is adversely affecting the budgets of local governments and threatening a range of emergency services that communities count on. As declining state revenues force governors and city managers to make difficult choices, the budgets for programs that assist firefighters, first responders, and local communities nationwide with the equipment, training, and personnel have all been reduced.

To help ease some of the burden, the Recovery Act and the FY09 Supplemental Appropriations Act included provisions designed to enhance the existing resources of the SAFER and AFG programs by waiving the matching requirements and restrictions for fiscal years 2009 and 2010. But, the Assistance to Firefighter Grant and the SAFER grants programs will expire in FY 2009 and FY 2010. We gather here today to reauthorize these programs until 2014.

Today, not only must fire departments fight fires, they must also handle emergency medical services, and serve as first responders in the case of terrorist attacks or natural disasters. As the array of tasks falling to local fire departments has grown, SAFER and AFG grants have helped local communities keep pace.

In addition to reauthorizing these two vital programs, H.R. 3791 permits the use of grant funds for volunteer and non-fire service emergency medical services organizations, increases funding for fire prevention and firefighter safety programs, and covers matching and maintenance requirements for fire departments facing economic hardship.

Mr. Chair, these programs are vital to the safety and welfare of the American people. They need to be reauthorized.

I encourage my colleagues to join me in support of H.R. 3791.

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

The CHAIR. All time for general debate has expired.

Pursuant to the rule, the amendment in the nature of a substitute printed in the bill, modified by the amendment printed in part A of House Report 111–340, shall be considered as an original bill for the purpose of amendment and shall be considered as read.

The text of the amendment in the nature of a substitute, as amended, is as follows:

H.R. 3791

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Fire Grants Reauthorization Act of 2009''.

SEC. 2. ASSISTANCE TO FIREFIGHTERS GRANT PROGRAM REAUTHORIZATION.

(a) IN GENERAL.—Section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229) is amended to read as follows:

''SEC. 33. FIREFIGHTER ASSISTANCE.

''(a) ASSISTANCE PROGRAM.—

''(1) AUTHORITY.—In accordance with this section, the Director may—

''(A) make grants on a competitive basis directly to fire departments of a State, in consultation with the chief executive of the State, for the purpose of protecting the health and safety of the public and firefighting personnel throughout the Nation against fire and fire-related hazards;

''(B) make grants on a competitive basis directly to State fire training academies, in consultation with the chief executive of the State, in accordance with paragraph (11)(C);

''(C) provide assistance for fire prevention and firefighter safety research and development programs and fire prevention or fire safety programs and activities in accordance with paragraph (4); and

''(D) provide assistance for volunteer, non-fire service EMS and rescue organizations for the purpose of paragraph (3)(F).

''(2) ADMINISTRATIVE ASSISTANCE.—The Director shall establish specific criteria for the selection of recipients of assistance under this section and shall provide grant-writing assistance to applicants.

''(3) USE OF FIRE DEPARTMENT GRANT FUNDS.—The Director may make a grant under paragraph (1)(A) only if the applicant for the grant agrees to use the grant funds for one or more of the following purposes:

''(A) To hire additional firefighting personnel.

''(B) To train firefighting personnel in firefighting, emergency medical services and other emergency response (including response to a terrorism incident or use of a weapon of mass destruction), arson prevention and detection, maritime firefighting, or the handling of hazardous materials or to train firefighting personnel to provide any of the training described in this subparagraph.

''(C) To fund the creation of rapid intervention teams to protect firefighting personnel at the scenes of fires and other emergencies.

''(D) To certify fire and building inspectors employed by a fire department or serving as a volunteer building inspector with a fire department.

''(E) To establish wellness and fitness programs for firefighting personnel to ensure that the firefighting personnel can carry out their duties, including programs dedicated to raising awareness of, and prevention of, job-related mental health issues.

''(F) To fund emergency medical services provided by fire departments and volunteer, non-fire service EMS and rescue organizations.

''(G) To acquire additional firefighting vehicles, including fire trucks.

''(H) To acquire additional firefighting equipment, including equipment for communications, monitoring, and response to a terrorism incident or use of a weapon of mass destruction.

''(I) To acquire personal protective equipment required for firefighting personnel by the Occupational Safety and Health Administration and other personal protective equipment for firefighting personnel, including protective equipment to respond to a terrorism incident or the use of a weapon of mass destruction.

''(J) To modify fire stations, fire training facilities, and other facilities to protect the health and safety of firefighting personnel.

''(K) To enforce fire codes and standards.

''(L) To fund fire prevention programs.

''(M) To educate the public about arson prevention and detection.

''(N) To provide incentives for the recruitment and retention of volunteer firefighting personnel for volunteer firefighting departments and other firefighting departments that utilize volunteers.

''(4) FIRE PREVENTION AND FIREFIGHTER SAFETY RESEARCH AND DEVELOPMENT PROGRAMS.—

''(A) IN GENERAL.—For each fiscal year, the Director shall use not less than 10 percent of the funds made available under subsection (e)—

''(i) to make grants to fire departments for the purpose described in paragraph (3)(L);

''(ii) to make grants to, or enter into contracts or cooperative agreements with, national, State, local, or community organizations that are not fire departments but—

''(I) that are recognized for their experience and expertise with respect to fire prevention or fire safety programs and activities and that partner with fire departments, for the purpose of carrying out such programs and activities;

''(II) engage in fire- and life safety-related activities as a primary purpose or function, for the purpose of carrying out fire prevention or fire safety programs and activities; or

''(III) that are recognized for their experience and expertise with respect to firefighter research and development programs, for the purpose of carrying out research on fire prevention or fire safety programs and activities or to improve firefighter health and life safety; and

''(iii) if the Director determines that it is necessary, to make grants or enter into contracts in accordance with subsection (c).

''(B) PRIORITY.—In selecting organizations described in subparagraph (A)(ii) to receive assistance under this paragraph, the Director shall give priority to organizations that focus on prevention of injuries to high risk groups from fire, as well as research programs that demonstrate the potential to improve firefighter safety.

''(C) GRANT LIMITATION.—A grant under this paragraph shall not exceed $1,500,000 for a fiscal year.

''(D) LIMITATION.—None of the funds made available under this paragraph may be provided to the Association of Community Organizations for Reform Now (ACORN) or any of its affiliates, subsidiaries, or allied organizations.

''(5) APPLICATION.—The Director may provide assistance to a fire department or organization (including a State fire training academy) under this subsection only if the fire department or organization seeking the assistance submits to the Director an application that meets the following requirements:

''(A) FORM.—The application shall be in such form as the Director may require.

''(B) INFORMATION.—The application shall include the following information:

''(i) Information that demonstrates the financial need of the applicant for the assistance for which applied.

''(ii) An analysis of the costs and benefits, with respect to public safety, of the use of the assistance.

''(iii) An agreement to provide information to the national fire incident reporting system for the period covered by the assistance.

''(iv) A list of other sources of Federal funding received by the applicant.

''(v) Any other information that the Director may require.

''(C) UNNECESSARY DUPLICATION.—The Director, in coordination with the Secretary of Homeland Security, shall use the list provided under subparagraph (B)(iv) to prevent the unnecessary duplication of grant funds.

''(6) MATCHING REQUIREMENT.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C) and paragraph (8), the Director may provide assistance under this subsection only if the applicant for such assistance agrees to match 10 percent of such assistance for any fiscal year with an equal amount of non-Federal funds.

''(B) REQUIREMENT FOR SMALL COMMUNITY ORGANIZATIONS.—In the case of an applicant whose personnel serve jurisdictions of 20,000 or fewer residents, the percent applied under the matching requirement of subparagraph (A) shall be 5 percent.

''(C) FIRE PREVENTION AND FIREFIGHTER SAFETY GRANTS EXCEPTION.—There shall be no matching requirement for a grant described in paragraph (4).

''(7) MAINTENANCE OF EXPENDITURES.—Subject to paragraph (8), the Director may provide assistance under this subsection only if the applicant for the assistance agrees to maintain in the fiscal year for which the assistance will be received the applicant's aggregate expenditures for the uses described in paragraph (3) or (4) at or above 80 percent of the average level of such expenditures in the 2 fiscal years preceding the fiscal year for which the assistance will be received.

''(8) ECONOMIC HARDSHIP WAIVER.—

''(A) IN GENERAL.—In exceptional circumstances, the Director may waive or reduce the matching requirement under paragraph (6) and the maintenance of expenditures requirement under paragraph (7) for applicants facing demonstrated economic hardship.

''(B) CRITERIA DEVELOPMENT.—The criteria under which the Director may waive or reduce such requirements shall be developed in consultation with individuals who are—

''(i) recognized for expertise in firefighting, emergency medical services provided by fire services, or the economic affairs of State and local governments; and

''(ii) members of national fire service organizations or national organizations representing the interests of State and local governments.

''(C) PUBLIC AVAILABILITY.—The Director shall make the criteria developed under subparagraph (B) publicly available.

''(9) VARIETY OF FIRE DEPARTMENT GRANT RECIPIENTS.—

''(A) IN GENERAL.—Of the amounts made available under subsection (e), the Director shall ensure that grants under paragraph (1)(A) for a fiscal year are allocated, to the extent that there are eligible applicants to carry out the activities under paragraph (3), as follows:

''(i) 25 percent shall be made available to career fire departments.

''(ii) 25 percent shall be made available to volunteer fire departments.

''(iii) 25 percent shall be made available to combination fire departments.

''(B) EVALUATION CRITERIA.—

''(i) IN GENERAL.—In awarding grants under paragraph (1)(A), the Director shall, within each category of applicants under subparagraph (A), consider a broad range of factors important to the applicant's ability to respond to fires and related hazards, such as population served, geographic response area, hazard vulnerability,

call volume, financial situation, and need for training or equipment.

''(ii) HIGH POPULATION AND INCIDENT RESPONSE.—In considering such factors under clause (i), applicants serving areas with high population and with a high number of incidents requiring a response shall receive a higher level of consideration.

''(iii) PROHIBITED BASIS FOR DENIAL.—In considering such factors under clause (i), the Director may not deny a grant to an applicant solely based on such applicant failing to demonstrate that the grant will be used to prepare for or respond to a terrorism incident or use of a weapon of mass destruction.

''(C) REMAINDER.—Of the amounts made available under subsection (e) that are not allocated for use and awarded under subparagraph (A) or designated for use under any other provision of this section, the Director shall provide for an open competition for grants among career fire departments, volunteer fire departments, and combination fire departments to carry out the activities under paragraph (3).

''(10) REPORT TO THE DIRECTOR.—The Director may provide assistance under this subsection only if the applicant for the assistance agrees to submit to the Director a report, including a description of how the assistance was used, with respect to each fiscal year for which the assistance was received.

''(11) GRANT LIMITATIONS.—

''(A) RECIPIENT LIMITATIONS.—A grant recipient under paragraph (1)(A)—

''(i) that serves a jurisdiction with 100,000 people or less may not receive grants in excess of $1,000,000 for any fiscal year;

''(ii) that serves a jurisdiction with more than 100,000 people but less than 500,000 people may not receive grants in excess of $2,000,000 for any fiscal year;

''(iii) that serves a jurisdiction with 500,000 people or more but less than 1,000,000 people may not receive grants in excess of $3,000,000 for any fiscal year;

''(iv) that serves a jurisdiction with 1,000,000 people or more but less than 2,500,000 people may not receive grants in excess of $6,000,000 for any fiscal year; and

''(v) that serves a jurisdiction with 2,500,000 people or more may not receive grants in excess of $9,000,000 for any fiscal year.

The Director may award grants in excess of the limitations provided in clauses (i), (ii), (iii), and (iv) if the Director determines that extraordinary need for assistance by a jurisdiction warrants a waiver.

''(B) LIMITATION ON EXPENDITURES FOR FIREFIGHTING VEHICLES.—Not more than 25 percent of the funds appropriated to provide grants under this section for a fiscal year may be used to assist grant recipients to purchase vehicles, as authorized by paragraph (3)(G).

''(C) STATE FIRE TRAINING ACADEMIES.—

''(i) IN GENERAL.—In accordance with clause (ii), the Director shall award not more than 3 percent of the amounts made available under subsection (e) for a fiscal year for grants under this subsection for State fire training academies.

''(ii) LIMITATION.—The Director shall—

''(I) award not more than 1 grant under this subparagraph per State in a fiscal year;

''(II) limit the amount of a grant to a State fire training academy to less than or equal to$1,000,000 in each fiscal year; and

''(III) ensure that any grant awarded to a State fire training academy shall be used for the purposes described in paragraphs 3(G), 3(H), or 3(I).

''(D) REQUIREMENTS FOR GRANTS FOR EMERGENCY MEDICAL SERVICES.—The Director shall award not more than 2 percent of the amounts made available under subsection (e) for a fiscal year to volunteer, non-fire service EMS and rescue organizations for the purposes described in paragraph (3)(F).

''(E) APPLICATION OF SELECTION CRITERIA TO GRANT APPLICATIONS FROM VOLUNTEER, NON-FIRE SERVICE EMS AND RESCUE ORGANIZATIONS.—In reviewing applications submitted by volunteer, non-fire service EMS and rescue organizations, the Director shall consider the extent to which other sources of Federal funding are available to provide the assistance requested in such grant applications.

''(F) CONSENSUS STANDARDS.—

''(i) IN GENERAL.—Any grant amounts used to obtain training under this section shall be limited to training that complies with applicable national voluntary consensus standards (if applicable national voluntary consensus standards have been established), unless a waiver has been granted under clause (ii).

''(ii) WAIVER.—

''(I) EXPLANATION FOR NON-STANDARD TRAINING.—If an applicant for a grant seeks to use the assistance provided under the grant to obtain training that does not meet or exceed applicable voluntary consensus standards, the applicant shall include in the application an explanation of why such training will serve the needs of the applicant better than training that does meet or exceed such standards.

''(II) PROCEDURES.—In making a determination whether or not to waive the requirement under clause (i) with respect to a specific standard, the Director shall, to the greatest extent practicable—

''(aa) consult with other members of the fire services regarding the impact on fire departments of the requirement to meet or exceed the specific standard;

''(bb) take into consideration the explanation provided by the applicant under subclause (I); and

''(cc) seek to minimize the impact of the requirement to meet or exceed the specific standard on the applicant, particularly if meeting the standard would impose additional costs.

''(III) ADDITIONAL REQUESTS.—Applicants that apply for a grant under the terms of subclause (I) may include a second grant request in the application to be considered by the Director in the event that the Director does not approve the primary grant request on the grounds of the training not meeting applicable voluntary consensus standards.

''(12) ELIGIBLE GRANTEE ON BEHALF OF ALASKA NATIVE VILLAGES.—The Alaska Village Initiatives, a non-profit organization incorporated in the State of Alaska, shall be considered an eligible grantee for purposes of receiving assistance under this section on behalf of Alaska Native villages.

''(13) ANNUAL MEETING.—The Director shall convene an annual meeting of individuals who are members of national fire service organizations and are recognized for expertise in firefighting or emergency medical services provided by fire services, and who are not employees of the Federal Government, for the purpose of recommending criteria for awarding grants under this section for the next fiscal year and any necessary administrative changes to the grant program.

''(14) GUIDELINES.—

''(A) IN GENERAL.—Each year, prior to ''accepting any application for a grant under each program'' under this section, the Director shall publish in the Federal Register—

''(i) guidelines that describe the process for applying for grants and the criteria for awarding grants;

''(ii) an explanation of any differences between the guidelines and the recommendations made pursuant to paragraph (13); and

''(iii) the criteria developed under paragraph (8) which the Director will use to evaluate applicants for waivers from program requirements.

''(B) SPECIFIC REQUIREMENT.—The criteria for awarding grants under paragraph (1)(A) shall include the extent to which the grant would enhance the daily operations of the applicant and the impact of such a grant on the protection of lives and property.

''(15) PEER REVIEW.—The Director, after consultation with national fire service organizations, shall appoint fire service personnel to conduct peer review of applications received under paragraph (5). In making grants under this section, the Director shall consider the results of such peer review evaluations.

''(16) APPLICABILITY OF FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to activities under paragraphs (13) and (15).

''(17) ACCOUNTING DETERMINATION.—Notwithstanding any other provision of law, rule, regulation, or guidance, for purposes of receiving assistance under this section, equipment costs shall include all costs attributable to any design, purchase of components, assembly, manufacture, and transportation of equipment not otherwise commercially available.

''(b) AUDITS.—A recipient of a grant under this section shall be subject to audits to ensure that the grant proceeds are expended for the intended purposes and that the grant recipient complies with the requirements of paragraphs (6) and (7) of subsection (a) unless the Director has granted a waiver under subsection (a)(8).

''(c) FIRE SAFETY RESEARCH CENTERS.—

''(1) IN GENERAL.—The Director may make a grant under subsection (a)(4)(A)(iii) to an institution of higher education, a national fire service organization, or a national fire safety organization to establish and operate a fire safety research center.

''(2) OBJECTIVES.—A grant received under this subsection shall be used by such an institution or organization to advance significantly the Nation's ability to reduce the number of fire-related deaths and injuries among firefighters and the general public through research, development, and technology transfer activities.

''(3) LIMITATION.—The Director may establish no more than 3 fire safety research centers. An institution of higher education, a national fire service organization, or a national fire safety organization may not directly receive a grant under this section for a fiscal year for more than 1 fire safety research center.

''(4) APPLICATION.—In order to be eligible to receive a fire safety research center grant, an institution of higher education, a national fire service organization, or a national fire safety organization shall submit to the Director an application that is in such form and contains such information and assurances as the Director may require.

''(5) GENERAL SELECTION CRITERIA.—The Director shall select each recipient of a grant under this subsection through a competitive process on the basis of the following:

''(A) The demonstrated research and extension resources available to the recipient to carry out the research, development, and technology transfer activities.

''(B) The capability of the recipient to provide leadership in making national contributions to fire safety.

''(C) The recipient's ability to disseminate the results of fire safety research.

''(D) The strategic plan the recipient proposes to carry out under the grant.

''(6) CONSIDERATION.—The Director shall give special consideration under paragraph (5) to an applicant for a grant that consists of a partnership between a national fire service organization or a national fire safety organization and at least 1 of the following:

''(A) An institution of higher education.

''(B) A minority-serving institution (defined as an eligible institution under section 371(a) of

the Higher Education Act of 1965 (20 U.S.C. 1067q(a))).

''(7) RESEARCH NEEDS.—Within 90 days after the date of enactment of the Fire Grants Reauthorization Act of 2009, the Director shall convene a workshop of the fire safety research community, fire service organizations, and other appropriate stakeholders to identify and prioritize fire safety research needs. The results of the workshop shall be made public, and the Director shall consider such results in making awards under this section.

''(d) DEFINITIONS.—In this section, the following definitions apply:

''(1) CAREER FIRE DEPARTMENT.—The term 'career fire department' means a firefighting department that has an all professional force of firefighting personnel.

''(2) COMBINATION FIRE DEPARTMENT.—The term 'combination fire department' means a firefighting department that has a combined force of professional and volunteer firefighting personnel.

''(3) DIRECTOR.—The term 'Director' means the Director, acting through the Administrator.

''(4) FIREFIGHTING PERSONNEL.—The term 'firefighting personnel' means individuals, including volunteers, who are firefighters, officers of fire departments, or emergency medical service personnel of fire departments.

''(5) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

''(6) VOLUNTEER, NON-FIRE SERVICE EMS AND RESCUE ORGANIZATION.—The term 'volunteer, non-fire service EMS and rescue organization' means a public or private nonprofit emergency medical services organization that—

''(A) is not affiliated with a hospital;

''(B) does not serve a geographic area in which the Director finds that emergency medical services are adequately provided by a fire department; and

''(C) is staffed primarily by volunteers.

''(7) VOLUNTEER FIRE DEPARTMENT.—The term 'volunteer fire department' means a firefighting department that has an all volunteer force of firefighting personnel.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated for the purposes of this section $1,000,000,000 for each of the fiscal years 2010 through 2014.

''(2) ADMINISTRATIVE EXPENSES.—

''(A) IN GENERAL.—Of the funds appropriated pursuant to paragraph (1) for a fiscal year, the Director may use not more than 3 percent of the funds to cover salaries and expenses and other administrative costs incurred by the Director to make grants and provide assistance under this section.

''(B) FORMULA.—The Director shall subtract the amount to be used for subparagraph (A) from the amount appropriated pursuant to paragraph (1) before making any allocations or apportioning any funds under subsections (a) or (c).''.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) from fiscal years 2003 through 2008—

(A) the funding appropriated for activities under section 33 of the Federal Fire Prevention and Control Act of 1974 declined by approximately 30 percent; and

(B) the number of fire departments receiving awards declined by nearly 40 percent, while the number of applicants increased, resulting in a reduction in applicant success rates from over 43 percent to just 25 percent;

(2) the House-passed conference report for the Department of Homeland Security Appropriations Act, 2010 appropriates $390 million for activities under such section 33, a decrease of over 30 percent below that provided in fiscal year 2009;

(3) declining funding reduces the Director's ability to successfully carry out the primary purpose of such section, which is to protect the health and safety of the public and firefighting personnel throughout the Nation against fire and fire-related hazards; and

(4) halting and reversing the decline in appropriations to ensure a high level of funding for the activities under such section 33 should be a top priority.

SEC. 3. EXPANSION OF PRE-SEPTEMBER 11, 2001, FIRE GRANT PROGRAM REAUTHORIZATION.

Section 34 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229a) is amended to read as follows:

''SEC. 34. EXPANSION OF PRE-SEPTEMBER 11, 2001, FIRE GRANT PROGRAM.

''(a) EXPANDED AUTHORITY TO MAKE GRANTS.—

''(1) HIRING GRANTS.—

''(A) IN GENERAL.—The Director shall make grants directly to career, volunteer, and combination fire departments, in consultation with the chief executive of the State in which the applicant is located, for the purpose of increasing the number of firefighters to help communities meet industry minimum standards and attain 24-hour staffing to provide adequate protection from fire and fire-related hazards and to fulfill traditional missions of fire departments that antedate the creation of the Department of Homeland Security.

''(B) REQUIREMENTS.—

''(i) DURATION AND USE.—Grants made under this paragraph shall be for 3 years and shall be used for programs to hire new, additional firefighters.

''(ii) RETENTION.—Grant recipients are required to commit to retaining for at least the entire 3 years of the grant period those firefighters hired under this paragraph.

''(iii) MAXIMUM.—The portion of the cost of hiring firefighters provided by a grant under this paragraph may not exceed 80 percent of such cost for each fiscal year.

''(C) PREFERENCE.—In awarding grants under this subsection, the Director may give preferential consideration to applications that involve a non-Federal contribution exceeding the minimums under subparagraph (B)(iii).

''(D) TECHNICAL ASSISTANCE.—The Director may provide technical assistance to States, units of local government, Indian tribal governments, and other public entities in furtherance of the purposes of this section.

''(E) VOLUNTEER ACTIVITIES ALLOWED.—Notwithstanding any other provision of law, any firefighter hired with funds provided under this subsection shall not be discriminated against for, or be prohibited from, engaging in volunteer activities in another jurisdiction during off-duty hours.

''(F) COMPETITIVE BASIS.—The Director shall award all grants under this section on a competitive basis through a neutral peer review process.

''(G) SET ASIDE.—

''(i) IN GENERAL.—At the beginning of the fiscal year, the Director shall set aside 10 percent of the funds made available for carrying out this paragraph for departments with majority volunteer or all volunteer personnel.

''(ii) TRANSFER.—After awards have been made, if less than 10 percent of the funds made available for carrying out this paragraph are not awarded to departments with majority volunteer or all volunteer personnel, the Director shall transfer from funds made available for carrying out this paragraph to funds made available for carrying out paragraph (2) an amount equal to the difference between the amount that is provided to such fire departments and 10 percent.

''(2) RECRUITMENT AND RETENTION GRANTS.—

''(A) IN GENERAL.—In addition to any amounts transferred under paragraph (1)(G)(ii), the Director shall direct at least 10 percent of the total amount of funds made available under this section annually to a competitive grant program for the recruitment and retention of volunteer firefighters who are involved with or trained in the operations of firefighting and emergency response.

''(B) ELIGIBILITY.—Eligible entities shall include volunteer or combination fire departments and organizations on a local, statewide, or national basis that represent the interests of volunteer firefighters.

''(b) APPLICATIONS.—

''(1) IN GENERAL.—No grant may be made under this section unless an application has been submitted to, and approved by, the Director.

''(2) CONTENTS.—An application for a grant under this section shall be submitted in such form and contain such information and assurances as the Director may prescribe.

''(3) REQUIREMENTS.—At a minimum, each application for a grant under this section shall—

''(A) explain the applicant's inability to address the need without Federal assistance;

''(B) in the case of a grant under subsection (a)(1), explain how the applicant plans to meet the requirements of subparagraphs (B)(ii) and (E) of such subsection;

''(C) specify long-term plans for retaining firefighters following the conclusion of Federal support provided under this section; and

''(D) provide assurances that the applicant will, to the extent practicable, seek, recruit, and hire members of racial and ethnic minority groups and women in order to increase their ranks within firefighting.

''(c) LIMITATION ON USE OF FUNDS.—

''(1) SUPPLEMENT, NOT SUPPLANT.—Funds made available under this section to fire departments for salaries and benefits to hire new, additional firefighters shall not be used to supplant State or local funds, or, in the case of Indian tribal governments, funds supplied by the Bureau of Indian Affairs, but shall be used to increase the amount of funds that would, in the absence of Federal funds received under this section, be made available from State or local sources, or in the case of Indian tribal governments, from funds supplied by the Bureau of Indian Affairs.

''(2) REPLACEMENT FUNDING PROHIBITED.—No grant shall be awarded pursuant to this section to a municipality or other recipient whose annual budget at the time of the application for fire-related programs and emergency response has been reduced below 80 percent of the average funding level in the 3 years prior to the date of application.

''(3) INDIAN COST-SHARE.—Funds appropriated by the Congress for the activities of any agency of an Indian tribal government or the Bureau of Indian Affairs performing firefighting functions on any Indian lands may be used to provide the non-Federal share of the cost of programs or projects funded under this section.

''(d) WAIVER.—In exceptional circumstances, the Director may waive the requirements of subsections (a)(1)(B)(ii), (a)(1)(B)(iii), (c)(1), and (c)(2) if the Director determines that the jurisdiction is facing demonstrated economic hardship in accordance with section 33(a)(8).

''(e) PERFORMANCE EVALUATION.—The Director may require a grant recipient to submit any information the Director considers reasonably necessary to evaluate the program.

''(f) SUNSET; REPORTS.—

''(1) SUNSET.—The authority under this section to make grants shall lapse at the end of the

10-year period that begins on the date of enactment of the Fire Grants Reauthorization Act of 2009.

''(2) REPORT.—Not later than 6 years after such date of enactment, the Director shall submit to Congress a report concerning the experience with, and effectiveness of, such grants in meeting the objectives of this section. The report may include any recommendations the Director may have for amendments to this section and related provisions of law.

''(g) REVOCATION OR SUSPENSION OF FUNDING.—If the Director determines that a grant recipient under this section is not in substantial compliance with the terms and requirements of an approved grant application submitted under this section, the Director may revoke or suspend funding of that grant, in whole or in part.

''(h) ACCESS TO DOCUMENTS.—

''(1) IN GENERAL.—The Director shall have access for the purpose of audit and examination to any pertinent books, documents, papers, or records of a grant recipient under this section and to the pertinent books, documents, papers, or records of State and local governments, persons, businesses, and other entities that are involved in programs, projects, or activities for which assistance is provided under this section.

''(2) APPLICATION.—Paragraph (1) shall apply with respect to audits and examinations conducted by the Comptroller General of the United States or by an authorized representative of the Comptroller General.

''(i) DEFINITIONS.—In this section, the term—

''(1) 'Director' means the Director, acting through the Administrator;

''(2) 'firefighter' has the meaning given the term 'employee in fire protection activities' under section 3(y) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(y)); and

''(3) 'Indian tribe' means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.)), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes of carrying out this section $1,194,000,000 for each of the fiscal years 2010 through 2014.''.

SEC. 4. STUDY AND REPORT.

(a) STUDY AND REPORT ON ASSISTANCE TO FIREFIGHTERS GRANT PROGRAM.—

(1) STUDY.—The Administrator of the United States Fire Administration, in conjunction with the National Fire Protection Association, shall conduct a study to—

(A) define the current roles and activities associated with the fire services on a national, State, regional, and local level;

(B) identify the equipment, staffing, and training required to fulfill the roles and activities defined under subparagraph (A);

(C) conduct an assessment to identify gaps between what fire departments currently possess and what they require to meet the equipment, staffing, and training needs identified under subparagraph (B) on a national and State-by-State basis; and

(D) measure the impact of the grant program under section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229) in—

(i) meeting the needs of the fire services identified in the report submitted to Congress under section 3603(a) of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005; and

(ii) filling the gaps identified under subparagraph (C).

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Administrator shall submit to ''Congress'' a report on the findings of the study described in paragraph (1).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Administrator of the United States Fire Administration a total of $300,000 for fiscal years 2010 and 2011 to carry out subsection (a).

The CHAIR. No amendment to that amendment in the nature of a substitute shall be in order except those printed in part B of the report. Each amendment may be offered only in the order printed in the report, by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report, equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

AMENDMENT NO. 1 OFFERED BY MS. TITUS

The CHAIR. It is now in order to consider amendment No. 1 printed in part B of House Report 111–340.

Ms. TITUS. Mr. Chairman, I have an amendment at the desk.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Ms. TITUS:

Page 6, after line 19, insert the following:

''(O) To acquire equipment designed to reduce the amount of water used in firefighting or training firefighting personnel.

The CHAIR. Pursuant to House Resolution 909, the gentlewoman from Nevada (Ms. TITUS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Nevada.

□ 1345

Ms. TITUS. I yield myself such time as I may consume.

Mr. Chairman, I rise today with an amendment to H.R. 3791, the Fire Grants Reauthorization Act of 2009. I'd like to first thank Chairmen GORDON and THOMPSON for their work on this important legislation and Chairwoman SLAUGHTER for making my amendment in order. I appreciate their willingness to work with me on this important issue.

The Fire Grants Reauthorization Act of 2009 will provide much needed funding for fire departments across the United States. Since 2001, the Fire Grants Program has provided more than $5 billion to local fire departments to help them fund the purchase of equipment, train firefighters, and hire additional personnel.

In all of our districts, local governments are struggling with their budgets. So these grants are especially important now to help ensure that fire departments all across the country are able to access the resources they need and provide the critical services that we all depend on.

My amendment to this important legislation is simple. It allows fire departments to apply for grant funding to purchase equipment that is designed to reduce water usage in fighting fires or in training to fight fires. This important expansion will provide fire departments the opportunity to purchase pieces of equipment that are not only effective in fighting fires, but are also efficient in water usage. By allowing and encouraging these purchases, we are helping fire departments not only fight fires in a safer way, but also in a way that uses less water. Preserving this valuable resource without diminishing firefighting safety and capability makes purchases by our local governments doubly beneficial.

In my congressional district in southern Nevada, like in many desert communities, water is a valued, precious commodity. As such, it is also our most significant limited resource. Accordingly, State and local management officials and citizens, especially in the West, are constantly working to meet the water demands of a growing population of residents and tourists. This provision will help them in that effort to improve the efficiency of water usage techniques and technology.

In preparing this amendment, I reached out to our local fire chief, Chief Steve Smith of the Clark County Fire Department. He informed me that with the right equipment, the amount of water used to fight a typical fire can be reduced by almost 80 percent. Not only does this technology reduce the amount of water required to extinguish a fire, it also limits structural damage, the threat of the fire rekindling, and runoff of dangerous chemicals into our local sewer systems.

For all of these reasons, I urge the passage of this amendment. It will save water, enhance firefighting abilities, protect property, and limit potential damage in the aftermath of fires.

I reserve the balance of my time.

Mr. SMITH of Nebraska. Mr. Chairman, I rise to claim time in opposition, although I am not opposed to the amendment.

The CHAIR. Without objection, the gentleman from Nebraska is recognized for 5 minutes.

There was no objection.

Mr. SMITH of Nebraska. This amendment, as the sponsor indicated, would allow grant funds under the AFG program to require equipment designed to reduce the amount of water used in firefighting or training. This amendment certainly makes sense, particularly in arid regions, which may be prone to fires and where water sources are often scarce.

I support this amendment.

I reserve the balance of my time.

Ms. TITUS. Mr. Chairman, at this time I would like to yield to the chairman of the committee, the gentleman from Tennessee (Mr. GORDON).

Mr. GORDON of Tennessee. I just want to thank the gentlelady for this

amendment. I think it demonstrates why having greater consultation makes a better bill. You bring unique expertise. We've got a lot more water in Tennessee than you have in Nevada. So thank you for this good amendment.

Mr. SMITH of Nebraska. I yield back the balance of my time.

Ms. TITUS. I'd just like to again thank the chairman and the ranking member for their support of this and urge its passage to help save water while fighting fires.

The CHAIR. The question is on the amendment offered by the gentlewoman from Nevada (Ms. TITUS).

The amendment was agreed to.

AMENDMENT NO. 2 OFFERED BY MR. PERLMUTTER

The CHAIR. It is now in order to consider amendment No. 2 printed in part B of House Report 111–340.

Mr. PERLMUTTER. Mr. Chair, I have an amendment at the desk that was made in order under the rule.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 offered by Mr. PERLMUTTER:

At the end of the bill, add the following new section:

SEC. 5. NATIONAL VOLUNTARY CONSENSUS STANDARDS.

(a) SURVEY BY THE DEPARTMENT OF HOMELAND SECURITY.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of Homeland Security, in consultation with the Task Force established under subsection (b), shall begin to conduct a survey of each career fire department, volunteer fire department, and combination fire department located in the United States in order to ascertain whether each fire department is in compliance with the national voluntary consensus standards for staffing, training, safe operations, personal protective equipment, and fitness.

(2) CONTENTS.—In carrying out the survey, the Secretary shall ascertain, for each fire department in the United States, the rates of compliance with each such standard of—

(A) career fire departments, volunteer fire departments, and combination fire departments;

(B) fire departments located in communities of varying sizes; and

(C) fire departments in each of the States.

(3) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a summary of the findings of the survey required under paragraph (1), including the rates of compliance under the categories specified under subparagraphs (A), (B), and (C) of paragraph (2).

(b) ESTABLISHMENT OF TASK FORCE TO ENHANCE FIREFIGHTER SAFETY.—

(1) ESTABLISHMENT.—Not later than 60 days after the date of enactment of this Act, the Secretary shall establish a task force to be known as the ''Task Force to Enhance Firefighter Safety'' (in this section referred to as the ''Task Force'').

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Secretary shall appoint members of the Task Force from among the general public and shall include—

(i) representatives of national organizations representing firefighters and fire chiefs;

(ii) individuals representing standards-setting and accrediting organizations, including representatives from the voluntary consensus codes and standards development community; and

(iii) other individuals as the Secretary determines to be appropriate.

(B) REPRESENTATIVES OF OTHER DEPARTMENTS AND AGENCIES.—The Secretary may invite representatives of other departments and agencies of the United States that have an interest in the fire service to participate in the meetings and other activities of the Task Force.

(C) NUMBER; TERMS OF SERVICE; PAY AND ALLOWANCES.—The Secretary shall determine the number, terms of service, and pay and allowances of members of the Task Force appointed by the Secretary, except that a term of service of any such member may not exceed 2 years.

(3) RESPONSIBILITIES.—The Task Force shall—

(A) consult with the Secretary to conduct the survey required under subsection (a); and

(B) develop a plan to enhance firefighter safety by increasing fire department compliance with national voluntary consensus standards for staffing, training, safe operations, personal protective equipment, and fitness, including by—

(i) reviewing and evaluating the report required under subsection (a) to determine the extent of and barriers to achieving compliance with national voluntary consensus standards among fire departments; and

(ii) considering ways in which the Federal Government, States, and localities can promote or encourage fire departments to comply with national voluntary consensus standards.

(4) REPORT TO CONGRESS.—Not later than 6 months after the date on which the Secretary submits the report required under subsection (a)(3), the Task Force shall submit to Congress and the Secretary a report containing the findings and recommendations of the Task Force together with the plan described in paragraph (3)(B).

(c) DEFINITIONS.—

(1) IN GENERAL.—The terms used in this section that are defined in sections 4, 33, or 34 of the Federal Fire Prevention and Control Act of 1974 shall have the meaning given such terms in such Act.

(2) NATIONAL VOLUNTARY CONSENSUS STANDARDS.—For the purposes of this section, the term ''national voluntary consensus standards'' means the latest edition of the national voluntary consensus standards for firefighter and fire department staffing, training, safe operations, personal protective equipment, and fitness available on the date of the enactment of this Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Homeland Security such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2013.

The CHAIR. Pursuant to House Resolution 909, the gentleman from Colorado (Mr. PERLMUTTER) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Colorado.

Mr. PERLMUTTER. I want to start by thanking my friend, BART GORDON; DAVID WU; Ranking Member RALPH HALL; HARRY MITCHELL; and my friend, ADRIAN SMITH, for their leadership on this bill. They have put together a strong bill which every Member should feel proud of supporting when they speak to their local firefighters.

Members should be proud this legislation gives those local firefighters the resources they need to best keep their communities safe and secure. Members should be proud that the training, protective equipment, and personnel this bill provides could potentially save the lives of those very firefighters. My amendment will, I believe, make this bill even better.

Every year, roughly 100 firefighters die in the line duty. This is a tragedy, and each one of those brave men and women is a hero for their sacrifice. But we think some of these deaths were preventable, so we must act. Studies have shown that all too often a contributing factor in their deaths was failure to comply with national voluntary consensus standards. These national voluntary standards are developed over years of collaboration and debate within the National Fire Protection Association, which I will call the NFPA.

As the independent experts on fire policy, the NFPA has developed these standards for over a hundred years to keep communities and the firefighters who protect them safe, yet the Federal Government does not have a thorough understanding of how fire departments follow various NFPA standards. We in the Congress dedicate a great deal of time and resources to help our fire departments, but we cannot gauge our overall effectiveness without knowing where we are successful and where we fall short.

My amendment authorizes the U.S. Fire Administration to conduct a first-of-its-kind survey of our Nation's fire departments to measure how well they are adhering to these safety standards. Once the study is complete, a task force of industry stakeholders will make recommendations to Congress on the methods to increase compliance. Especially in the post 9/11 world, where firefighters play a vital role in our homeland security, a stronger emergency response capability means a weakened threat of terrorist attack.

I should add that this amendment is nearly identical to my bill, the Firefighter Fatality Reduction Act. That bill has broad, bipartisan support of 31 Members from rural, urban, and suburban districts. It is supported by the International Association of Firefighters, the International Association of Fire Chiefs, and the National Fire Protection Association.

This amendment is simple. These safety standards can save firefighters' lives. Let us study how well our fire services are using these standards and bring in an industry task force to think creatively about ways to boost

compliance. It's good for our firefighters, it's good for our local communities, and it's good for homeland security.

With that, I reserve the balance of my time.

Mr. SMITH of Nebraska. I rise to claim time in opposition to the amendment, although I do not oppose it.

The SPEAKER pro tempore. Without objection, the gentleman from Nebraska is recognized for 5 minutes.

There was no objection.

Mr. SMITH of Nebraska. I would like to ask the gentleman from Colorado to enter into a colloquy regarding his amendment—a clarification.

Mr. PERLMUTTER. Yes.

Mr. SMITH of Nebraska. Thank you. I appreciate that. I thank the gentleman for offering the amendment to assess fire department readiness through a survey of compliance with national voluntary consensus standards for staffing, training, equipment, and other factors important to a department's ability to respond to hazards. I do support the amendment but would like to seek clarification for the RECORD regarding the gentleman's intent on two aspects of this amendment.

First, I recognize the value of improved data regarding fire department compliance with response standards, and I agree that we should aspire to help the fire service achieve higher compliance rates. However, I think it is important to note that a lack of compliance with these standards does not necessarily indicate a problem on the part of the department or local municipality.

There are over 25,000 fire departments in the United States, all working under unique circumstances with respect to local hazards, populations, mutual aid agreements, operating budgets, and so on. In many cases, it simply does not make sense for departments to be in full compliance with what the Federal Government would consider full compliance with these standards based on their individual circumstances, particularly in rural areas where resources are very limited.

For these reasons, I would hope that the task force established by this amendment considers these practical barriers to standards compliance in making recommendations to Congress regarding how best to improve standards compliance. I would just ask the gentleman if he would agree with this interpretation.

Mr. PERLMUTTER. I thank my friend from Nebraska. And yes, I entirely agree with him. According to the most recent U.S. Fire Administration fire department census, my own State of Colorado has 323 fire departments. Of those, 35 are career departments, 165 are volunteer departments, and 123 are combination. Each has it own needs, faces its own threats, and relies on different funding streams.

The recent downturn in the economy has hurt fire departments all across the country. So, of course, the task force established in this amendment should reflect the differences among the three types of departments and the challenges that they face.

As written, my amendment would include on the task force ''representatives of national organizations representing firefighters and fire chiefs.'' It is a reasonable implication that volunteer firefighters are included on the task force, and I will work with the gentleman to ensure that this is the case. Although needs of each fire department are unique, I do feel there are several areas of general agreement among them, which is precisely why I propose to establish this task force. As I said, I agree with the gentleman and his concerns.

Mr. SMITH of Nebraska. I thank the gentleman from Colorado. Second, while the cost of the study called for in the gentleman's amendment is not precisely known at this time, it may be a significant undertaking. Accordingly, I hope that it is the gentleman's intent that the funding for this study, which is authorized by the Secretary of Homeland Security, not come out of the core budget for either of these grant programs or the budget of the U.S. Fire Administration.

Does the gentleman agree with this interpretation?

Mr. PERLMUTTER. Again, I agree with my friend. First, I'd like to note this survey is an undertaking which I intend to do similarly to the U.S. Fire Administration's periodic census, which determines the number of fire departments in the Nation, as well as the number of firefighters. The census is done by mail, and I would expect this survey to be done similarly or even electronically to save on costs.

To the specific point about funding, I believe FIRE and SAFER funds are best used going to fire departments. I also believe the U.S. Fire Administration is cash-strapped. This year's Homeland Security Appropriations Act funded it at $45.6 billion. If I were an appropriator, I would have doubled that figure.

To avoid funding this provision through the grants themselves or the USFA, I have an additional authorization of appropriation from outside those funds. I wish to continue to work with the gentleman to perfect and clarify this intent.

I thank the gentleman from Nebraska and give him notice now to be aware of my Colorado Buffaloes next week. We aren't going to a bowl game this year, but our bowl game is against the University of Nebraska—and we will win.

Mr. SMITH of Nebraska. I thank the gentleman from Colorado for his graciousness, with I guess just one exception. But I appreciate the confidence he shows in his college football team.

I yield back the balance of my time.

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

The CHAIR. The question is on the amendment offered by the gentleman from Colorado (Mr. PERLMUTTER).

The question was taken; and the Chair announced that the ayes appeared to have it.

Mr. SMITH of Nebraska. Mr. Chairman, I demand a recorded vote.

The CHAIR. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from Colorado will be postponed.

□ 1400

AMENDMENT NO. 3 OFFERED BY MR. FLAKE

The Acting CHAIR (Mr. SERRANO). It is now in order to consider amendment No. 3 printed in part B of House Report 111–340.

Mr. FLAKE. Mr. Chairman, I have an amendment at the desk, designated as No. 3.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 3 offered by Mr. FLAKE:

At the end of the bill, add the following new section:

SEC. 5. PROHIBITION ON EARMARKS.

None of the funds appropriated to carry out the amendments made by this Act may be used for a congressional earmark as defined in clause 9, of Rule XXI of the rules of the House of Representatives of the 111th Congress.

The Acting CHAIR. Pursuant to House Resolution 909, the gentleman from Arizona (Mr. FLAKE) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Arizona.

Mr. FLAKE. I thank the Chair.

This amendment would simply prohibit the Assistance to Firefighters Grant program and the SAFER grant program from ever being used as vehicles for earmarking. As my colleagues are likely aware, I have offered a similar amendment several times this year. It's been adopted this year six times by voice vote and again by a roll call vote at least once.

As before, H.R. 3791 stipulates that the grant programs it authorizes are to be run on a competitive basis or on some basis based on need. While we have language prohibiting earmarking in there somewhat, this may seem redundant, but we all know that just because grant programs are labeled competitive doesn't mean that they won't be vehicles for earmarking.

In fact, we've had in some other programs, like FEMA's Pre-Disaster Mitigation program, that's a competitive grant program designed to save lives and reduce property damage by providing funds for hazard mitigation planning, acquisitions, and relocation of structures out of the flood plain; unfortunately, that program, although

it's supposed to be competitive, has been completely earmarked, like 100 percent of the funds have been earmarked. We want to prevent that from happening here.

If we're going to establish a grant program and call it a competitive program, we need to ensure that it is, indeed, competitive. That's what this amendment seeks to do.

With that, I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Chairman, I rise to claim time in opposition to the amendment, although I am not in opposition to the amendment.

The Acting CHAIR. Without objection, the gentleman is recognized for 5 minutes.

There was no objection.

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

I have no objections to this amendment. I want to point out that the underlying programs or competitive grant programs are peer reviewed by members of the fire service.

I yield back the balance of my time.

Mr. FLAKE. I yield 1 minute to the gentleman from Nebraska (Mr. SMITH).

Mr. SMITH of Nebraska. Mr. Chairman, I rise in support of this amendment. The Assistance to Firefighters Grants (AFG) and SAFER grant program have not been subject to earmarking and, instead, have been awarded to the applicants which are determined to have the greatest need. This process of awarding grants based on merit has proven effective for this program. Allowing these funds to be allocated through earmarking would pit those districts in need against those with the most powerful Members of Congress. I believe this would be a disservice to the American taxpayer. Mr. FLAKE's amendment will ensure that the funding, which we are authorizing here today for the grant programs for firefighters, continues to be allocated through a competitive process based on need.

I urge my colleagues to support this amendment.

Mr. FLAKE. I thank the chairman of the subcommittee and also the ranking minority member for supporting the amendment.

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from Arizona (Mr. FLAKE).

The question was taken; and the Acting Chair announced that the ayes appeared to have it.

Mr. GORDON of Tennessee. Mr. Chairman, I demand a recorded vote.

The Acting CHAIR. Pursuant to clause 6 of rule XVIII, further proceedings on the amendment offered by the gentleman from Arizona will be postponed.

AMENDMENT NO. 4 OFFERED BY MR. HOLDEN

The Acting CHAIR. It is now in order to consider amendment No. 4 printed in part B of House Report 111–340.

Mr. HOLDEN. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 4 offered by Mr. HOLDEN:

Page 24, strike line 18 and all that follows through page 25, line 3 and insert the following:

''(6) VOLUNTEER, NON-FIRE SERVICE EMS AND RESCUE ORGANIZATION.—

''(A) IN GENERAL.—The term 'volunteer, non-fire service EMS and rescue organization' means a public or private nonprofit emergency medical services organization that—

''(i) is not affiliated with a hospital;

''(ii) does not serve a geographic area in which the Director finds that emergency medical services are adequately provided by a fire department; and

''(iii) is staffed primarily by volunteers.

''(B) INCLUSION.—Such term includes a river rescue organization if such organization otherwise meets the definition in subparagraph (A).

Page 25, after line 7, insert the following:

''(8) RIVER RESCUE ORGANIZATION.—The term 'river rescue organization' means an organization that provides emergency search and rescue services to a person affected by a flood, a water-related accident, or another disaster for which services, including water rescue and patrol, dive rescue and recovery, emergency first response, flood recovery, or fire and rescue services on the water, are required.

The Acting CHAIR. Pursuant to House Resolution 909, the gentleman from Pennsylvania (Mr. HOLDEN) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Pennsylvania.

Mr. HOLDEN. Thank you.

First of all, Mr. Chairman, I would like to congratulate and thank Chairman GORDON and the gentleman from Nebraska for their hard work on this important piece of legislation. It has been tremendously successful all across the country and in the Commonwealth of Pennsylvania and in my congressional district.

Mr. Chairman, the purpose of my amendment is to allow river rescue associations to participate in the grant program under the Volunteer, Non-Fire Service EMS and Rescue Organizations section of the reauthorization.

Mr. Chairman, this situation was brought to my attention by Mr. Steve Ketterer of the Harrisburg River Rescue Association, which is the capital city of the Commonwealth of Pennsylvania and the largest city in my congressional district. It sits on the Susquehanna River, and the Harrisburg River Rescue Association does a tremendous job all year long, not just in flooding situations, performing rescue operations on the Susquehanna River. They have applied repeatedly to this program for a grant and have been determined to be ineligible. My amendment simply would make river rescue associations eligible under the Volunteer, Non-Fire Service EMS and Rescue Organizations section of the bill.

At the direction of the chairman and his staff, we have reached out and have had consultation with the International Association of Fire Fighters and the National Volunteer Fire Council. Both groups are satisfied with the amendment making river rescue eligible under the rescue organization section of the bill and felt it did not harm either the intention or the compromise of the bill. This would not take any funding from firefighters. This makes them eligible for funding under the EMS funding.

So I would encourage adoption of the amendment and reserve the balance of my time.

Mr. SMITH of Nebraska. Mr. Chairman, I rise to claim time in opposition to the amendment, although I am not opposed to the amendment.

The Acting CHAIR. Without objection, the gentleman is recognized 5 minutes.

There was no objection.

Mr. SMITH of Nebraska. Mr. Chairman, this amendment would simply clarify that river rescue organizations will be eligible to apply for a grant under the program authorized by the bill. I have no objections to this amendment.

I yield back the balance of my time.

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

The Acting CHAIR. The question is on the amendment offered by the gentleman from Pennsylvania (Mr. HOLDEN).

The amendment was agreed to.

AMENDMENT NO. 5 OFFERED BY MR. CARDOZA

The Acting CHAIR. It is now in order to consider amendment No. 5 printed in part B of House Report 111–340.

Mr. CARDOZA. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 5 offered by Mr. CARDOZA:

Page 12, line 24, insert ''including unemployment rate of the area being served'' after ''financial situation''.

The Acting CHAIR. Pursuant to House Resolution 909, the gentleman from California (Mr. CARDOZA) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from California.

Mr. CARDOZA. Thank you, Mr. Chairman. I yield myself such time as I may consume.

Mr. Chairman, my district in California has been especially hard hit by the current economic crisis. Even if nationwide indicators begin to reveal a healthier national economy in the

coming months, it is clear that my district and others in California's Central Valley region will suffer from severe economic underdevelopment for years to come. The 18th Congressional District's struggling economy is the reason I continue to try to use every available opportunity to push for amendments and legislation that will spur job creation and economic development and provide relief to the hardest-hit communities in the country. The Bureau of Labor Statistics ranks the metro area of Merced, Modesto, and Stockton with some of the highest unemployment rates in the Nation. All three are above 15 percent, and all three well above the national unemployment rate of 10.2 percent.

My amendment simply provides a little more direction during the grant writing process by including unemployment rates in the criteria used to evaluate these various grant applications. This will provide a little extra help to communities like Los Banos and Merced to maintain and improve their fire protection services. These and many other cities in my district and across the country have critical needs that they cannot meet under the current financial stress that they are having. Instead of hiring additional personnel and boosting employment, they are forced to lay off valuable employees and risk the safety of their communities.

I ask my colleagues on both sides of the aisle to support this commonsense amendment.

I reserve the balance of my time.

Mr. SMITH of Nebraska. Mr. Chairman, I rise to claim time in opposition to the amendment. Although I am not necessarily opposed to this, I do have some concerns.

The Acting CHAIR. Without objection, the gentleman from Nebraska is recognized for 5 minutes.

There was no objection.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman.

This amendment would require that local unemployment rates be considered as a factor in awarding grants to fire departments. While I understand the current state of the economy should make this a concern in bills we consider, the Fire grant program has, since its inception 8 years ago, awarded grants competitively based upon the potential of the applicant's proposal to enhance a fire department's ability to respond to fires and related hazards. I am somewhat concerned that this change may result in an upset in the delicate balance of consideration that has been achieved over the years.

The factors used by FEMA in evaluating these proposals have been carefully developed and refined in consultation with national fire service organizations. They include, for example, a department's geographic response area, its population served, unique hazard vulnerabilities, and its budgetary situation. All of these factors directly impact the department's ability to respond to hazards and, thus, are appropriate criteria.

I believe the gentleman's amendment is well intentioned, but I am concerned that the unemployment rate of the locality a department protects is simply not directly related to fire hazards or the department's ability to respond to them. While a fire department's operating budget could potentially be indirectly impacted by a poor local economy that impacts tax revenues, this factor is already explicitly noted in the legislation based on need.

Further, I would caution generally against the practice of Congress dictating the specific criteria to be used by FEMA in making awards. This bill codifies consideration of high-level factors that were developed by the fire service and are currently used by FEMA, but it does not attempt to incorporate new ones based on particular interests. If we begin to open up this program to congressional direction of this sort, we risk adding a level of prescription that could transform the current highly competitive process to one driven by interests unrelated to the needs of the fire service.

I reserve the balance of my time.

Mr. CARDOZA. Mr. Chairman, I will respond to my friend and colleague that we have taken and watered this language down so that it applies to all areas. Severe unemployment is only one of many criteria that can be considered and only when the situation is a desperate situation.

We talked about our area in central California being the Katrina of California where we have such devastating consequences that we may not be able to meet some of our fire needs in our communities as they just collapsed financially. So if we find situations where we're not meeting the fire protection needs of those communities, we think that it's very important. This has just become one of many criteria in evaluating these grants. Not the sole criteria, not the most important criteria, but certainly to allow those individuals who are making the decisions to just take this into consideration. That's the purpose of my amendment.

The communities of Merced and Los Banos, in particular, have contacted my office, indicating that this is something they feel is a necessary imperative. But I can imagine cities across the country—Miami, Detroit, other places—where they may find themselves in similar kinds of economic situations. It might be your State by the time this bill becomes law.

So I would just say that I think it's something that is important for everyone to have as a capability to be taken into consideration. It's not something that will override the other considerations that the gentleman has outlined.

I yield back the balance of my time.

Mr. SMITH of Nebraska. Mr. Chairman, I certainly want to be sensitive to the economic conditions that hit some parts of the country harder than others, and I want to be mindful of the wise use of resources at the Federal level. I don't want to get into other policies that might impact our economy in any a very negative way. I don't have enough time to do that right now. But I certainly hope that we can arrive at good policy decisions today and down the road so that we don't stand in the way of the wise use of government and taxpayer resources.

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from California (Mr. CARDOZA).

The amendment was agreed to.

Mr. GORDON of Tennessee. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. JACKSON of Illinois) having assumed the chair, Mr. SERRANO, Acting Chair of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 3791) to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes, had come to no resolution thereon.

□ 1415

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Record votes on postponed questions will be taken later.

WELCOMING INDIAN PRIME MINISTER MANMOHAN SINGH

Mr. ACKERMAN. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 890) welcoming the Prime Minister of the Republic of India, His Excellency Dr. Manmohan Singh, to the United States.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 890

Whereas the Republic of India achieved its independence from the British Empire on August 15, 1947, and has since maintained a democratic system of government;

Whereas from April 16 to May 13, India conducted the world's largest democratic election, which returned Prime Minister Singh to power;

Whereas India's relationship with the United States has deepened in past years and encompasses cooperation on matters relating to international security, world trade, technology, science, and health;

Whereas the relationship between the United States and India has great potential to promote stability, democracy, prosperity, and peace throughout the world and enhance the ability of both countries to work together to provide global leadership in areas of mutual concern and interest;

Whereas the Prime Minister of India, His Excellency Dr. Manmohan Singh, has helped shape India's economic policies to permit the expansion of a market economy, which has led to greater economic prosperity for India and the growth of a middle class;

Whereas Americans of Indian origin have made diverse and numerous contributions to the United States; and

Whereas Prime Minister Singh has accepted an invitation by the United States to make an official visit to Washington, DC, and is the honoree of President Barack Obama's first State Dinner: Now, therefore, be it

Resolved, That the House of Representatives—

(1) commends the maturating of the relationship between the United States and the Republic of India, exemplified by the current official visit of the Prime Minister of India, His Excellency Dr. Manmohan Singh;

(2) looks forward to continuing progress in the relationship between the United States and India; and

(3) welcomes Prime Minister Singh to the United States.

The SPEAKER pro tempore (Mr. SERRANO). Pursuant to the rule, the gentleman from New York (Mr. ACKERMAN) and the gentlewoman from Florida (Ms. ROS-LEHTINEN) each will control 20 minutes.

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. ACKERMAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and to include extraneous material on the resolution.

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

There was no objection.

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

Mr. Speaker, I rise in strong support of this resolution and of the U.S.-India relationship. Next week, the Prime Minister of India, Manmohan Singh, will come to Washington for a State visit, and I am pleased that with this resolution, the House will offer him its own welcome.

Prime Minister Singh has worked hard to improve our already strong ties and has courageously already taken political risks for our bilateral relationship that few others would venture. But when the Prime Minister put his government and his career on the line, it wasn't for us, though his victory has certainly proved to be to our advantage. No, Prime Minister Singh took his chances for India, for its future and for the fulfillment of that country's enormous potential.

And our partnership is built on this foundation: that India's rise as a great power in Asia and as a global player advances critical American interests ranging from the promotion of democracy and democratic values, to improving stability and security throughout all parts of Asia.

We do not fear a growing India for one simple reason: India's values are our values. India is a real democracy with real institutions that are subordinate to the rule of law. India, though ready to defend itself, doesn't start wars or harbor terrorists. India, though as fastidious as any state about protecting its sovereignty, can be relied upon to keep its word once committed to a treaty or an international agreement. India struggles to preserve its tradition of religious, cultural, and ethnic pluralism. India safeguards sensitive technologies. India fights terrorism.

We do not see ourselves when we look at India, though this Nation has benefited immensely from Indians who have become Americans. India is vastly larger in population, vastly older in history, and vastly more complex culturally with some 2,000 ethnicities and 29 major languages.

We do see similarities. We do see a nation committed to lifting itself by its own means. We do see a nation open to the world, and we do see a nation committed to the same vision of peace and security that has guided our own Nation.

There are, as to be expected, differences between us. Some of them—and I would note particularly the issue of Iran—are very serious. But as nations committed to a relationship of equals, a relationship of mutual benefit and mutual respect, I believe we can work through our differences and achieve enormous progress in many areas of our mutual concern.

I am delighted that Prime Minister Singh, a man who is one in a billion, is returning to the United States, and I am proud of the House today in offering him such a well-deserved and warm welcome.

I reserve the balance of my time.

Ms. ROS-LEHTINEN. I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of House Resolution 890, a measure welcoming the Prime Minister of India, His Excellency Dr. Manmohan Singh, to the United States. I am pleased to be a cosponsor of this timely resolution which recognizes the forthcoming visit by India's distinguished and universally accepted and respected Prime Minister to the United States.

This will be the first official visit by a foreign head of government during this administration. And, Mr. Speaker, that makes it wholly appropriate that Prime Minister Singh and India be accorded this wonderful honor.

Without doubt, the high status accorded to his visit reflects India's growing global role and its increasingly comprehensive relationship with our country, the United States. Implicitly, however, the pomp and the circumstance associated with his visit also reflect the extraordinary contribution of Indian Americans to solidify our people-to-people relationship and all of the dynamism that they have brought to our diverse and vibrant society.

In any regard, the Congress fully shares with the executive branch a deep commitment to strengthening our partnership with India and to expand our cooperation on a wide range of bilateral and global issues. These opportunities for mutual cooperation range from global security to economic growth, trade promotion, human development, and the expansion of our two-knowledge societies, and also nuclear nonproliferation, and protection of the environment.

Mr. Speaker, it is altogether fitting that we should honor the Indian-American relations as strong as they are and ever closer every day and the visit of Prime Minister Singh by adopting this thoughtful resolution.

I urge its support, and I reserve the balance of our time.

Mr. ACKERMAN. Mr. Speaker, I am delighted to yield 2½ minutes to the gentleman from Washington (Mr. MCDERMOTT).

Mr. MCDERMOTT. Mr. Speaker, I want to raise my voice in strong support for H. Res. 890, a resolution introduced to welcome Prime Minister Manmohan Singh, to the United States. As co-Chair of the caucus on Indian and Indian Americans, I extend our hand in friendship to our close friend and strategic ally in South Central Asia. I've known Prime Minister Manmohan Singh since he was the finance minister in 1990 who really brought about the Indian miracle.

The President has chosen to recognize the close ties between our nations by honoring India with its first official State dinner at the White House next week, and I look forward to participating.

In the 21st century, the world's oldest and largest democracies have much to share and learn from each other. Over the years, I visited India 22 times, but perhaps the most memorable visit came this year as a part of the congressional delegation with John Lewis.

We were there to commemorate the 50th anniversary of the historic visit to India by Dr. Martin Luther King, Jr., and his wife. At the end of the visit, Dr. King said, "The choice today is no longer between violence and nonviolence; it is either nonviolence or nonexistence." That truth is self-evident today.

Both India and the United States must deepen our ties—even if we respect different cultures—if we are to make this a safer and better world. And we are up to the challenge. The Prime Minister has made significant economic progress for the people of India and that has resulted in new business opportunities for American companies and U.S. jobs. In Seattle, the heart of my congressional district, Boeing builds airplanes for a major customer, Air India. That is just one of the examples of the business ties that bind us together.

We also cooperate in science, technology, trade, and education. All of this draws us together in countless ways.

Recently, I joined Her Excellency, Meera Shankar, the Ambassador of India, for the unveiling of a statue of Gandhi at the King County Public Library. And last weekend in Seattle, we celebrated the festival of Diwali.

In the 21st century, the Internet has removed the borders that separated nations, but it will take people to unite us into one world. That is what makes a State visit like this so important. Leaders working in good faith on behalf of the people can bridge any divide no matter how wide and deep. As Nelson Mandela in South Africa once said, ''It always seems impossible until it's done.''

This resolution is a down payment on the future, and I urge my colleagues to support it.

Ms. ROS-LEHTINEN. I would like to reserve, Mr. Speaker.

Mr. ACKERMAN. Mr. Speaker, it's now my pleasure to yield to the distinguished gentleman from Maryland (Mr. HOYER), the majority leader of the House, 1 elastic minute.

Mr. HOYER. I thank my friend, Mr. ACKERMAN, for yielding, and I thank the ranking member, Ms. ROS-LEHTINEN, for bringing this resolution to the floor.

Next week, as has been said, President Obama will be hosting the first State dinner of his administration, and the guest of honor, appropriately, will be the Prime Minister of the Republic of India, Dr. Manmohan Singh.

Prime Minister Singh visits America at a time when the relationship between our two nations is as strong as it has ever been. In India we see a vital partner on issues of national security to world trade. We see a nation that confronts many of the threats that challenge America, from terrorism to global warming. We see an emerging economic power with a growing middle class. And though our nations are separated by distance, language, and culture, we recognize in one another the democratic values we share; and of course we have a language in common as well, as well as common values, despite its great size and diversity.

And for those who may not know, India will soon be not only the largest democracy, but the most populous nation in the world.

India has remained a democracy since its independence more than 60 years ago. And this year, Prime Minister Singh was returned to power in the world's largest democratic election. In fact, India made him the first Prime Minister since Nehru to return to office after completing a full term, a truly remarkable accomplishment.

All of us should be proud, and I know we are, to host the leader of one of America's most vital allies. On behalf of the House of Representatives, Speaker PELOSI, and all of us on both sides of the aisle, and Mr. BOEHNER, I am pleased to have this opportunity to welcome Prime Minister Singh to the United States and rise in strong support of this resolution.

Ms. ROS-LEHTINEN. Mr. Speaker, I would like to thank the sponsor of this measure, Mr. MCDERMOTT, and the gentleman from California (Mr. ROYCE) for providing us with an opportunity to recognize this ever-growing tie in the relationship between our democratic nations and to welcome, in an official way, Prime Minister Singh.

Mr. FALEOMAVAEGA. Mr. Speaker, I rise in strong support of H. Res. 890, which welcomes the Prime Minister of the Republic of India, His Excellency Dr. Manmohan Singh, to the United States, and commends the maturation of the U.S.-India relationship.

That relationship has made remarkable strides in the past 2 decades. And one of the critical elements helping launch our improved ties was the series of economic reforms India initiated in 1991, reforms developed and implemented under the leadership of then Finance Minister, Dr. Singh.

With his rise to Prime Minister in 2004, Dr. Singh provided the leadership required for his country to strike the landmark U.S.-India Civil Nuclear Cooperation Initiative with us, a deal that facilitates nuclear cooperation and offers the bilateral relationship a major strategic opportunity.

After his party's victory in this year's general elections, Dr. Singh became the first full-term Indian Prime Minister to be returned to power since 1962. The particularly strong electoral mandate he received in the recent election is testament to his accomplishment. It also offers our two countries a chance to move our partnership to an even higher level, better positioning us to advance solutions to the key regional and global challenges we confront, from pandemic disease, to the proliferation of weapons of mass destruction, climate change, and poverty.

Reflecting India's emergence as a major international player and the importance of the U.S.-India relationship, the Prime Minister's visit here next week will be the first official state visit by any foreign dignitary to the Obama White House.

The Prime Minister should know that the United States Congress values his leadership and our bilateral partnership just as much as the new Administration, and so I urge my colleagues to join me in supporting H. Res. 890.

Mr. ROYCE. Mr. Speaker, I rise in support of this resolution. I want to thank Mr. MCDERMOTT, my cochairman of the India Caucus.

Indian Prime Minister Singh's visit to Washington for an official visit is an important signal of deepening relations between the United States and India. His visit sends a signal to the Indian people that their country is a valued partner. This resolution recognizes this relationship—its past successes, and hopes for its future.

Significantly, Prime Minister Singh's visit will come almost to the day of the horrific terrorist attacks on Mumbai carried out by Islamist militants. On that day 163 people were cut down in a bloody rampage. Our thoughts will be with Indian people on that anniversary.

Mr. Speaker, over the past decade, relations between the U.S. and India have undergone a renaissance. Prime Minister Singh has done much to bring the United States and India together, but perhaps nothing more consequential than signing the landmark civil nuclear cooperation agreement between the two countries.

Indian officials have told me about their ambitious plans to expand nuclear power. India needs additional electricity to fuel its growing economy and nuclear energy is a clean source. With this deal, the Indian nuclear industry is overcoming the international restrictions that have curtailed it since 1974, to reach its full potential. India will still rely on other energy sources, but it is smart policy for any country to diversify. We in the U.S. should learn that lesson. We are expecting U.S. companies to be part of the Indian nuclear industry. We should give them more opportunities at home too.

Official visits should lead to concrete policy improvements. If this relationship is to move ahead, progress must be made on trade. Right now, the signs aren't good. Both countries need to get serious on advancing trade, or we'll both lose.

The U.S.-India relationship has made great strides, but progress can't be taken for granted. We have many common interests: economics, counter-terrorism, energy. While President Obama was in China this week, India is another very important country. The India Caucus will be watching next week's visit in hopes that specific advances will be made.

Ms. ROS-LEHTINEN. I urge unanimous support for this measure, and I yield back the balance of my time.

Mr. ACKERMAN. I thank the gentlelady for her support and endorsement of the resolution and her wonderful comments; and we yield back the balance of our time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. ACKERMAN) that the House suspend the rules and agree to the resolution, H. Res. 890.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

□ 1430

RECOGNIZING ANNIVERSARY OF THE VELVET REVOLUTION IN CZECHOSLOVAKIA

Mr. ACKERMAN. Mr. Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 212) expressing the sense of Congress on the occasion of the 20th anniversary of historic events in Central and Eastern Europe, particularly the Velvet Revolution in Czechoslovakia, and reaffirming the bonds of friendship and cooperation between the United States and the Slovak and Czech Republics, as amended.

The Clerk read the title of the concurrent resolution.

The text of the concurrent resolution is as follows:

H. CON. RES. 212

Whereas, on September 3, 1918, the United States Government recognized the Czecho-Slovak National Council as the official Government of Czechoslovakia;

Whereas, on October 28, 1918, the peoples of the present day Czech Republic and the present day Slovak Republic proclaimed their independence in the common state of the Republic of Czechoslovakia;

Whereas between 1939 and 1945, Nazi Germany annexed part of Bohemia, set up a fascist ''protectorate'' in the rest of Bohemia and in Moravia, and installed a puppet fascist government in Slovakia;

Whereas, on November 17, 1939, in response to widespread student demonstrations, Czech institutions of higher learning were closed by the Nazis, many students were taken to concentration camps, and 9 representatives of the student movement were executed;

Whereas the Moscow-directed Communists took over the Government of Czechoslovakia in February 1948;

Whereas troops from Warsaw Pact countries invaded Czechoslovakia in August 1968, ousted the reformist leadership of Alexander Dubcek, and restored a hard-line communist regime;

Whereas, on November 17, 1989, the brutal break up of a student demonstration commemorating the 50th anniversary of the execution of Czech student leaders and the closure of universities by the Nazis triggered the explosion of mass discontent that launched the Velvet Revolution, which was characterized by reliance on nonviolence and open public discourse;

Whereas the peoples of Czechoslovakia overthrew 40 years of totalitarian communist rule in order to rebuild a democratic society;

Whereas, since November 17, 1989, the people of the Slovak Republic and the Czech Republic have established vibrant, pluralistic, democratic political systems based upon freedom of speech, a free press, free and fair open elections, the rule of law, and other democratic principles and practices;

Whereas the people of the United States, the Slovak Republic, and the Czech Republic have maintained a special relationship based on shared democratic values, common interests, and the strong bonds of friendship, mutual respect, and close cooperation; and

Whereas the people of the United States have an affinity with the peoples of the Slovak Republic and the Czech Republic and regard them as trusted and important partners and allies: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That Congress—

(1) recognizes the 20th anniversary of the historic events in Central and Eastern Europe that brought about the collapse of the communist regimes and the fall of the Iron Curtain;

(2) commemorates, with the Slovak Republic and the Czech Republic, the 20th anniversary of the Velvet Revolution in Czechoslovakia, which underscores the significance and value of reclaimed freedom and the dignity of individual citizens;

(3) commends the peoples of the Slovak Republic and the Czech Republic for their remarkable achievements over the past 20 years in building free, democratic, and prosperous societies;

(4) appreciates the contribution of the Slovak Republic and the Czech Republic as members of the North Atlantic Treaty Organization and the European Union to the promotion and defense of common values of freedom, democracy, and liberty around the world;

(5) reaffirms the bonds of friendship and close cooperation that have existed between the United States and the Slovak Republic and the Czech Republic; and

(6) extends the warmest congratulations and best wishes to the people of the Slovak Republic and the people of the Czech Republic for a peaceful, prosperous, and successful future.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. ACKERMAN) and the gentlewoman from Florida (Ms. ROS-LEHTINEN) each will control 20 minutes.

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. ACKERMAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on the concurrent resolution.

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

There was no objection.

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

I thank my good friend, the gentleman from Florida (Mr. MICA) for introducing this important resolution that recognizes the historic events in Czechoslovakia in 1989 and enables Congress to reaffirm its strong friendship and support for the people of the Slovak Republic and the Czech Republic.

Twenty years ago, on November 17, communist riot police broke up a peaceful pro-democracy demonstration in Prague, brutally beating many of the student protesters.

Rather than silencing the students, however, these violent reprisals led to an avalanche of protests between November 17 and December 29 that ultimately led to the fall of the Communist Party in Czechoslovakia.

In the days after the initial protest, a pro-human rights group, known as Charter 77, united with other groups to become the Civic Forum, a strong voice calling for reform, civil liberties, and rights for all citizens.

Led by dissent playwright Vaclav Havel, the Civic Forum succeeded in forcing the communist government to resign, paving the way for Havel's election on December 29 as the President of Czechoslovakia.

Known around the world as the Velvet Revolution, these historic events further cemented the collapse of the communist regimes throughout Central and Eastern Europe, and helped to precipitate the end of the Cold War.

In June 1990, Czechoslovakia held its first democratic election since 1946, bringing into power its first completely noncommunist government in over 40 years. In the 20 years since these momentous events, the Czech Republic and the Slovak Republic have become strong, vibrant democracies, close NATO allies, and staunch friends of the United States.

They continue to contribute to international peace efforts, including by providing troops and assistance under NATO command in Afghanistan.

Millions of Americans trace their roots to these two great nations, and the United States is strengthened by their rich cultural heritage and their many significant achievements and contributions.

Mr. Speaker, this resolution acknowledges and commemorates the Velvet Revolution in Czechoslovakia 20 years ago this month. It also reaffirms the bonds of friendship and cooperation between the United States and the Czech Republic.

I urge all of our colleagues to support this important resolution.

Mr. Speaker, I reserve the balance of my time.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of House Concurrent Resolution 212, which commemorates the 20th anniversary of the historic events that took place in Central and Eastern Europe, particularly the Velvet Revolution in Czechoslovakia, and also reaffirms the bonds of friendship, the bonds of cooperation between the United States and the Slovak and Czech Republics.

I would like to thank my friend and Florida colleague, and my fellow ranking member, Mr. MICA, for introducing this important and timely resolution.

Mr. Speaker, in 1989, the world witnessed momentous events in which the people of Eastern and Central Europe broke the chains of their communist oppressors. Among the many important events which took place, the trade union Solidarity won its historic victory in Poland; 2 million people living in Latvia, Lithuania, and Estonia linked hands to form a human chain almost 400 miles long in a peaceful protest against Soviet rule; and the Berlin Wall fell.

A prominent place among the events of 1989 is held by the so-called Velvet Revolution, which rose spontaneously from protests in Czechoslovakia that led directly to free and democratic elections in that country. That revolution, in what was then Czechoslovakia, began on November 17, 1989, as a peaceful student demonstration to commemorate the murder of Czech students by the occupying Nazi forces 50 years earlier. But riot police severely beat many of these peaceful protesters. Yet the demonstrations grew, and they continued, eventually leading to the abolishment of the communist hold on power and the election of Vaclav Havel, a dissident critic of the communist regime, to the presidency of Czechoslovakia.

After their subsequent peaceful decision to become independent states, the Czech Republic and the Slovak Republic have flourished, establishing free and democratic societies, and becoming members of the NATO alliance and the European Union.

As a political refugee from Cuba's communist regime, Mr. Speaker, I view the events that took place in Europe in 1989 as a source of tremendous inspiration. They truly provided me with the hope that the freedoms now enjoyed in Central and Eastern Europe will soon reach the oppressed people of Cuba, where a brutal communist dictatorship still rules. As its fellow Communists did in Eastern Europe, until they were overthrown by their oppressed people, the Cuban communist regime engages in gross violations of human rights and fundamental freedoms; detains, tortures and disappears anyone who disagrees or dares to challenge the regime; engages in corrupt activities that enrich its leaders; conducts espionage against the United States and its citizens; and engages in activities that threaten U.S. security interests and global peace and stability.

Still, we can and we must hope that the events of 1989 show us what the future could hold for Cuba, and hopefully soon. I would like to again thank my good friend and colleague, Congressman MICA, for introducing this important and so timely resolution. I strongly support its passage. I urge my colleagues to do the same.

I reserve the balance of my time.

Mr. ACKERMAN. I continue to reserve.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. MICA), the ranking member of the Committee on Transportation and Infrastructure and the author of this important resolution.

Mr. MICA. Mr. Speaker, I have to thank the ranking member, Ms. ROS-LEHTINEN, for having this resolution come before the House this afternoon, as well as Mr. ACKERMAN and Mr. BERMAN, and I thank the staff on both sides of the aisle.

I have been here 17 years, and I have never had a resolution with my name on it. This is an historic occasion. It is historic for me personally for several reasons. First, I have never had a resolution with my name on it; and, secondly, because of my personal ethnic background. Many people know the name John Mica and think it is Italian. And actually, my mother's side is Italian, but Mica is not an Italian name; it is a Slovak, a Czech-Slovak name. John Mica, my great-grandfather, came to the United States about 100 years ago this year, a century ago, and settled in upstate New York.

Some of you know, the Mica family has a unique place in the history of the Congress. My brother, Dan Mica, was a Member of Congress from 1978 to 1988, some 10 years. He was a Democrat Member, and I am a Republican Member. We are the only brothers to serve since 1889 from different political parties. Maybe that is part of our rich Slovak American, Italian American heritage. But it is kind of neat to bring this resolution.

I would venture to say most Americans probably even today couldn't find the Slovak Republic or the Czech Republic on a map. But there are, as Mr. ACKERMAN pointed out, millions of Americans, many in Congress, too, who have roots and heritage with what is today the Czech Republic and the Slovak Republic.

The Czech and Slovak people for centuries, actually millennia, lived under somebody else's rule or oppression. I appreciate the comments of the ranking member, Ms. ROS-LEHTINEN. She and her family only lost their country for the last half a century or so; but these people in Europe, some of my ancestors lost their freedom and independence and were dominated by someone else for millennia. Maybe that is why they appreciated so much the opportunity, some 20 years ago, when students came out in commemoration of a slaughter that had taken place some half century before; 20 years ago yesterday they came out into the streets of Prague, led by students.

I have to tell you, that sounds like not much, but I have been there. The first time I traveled to what was Czechoslovakia was in the 1960s, and then again in the 1980s. I went through the barbed wire, the dogs, and the landmined areas to get to the area where my grandparents came from. When I got there, everything was gray. Everything was dark. It was one of the most depressing things I had ever seen. People when they walked down the street would not look you in the eye; they looked down. The repression under several regimes, under the Communist, was one of the worst in the world and the worst in Europe. The economic situation was deplorable. The rape of the beautiful landscape of Czechoslovakia—the Communists polluted the streams and destroyed the landscape and the economy.

Before that, they had the misfortune of being dominated by the Nazis. I saw some villages where they took the Jews out, and nobody still lived there. They loaded them into boxcars and they loaded them into trucks and trucked them off, and in 1980, no one lived in those homes, because they had taken the people and destroyed them and their lives. All that was left was the vacant houses. I still remember that.

These people, led by students 20 years ago, came out into the street. After the students came out, then the average citizens came out. They came out by the tens of thousands, and they filled the streets. They basically said they had had enough.

And you know, people weren't killed in 1989. There weren't the killings that they had had over their history. That is why it is called the Velvet Revolution. Most people don't understand that. But in the Czech Republic and the Slovak Republic, they had had enough. And within no time at all, they had cast their communist bonds aside.

One of the most incredible experiences I have ever had, I wasn't a Member of Congress, but I sat up in the gallery across from me as a citizen, and I heard Vaclav Havel, the just-elected President of the Czechoslovakia Republic, Mr. Speaker, come up and speak from just below where you are, and I will never forget his words. Here are his words, The last time they arrested me on October 27 last year, I didn't know whether it was for 2 days or for 2 years.

Here was someone who had been in jail just weeks and months before speaking before the House of Representatives in a joint session. He went on to say, Today, less than 4 months later, I am speaking to you as the representative of a country that has set out on the road to democracy, a country where there is complete freedom of speech, which is getting ready for free elections and which wants to create a prosperous market economy and its own foreign policy.

He said that to us here.

□ 1445

So thank you for bringing this resolution up to commemorate the Velvet Revolution. Thank you for recognizing that people, no matter how much you repress them, whether it's in Cuba, whether it's in Myanmar or Burma, as they call it, whether it's in China, Tibet, somewhere in the heart of mankind is a quest, a yearning to be free and independent. And that's what this resolution today recognizes is that 20 years ago people stepped up and they'd had enough. They wanted to be free. And they have turned into two of the most incredible allies, the Czech Republic and the Slovak Republic, great

economies, some of the strongest of the former Eastern bloc, productive citizens, incredible citizens, and not only of their country but of the world community, and great allies to the United States.

So I thank you for allowing me to have the opportunity along with many of my colleagues to bring to the floor this special resolution with that little name on it.

And for those who were interested in linguistics, ''Mica'' there its pronounced ''Meecha.'' It has a caret over, like, the ''c.''

I'm very proud to have this resolution offered today in the House in commemoration of my grandparents and those that came before them and those who on the 17th of November 1989 and today we celebrate the 20th anniversary of that occasion yesterday to recognize their freedom.

Ms. ROS-LEHTINEN. Will the gentleman yield?

Mr. MICA. I yield to the gentlewoman from Florida.

Ms. ROS-LEHTINEN. I congratulate you for this resolution. It speaks to the heart of every freedom-loving American in this Chamber, which is each and every one of us. So, Mr. ''Meecha,'' I believe that we should have a roll call vote because a legislative virgin no more.

Mr. MICA. Thank you. And I think that would be very fitting, too, to show the people again and the House and the Senate that have their roots there and across the great country that we remember all they did to become free and independent.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield back the balance of my time.

Mr. ACKERMAN. Mr. Speaker, it's now my pleasure to yield 4 minutes to the gentleman from Minnesota, the distinguished chairman, JIM OBERSTAR.

Mr. OBERSTAR. I thank the distinguished Chair, Mr. ACKERMAN, for the time and compliment my colleague.

Hvala lepa, moj Slovaski prijatelj, and we're all together. What I said simply was thank you. And I'm Slovene, you're Slovak, and we're all together in the spirit of the Slovak peoples yearning for freedom after conquest by foreign powers, domination by other governments, subjection to cultures and language of other peoples. I recall my grandmother who emigrated from Sodrazica in Slovenia telling me that in her youth they were required in the morning to study in German because it was the Austro-Hungarian empire, and only in the afternoon could they speak their native language, Slovene.

This sense of Congress on the occasion of the 20th anniversary particularly of the Velvet Revolution in Czechoslovakia is one that we must pay attention to, that we must address. As the distinguished gentleman from Florida so warmly, thoughtfully, with deep spirit, a deep personal sense of understanding so well expressed, the freedom that peoples of formerly Eastern Europe felt in their heart, the courage they took, the courage it took for them to stand up against oppression.

It's not just the Velvet Revolution. A hundred sixty-one years ago was the great Prague Revolution. The Prague Spring of 1848 when the people of this great historic cultural center, Prague, marched to the streets, led by the students, to proclaim a time of freedom and democracy and liberty and opening and were suppressed.

In 1939, the Nazis closed the Czech institutions of higher learning and those of the Slovak people as well. Many were sent off to concentration camps. Student leaders were executed. And 50 years later, students again led the way. On November 17, they took to the streets to mark the anniversary of the execution of Czech student leaders and the closure of universities by the Nazis. The government used violence once again to move in, break up this peaceful gathering of students.

So we have the Prague Spring, the 1939 suppression, the Velvet Revolution, suppression once again. Those 42 days of the Prague-Velvet Revolution were momentous, popular demonstrations, public outpouring, people taking to the streets.

But by December 10, the Czechoslovak President Gustav Husak appointed the first largely noncommunist government since 1948. And in 1990, Czechoslovakia held its first democratic elections and then split into both the Czech Republic and the Slovak Republic.

It has very special meaning for me both at the Prague Spring, the 1939 events, closing of the universities and the Prague student Velvet Revolution. In 1956, I was a student at the College of Europe in Brugge, Belgium.

The SPEAKER pro tempore (Mr. RAHALL). The time of the gentleman has expired.

Mr. ACKERMAN. I'm happy to yield an additional minute.

Mr. OBERSTAR. I was a student at the College of Europe in Brugge, Belgium, when Hungarian students took to the streets to rise up against the Soviet occupation and oppression of their homeland, and they too were suppressed brutally as tanks rolled down the street and machine-gunned students. We were only 600 miles away from those momentous events in Brugge, Belgium. And students of the College of Europe organized a grand bal des etudiants du College de L'Europe, raised a scholarship to bring a Hungarian student to the College of Europe to study with us. And when he arrived, we asked him, What was your first reaction on coming into the West? And his comment was, The ability to walk up to a policeman on a street corner and ask direction without fear of being put in prison.

That's what freedom means. So simple. That's what the gentleman from Florida was talking about. That's what this resolution recognizes. A revolution is not simply a continuous movement in one direction to come back where you started but an opportunity to change direction and move the human spirit ahead, and that is what we recognize in this 20th anniversary recognition of the Velvet Revolution.

Mr. ACKERMAN. Mr. Speaker, I'm pleased at this time to yield 3 minutes to the gentleman from Pennsylvania (Mr. SESTAK).

Mr. SESTAK. Mr. Speaker, I'm rising today in strong support of House Concurrent Resolution 212.

Twenty years ago this week, the brutal crackdown occurred on the student-led demonstration in Prague. The students were commemorating the 50th anniversary of the execution of Czech student leaders and closure of universities by the Nazis, it turned out, would be silenced no longer by the repressive Soviet-backed regime. A mere 8 days after the fall of the Berlin Wall, they set events in motion which would culminate in the dissolution of the politburo and which would lead to the peaceful establishment of independent Czech and Slovak states in 1993.

As a son of a Slovakian immigrant, these bonds that join us together are so strong. I can remember in the midst of my 30-year naval career going over to see Czechoslovakia in the mid 1980s. Lots of top secret clearances and special access programs I had, and I had to get special permission to go there, but I wanted to see my father's hometown.

I went through Prague. What a city. So beautiful that the movie ''Amadeus'' about the great composer Mozart was filmed there because it was kept so whole in its beauty as Vienna had been. And then to Bratislava and the small village outside where my father grew up. I spoke English, not Slovak, so we conversed. And I had a wonderful dinner and evening and breakfast the next day. And to this day, I'm still not sure they were my relatives. But what a great homecoming I felt I had in that land. I think that's because the backbone of revolutions, both of theirs and ours, was against the greatest empires of the time. A mere spontaneous gathering in the case of Slovakia, like ours, but theirs was of workers, students, and common citizens, not unlike ours, able to shrug off decades of Soviet oppression.

When enough people realize their God-given right to liberty is within reach, they just can't be stopped. Victor Hugo, that great chronicler of revolution, said it best: ''Nothing can resist an idea whose time has come.''

I can remember the evening in Bratislava walking to the border and overlooking the barbed wires into Austria, and the man I walked there with said, ''Some day.''

If there is anything to be called a march of history, it must be this struggle between power and justice, between violence and the endurance of human dignity, the steady triumph of those who meet brute force with the power of a self-evident ideal. Justice, the prerequisite to equality.

Americans of Slovakian descent, such as football player Chuck Bednarik; Tom Ridge, former Governor of my home State of Pennsylvania; Andy Warhol; Stefan Banic, inventor of the parachute; the inventor of the radio, Jozef Murgas; Paul Newman; Michael Strank, the one who raised the American flag on Iwo Jima, have contributed greatly through their wonderful thread in this great national security fabric of the United States of America to our future. I'm proud to honor them today for the revolution so similar to ours.

Mr. ACKERMAN. Mr. Speaker, I would like to note at this time that all of us here in the House bask in the obvious and well-felt pride that has been expressed especially from our Czech and Slovak colleagues that are here. Congratulations to them as well as in a few moments we pass this resolution.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. ACKERMAN) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 212, as amended.

The question was taken.

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

Ms. ROS-LEHTINEN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

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

FIRE GRANTS REAUTHORIZATION ACT OF 2009

The SPEAKER pro tempore. Pursuant to House Resolution 909 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the further consideration of the bill, H.R. 3791.

□ 1459

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the further consideration of the bill (H.R. 3791) to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes, with Mr. SERRANO (Acting Chair) in the chair.

The Clerk read the title of the bill.

The Acting CHAIR. When the Committee of the Whole House rose earlier today, amendment No. 5 printed in part B of House Report 111–340 by the gentleman from California (Mr. CARDOZA) had been disposed of.

ANNOUNCEMENT BY THE ACTING CHAIR

The Acting CHAIR. Pursuant to clause 6 of rule XVIII, proceedings will now resume on those amendments printed in part B of House Report 111–340 on which further proceedings were postponed, in the following order:

Amendment No. 2 by Mr. PERLMUTTER of Colorado.

Amendment No. 3 by Mr. FLAKE of Arizona.

The Chair will reduce to 5 minutes the time for any electronic vote after the first vote in this series.

AMENDMENT NO. 2 OFFERED BY MR. PERLMUTTER

The Acting CHAIR. The unfinished business is the demand for a recorded vote on the amendment offered by the gentleman from Colorado (Mr. PERLMUTTER) on which further proceedings were postponed and on which the ayes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The Acting CHAIR. A recorded vote has been demanded.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 358, noes 75, not voting 7, as follows:

[Roll No. 899]

AYES—358

Abercrombie
Ackerman
Aderholt
Adler (NJ)
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Bono Mack
Bordallo
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burton (IN)
Butterfield
Calvert
Camp
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Cassidy
Castle
Castor (FL)
Chandler
Childers
Christensen
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Fleming
Fortenberry
Foster
Frank (MA)
Frelinghuysen
Fudge
Gallegly
Garamendi
Giffords
Gingrey (GA)
Gonzalez
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Hunter
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson, E. B.
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lynch
Mack
Maffei
Maloney
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCaul
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Norton
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paulsen
Payne
Perlmutter
Perriello
Peters
Peterson
Pierluisi
Pingree (ME)
Pitts
Platts
Polis (CO)
Pomeroy
Posey
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (KY)
Rogers (MI)
Rooney
Ros-Lehtinen
Roskam
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sablan
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schmidt
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Shuster
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Whitfield
Wilson (OH)
Wolf
Woolsey
Wu
Yarmuth
Young (AK)
Young (FL)

NOES—75

Akin
Bachus
Bartlett
Barton (TX)
Bishop (UT)
Boehner
Bonner
Boozman
Boustany
Brady (TX)
Broun (GA)
Burgess
Buyer
Campbell
Cantor
Carter
Chaffetz
Conaway
Deal (GA)
Dreier
Duncan
Flake
Forbes
Foxx
Franks (AZ)
Garrett (NJ)
Gohmert
Goodlatte
Hensarling
Hoekstra
Inglis
Issa
Johnson (IL)
Johnson, Sam
King (IA)
Kingston
Lamborn
Lewis (CA)
Linder
LoBiondo
Lummis
Lungren, Daniel E.
Manzullo
McCarthy (CA)

McClintock
McMorris Rodgers
Miller (FL)
Myrick
Neugebauer
Nunes
Paul
Pence
Petri
Poe (TX)
Price (GA)
Radanovich
Rogers (AL)
Rohrabacher
Royce
Ryan (WI)
Scalise
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Simpson
Souder
Stearns
Sullivan
Thornberry
Walden
Westmoreland
Wilson (SC)
Wittman

NOT VOTING—7

Barrett (SC)
Brown (SC)
Faleomavaega
Gerlach
Moore (WI)
Rothman (NJ)
Tanner

□ 1529

Messrs. WALDEN, DEAL of Georgia, RYAN of Wisconsin, CANTOR, GOODLATTE, BOOZMAN, WITTMAN, CHAFFETZ, BUYER, MANZULLO, HOEKSTRA, DREIER, STEARNS, SIMPSON, BACHUS and LOBIONDO and Mrs. MCMORRIS RODGERS changed their vote from ''aye'' to ''no.''

Mr. NEAL of Massachusetts and Ms. FALLIN changed their vote from ''no'' to ''aye.''

So the amendment was agreed to.

The result of the vote was announced as above recorded.

AMENDMENT NO. 3 OFFERED BY MR. FLAKE

The Acting CHAIR. The unfinished business is the demand for a recorded vote on the amendment offered by the gentleman from Arizona (Mr. FLAKE) on which further proceedings were postponed and on which the ayes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The Acting CHAIR. A recorded vote has been demanded.

A recorded vote was ordered.

The Acting CHAIR. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 371, noes 63, not voting 6, as follows:

[Roll No. 900]

AYES—371

Ackerman
Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrow
Bartlett
Barton (TX)
Bean
Berkley
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Christensen
Chu
Clarke
Clay
Cleaver
Coble
Coffman (CO)
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Giffords
Gingrey (GA)
Gohmert
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Guthrie
Gutierrez
Hall (TX)
Halvorson
Harman
Harper
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kennedy
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (NY)
Levin
Linder
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Myrick
Neugebauer
Norton
Nunes
Nye
Olson
Ortiz
Owens
Pallone
Pascrell
Paulsen
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pierluisi
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Putnam
Quigley
Radanovich
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Royce
Rush
Ryan (WI)
Sablan
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Shimkus
Shuler
Shuster
Simpson
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Taylor
Teague
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Wu
Yarmuth
Young (AK)
Young (FL)

NOES—63

Abercrombie
Becerra
Berman
Bordallo
Brady (PA)
Brown, Corrine
Carson (IN)
Clyburn
Cohen
Costello
Cummings
Delahunt
DeLauro
Doyle
Farr
Fattah
Filner
Fudge
Garamendi
Grijalva
Hall (NY)
Hare
Hastings (FL)
Hinchey
Jackson (IL)
Jackson-Lee (TX)
Johnson, E. B.
Kaptur
Kildee
Kilpatrick (MI)
Kucinich
Lee (CA)
Lewis (CA)
Lewis (GA)
Lipinski
McDermott
Moore (WI)
Moran (VA)
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Pastor (AZ)
Paul
Payne
Price (NC)
Rahall
Roybal-Allard
Ruppersberger
Ryan (OH)
Sherman
Sires
Thompson (CA)
Thompson (MS)
Towns
Wasserman Schultz
Waters
Watson
Watt
Woolsey

NOT VOTING—6

Barrett (SC)
Brown (SC)
Faleomavaega
Gerlach
Rothman (NJ)
Tanner

ANNOUNCEMENT BY THE ACTING CHAIR

The Acting CHAIR (during the vote). There is 1 minute remaining in this vote.

□ 1538

Ms. ROYBAL-ALLARD, Messrs. NEAL of Massachusetts, PASTOR of Arizona, and CARSON of Indiana changed their vote from ''aye'' to ''no.''

Mrs. LUMMIS changed her vote from ''no'' to ''aye.''

So the amendment was agreed to.

The result of the vote was announced as above recorded.

The Acting CHAIR. The question is on the amendment in the nature of a substitute, as amended.

The amendment in the nature of a substitute, as amended, was agreed to.

The Acting CHAIR. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. CUELLAR) having assumed the chair, Mr. SERRANO, Acting Chair of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 3791) to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes, pursuant to House Resolution 909, he reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

The question is on the amendment.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GORDON of Tennessee. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 395, nays 31, not voting 8, as follows:

[Roll No. 901]

YEAS—395

Abercrombie
Ackerman
Aderholt
Adler (NJ)
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrow
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Cantor
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Cassidy
Castle
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Cohen
Cole
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Giffords
Gingrey (GA)
Gohmert
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Herseth Sandlin
Higgins
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lungren, Daniel E.
Lynch
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sessions
Sestak
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Sullivan
Sutton
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (AK)
Young (FL)

NAYS—31

Akin
Bishop (UT)
Broun (GA)
Campbell
Carter
Chaffetz
Coffman (CO)
Conaway
Culberson
Flake
Franks (AZ)
Hensarling
Herger
Inglis
Issa
Johnson, Sam
Jordan (OH)
King (IA)
Kingston
Lamborn
Linder
Lummis
Mack
McClintock
Mica
Neugebauer
Paul
Royce
Sensenbrenner
Shadegg
Thornberry

NOT VOTING—8

Barrett (SC)
Brown (SC)
Gerlach
Hill
Neal (MA)
Rothman (NJ)
Stupak
Tanner

□ 1556

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

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

Mr. COHEN. Mr. Speaker, I ask for unanimous consent to withdraw my name as a cosponsor of H. Res. 648.

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

There was no objection.

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

Mr. TERRY. Mr. Speaker, I ask unanimous consent to have my name removed as a cosponsor of House Resolution 648.

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

There was no objection.

HONORING THE 25TH ANNIVERSARY OF REV. JESSE JACKSON'S PRESIDENTIAL CAMPAIGN

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

Mr. COHEN. This morning during 1-minutes, 15 Members of the Democratic Caucus honored Rev. Jesse Jackson on the 25th anniversary of his Presidential run. He was the first African American male to run for President, and his contributions to our society cannot be overstated. He has a long career in civil rights work, and his leadership in forming the Rainbow Coalition is well known to all Americans.

It is important to note his place on the world stage, a role in which he has been an effective leader, negotiator, and voice for America around the world. Rev. Jackson's skills have been applied to international relations in Syria, where he freed Navy Lieutenant Robert Goodman in 1983. President Reagan recognized Rev. Jackson's essential contribution by hosting Rev. Jackson and Lieutenant Goodman at the White House. In 1984, Rev. Jackson negotiated the release of 22 Americans held in Cuba.

Although Rev. Jackson declined an opportunity to become Ambassador to South Africa because he wanted to help his son Congressman Jesse Jackson, Jr., seek election—which he did, as he was elected to this body in 1996—President Clinton had requested he be named Ambassador. He, instead, named him a special envoy for democracy in 1997. Subsequently, Jesse Jackson met with Kenyan President Daniel arap Moi to promote free and fair elections in Kenya. In 1999, he was in Kosovo and negotiated the release of three POWs.

Jesse Jackson's career on the international stage has been spectacular, and his place in history is assured. His passion, his dedication, and his continuing influence for change are hallmarks of his life. We need look no further than today's tribute to him when a group of House pages, a Rainbow Coalition themselves, excitedly sought to have their picture taken with the Reverend Jackson and did, after he finished his appearance here in the gallery and listening to the 1-minutes this morning.

I join my fellow House Members in recognizing this 25th anniversary of the Presidential run of Rev. Jesse

Jackson and appreciate what he's done for our Nation.

HONORING RYAN DILLON DURING NATIONAL EPILEPSY AWARENESS MONTH

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

Mrs. EMERSON. Mr. Speaker, I stand here today to tell you about Ryan Dillon, a remarkable young man from Missouri's Eighth Congressional District, which I represent.

As a teenager, Ryan was highly active in school and clubs when, one day while brushing his teeth, his world went black. Ryan had had a seizure. Ryan went on to Westminster College in Fulton, Missouri, where he majored in political science. At Westminster, Ryan remained politically active, became vice president of the Student Government Association, and was elected Homecoming King during the fall of his senior year. All the while, he hid his epilepsy from his peers.

Epilepsy is one of the most common disorders of the nervous system. It affects people of all ages, races, and ethnic backgrounds. More than 3 million Americans of all ages are living with epilepsy, and every year, 200,000 Americans will develop seizures and epilepsy for the first time. Epilepsy can develop at any time of life, especially in early childhood and old age. It's a neurological condition that makes people susceptible to seizures.

Ryan is now 25 and serves as a congressional aide. He hopes to use his experiences and influence to raise awareness. As November is designated National Epilepsy Awareness Month, I am honored to help Ryan promote his message for increased research, awareness, and education to openly work toward a cure.

□ 1600

AMERICA'S LIFE LINE FOUNDATION

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

Ms. ROS-LEHTINEN. Mr. Speaker, I rise today to recognize the America's Life Line Foundation, a local nonprofit committed to serving our south Florida community. As part of its many activities, this caring group provides assistance to the many members of our Armed Forces and their families. Their upcoming event, Tribute to Our Troops, will be on December 12 at the Kendall Hotel to honor the men and women who continue to preserve our freedom with service to this great Nation.

This event will help make the holidays a little bit brighter for our military families. I applaud everyone who is a volunteer at America's Life Line Foundation for their continuing efforts, especially for the members of this worthy organization who motivate and inspire our community to patriotism and action during this season of giving.

I encourage everyone in south Florida to join America's Life Line Foundation at their tribute to our troops event in December.

CONGRATULATIONS TO OCALA RECYCLING

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

Mr. STEARNS. Mr. Speaker, I rise today to congratulate the Ocala Recycling Company, which is located in my home town of Ocala, Florida, for becoming the first RIOS certified scrap recycling facility in the world. RIOS, which stands for Recycling Industry Operating Standard, was developed by the Institute of Scrap Recycling Industries and is an integrated standard encompassing environmental and health and safety controls into one streamlined management system.

Since 1988, Ocala Recycling's 34-acre facility has recycled everything from bottles and paper to automobiles and even washing machines. Each month, Ocala Recycling collects more than 16,000 tons of recycled goods. This unique honor and certification demonstrates the ongoing commitment of Ocala Recycling to recycle and process quality products in an efficient, safe, and environmentally responsible manner in a manufacturing environment.

THE REALITY OF THE FORUM ON JOBS AND ECONOMIC GROWTH

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

Mr. BURTON of Indiana. Mr. Speaker, the Associated Press reported that President Barack Obama says creating jobs is not the goal of the upcoming White House forum on jobs and economic growth. The President told NBC News on Wednesday that the purpose of the December 3 summit is to figure out how to encourage hiring by businesses still reluctant to do so.

Businesses are being taxed too much. And I'll tell you, if I were talking to the President, I would say, Mr. President, if you want to create jobs, cut government spending, cut taxes, and not raise taxes. It's the wrong thing to do in this economic climate.

GUANTANAMO TERRORISTS IN NEW YORK

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

Mr. DUNCAN. Mr. Speaker, people all over the Nation are upset and angry about five of the Guantanamo terrorists being scheduled for trial in New York.

This is happening only because President Obama issued an executive order in the early days of his administration stopping the military tribunal process. The Congress, both House and Senate, voted by large margins in 2006 to try these terrorists by military tribunals.

This could have been done in Guantanamo, but President Obama overruled Congress by his executive order and the Defense and Justice Departments then started the process of bringing the terrorists to trial in this country. This will result in very large legal and security expenses that would not have been necessary if these men were tried at Guantanamo.

To try all of these terrorists here—the first five and others later—creates a very unnecessary security risk for untold numbers of people.

I hope President Obama will listen to the outcry of the American people and not continue to insist that all of these terrorists be tried in the United States. The families of our victims deserve better.

HONORING CAPTAIN WILLIAM ECKER

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

Mr. ROONEY. Mr. Speaker, I rise today to honor the life of Captain William B. Ecker of Punta Gorda, Florida, in my district, who passed away earlier this month. Captain Ecker flew combat missions in the Pacific during World War II, serving 32 years in the United States Navy. Most notably on October 23, 1962, Ecker led low-level sorties over Cuba collecting photographic evidence of the Soviet missiles fueling vehicles and other related equipment.

Flying the F–8 Crusader, Captain Ecker was able to fly at lower altitudes than the U–2 spy plans. At the lower level, Ecker took close-up pictures of a site near the town of San Cristobal in western Cuba proving without a doubt that Soviet missiles were in Cuba.

Captain Ecker received the Distinguished Flying Cross for his quick and risky flights over Cuba. The unit Ecker commanded, VFP–62, received the first peacetime Navy Unit Commendation in history by President John F. Kennedy.

Captain Ecker leaves behind his wife, Kit, of 62 years and his two sons, Richard and David, and a Nation grateful for his distinguished service.

SYSTEMIC REGULATORY EXPANSION BILL

(Mr. KINGSTON asked and was given permission to address the House for 1

minute and to revise and extend his remarks.)

Mr. KINGSTON. Mr. Speaker, you know, last year without a single vote from anyone in Congress, the Federal Reserve spent $29 billion bailing out Bear Stearns and then $85 billion to bail out AIG, which has now gone to about $140 billion.

Now, if that is not bad enough, the House Banking Committee wants to codify that authority. That's right: they want to give the Federal Reserve and the FDIC permanent bailout authority so that anyone who comes around that they call a systemic risk can now get permanent TARP money without having to come back to Congress for our scrutiny.

What does this lead to? Well, number one, the Federal Reserve is in charge of monetary policy, not bailouts. It will take the eye off the monetary policy, and if you think the economy is going great now, think what happens when the Federal Reserve is even more distracted.

It will also lead to unfair competitive advantage because if you're too big to fail, that means you can do anything you want to and compete against regular banks who won't get the bailout money. So it is an unfair competitive advantage.

And, finally, it will increase the moral risk, that is to say, you can make crazy loans because you know good old Uncle Sugar is going to stand behind you and bail you out time and time again after your fiscal irresponsibility.

This is a bad bill. This is a bad idea. We need to vote ''no'' on this systemic regulatory expansion bill.

HONORING THE REVEREND JESSE JACKSON

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

Mr. PAYNE. Mr. Speaker, I rise today to pay tribute to Rev. Jesse Jackson who is celebrating his 25th anniversary of active civil rights activities.

As we all know, Rev. Jackson was born in South Carolina and began his activities in civil rights at an early age. He became a confidant to the late Rev. Dr. Martin Luther King and was one of the leading advocates for peace and justice in this Nation.

His successful run for President had America spellbound when he addressed the House. He started Operation Bread Basket, then the Rainbow Coalition. And I would just like for all of us to pay tribute to a great American, Rev. Jesse Jackson and thank him for coming to New Jersey for my election back in the 1980s.

NEW YORKERS ARE BEING USED IN TERRORIST TRIALS

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

Mr. GOHMERT. Mr. Speaker, our Attorney General intends to bring self-confessed terrorists to the most densely populated area in America. I know we have friends from New York that think this is a grand idea. They don't realize they're being used. We even have friends from New York who say, Bring these terrorists to New York; we want to try them so we can look them in the eye and sentence them to death.

Well, coming from a judge, a former judge, who has looked people in the eye and sentenced them to death, I know something about it. They're being used.

Once those terrorists set foot on New York—probably not before—the change of venue motion will be filed and people's comments like that—''we want to try them, then put them to death''—those will be used in support of the motion to change venue. They are not likely to be tried there with or without the terrorist activity and the threats and all that will follow. It is a bad idea. I hope cooler minds will prevail so they get the punishment they deserve.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

DESERT RAT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

Mr. POE of Texas. Mr. Speaker, yesterday the United Nations had an update on the government of the tiny tyrant in the desert of Iran. The U.N. nuclear watchdog agency, the International Atomic Energy Agency, or the IAEA, has released their new report on Iran's nuclear site. This facility, called Fordo, is being built inside a mountain near the religious city Qom. The IAEA concluded the facility had no relevance to any alleged civilian power program.

Western analysts say Fordo's small size will only allow enrichment of small amounts of uranium enough to make a nuclear bomb, but not enough to fuel a nuclear power station. Are we surprised with this finding.

The IAEA said in its report that Iran was not able to convince them that they weren't hiding other nuclear sites. Well, imagine that.

The Government of Iran sponsors acts of terrorism all over the world. Now this thuggish government seeks to threaten the world with nuclear holocaust. For 30 years, Iran has used terrorism, assassination squads, and hostages as their foreign policy.

And, Mr. Speaker, just look at the way this government treats its own people. The people of Iran live in fear of their own government and their own President. Iranian state television yesterday reported that five Iranian citizens were sentenced to death for peaceably protesting the fraudulent Presidential elections in June. That's right. They got the death penalty for exercising the human right to peaceably assemble. And in this Third World country, the death penalty rules the day.

Further, Mr. Speaker, the world witnessed earlier this year how the government even murdered its own people in the streets who peacefully protested the Presidential elections that were rigged by Ahmadinejad.

□ 1615

The cries of the murdered are from the blood of the Iranian freedom patriots who want freedom in their own country. More than 100 prominent opposition leaders in Iran are now being tried for peacefully protesting. Brave men and women of Iran who refuse to be trampled by the tiny tyrant, Ahmadinejad.

The United States should stand with the people of Iran that oppose this illegitimate reign of terror by their government and by their president. The government of Iran is the threat to world peace, especially peace in the Middle East. The sanctions that have been imposed by the U.N. and other Nations on Iran have failed to get the attention of the desert rat, Ahmadinejad. He continues to build his nuclear weapons. He continues to build intercontinental ballistic missiles so that he can fire those nuclear weapons. He continues to finance terrorist groups like Hezbollah and Hamas. He continues to meddle in the lawful affairs of Iraq, including supporting assaults and assassinations against the Iranian people that are in Camp Ashraf.

He sends aid and comfort to al Qaeda and to the Taliban in Afghanistan that war against American troops and NATO troops. The key to world peace and peace in Iran is a regime change sponsored by the freedom-loving citizens of Iran. Those noble citizens who have now become the enemy of their own government deserve our support and our encouragement here in America.

Mr. Speaker, deep down in the soul of every person who ever has been or ever will be born is the spark for freedom. The sons of liberty and the daughters of democracy in Iran have in their hearts that spark for liberty, and they will not be quenched by the tiny tyrant of Iran.

It is imperative that the United States recognize the true threat to world peace, Ahmadinejad, and that we

as a Nation and that we as a people stand shoulder to shoulder with the good folks of Iran, the citizens of Iran that want a change in their government.

And that's just the way it is.

FLORIDA'S FISHERMEN NEED OUR HELP

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Florida (Ms. ROS-LEHTINEN) is recognized for 5 minutes.

Ms. ROS-LEHTINEN. Mr. Speaker, I have been to the floor of this Chamber on several occasions to discuss the tremendous economic hardships being shouldered by the residents of my congressional district of south Florida. This evening I would like to highlight the men and women of Florida's commercial and recreational fishing industries, and their efforts to weather this economic storm.

Mr. Speaker, Florida's recreational fishing industry is the largest in the Nation. Its economic impact to our State is to the tune of $5.3 billion, and more than 5,400 jobs are generated by this industry. Similarly, Florida's commercial fishing industry is nearly 13,000 strong and contributes a staggering $1.2 billion to our economy.

The strength of Florida's fishing industries is due largely to the diversity and the abundance of species within the Gulf of Mexico and the South Atlantic area. There are grouper and snapper, wahoo and yellowfin tuna, not to mention Keys lobster and stone crab. Thanks to this diversity, Florida's fishing industry is particularly resilient in the face of increased zoning regulations, bag limits, and even fishery closures. Our fishermen understand that maintaining a robust, healthy fishery through appropriate regulation is the key to their economic success.

However, present Federal action to implement multiple fishing regulations will have a chilling effect on this historic and important industry. In particular, Mr. Speaker, the South Atlantic Fishery Management Council is considering regulations which include but are not limited to: a complete ban on deepwater grouper fishing; annual catch limits on black grouper and red grouper; and catch limits on red snapper fishing.

The comprehensive nature of these prohibitions will leave our fishermen with little or no alternative for their economic livelihood. These prohibitions, compounded by a reduction in tourism throughout south Florida, and that includes the Florida Keys, will force generations of Florida fishermen to walk away from their boats in search of other types of employment. This is unacceptable.

That is why I have called on Secretary of Commerce Gary Locke to reconsider these ill-timed proposals. Additionally, I have asked Secretary Locke to refrain from implementing any emergency rules which impose short-term restrictions on Florida's fisheries. These emergency rulings completely circumvent the public comment process, which is an essential element to any fishery management plan. Sound science is also a critical component to sound management.

My congressional colleagues and I have called on the House Natural Resources Committee to conduct a hearing on the legislation introduced by Congressman JOHN MICA and Congressman HENRY BROWN which would require the Department of Commerce to conduct a non-biased, science-based study on the health of the red snapper population in the South Atlantic.

My colleagues from Florida understand that scientific data collection processes need to be improved, and economic impacts must be taken into account when considering a fishery closure. I have also asked the Department of Commerce to provide economic assistance to those fishermen and businesses that cannot survive the restrictions that are being implemented.

For Keys recreational angler Andy Griffith, the upcoming 4-month grouper closure has resulted in a 90 percent loss of business for the 2010 fishing season. His season for 2010 will only be 2 months long. For the rest of the year his boats will sit by the dock racking up insurance costs. Fishermen like Andy need economic relief. They need our help.

The Magnuson-Stevens Fishery Conservation and Management Act, last amended by Congress in the year 2007, directs how the Federal Government will manage saltwater fisheries. But the lack of flexibility provided to local managers in this law is of serious concern to many of us. That is why I support legislation which would amend the Magnuson-Stevens Act to provide flexibility to State regulators and regional fishery management councils in their work to rebuild healthy fisheries.

Mr. Speaker, the livelihood of Florida's fishing industry demands that we act.

HOUSING CRISIS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

Ms. KAPTUR. Mr. Speaker, unemployment and foreclosures are on the rise. In my hometown of Toledo, Ohio, unemployment is officially at 11.1 percent, but that is just those who are looking for jobs. The real number is much higher as so many people have dropped out or are working part time and they really want full-time jobs. Many, many more people are discouraged and are no longer trying to find jobs. Kids are moving in with their parents. These are people, many of whom are losing their homes. The housing crisis continues.

Before the financial crisis unfolded, our housing crisis was unfolding. In fact, it triggered the financial crisis. Congress acted, passing the Housing and Economic Recovery Act of 2008 at the end of July last year. I didn't vote for it because I knew it would not work. And you know what, it hasn't worked.

The HOPE for Homeowners program has failed so miserably that HUD had to change the program, and Congress since has had to pass fixes to try to get more participation into it. It hasn't worked. As of mid-July this year, the program that the Congressional Budget Office estimated would help up to 400,000 people rework their mortgages has closed 50. Fifty mortgages. That's five-zero, from a program that was supposed to help 400,000 people. Fifty homeowners have been helped?

The administration announced the Making Homes Affordable Program in February, released rules and regulations in March, and they told us that the program would help 3 million to 4 million homeowners. As of September 30, Treasury reported that 758,000 modification offers, listen to the words, my friends, had been extended with 487,000 trial modifications begun. Hmm. I will be interested to hear when the first modification moved from a trial to a real modification that actually kept somebody, a real person or family, in their homes.

There is no peace for the family while they are in this trial period. They still have to have a backup plan in case something falls through. They are still stressed beyond what you and I can imagine.

The servicers get to sit back and wait, keep making their money. Either way, they make plenty, either from the homeowner or from the government. They have got it at both ends. This program probably won't even help a handful of homeowners.

So we have just 487,000 homeowners with these trial modifications out of the millions of people who are losing their homes. Now that's not 4 million people, like the program said it would take care of. And again, it is just trial modifications. Trial, not real. They get 3 months to show they can handle the modification payments. What happens if they lose their job? If they have already lost their job, unemployment income does not count as income for modification. Can you believe that? We can still tax it, but it does not count to banksters and servicers when they are looking to rack up fees, kick people out, sell the homes for a fraction of what they are worth and maybe pull a profit; and if not, they move that property and destroy the stability of the family that once resided in the home.

I still hear that servicers and banks are hard to work with on modifications. Boy, is that an understatement.

I heard that the Making Homes Affordable Program isn't working. Well, it isn't. The solutions are not working because the system does not work. The housing crisis will continue as long as the job situation is so poor. It takes employment to make house payments. It takes workouts to keep people in their homes, even with lease-to-own programs over a 40-year mortgage.

That is why I am joining my colleague, BOBBY RUSH, in forming the Jobs Now Caucus. Please join us in taking a stand for putting our communities, our families, our Nation back to work and keeping them in their homes. This new caucus will advocate for policy initiatives that stimulate and maintain a strong economy that is based on sustainable development that will lead to one common goal across the political spectrum: Creating jobs again in America.

The American people want to work. Employment brings stability, and the ability to stay in your home or buy a home and build your community makes this Nation truly strong. Please join Congressman BOBBY RUSH, myself, and Congresswoman CANDICE MILLER in our bipartisan Jobs Now Caucus.

ABOLITION OF THE ESTATE TAX

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

Mr. GRIFFITH. Mr. Speaker, I rise today to ask Congress and the administration to permanently eliminate a punitive tax that has plagued family farms and businesses for over 100 years. The estate tax only serves as a double taxation to those who have worked tirelessly to build their estates for themselves and their family. These entrepreneurs are not only working for themselves; they are working for their children and their grandchildren, and future generations of Americans.

Building a small business from the ground up is the very fabric of the American dream, and the estate tax tears that fabric apart. This punitive tax inflicts great harm on the hardworking families of America. The estate tax costs small business owners thousands of hours in manpower and millions of dollars in legal counsel. It is time to eliminate the estate tax.

Madam Speaker, I urge Congress to prioritize the quick and permanent abolition of the Federal estate tax in order to accelerate our economic recovery and foster a greater environment for business and rural development.

□ 1630

TRIBUTE TO PRIVATE FIRST CLASS BRANDON M. STYER, U.S. ARMY, OF LANCASTER, PENNSYLVANIA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania (Mr. PITTS) is recognized for 5 minutes.

Mr. PITTS. Mr. Speaker, I rise today to remember and honor Private First Class Brandon M. Styer of Lancaster, Pennsylvania.

On October 15 of this year, Brandon lost his life from injuries sustained when an improvised explosive device detonated near his vehicle in Kandahar province, Afghanistan.

Brandon exhibited a willingness and enthusiasm to serve and defend his country by joining the United States Army. He understood what it means to live a life with purpose. He served a cause greater than himself. He served the cause of liberty. He gave his life so that we might be safer.

Brandon told his father that he loved the camaraderie and excitement of serving in the Army. He enlisted just last year, his senior year at Conestoga Valley High School. Upon graduation, Brandon completed his basic training at Fort Leonard Wood, Missouri, and Fort Benning, Georgia. He then was transferred to Fort Carson, Colorado, for additional training.

In March of 2009, Brandon deployed to Iraq for 7 weeks before being transferred to Afghanistan. Assigned to the 569th Mobility Augmentation Company, Fourth Engineer Battalion as a combat engineer, Brandon worked to dismantle, remove, and destroy improvised explosive devices. The 569th MAC Company has a storied history of participating in campaigns in World War II and Vietnam and, more recently, Operation Iraqi Freedom and Operation Enduring Freedom. It is entirely fitting that Brandon joined their ranks.

As an exceptional young man, Brandon was determined to serve our country and keep his fellow soldiers safe from roadside bombs. It is tragic that one of these bombs claimed his life.

Brandon was also a noble and selfless friend and family man, a compassionate son, brother, and uncle. He leaves behind a family proud of all that he accomplished throughout his distinguished life and career in the military. His valor and service cost him his life, but his sacrifice will live on forever among the many dedicated heroes this Nation has sent abroad to defend freedom.

Brandon earned a number of awards throughout his brief career in the Army, which demonstrates his professionalism and his outstanding ability as a soldier. His awards include the National Defense Service Medal, the Afghanistan Campaign Medal with Bronze Service Star, the Iraq Campaign Medal with Bronze Service Star, the Global War on Terrorism Service Medal, the Army Service Ribbon, the Overseas Service Ribbon and Bar, and the Weapons Qualification Badge.

Posthumously, Brandon received the Bronze Star Medal, the Purple Heart Medal, the Army Good Conduct Medal, the NATO Medal, and the Combat Action Badge.

May God grant to Brandon's family the peace that surpasses all understanding. Our prayers and most heartfelt gratitude go out to them, and I offer them my deepest condolences.

I am humbled by the dedicated service and sacrifice of their loved one.

Brandon joins the revered ranks of the many thousands of men and women throughout American history who have gone before him in battle to secure the freedom of the people of United States of America and people around the world.

He is an inspiration to us all.

AMERICANS DESERVE MORE THAN OVER-THE-TOP RHETORIC

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida (Mr. STEARNS) is recognized for 5 minutes.

Mr. STEARNS. Mr. Speaker, in recent floor speeches and in numerous media appearances, some Members of Congress continue to repeat the mistaken idea that a significant number of people will die automatically because of lack of access to health insurance. Now, as Franklin Roosevelt said, ''Repetition does not transform a lie into truth.'' The American people deserve better than this kind of rhetoric. The American people deserve a Congress that can work together to find solutions to our most pressing problems.

This argument is based upon a questionable study conducted by biased researchers, inaccurate characterizations, and faulty ideas. Oftentimes these Members quote from a Harvard study, which estimates that 45,000 deaths per year in the United States are associated with the lack of health insurance. What they neglected to tell you was that the two authors of this study, Dr. Himmelstein and Dr. Woolhandler, are cofounders of the Physicians for a National Health Program. And what do they support? This program supports government-backed, single-payer health coverage.

In fact, Dr. Woolhandler testified before the Energy and Commerce Committee, where I serve on the Health Subcommittee, on June 24. What did he testify on? On the absolute need, in his opinion, for a single-payer system. So he is totally biased. This report reflects his demand and his desire for a one-payer system. It's clear that this study was conducted by researchers who knew what they wanted the outcome to show before they even conducted the study.

Furthermore, this study used questionable methodology to reach its conclusion. According to analysis by John Goodman of the National Center for Policy Analysis, the authors of this Harvard study ''interviewed the uninsured only once and never saw them again. A decade later, the researchers assumed that participants were still uninsured''—this is after 10 years they assumed it—''and, if they died in the interim, lack of insurance was blamed as one of the causes.'' Obviously, that's faulty logic.

Yet, like unemployment, uninsurance happens to many people for short periods of time. It happens to a lot of people. Most people who are uninsured again regain insurance within 1 year, yet they forgot about this statistic. The authors of this study did not track what happened to the insurance status of the subjects over the decade examined, what medical care they received, or even the causes of their death. How can they make those claims?

In Massachusetts, for example—the public option here in Congress is patterned after Massachusetts. It has the highest percentage of its residents insured in the United States at 97 percent. We can see the effects of a government-run health care system by looking at Massachusetts. According to a 2009 survey by Merritt Hawkins & Associates, there is a 63-day wait to see a family medical doctor in Boston, the longest of the 15 cities surveyed. This long wait is, in large part, due to Massachusetts' health care initiative. So, instead of waiting over 2 months to see a doctor, patients are flooding the emergency room since they cannot find a doctor, and this is putting a major strain on already overburdened and crowded emergency rooms. Obviously, these supporters of the public option here in Congress don't tell you how many people would die waiting for a medical doctor.

The United States has the best health care in the world, especially in comparison to countries that have a one-payer system. In 10 of 16 specific cancers, American patients have statistically better outcomes than their European counterparts. A new report released found that up to 15,000 lives could be saved every year if patients in Britain's National Health Service received the same type of quality care that patients in the United States receive. British Government responded by saying it's going to give patients the ''right'' to see a cancer specialist within 2 weeks of diagnosis.

I could go on. There are horror stories all around this world from countries that are practicing socialized medicine. From 2001 to 2003, the British health system would only allow doctors to prescribe a treatment to preserve vision for those suffering from age-related macular degeneration after the patient had lost vision in one eye. Only after they lost one eye. A woman with epilepsy in the United Kingdom faced a 56-week wait to see a doctor. Also, in the United Kingdom, Christine Preuth, 72 years of age, was told she was too old to receive treatment for a head injury at a 24-hour walk-in center. While walking in, she tripped and fell on the pavement. Bleeding from the head, the nurse said she was not able to receive full treatment because she was over 65 years of age and her complaint was a head injury.

We need to support health care reform that provides greater access to private insurance, lowers costs, and allows people who like their insurance to keep it. The public option does not allow that. Unfortunately, Democrats believe that the government-run health care system, spending over a trillion dollars, will solve the problem. The facts in all socialized countries do not bear that out. The numbers just don't add up, and future generations will be on the hook for paying for this dangerous Democrat health care experiment.

CLEAN ENERGY ECONOMY FOR THE FUTURE

The SPEAKER pro tempore (Ms. KOSMAS). Under the Speaker's announced policy of January 6, 2009, the gentleman from New York (Mr. TONKO) is recognized for 60 minutes as the designee of the majority leader.

Mr. TONKO. Madam Speaker, we're going to utilize our 60 minutes this evening on the floor so as to have Democrats speak to jobs as they relate to this energy rethinking so that we can address the energy reforms that are essential for the strengthening of this Nation, to embrace our intellectual capacity, and to provide opportunities in job growth by promoting a strong sense of energy security, enhancing our energy independence, and therefore addressing favorably, Madam Speaker, our national security. All of these fine dynamics are met as we think outside the barrel, if you will, on energy policy.

How do we create these jobs? Well, there is just a sampling in the American Recovery and Reinvestment Act that, when passed in early February, spoke to the creation of a half million jobs. That will now be invested through the Department of Energy, other resources, other agencies on the Federal level of government to make certain that we grow these opportunities through research and development investment, through energy efficiency, through renewables that are available through wind, solar, and the Earth, through geothermal; making certain that we can go forward with a progressive agenda so as to speak to a cleaning up of the environment and the security strengthener for the American economy by growing less reliant on fossil-based fuels. That gluttonous dependency that this Nation has on those fossil-based fuels is driving down our economy, and we have the potential here to enter a clean energy race, a global energy race, and win that race.

I am joined this evening, Madam Speaker, by two of our colleagues who have asked to participate so as to insert their thinking and to share their enthusiasm with the American audience and those here in the House about the job potential as it relates to energy reforming and energy transformation. We're joined by Representative JAY INSLEE from the State of Washington, the First District of the State of Washington, and we're also joined by Representative BEN LUJAN from the Third District in the State of New Mexico. Both are outstanding Representatives as it comes to energy transformation but also outspoken voices about job creation, job retention as it relates to energy policy.

Representative INSLEE, because we are all, the three of us, partners in this new developed SEEC, the coalition that is provided for a Sustainable Energy and Environment Coalition, a group that has brought together soundness of thinking and the advancement of progressive policy. You serve as a cochair of that panel on which both Representative LUJÁN and I serve. And so this evening if you would just share your comments with us about job potential as it relates to energy as an arena.

Mr. INSLEE. Well, with 10 percent unemployment, we know this country needs to act and we need to act quickly, and we need to act quickly in the job front of jobs that just won't be temporary and just won't be make-work jobs but will be part of the transition of our Nation to a Nation that can lead the world in the clean energy economy of the future. And we know that we have to get in that race for those jobs right now. We have bills pending, as we have already passed in the House the energy bill, which is now pending in the other Chamber; the stimulus bill, which is still in the process of being implemented; and we may have another bill on the floor of this House within the next month. All three of those bills are ways that we can jump-start the job growth in this economy by putting people to work on the jobs that are going to be the long-term jobs.

I want to note something. Our President was in China yesterday. I believe he's still there today. I was there about 4 months ago meeting with Speaker PELOSI, the President, and the Premier of China, and I will tell you the risk our country really has is that there is a country across the Pacific who fully understands where the jobs of the future are going to be. And when we talked to the President and Premier of China, they made very clear that they

were going to try to dominate these industries and dominate job creation in building electric cars, electric motors for electric cars, wind turbines, solar voltaic plants, solar thermal plants. The Chinese are spending about $12 million an hour on renewable energy job creation. They spent three times as much on their stimulus bill as we did on ours in job creation in clean energy. They want to dominate the job creation of the future. And we are determined in this Chamber to get in that race both in the energy bill we passed in August and in this job creation bill we hope to be considering in the next month on the floor to continue this job creation.

I just want to mention two things that I think we ought to do very quickly. Number one, we should be putting thousands of Americans to work in retrofitting our homes and our businesses and our public buildings and our schools to make them energy efficient.

□ 1645

We started down that road in the stimulus bill, but there's more we can do to put people to work putting insulation in our homes, putting new windows on our homes, putting more energy efficient heating and cooling systems in our homes, in our schools and our buildings; and we will be proposing to leadership in the House, actually, this afternoon of this Sustainable Energy and Environment Caucus four or five ways to promote that type of job creation.

Second, we hope to use the Tax Code to continue incentive for Americans to make these kind of investments. We have a tax credit for homeowners right now, but it's just a credit you could take at the end of the year. We want to make that an advance so homeowners possibly can get the cash to work with this right now to hire people to put people to work in retrofitting their homes. We want to use the Tax Code to extend a couple of the tax credits that we're now using to develop job creation, for instance, the bio-fuel industry, that is expiring this December if we don't extend it. So there's just two ideas. I know we'll have some time tonight, but I would suggest that we could at least start at those two ideas.

Mr. TONKO. Absolutely. Thank you, Representative INSLEE.

You talk about energy efficiency. I think we need to regard energy efficiency as our fuel of choice. We should give it highest priority because, for too long, supply-side solutions were encouraged without any addressing of demand side. We have a gluttonous dependency on whatever fuel mix we have in this country. We have got to do it with more efficiency. And I think that the kilowatt hours saved represent those cheapest that we need address into the future. The plant you never have to build will be the outcome here that provides for the cheapest kilowatt addressed.

We set a record, an historic record, with the $70 billion worth of investment in energy transformation, in renewables and energy efficiency and R&D through ARPA–E. All of this is a record proportion in this country's history. If it were a stand-alone bill outside of the Recovery Act, that would be the case. And so we can take great pride. There are people who are advancing this agenda because we know it is the right thing to do. And as you indicated, competing nations out there are already deeply invested into the race. We do not have the luxury to sit by idly and lull in some sort of sense of complacency and believe that we can escape this race. We need to be in it as we were in the Space Race in the sixties.

Mr. INSLEE. And I may note, if I can, efficiency, some people think that means just turning off your lights when you're not in the room. Efficiency needs to be seen as a job creation engine because when you become efficient you do two things: one, you make investments in your infrastructure to make it more efficient. And when you make those investments, you hire sheet metal workers to do the duct work, you hire people in the construction trades to do the retrofitting, you hire people who are manufacturing energy efficient refrigerators and energy efficient air conditioners, and a whole slew of these new businesses. So efficiency is a job creator first.

Secondly, after the efficiency is installed, you free up money for other investments. A business that can save 20 percent on its energy costs, and many businesses can, there's a company called McKinstry in Seattle which is leading the world and putting thousands of people to work. They're freeing up that money for businesses to make other investments. This is a job creator. We've just got to use the Tax Code on something like the PACE bonds, another idea that we will be proposing to leadership, to allow municipalities to float bonds, use that money to give to homeowners, let the homeowners retrofit their home and pay back the municipality on their property taxes. It's a surefire winner for everyone to get money to homeowners fast so that they can hire people to fix up their homes and have security for municipalities of getting paid back.

Mr. TONKO. You're absolutely right. And I'm very proud to serve on Science and Tech as a committee assignment in this House with Representative BEN LUJÁN. We see, firsthand by that committee assignment the innovation that is sparked, that the policy we're developing is investing in all of this intellect here in the States, in the United States where we can provide these opportunities; many are shelf-ready. We're not even utilizing those. So we need to advance those efforts. Science and Tech is a good way. The SEEC Coalition, the Sustainable Energy and Environment Coalition, is a great opportunity on which all three of us serve.

Representative LUJÁN, I know you have great thoughts about where we can go with energy policy. You're an outspoken voice, to your credit. It's great to haye you here this evening.

Mr. LUJÁN. Thank you, Mr. TONKO. It's an honor to be here with you tonight. I just want to say thank you for making sure we got this hour moving, and especially to be here with such a distinguished Member as Mr. INSLEE to talk about these important projects that are moving forward.

If I could just pick up a little bit where Mr. INSLEE left off there, when we talk about energy efficiency and the investments that are made in people's homes, let's walk through with everybody tuning in what that entails. So, at the most basic level, someone that owns a home or someone that has a place where they live, they walk down to the local hardware store, they purchase, whether it's caulking or some insulation that they can install on their own, maybe change out some light bulbs, some basic things that they can do on their own. So they go and they support the local store, make some investments there, help that local economy churn a little bit. They go back home, they make these installations, they're going to see that utility bill drop a little bit.

Now with the investments that we've put forward in both the Recovery Act and what we hope to see with the energy bill that we passed out of this House and out of this Chamber and what the Senate is working on right now, we're expanding those opportunities. All across the country and going on right back at home, we've been part of going into people's homes where they've had some weatherization projects recently, where it's a little more complex, where they're working with local contractors; local contractors that are going to the community college or going back to some of those apprenticeship programs and learning some new skills so that way they can further their business, take advantage of some of the investments that we've put forward when they're installing now more insulation in the roof tops, those shinglings that Mr. INSLEE was referring to that sheet metal workers are now putting in businesses and homes, maybe changing out that furnace if it's been there for 20 or 30 years, maybe it's even that water heater which has been there for 50 years, doing something with that second refrigerator that's maybe taking up a lot of energy.

Now we're putting people to work. We're making investments in homes. We're adding value to the home, so now we're helping people in their communities, putting a little bit more money

in their pockets. If we can do this in every home and people across the country are taking advantage of these programs and we're making these investments, how much less energy is needed? When we talk about that we go to rates, rates that they're going to see coming from utility companies as a whole. If we can prevent one more coal plant from being built or one more big facility from being built in an old conventional way and we're able to employ new technologies, so that way we're bringing in more job skills and more job creation, looking at the way we can take advantage of abundant resources we have here in the U.S., making sure we're building out transmission in a smart way, taking advantage of new materials, employing the scientists, the engineers, the researchers who are looking at these applied technologies, making sure that they're looking at modeling, employing and bringing in the expertise from our national laboratories into this now?

We've got everyone from the person that's in the home that can pick up that hammer and could do a little bit of work themselves, to the contractor who can go into those homes and make sure that they're making those investments, the local hardware person making some investments, to physicists, engineers, researchers who are adding to this. Now, we don't see the possibility from a job creation perspective, and it's unfortunate that we still hear from some of those that are opposed to investing in America and in investing in energy, from creating these new jobs and making things happen, I don't know what more we need to do to convince them, because all across the country this is happening. That's why we need to continue making these strides forward and making these investments in America, because if we do things smarter and we do things better, we're going to get this economy turned around. And making sure that we're investing and taking advantage of a new way of investing in energy, investing in energy efficiency, investing in weatherization and investing in renewable generation, we can make all these wonderful things happen.

And even going a step further to what Mr. INSLEE was talking about with the bio-fuel tax credit extension, so we're being less dependent on foreign sources of fuel, foreign sources of oil, and we're able to build that right here in America. What a great idea. It's just an honor to be a part of that.

Mr. TONKO. Thank you. It's also a way to clean the environment. You know, the ripple effects of this whole exercise are so great that they reach out over the spectrum of jobs in so many dimensions. There are the trades that Representative INSLEE mentioned a while ago. There are those with a bachelor's degree or an associate's degree, a master's degree, a Ph.D., all are brought to the table because we need the strengths of every one of those sectors of the work force to respond to this energy innovation. And I saw from where I sat prior to my entry here in Congress, as President and CEO of NYSERDA, the New York State Energy, Research and Development Authority, where job creation was a big part of the outcome, whether we're retrofitting a factory to make it smarter.

Many are suggesting, well, we can't compete in a global marketplace because the workforce is paid so little in some other communities, in some other global communities. That may be true. But what we also can do is work smarter, and the working smarter is where you embrace the intellectual capacity of this country and put it to work for our manufacturing sector, put it to work for the businesses across this country, where we can reduce that cost of energy, reduce the cost of their products and then make them more viable on the global scene, where we sharpen that competitive edge, don't dull it with the exorbitantly high cost of energy, and where innovation and intellect are not embraced in a way that can really make a difference. We see it all the time.

Representative INSLEE, I know you want to hop in here because you are that outspoken voice from the west coast, if we might add.

Mr. INSLEE. You made me think of something. You mentioned smart people and smart ideas.

I had a very smart person in my office today. His name is Mike Town. He's an environmental science teacher at Redmond High School, the Redmond High School Mustangs in Redmond, Washington. Mike is leading a national effort called Cool Schools. It's something he started at Redmond High School to try to see if his high school could figure out how to not waste so much energy and save the school district money. They now have saved something like, it's about $25,000 a year just for their high school by doing some commonsense efficiency things that they have done and in investments they've made at Redmond High School.

They now have a group called Cool Schools which are trying to get schools across the country to engage in this kind of a challenge to see how much energy you can save; and the brilliant ideas a lot of the kids are coming up with—kids meaning 15-, 16-, 17-, 18-year-olds—the ideas on how to green their schools that are making their schools a lot more cost effective so the taxpayer can save money, and a lot more green for the environment. And the kids learn a lot about science as well. I just mention it because the schools can be a factory of ideas, but it's a place to put some investment to save taxpayers money. When we make the public buildings more efficient, we save taxpayers money.

But here's the challenge, and here's where I think our last energy bill, and perhaps our next jobs bill which might be on this floor in December sometime can really do a service. The challenge has been for homeowners, how to get the up-front financing to pay the contractor to fix your house up. Everybody knows that you might spend a few thousand dollars fixing your home up, and you're going to save a lot more over the long run because it's going to reduce your energy bill. But the question is, how do you come up with the scratch to do the first contract?

Well, where we can help, and we're going to be proposing several ideas in this jobs bill that will essentially help the homeowner finance that, and there are several ways to do that: one, to give them an advance credit on the credit that now exists on your income taxes, to actually give an advance so you can pay the contractor to get it going.

Second, we want to make it easier for cities to do what some cities like Boulder, Colorado are doing. They have a program where basically the city gives the money to the homeowner, the homeowner hires the contractor, then the homeowner pays the city back on their property tax. And it's a lien on the house, so the city knows they're going to get their money back. The city then issues a bond to generate the capital to pay for this program. We want to help some cities by guaranteeing that bond, they can sell it on the bond market for less money then and generate more bang for their buck.

This is the kind of program that is just difficult really to see how it will fail, because almost any investment that people make to their homes seem to pay off in the long run in reduced energy bills. It's just getting that original capital to get going. So, as part of our jobs bill, we're going to be proposing a way to accelerate the ability of homeowners, small businesses, school districts, public utilities, can generate that capital to get the money investment done and then save money over the long run. And when we do that, everybody wins.

I mean, I know this seems likes a no-brainer. Why isn't it happening naturally? It's not happening naturally because people can't get the capital to make these worthwhile investments. And when we do this we're putting carpenters to work, we're putting plumbers to work, we're putting sheet metal workers to work, we're putting truck drivers to work, we're putting architects to work, we're putting designers to work. This is really a sweet spot for us, and I hope that we can accelerate this.

Mr. TONKO. I think the point you make is a very important one. There are so many strategies that we can utilize, so many approaches to network

with consumers out there, be they residential, business, commercial, industrial, we can reach them because there are ways with these quick payback periods that come with much of this retrofitting or with the energy or conservation measures that we can utilize the efficiency efforts.

□ 1700

We can show people where they can recapture that money that was invested simply through savings in their energy bill. And I think what happens also is that as it catches on in a way that inspires one another, neighborhoods, communities and States start getting into programs, and it spreads; the good news spreads.

We did, when I was at NYSERDA, a dairy program that invested in energy efficiency at dairy farms. Now they were not getting what they believed was a fair enough price, and I agree with them, for their product. We couldn't control that at a State level, but we could reduce their costs of production. And we did it by reducing, through energy efficiency, their energy bill. And they would take pumping and cooling processes at the farm, they would take all of the elements that needed to be put into the process, the business plan of that dairy farmer, and reduced, in a very clever way, by working with Cornell University, working with the local utility, working with NYSERDA, and working with the Farm Bureau, we came up with a program that really saved a lot of farms.

Today that program is very popular in a couple of counties in the State of New York where the demonstration was begun. And it is something that could be stretched through time over a larger bit of geography for many farmers to utilize such a program.

When Representative INSLEE talked about the school system and saving the schools money so that they could then, with that fungible notion of that budget, transfer some of those savings over to investment in the classroom, that's great. But I also think we teach by example.

Our students watch what we are doing. I spoke at a high school graduation this summer at North Colonie School System at Shaker High, about 500 or so graduates, and incorporated all of the talk about energy transitioning, innovation economy and the need to protect the environment and strengthen the environment. I have to tell you, throughout the course of the summer, so many students from that high school reached out to me. They would see me and in casual conversation they would support the statements that you offered, the ideas that you were sharing at their graduation. They are going to push us. They are going to push these generations that are today making decisions to move forward with a progressive plan, with an idea that really saves our Earth and allows this economy to jump-start.

I think of that idealism, and I take myself back 40 years. what a great opportunity to shake the hands of the Apollo 11 team a couple months ago in July when everyone was in town celebrating the 40th anniversary of having won that space race. The U.S. landed a person on the Moon, and look at the technology improvements that came from that race. And we won it.

We need that same passionate resolve to enter into this race. We don't have the luxury to say we won't enter this clean energy global race. We know there are other partners already out there. And in my heart, I totally believe that we can win this race. But we can't afford to sit by because China, India, Japan and Germany—Germany is investing in solar PV hot water systems where they are training a niche of plumbers to retrofit homes where they are using the sun to power the hot water needs that they need. It's available.

All these opportunities are there. We simply need to move forward.

Representative INSLEE, you wanted to jump in.

Mr. INSLEE. I just want to make one comment before I leave. There is some really good news out here for America on the job front in clean energy. Two weeks ago on the Microsoft campus out in Washington State, I drove a Ford Focus, which will probably be the first American, mass-produced all-electric vehicle. And this car is the bomb. When Americans get in an all-electric car and understand how much torque an all-electric car can generate, this is the fastest car I've been in since I was in my buddy's Chevy 404 in 1968. When you hit the pedal, it's not a gas pedal, I guess we will call it the accelerator, they will still call it the gas pedal anyway, even though it's all-electric, unbelievable power is generated because an electric engine gives you immediate torque. In an internal combustion engine, you have the pistons and you have to get the momentum up. Electricity is immediate torque.

Now everybody has been talking about electric cars because they are so efficient. They can wean us off of our Middle Eastern oil addiction, which is so dangerous to us. They can reduce global warming. But what Americans will really love is how fast they are and the acceleration you get from them. That will be the fun thing about them.

The good news is we now have an opportunity to get thousands of Americans to work building electric cars, building plug-in hybrid cars. And General Motors has the Volt, which will be coming out. You plug it in, and it goes 40 miles on all electric, and then it has an internal combustion motor so you can go another 200, 250 miles without having to get another charge.

They have taken a little different approach. Americans will have a choice of how to move forward in electric cars. The Tesla is already on the street, which is all-electric, which is the sportiest, fastest and most amazing-looking car you've ever seen. They're a little expensive right now, but they're working very well.

The point I want to make, though, is we have got to jump-start this progress because the Chinese want to dominate this industry. And once they get a foot in the door internationally, you don't want to be the second place coming out of the chute in the provision for the electric car. And what we did in our energy bill and our stimulus bill has given very significant investment capability in the industry to produce these cars.

We also did it for the batteries. We had $2 billion in the stimulus bill to try to jump-start a domestic lithium ion battery system to run these cars. Now there are some other things we can do perhaps even to move further to get jobs in these industries.

The point I want to make is we can't sit around for 10 years and maybe do this 10 years from now. We have to do it right now for two reasons: one, we've got a 10 percent unemployment rate, and people are desperate out there. We know how trying and the anxiety that unemployment creates. It is one of the most difficult things for people who want to be productive, who want to take care of their families. This is very difficult for thousands of our fellow Americans right now.

But, two, this is the opportunity of the lifetime or maybe several generations that we can't lose to these other countries. And so that is why it's important that the other Chamber pass this energy bill. That's why it is important in our upcoming jobs bill to investigate other ways.

Here is one idea I hope will be considered in the jobs bill: we need to provide charging stations for people. If we are going to have electric cars, we need charging stations. And helping municipalities build these charging station networks is something we might be able to do to get electrical workers, IBEW members, machinists, electrical engineers employed, working with the infrastructure to create charging stations around the Nation. Now we don't need as many as you might think because 60 percent of all our trips are under 40 miles anyway, and these cars are going to have at least a 100-mile range. So most of our trips don't require a car that has 300 mileage. But we still need some in case you want to go a long distance.

So I hope in our jobs bill we will consider ways to jump-start the building out of these electrical systems to get that job done. I want to thank you for letting me participate tonight. I look forward to our next discussion.

Mr. TONKO. Thank you, Representative INSLEE, and thank you not only for

your dedication to the efforts of reforming energy policy, but your determination to keep fighting to that finish line. And it's that kind of advocacy that will get it done. We thank you for joining us this evening.

Representative LUJÁN, we hear about the messaging that is so important about creating jobs. We have an environment out there that needs to be strengthened, cleaned and protected. We have energy crises of various types that need to be resolved. And all of this can respond to a job crisis in this Nation and in this world.

There are hurting economies. There's a recession that went deeper and longer than many projected. There was a deficit inherited by this administration that was developed over the course of 8 years that really puts this economy into a hurting situation.

And so now it's our task, the Obama administration's challenge, to take that deficit inherited that really destroyed an economy, and now we have the opportunity to rebuild that economy but, at the same time, to respond in a way to the dynamics out there of energy reform, of environment, of strengthening the environment response, and at the same time, developing jobs of all types, from the trades on over to the Ph.D.s.

I know that you're in the middle of that battle. I know from your statements made in the Science and Technology Committee and from your statements made on the floor that no one can second guess where your heart is and where your thinking is on this issue.

Mr. LUJÁN. Mr. TONKO, we have an opportunity to work on these issues together, to move legislation and work with our colleagues to talk about what tomorrow will look like and not wait for a few years to come before we get a lot of this policy in place to create these jobs, to be smart about the way we do things, to invest in this technology and to really embrace this opportunity that we have now.

As I travel around the district, I remind people how, not too long ago, we had $4.50 gasoline. If you were using diesel and you were out on the farm in some of the rural parts of the country, we had $5 diesel fuel, and how a lot of those people that were making the profits off of that, where this money was going overseas, they weren't really our friends. And they still aren't. We see where that money is going. We have an opportunity now to change that as a way that we look at energy in the country, in the United States of America, in this beautiful place that we call home.

Now, as we talk about the tax incentives necessary for homeowners and businesses to be able to invest in their homes, I think Mr. INSLEE is right on track there. As we talk about what we can do, in looking at being smarter about the way that we look at policy, adopting better ways of doing things, encouraging people to invest in their homes in a way that's going to save them money in the long run, that's going to add value to their home in the long run is brilliant, I hope that we have something like that in the new jobs bill.

Now, Mr. TONKO, you were talking about how you were able to work with schools in your community, with Cornell, with leading institutions and universities, to work with the local public schools or with the dairies to create more efficiency so that way they could put more money back into their pockets, have a more competitive cost structure with their products as well.

When we invest in our schools, we create living classrooms. We create classrooms where we are teaching our students these jobs skills of tomorrow by encouraging them to go learn a trade or go to college to become that electrical engineer, the mechanical engineer, to become the entrepreneur to start a business so that way they can go and make these investments in our community.

What better way to get more young people encouraged and to really get that ingenuity moving, to get the creativity alive and well again in our country? This is the way to get it done. There is no reason that we can't be working more closely with our students, teaching them in the classroom, leaning on our universities, our national laboratories, to be able to partner up with our businesses and show them how to do things better, how to use less energy, how to take these products to market better and how to build them right here in the good old U.S. of A.

We talked a little about vehicles. Now as we transition and we are investing in these technologies where we have hybrids and plug-ins, we need to look to see how we can do better here in this country as well. And that's something where I'm encouraged where a little more people are talking about how even natural gas can be used in our vehicles, which burns a lot less carbon, but is abundant in different parts of our country that can go into our vehicles.

Now it's being smarter about the way we do things, and it's using technology a little differently; and it allows us to be able to not have to depend on foreign sources of oil while we're getting there. And those investments will be used in electric vehicles and hybrids and making sure we are making these technologies available to everyone. And it is just so exciting because as I go home and I talk to our national laboratories and I talk to businesses. I have seen an opportunity now where we can maybe build and retrofit a refinery back in New Mexico to have a biofuel refinery.

These are exciting things that we can do to put people to work, to bring people back to work and to even show this technology off to the rest of the world.

It's happening right here at home. And it's only going to continue, though, if we make these investments and we get more people on board and the people around us, people all across America realize that this is something that we can do. It's a job starter. It's a job creator. And it's really where we need to go as a country to get back in front of everything.

Mr. TONKO. Well, Representative LUJÁN, what I believe you're expressing here is the greatness of America. And that is driven by a belief, a set of values, a skill set, an investment in education that says we have succeeded in the past, we can continue to succeed, and we will succeed because the success that is driven oftentimes is determined by a tone that is established. This administration has said, enough with these deficits that were created that we inherited and now we have to resolve. We have to move forward with an investment that carries us through these dark times that were developed.

□ 1715

And how do we do that? Well, you and I, both working through the Sustainable Energy and the Environment Coalition—SEEC, as is commonly referenced—heard from the former minister of energy from Denmark. He talked about transitioning that economy of Denmark, transitioning their energy thinking. Afterward, I talked to him and said, Just how did you do it? Some of the ideas were driven by the American think tank. They took patents from this country and they deployed that thinking into their economy and they invested in their economy. Well, now that's sharp thinking. That's the sort of efficiency that we all should strive for in government.

Now, in this process we need to invest, yes, in the R&D, but we need to then transition those discoveries in the lab, those whiz-kid ideas. We need to take those and deploy them to manufacturing, we need to deploy them to the commercialization sector, so as to realize the discovery here in a way that provides for improvements in society and new responses to energy crises.

Well, just recently the President traveled to my district, to the capital region of New York, to Hudson Valley Community College. We have been talking about the wonderful economy, regional economy, that has been a foundation, a fertile ground for fostering the thinking of nanoscience and semiconductor as an industry. There is that fertile investment that now is anxious to couple with Federal thinking, with Federal resources.

And so the President showcased this wonderful thinking in the region,

through the community college, developing curricula for green-collar workforce development; dealing with construction majors who will know state-of-the-art solar or PV installation; working with all those budding scientists and skill sets from the trade sector that are going to be there to transition us.

So he talked about the investment in human terms, in capital terms, in ways that will allow us to now transition. This is how we grow out of this deficit situation, which we inherited from no sense of vision and from poor management of resources. Now we're going to work together to develop energy plans, to work on a situation that grows jobs.

This is all about growing jobs. We hear it all across America. People are looking for jobs. This is a good way to develop those jobs—R&D jobs, manufacturing jobs. Once you invest in that so-called ''valley of death'' where there isn't that network of Federal resources to be matched with the angel network and the venture capitalists that take the idea from the lab, from the investment, from both the private sector, academia, or maybe even government, taking that and transitioning it over into the commercial sector, into the manufacturing sector—that is the resource we need.

And when the President traveled to the district, he heard how we needed to connect those dynamics so that the confluence of those ideas and those resources spell success, spell new ideas. The American intellect is so very capable of making that happen. That is the greatness of America. And we can underscore that greatness by investing and inserting the sort of policy that makes the total difference here.

Again, we don't have the luxury to wait. We cannot sit by in some sort of idle complacency that finds us comfortable with where we're at today without stretching, without transforming, without moving forward in a way that we did 40 years ago with the space race. And we were proud when we won that.

When I was a kid, we heard Sputnik all the time—in school, at home, at church, wherever you traveled in the community. People were passionate about making that happen. We were going to move forward, we were going to invest. We shared a vision. We fine-tuned that vision as an American people and then won that prize by landing that person on the moon. That influenced all sorts of technology growth and inspiration.

We have that same golden opportunity here. What a mistake if we're to let it go by. We will fail generations to come if we do not seize this moment and make it work in policy terms, in investment terms, in resource terms, in a way that spells a new day for energy generation, energy efficiency, and energy investment through R&D.

Representative LUJÁN, I know that working on these several projects, we can make a difference.

Mr. LUJÁN. Mr. TONKO, well said. As we talk about what this has to offer the country, where we can go from here and how we can learn from some of the mistakes that were made in the past, you know, this notion of the over $4 a gallon gasoline and up to $4.50 and $5 that we saw recently, not too long ago—we saw what was happening and how we're creeping, yet the investments weren't made.

Now, those that are critical of the President and of this Congress for making investments that are going to make a difference tomorrow so that we're solving these problems, we don't have the dependence on these foreign sources of oil; we're going to take the latest and greatest, the scientists, the smartest people, the individuals that are starting their own businesses, those contractors, the tradespeople, the builders, and bring everyone together to do it better, to do it smarter. I don't understand it, why there are still those that don't think these are good ideas.

We talked a lot about the space program. Now let's put this into perspective. When we won the space race here in the United States and we developed the technologies that enabled us to win that space race, solar panels were part of that. And where are we now, Mr. TONKO? With the rest the world, falling behind when it comes to solar technology, to using it and integrating it into everyday use. Now this is a technology that we developed here that enabled us to win the space race and generate the power needed to keep the men that were in space safe and get them back home. We can use it to power our homes. We can use it to diversify the way that we generate power for the country. We can use it to create jobs. We can use it to develop more and more exciting, innovative ways of looking at the way we do things. And, as you so eloquently put it, talking about nanotechnology; building things smaller and smaller, where we have been able to do this with the way that we use computers now, where they use less energy; the phones that we use.

All the technology that has come out of what we achieved with the space race, and how we in the country have fallen behind now—that's what we're talking about here. It's investing in America. It's staying ahead of the curve here. It's making sure that we provide the best education for our kids, that we're making this commitment in science and technology and engineering and math, and that we're keeping it here to build the things here, to build these components, to create these jobs back here at home. That's what we're talking about here. And I just hope that more and more of our colleagues, Democrats, Republicans, independents, that we can come together to make this investment in America, because we can't afford not to.

We have always been leaders when it comes to innovation. Now let's take that leap, let's take that step, and let's make that commitment to invest in America, invest in ingenuity, create these jobs, and do things better and smarter for tomorrow.

Mr. TONKO. Representative LUJÁN, I couldn't agree more. And I really do believe that many of us were sparked—our interest was sparked by just the vision that we shared and by the news that we would hear on a daily basis. We'd come home from school and hear it on the night news. That sparked so many people to look at math, at science, at engineering, because we had leaders that really saw that we had this greatness of potential within us.

So everyone marched along in this chorus of belief that we could make the world a better place. There was a sense of global community. There was a commitment of this Nation to really lead in a way that provided for great outcomes.

That sort of leadership is coming back here. I think that this administration, the leadership here with Speaker PELOSI and the leaders of so many committees in this House see it, they get it. They know we can solve this job crisis by bringing in the nuances of energy reform, of health care reform, of providing for a jobs agenda.

You know, when you look at some of these issues where you take nanoscience within my district, where they're really developing this precision testing—the mass production of the past Industrial Revolution was about a great idea, perhaps started in your garage and then developed into a factory-size space because you had to meet demand. Well, today it's about precision. As you pointed out, something as thin as a strand of hair will be what they're working on.

And so the prototyping, the testing, the evaluating, are all elements of success. Very pricey. And so there's a role here for the Federal Government to insert itself, to say, Look, you're an entrepreneur; you're a budding scientist; you're an emerging technology that's being driven by your intellect. Let us partner with you, let us partner with the angel network, with the investor communities, so that we can take this idea and make it real and put it on the shelf. That's what it's all about.

Other countries are using our ideas—and our ideas are still those that are driven by an investment in education, in higher education. So this is a full set of circumstances by which we will govern ourselves, our thinking, in a way that transitions this economy. That's what it's about, the innovation economy. And yes, there's a jobs crisis. But yes, we saw what the deficit that had

been going far too long did to our employment issue. Did this happen overnight? Did this just happen 3 months ago? Did we just start to lose jobs just weeks ago? I don't think so. But now the transitioning into an innovation economy is driven by heart and the mind—the thinking here that we can do better and we will do better. And that's what it's all about. It's taking the stand and making certain that we invest our way through some very difficult times.

Mr. LUJÁN. Mr. TONKO, I'm glad that you're reminding everyone watching today that these job losses and what's happening with the economy and the deficit, that this just didn't happen 3 weeks ago or 3 months ago or even 6 months ago. That this is something that was developing and building.

We're going to hear those that say we can't invest in the country when it comes to clean energy, we can't do this, we can't do that. Well, I say to them: We can't afford not to. We're going to continue to hear how others want to scare the American people and don't want to see this President succeed or this Congress succeed in investing in America. We need to do things better here. And I know, Mr. TONKO, we're both new to Congress. But when it comes to putting the American people first and remembering why we came here and continuing to invest in this great Nation of ours to make it stronger and better and providing an environment where we can let people that want to start a business, start a business; where we invest in that science and that ingenuity and that creativity which allows them to do it, that's what we can do.

Mr. TONKO. Absolutely. And it's responding to the needs of middle-income America, working families across this country, who are part of the solution. They are part of the solution. We need simply to bring everybody together into a working semblance that then allows us to move forward.

You know, I think of the wind energy efficiency bill that I got passed in this House that started in the Science and Tech Committee, taking a step back to look at how we can improve not only the placement but the wind forecasting. But also the manufacturing, the materials that are utilized. The gear assembly. How do we do this? Well, you couple that with the nanoscience sector and you can take that nanoscience growth, that intellect that's being developed, that's being fostered in the various centers of nanotechnology, and couple them with perhaps agriculture or pharmaceutical as an industry, or the health care industry, certainly the energy industry, and produce stronger materials, lighter materials, more durable materials, working on situations that provide for the greatest efficient outcome with the resources that we invest.

I look at kinetic hydropower that was used as a demonstration project at NYSERDA, where I used to serve as president and CEO. We used the turbulence of the East River along the island of Manhattan, and we utilized that water movement to turn the turbines sub water to create power needs for Roosevelt Island. Well, that's just a snippet of the imagination that can be tapped into.

Today, after improvements through the DOE lab in Colorado, we're now looking at the potential of 1,100 megawatts of power produced by kinetic hydro. That's just a sampling of what can happen. We see geothermal and its potential. I was there for a ribbon-cutting for a project at the Culinary Institute of America utilizing geothermal to help run the campus activities.

All of this has immense potential, immeasurable at times, and all we have to do is unleash the talent. A leading Nation such as ours cannot, again, be complacent. And we need to continually energize our thinking and our behavior. No lead nation can allow itself to slip backward. Unless we encourage our workforce and our students out there, our youth, to desire, to invent, and discover and explore, we will not maintain a leadership status.

So I agree with you, for those who are agents of no, for those who wanted to settle for the status quo, those who are perhaps using partisan approaches to deny progress with this administration, need not put the burdens and the hurdles before us.

□ 1730

We need to march forward in progress, sharing a boldness of vision, created by a situation here that has really triggered the need for the American ingenuity, the American intellect, and the American resolve to move us forward.

Representative LUJÁN, it's great to have you here this evening.

Mr. LUJÁN. Well, it's great to be with you, Mr. TONKO. I'm not sure if there is anything to add after that.

When you talk about the piece of legislation that you brought to the floor and we were able to get passed that would make new investments in wind energy, back home in a little community by the name of Tucumcari, New Mexico, we have the North American Wind Research and Training Center at Mesalands Community College where they're training young people how to maintain these wind turbines across New Mexico, across Texas, up to Colorado, and across the country. I will tell you, job creation, investments in new energy, investments in clean energy, they're all connected. That's one example of a piece of legislation that's allowing us to achieve this and make it happen.

It's just great to be on the floor with you this evening, Mr. TONKO, as we're able to talk to the American people and those that want to see this happen, those that are hungry for this investment, those that are hungry to see their kids have these opportunities for years to come, that they want more generations behind them to have as well. I'll tell you, we're almost there, Mr. TONKO, and we're going to make this happen, and it's going to be the American people to help push us over the top.

Mr. TONKO. Well, I agree. And thank you for leadership like that that you have provided, because it's that advocacy, that voice of can-do that will make the difference. I think of the opportunity that we have to make solar a legacy piece.

Representative GIFFORDS introduced her solar efficiency roadmap legislation, and allowing for us to look again at the efficiencies that we can drive into the solar discussion, the solar outcome, we should create a legacy piece of that. We need to look at thin film and R&D that can put us into a situation where we discover the materials that can shave the priciness of some of these renewable opportunities that then make them all the more competitive, make them all the more connected to consumer behavior out there.

You know, if we can utilize the sun, and if we can utilize water, and if we can utilize the wind, and if we can utilize the soil to provide for our needs in a benign way, then what a tremendous legacy, what a tremendous bit of progress to leave that next generation as they will continue to grow upon our success stories. But what a tragedy if we're to look back and say that we thought status quo was fine, that 40 years ago we won a space race and we were content to sit still. Nothing could be more un-American than that thinking.

So in this House, in this loftiness, we require lofty thinking, and that's what it's about. I'm so proud of this majority in that they do speak in lofty terms, Madam Speaker. I think this is the way we get things done, and I am just impressed with what I see here being brought forward not only in resolve for an energy problem or problems or with environmental concerns, but in job creation, where we're allowing as a down payment a half million jobs with the American Recovery and Reinvestment Act, but then looking at the millions of jobs that come forward through a program like ACES, the American Clean Energy and Security Act, that allows us to, again, think outside that barrel and say, That's not good enough for us.

Fossil-based fuels, you know, the dependency to send hundreds of billions of dollars to foreign economies where there are unfriendly governments that are utilizing those monies in their Treasury that are poured in from the American pockets and then fight us as

terrorist regimes or what have you, we have got to step back and say, There is a better way. And there is a better way, and we're promoting it. We're advancing it here, and it's all in the name of job creation, job retention, which I believe is a benefit that is immeasurable in its kind.

Madam Speaker, we thank you for the opportunity this evening to share sentiments on behalf of Democrats in the House who are advancing the notion of progressive energy policy, of resources that will enable us to think in new capacity as we speak to the energy needs of this Nation all while advancing the notion of jobs. We thank you for that opportunity.

Representative LUJÁN, any closing comments?

Mr. LUJÁN. Madam Speaker, we just appreciate the time this evening to remind the American people what we can do, the jobs that can be created when we can come together and make investments in this great Nation of ours. Investing in energy and being smart about the way we do things, it's all part of the mix. It's just great to know that this Congress and this President are serious about getting something done to be able to put the American people first.

GROWING THE GOVERNMENT

The SPEAKER pro tempore (Ms. KOSMAS). Under the Speaker's announced policy of January 6, 2009, the gentleman from Missouri (Mr. AKIN) is recognized for 60 minutes as the designee of the minority leader.

Mr. AKIN. Thank you, Madam Chair.

It's a pleasure to join you this evening and to join my friends as we take a look once more at a debate which has stirred the imaginations and minds of Americans and has perhaps even tried the patience of many Americans now for many months, but something that is not complete, it's not done, and that is the question of health care.

One of the things that I want to do is to recognize the speakers from the previous hour, as they were talking in glowing terms about free enterprise and about the possibilities of what America can do in the future and about setting bold new objectives and all. All of that sounded pretty good. I agreed with all of it. Except the only trouble is what we've really been doing for the last 10 months, which is the government's taking everything over. So it's a vision, but it's not a bold vision.

I don't know of any nation that really set any great records or achievements in a positive sense by the government taking over more and more things. In fact, most nations, when the government takes over more and more things, they do more and more mischief and damage. Indeed, we have many nations that are government-run that have given us the worst tyrannies in history. For instance, the history of communism, a phenomenon of the last century. The communist nations of the world killed more of their own populations than all of the wars in history. So the idea of expanding government at a rapid and radical pace and sort of saying that this is free enterprise is amusing.

There was also a comment made that all of this unemployment was, implied that that happened a long time ago. It was somebody else's fault. The only thing I remember was that just a few months ago we had a stimulus bill. It was a guarantee. They said we're supposed to pass the stimulus bill. I called it the porkulus bill. If we didn't pass the stimulus bill, by golly, unemployment could get all the way to 8 percent. So you have got to jump on and spend $787 billion by expanding Medicare and giving money to community organizing organizations like ACORN because this is really important stimulus money. So we passed, not with my vote and not with one Republican vote, the stimulus bill. That was to make sure that we didn't have this problem of unemployment. Well, now it's 10.2, and that stimulus bill doesn't seem to have worked.

Now, you don't have to be a rocket scientist to know it wouldn't work. All you had to do was look back at the Great Depression. Look at Henry Morgenthau. He was a guy that marched right along with Little Lord Keynes, saying, Hey, if we're going to stimulate the government, we're going to stimulate the economy by having the government spend tons of money. Well, Henry Morgenthau comes to the Congress, to the Ways and Means Committee in 1939, and he said, Well, we tried the stimulus idea. Friends, it didn't work. We have got unemployment as bad as ever, and we're in a tremendous amount of debt to boot. Now, we aren't going to learn from that. We're going to march on with this bold new vision of the government spending money like mad, and they justify it in the name of free enterprise. I find that amazing.

We have another example of this bold new spending initiative, and that is what happens in the area of health care when the government tries to take over one-sixth of our economy.

I am joined by my very good friend, Congresswoman FOXX, who has agreed to come here in spite of an extremely busy schedule this evening, a young lady that adds tremendous vigor to the Republican Caucus. And anybody gets out of line, you've got the grandmother to deal with. So everybody knows you've got to line up.

Congresswoman FOXX, we've just heard a vision of tremendous free enterprise, new materials, all sorts of things, and we're marching boldly because we don't want to stay in the staid ways of the past. But the solution seems to be more government spending, more government takeover of things. Can you think of any civilization that you can think of that became great because the government grew and took over everything?

Ms. FOXX. No, I can't. And I want to thank the gentleman from Missouri for taking on this Special Order tonight and for bringing up issues that are very, very important to the American people and doing it on such a consistent basis. You've done a terrific job.

I think, as I heard today in a meeting—I'm not sure if you were in that meeting when somebody pointed out—when the Communist Chinese start lecturing us on having too large a deficit, something is out of kilter in the world. And we know that in the last few days the President's been in China, and they have been lecturing us about this issue.

Mr. AKIN. Just reclaiming my time, there is something that's almost funny about that. It shouldn't be funny. It should be sad, I suppose, that the Communist Chinese are lecturing us about the government spending too much money and taking too many things over. It's, of course, because they own a whole lot of American treasuries, and they don't want to see us mess the whole system up. So here we have the Communist Chinese talking to us about excessive big government. I mean, this has been a year of amazing things, hasn't it?

We saw the government fire the president of General Motors. Just on the face of it, that's kind of a weird thing to see. We've got czars now in charge of all kinds of areas of government, people that have never been approved by the Senate. They're unconstitutional, and they're setting the prices of American executives, how much they're paid. So we've got the government doing that. Now they want to take over a sixth of the economy in this health care situation, and they're not thinking of this as any kind of problem at all.

But Congresswoman FOXX, you know, when the government does too much, we see these kinds of typical symptoms: bureaucratic rationing, inferior quality, inefficient allocation, excessive expense. We've seen that in department after department of Federal Government when they grow and try to do too much. It has led to the quip, ''If you think health care is expensive now, just wait until it's free.''

Ms. FOXX. Would the gentleman yield?

Mr. AKIN. I do yield.

Ms. FOXX. You mentioned a minute ago about the fact that this has been a year of very unusual things to have happen. I learned just recently that there is a poll that was done, and we know people are polling in this country all the time. But a poll was done that

said that two-thirds of Americans believe it is more likely that we'll discover life in outer space than that the Democrats' health plan will be deficit-neutral.

Now, I think that's a good sign for our country. It's a good sign that people are paying attention to what is happening in this country and what is happening in this House and in the Senate, the fact that two-thirds of our citizens don't believe the line that's being fed to them that this health care bill is deficit-neutral.

That deficit, as you say, is causing tremendous harm, not just because the Chinese are nervous about it, but from the money it's taking out of the private sector and the problems it's causing small businesses. I know you want to talk a little bit about that tonight, and I hope that you will. I'm not going to be able to stay with you for the whole hour because I have the great pleasure of going over to be with Senator Jesse Helms' family who are in town for the unveiling of his portrait tonight, but I want to stay with you for a few minutes. I can just imagine Senator Helms watching us from heaven thinking, ''Oh, I wish I were there to be in this fight.'' The Senate right now is behind closed doors, behind closed doors despite all the promises of transparency, working on a bill that's going to create havoc. But the American public has awakened, and it knows this is not right.

Mr. AKIN. You just tickled my imagination. So we're saying that two-thirds of Americans in this poll said that they think there is more chance to discover life in outer space than there is that this health care bill is going to be budget-neutral. That gets to the very top excessive expense.

Let's just talk about the big picture of what's going on. You remember just a year or so ago, we heard that President Bush spent too much money. Do you remember hearing that? The Democrats said it all the time, and some Republicans said it a fair amount, too. So let's take a look at President Bush's worst year in deficit spending.

□ 1745

His worst year was 2008—and the Democrats controlled Congress—and his worst spending was about $450 billion, which was too much deficit spending but was 450.

Now this year, the bold new vision says we are going to do things differently. And so what is our deficit spending now? Well, it's $1.4 trillion. So we've tripled the deficit this year, and we are kind of wondering, Gosh, gee, I wonder why we have got problems with unemployment.

You know, one of the things that the Democrats, at a minimum, should do is they ought to learn from other Democrats even if they won't listen to Republicans. I can understand they don't want to listen to Republicans because we say things that are uncomfortable truths that they want to ignore such as laws of supply and demand and gravity and other miscellaneous things.

But they could listen to JFK. He was met with a recession, and what he figured out was he wanted more jobs. He thought, Gosh, gee, where did the jobs come from? Oh, small businesses, where most of the jobs are. If you look at America, 80 percent of the jobs are in small businesses, that is 500 or fewer employees.

So he says, How are we going to get these small businesses to hire people? Well, maybe let's back off on taxes, give them some more room, some money to work with. Then they will add wings on the buildings, new machines, new ideas, innovation. We have heard a lot about innovation. Innovation doesn't come from the Federal Government, taking everybody's money. JFK understood that. So he backed off on taxes, and the small businesses started producing jobs, and we pulled out of the recession.

Now, Ronald Reagan understood that. He did the same thing, and we pulled out of a recession because we allowed small businesses to create jobs. And Bush, II, did that with dividends, capital gains, death tax. He allowed the small businessman—instead of taxing him into the dirt, he gets them going.

What we're seeing under the Pelosi plan, this is a repeat of FDR. We're going to turn a recession into a depression because they haven't learned even from the Democrats, which is such as Henry Morgenthau or JFK.

Ms. FOXX. Will the gentleman yield?

Mr. AKIN. I yield.

Ms. FOXX. I have quoted Morgenthau many, many times saying we've spent, we've spent, we've spent, and we can't do anything about the unemployment rate. And I think we need to keep repeating that quote. And I know you have it, and it's a little more eloquent than what I have summarized here.

But I wanted to go back for a moment when you started out talking about our colleagues who were here earlier on the floor talking small businesses and about small government. You know, we hear that talk from our colleagues across the aisle all the time; and it reminds me of the North Carolina motto, which I've occasionally used on the floor when I have heard those kinds of speeches being made. The North Carolina motto is ''To be, rather than to seem.''

Unfortunately, our colleagues talk a good line, but when it comes down to doing what needs to be done, they want to seem rather than to be. So they try to tell their folks at home—they act like they're conservatives. They act like they're going to be good people with the purse, that they're protecting people. Then they come up here and they vote to spend money. Day after day after day we see all of these bills coming up authorizing expenditures, spending money. And as you said, we have the largest deficit right now that we have had, than we had with our first 43 Presidents. And it is really dragging down our economy.

You know, my daughter runs our nursery and landscaping business, a business my husband and I started a long time ago; and I can remember going to my husband at times and saying, You know, I'd like to do this in the garden shop and spiff it up a little bit. And he would say to me, Well, how much is that going to help our bottom line? Is it going to bring in more money? And I would sometimes say, No, it will just make things look better. He would say, If it isn't going to bring in more money, then we shouldn't be doing it.

That is the decision small business people have to make every day of their lives. Some of them lay awake at night worrying how am I going to pay my bills, how am I going to make my payroll. They personally sacrifice to take care of their employees. I know. We've been there. And yet we have people up here who've never worked a day in their life, a real job. They have been in Congress for 50, 40, 30 years, and they have no concept of how hard it is to run a business and how dedicated small business people are.

Mr. AKIN. They seem to understand one thing, which is what Ronald Reagan always said: taxing and spending.

Let's take a look at what we've got here. We're talking about just this year. Here's $350 billion for the Wall Street bailout. Here's another $787 billion. That's the one that's supposed to make sure we don't have unemployment, right?

Ms. FOXX. Will the gentleman yield?

Mr. AKIN. I yield.

Ms. FOXX. If I remember right, the promise was if that passes, unemployment will not go above 8 percent; is that correct?

Mr. AKIN. Yeah.

Ms. FOXX. What is our unemployment right now?

Mr. AKIN. Last time I checked it was 10.2, and you know those were conservative numbers because it doesn't include somebody being unemployed more than a year. They take their name off the list. It doesn't mean they got the job.

Ms. FOXX. I have heard from many economists that the actual unemployment rate is probably 17 to 20 percent because of the folks you mentioned, those who've given up looking for jobs, those who have gone to work part time. So it was not supposed to go above 8 percent.

This really has damaged the credibility, I think, of both this Congress and this administration because all

these promises have been made and none of them have been kept.

Mr. AKIN. The implication is that the unemployment that we're having trouble with was really Bush's fault. Everything that doesn't work right, well, it was Bush's fault. Bush, when he came in—I was here; I came in the same year he did—and we had a problem with a sagging economy. We were going into a recession, and he dealt with it the same way that JFK had done it and Ronald Reagan had done it, and that is he got off the back of the small businessman because he knew he had to let that guy have some breathing room to get those jobs going. We're doing the exact opposite, which is what Henry Morgenthau did, and we're going to turn a recession into a depression if we're not careful.

And when this thing passed, this stimulus bill, we stood here on the floor—and I think you were with me, young lady—and we said it's not going to work. I don't mean to be an ''I told you so.'' You don't have to be an ''I told you so.'' All of history is screaming that this is not the way to solve this problem.

And now we hear, well, because we have unemployment, it must be the Republicans' fault somehow when we're 40 seats in the minority.

Ms. FOXX. Will the gentleman yield?

Mr. AKIN. Yeah.

Ms. FOXX. My recollection is every single Republican voted against the stimulus package in the House.

Mr. AKIN. That's correct.

We've been joined, as you know, by my very good friend, Congressman BISHOP from Utah, a gentleman that is so commonsense and so straightforward in explaining himself. He has already made a great reputation here, and I would like to yield time to my good friend.

Mr. BISHOP of Utah. You're very kind, Mr. AKIN. I wish I believed what you said about me.

You know, I was intrigued by the original chart that you had up there when government does too much. Sometimes we tend to overlook that.

I have always contended that the issue of health care we saw was foretold by our Founding Fathers over 200 years ago when they instituted a system of federalism, because they knew back in that time even though there were only 13 States in the original country—actually 11 when we started, eventually 13—that the Federal Government would always be too big to take—to do anything other than a one-size-fits-all approach. And that if indeed you wanted to have justice, take in the circumstances, creativity or perhaps a program if it failed, it didn't destroy an entire country. You had to have it done by State and local government. That is the value of it.

Mr. AKIN. It's called federalism, as I recall.

Mr. BISHOP of Utah. You know, they didn't limit the power of the Federal Government just for the fun of it. There was a reason and a purpose to it.

One of our great Justices on the Supreme Court once said, The Constitution protects us from our own best intentions. It divides power precisely so that we will resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.

Now, he was not writing, obviously, about the health care bill that passed this House, but it applies. And what we did was simply lose sight of the structure the Founding Fathers put in place to create balance and creativity and empowerment of individuals.

I'd like to talk simply about one of the things the States are doing, specifically in my State, because my State recognizes we have a unique demographic.

Mr. AKIN. What you were talking about I think at one point it was viewed that States were, in a way, kind of a laboratory of creativity. So you have got now with 50 different States, if some State wants to get a little bit out in the land of fruits and nuts, and California wants to spend a whole lot of money and do things one way, there is some flexibility to do that. But that doesn't mean that Missouri or Utah has to do it the same way.

And certainly in the area of health care we've seen that. We've seen a couple of States try some innovative ideas in health care. One was Massachusetts, and one was Tennessee. And both fell flat on their faces because they did the same thing that is being done here.

I don't want to get ahead of you.

Mr. BISHOP of Utah. That is part of the issue.

Massachusetts has a program that is expensive. They appear to like it, but it's very expensive. It would not work in Utah. Our program would not fly back in Boston.

Utah has unique demographics. We're a very young State. We have a lot of kids, whereas most small businesses, 42 percent of the Nation, provide insurance. In Utah it's only 32 percent. That's a unique demographic challenge that we have to face.

What would happen, though, if we simply go along with the PelosiCare that we passed is that every one of the small businesses in Utah rather than getting help to solve the problem would be hit with a 5 percent tax that would attack 5,500 small businesses already nickled and dimed. What they really want is for us to get off their backs with mandates and out of their pockets with taxes so they can solve problems.

So what the State legislature in Utah provided is a way of solving those problems by recognizing that small business has a great concern once they get into health care because they don't know what their costs will be over the period of time, and it's very marginal.

So what they have tried to do is come up with a concept which empowers individuals to choose. Small businesses now can give a pot of money they would be giving to an employee as a defined contribution, they could then go and buy the health care service that they want.

Mr. AKIN. That idea sounds like freedom. I am really liking this already.

Go ahead.

Mr. BISHOP of Utah. It's dangerous, isn't it? It's almost scary as we think about it.

But the goal is to have a clear, transparent index in which all of the options that are legal in the State of Utah—and right now there are 66 options from which people can choose. They are easily adaptable, easily accessible, easily understandable. If you change jobs, you're still in the insurance. So there's a portability.

Mr. AKIN. So you have portability?

Mr. BISHOP of Utah. Costs are stabilized for the business; employers now have options from which to choose. And this is only in the first year. It has had a phenomenal response, and we are just beginning.

If the Federal Government were then to try and help that out by doing simple things like allowing—removing barriers for cross-state purchases, doing tort reforms which would bring down the costs, the number of people who are truly uninsurable because of preexisting conditions can be shrunk to an area that is possible for States to easily handle and maybe even the Federal Government could give grants to that.

Mr. AKIN. Can I ask you about what you've got, because that's really an exciting concept.

First of all, what you're saying is that a small business has some employees, they want to treat their employees right but they also have to make the small business make money so they can say, Look, we're going to put aside this amount of money for each of our employees to help them with health care, but we're going to allow those employees to have some choices as to what they buy.

So, for instance, let's just say that I am a husband. I've got a job in small business. I have a wife. And it turns out we know that we're never going to have any children. So I don't really need to get the coverage for childbirth or something that maybe somebody else does. So I could find a policy that would suit, that would be more tailor-made to our family and therefore could get better coverage in some other areas possibly.

So you have a way to fine-tune something that meets your particular situation.

Mr. BISHOP of Utah. And by controlling your own money with your own choices.

When I go into a grocery store to pick up cereal, there's an entire wall of choices. I pick the kind I like. You would go in with me and you'd go over and pick another one. Why isn't the role of government to allow people to have choices?

I have one of my fellow teachers who was upset because in his plan the district only allowed him two options. If you actually go to a single-payer system by the Federal Government, you get one.

The State of Utah is saying there are 66 options, which is a comparative advantage of that. It also means one of the situations that we have in large business provides insurance for its workers. The owner or the manager picks what company it is and everybody has to follow along. In this program, the large business already providing insurance could do the same thing by providing the amount of money to an individual who could then go on the State index and pick what he or she wants to do.

□ 1800

Here is the kicker: This is a great idea.

Mr. AKIN. Of course this Pelosi bill is going to absolutely torpedo everything that you are talking about, isn't it?

Mr. BISHOP of Utah. You just took the words out of my mouth because that is the kicker. States have the ability of becoming creative. They are, as you were earlier quoting Louis Brandeis, becoming laboratories of democracy. They have the idea of making a system that meets the demographic needs of that particular State. What we should be doing is encouraging that kind of creativity, encouraging those kinds of options. But you are exactly right, with the bill that we passed the other week, that stops that concept dead in its tracks.

Mr. AKIN. First of all, the Pelosi bill has all of these mandates in it, and let's just talk about this mandate. This one here is the mandate for, let me get it on the chart, this is the mandate for employers. First of all, employers have to offer a qualified health care plan to all full and part-time employees. What do you think that ''qualified health care plan'' means?

Mr. BISHOP of Utah. We may be comfortable today with what is defined as qualified. Unfortunately, and this is what the Supreme Court Justice was saying, the Constitution protects us from our own instincts of doing this, that by creating a commission that in the future will tell what the private sector will do when it is in competition with the Federal Government. What may be qualified in the future is not necessarily what is qualified today.

As you stated very convincingly earlier, if you have a specific need, what is your need may not be what some distant bureaucrat in Washington determines to be qualified. And, in fact, one of the biggest problems we have when people talk about health care, no one has ever really defined what health care actually is. Is cosmetic surgery part of it? Is mental health part of it? Nursing homes, are they part of it? What is the goal or purpose of it? We have yet to do that. See, that is what we are allowing a bureaucrat in the future to do as opposed to what some of the States wish to do in allowing citizens, employees, to have options and choices so they have control over their own lives.

Mr. AKIN. There will be a number of our colleagues who may be watching, and other Americans who are hearing this discussion. Which would you prefer to have? The option that you are offering, which is what Utah is doing—your employer gives you some money, you can go out and use that money to buy something. You can buy one of, what was it, 66 different policies, and try and find something that really fits the need of you and your family. That is one alternative.

This is the old Henry Ford alternative: You can have any color car you want as long as it is black. This is the government plan: Employers must offer a qualified plan. Who says what qualified is? The Federal Government says what qualified is.

How does it work? First of all, the employer has to pay somewhere between 65 and 72 percent of the cost of the plan. Now we have already defined this because the government knows what the employer should provide. It shouldn't be 50, it shouldn't be 80; it has got to be this.

Or if you don't do that, you have to pay a tax of 8 percent of the payroll costs. Here is how this works. You have 20 employees. One employee decides he wants something else. That means just one out of 20 doesn't take your plan that the business offered, and now the business gets hit with 8 percent, regardless if the other 19 employees were happy with it. So now they are going to get whacked with this 8 percent tax off of payroll, so you are hammering small business, which makes it less efficient and forces everybody into, guess what, Henry Ford's one color, black. You've got a qualified health care plan. Which qualified health care plan? The one by the Federal Government.

You have a choice of one, one, or one. The insurance companies, what are they going to write? The qualified plan. Because if you don't write the qualified plan, what happens is, you get fined by the Federal Government, because you had a nice health plan that fits some people's needs that you thought was a good deal, and you are going to get fined instead. That is mandate. That is not freedom.

Mr. BISHOP of Utah. If I can add one thing here, because I notice that we have been joined by two other colleagues who have given their entire professional career in this area. They know what they are talking about. I would add our Founding Fathers, sitting over there with their knee britches and their powdered wigs, knew exactly what we needed today because their highest goal was to provide individual liberty for the citizens so that people could make choices for themselves. They realized it is not the role of government to tell people what is best for them. That is a risk-aversive system of nanny government where we tell people what to do because we know what is best, and it is cheaper as we see it.

Our goal should be to provide people with choices and options that ennoble their souls and allow them to control their own destinies. The only way of doing that is allowing States to move forward on their own, as Utah is trying to do, and not be stopped by this Pelosi care bill which will stop the States' progress and all of the innovations that are taking place out there.

Some time we have to realize that you don't solve problems by putting a lot of experts in a room in Washington, D.C. There is a font of knowledge out there that is waiting to blossom and provide new solutions. Our salvation as a Nation is to go back to the Constitution and believe in federalism. That is how we move forward.

Mr. AKIN. Well, I very much appreciate the gentleman from Utah. Congressman BISHOP, you are just an inspiration, and that really is a breath of fresh air flowing through this Chamber, the idea of freedom and the idea of limited government and the idea that we will allow States to solve their own problems instead of the Federal Government, the one-size-fits-all Pelosi plan. And it also takes the pressure off of intense levels of Federal spending that are bankrupting our Nation. We talked about earlier—can you believe that the communist Chinese were telling us that our government is spending too much money and getting too big? That is a wrong day in American history. It is something else.

I am joined by Dr. GINGREY from Georgia, who has some great charts. They look more interesting than mine, so I yield to Dr. GINGREY.

Mr. GINGREY of Georgia. Thank you, Mr. AKIN. Referring to the gentleman from Utah (Mr. BISHOP), the historian, what he was talking about, I carry this with me in my pocket all the time, and I am sure many of my colleagues do, a pocket Constitution. This is the inconvenient truth, and this is exactly what my colleague was just talking about.

You go in the back and look up in the glossary or the index and try to find anything about health care, it is not in there. It is not in there. My colleague, Mr. Speaker, referred to some of the

posters that I have with me. I do want to point those out to Members on both sides of the aisle, because I think in many instances a picture is worth a thousand words. In this instance these posters are worth a thousand words.

Focusing in on the first one, Mr. Speaker, it shows the ship of state and the captain of the ship. That would be the administration, that would be the President of the United States, and that ship is the economy. Down here at the bottom of the poster it shows a trailer as we see on television news a lot of times: Alert, bulletin: 10.2 percent unemployment, and then the caption, ''Good news, I'm almost done reorganizing the medicine cabinet'' as the ship of state is sinking.

Mr. Speaker, it is a point that I have made over and over and over again. When the President sat right where you are, or stood right in front of where you are and spoke to the Nation before a Joint Session of Congress and said our number one priority is to reform our health care system. One-fifth of our economy, colleagues, I believe we are talking about, and yet we have spent $787 billion on an economic bailout when our unemployment rate was 8 percent, now 10.2 percent, and I think we have lost, and correct me if I'm wrong, Mr. Speaker and my colleagues, the loss of jobs since February of 2009 when we passed this so-called economic stimulus, which was supposed to stem the unemployment at 8 percent, it is now 10.2, and we have 16 million

People out of work, an additional 3.5 million since February of this year. Why is that not our number one priority instead of reorganizing the medicine cabinet?

I have some other posters that I want to refer to as well, but I want to yield back to the gentleman controlling the time because there are other Members who would like to speak. Hopefully you will have an opportunity to come back to me.

Mr. AKIN. I appreciate that, and I look forward to doing that. I thought you were going to bring some sort of gory medical pictures here.

Mr. GINGREY of Georgia. If the gentleman would yield, I definitely do have some of those that I will bring up.

Mr. AKIN. We also have my good friend, G.T., joining us. I think it is good to have different people from different States to have a part in this discussion. We haven't had too much of a part because all of the doors have been closed and we have been on the outside, but we have a few ideas.

One thing we know how to do is to reduce the cost of health care; and we also know that one size fits all doesn't sound like freedom. Mr. THOMPSON, I would like to yield to you at this time.

Mr. THOMPSON of Pennsylvania. I thank my good friend from Missouri.

I came here in January, and I came here knowing that I had a pretty good handle on health care. I worked in health care for almost 30 years. I actually think we have a pretty good health care system, but it can be improved. And much of the improvements that I saw was getting government out of the way. The frustrations I had as a health care professional, as a health care manager, as a therapist, as a nursing home administrator, is when the government was creating problems, preventing access to cost-effective care, increasing costs because of these arbitrary ways that it gets involved.

To me, I think, as my good friend Mr. BISHOP talked about, it is about the wisdom that our Founders had, and it is about free market.

You look at all the Republican proposals we have; they are free market proposals. It is not about inserting more government; it is getting government out of the way. And it is about the arbitrary rules that we have on where we can buy our health insurance from. The government tells us we can only buy within the confines of our own State, and it is about the government telling us we can't group together and form association health plans, that we have to endure medical liability. That becomes legislated and codified into our lives and adds just hundreds of billions of dollars of waste onto the health care system.

I am just so proud of the proposals that Republicans have put forward. I don't know how many in total we have, but between 35 and 40, I believe.

Mr. AKIN. I heard there are over 50 different bills at this point. Some are a combination of different ideas and put together in different ways.

You know, you used to be an administrator and you had to deal with red tape and bureaucracy. What we have just done is we have got a 1,990 page bill. It passed with less than 72 hours for the public to review it. It creates 118 new boards, bureaucracies, commissions and programs, and it is full of new mandates. And it contains the word ''shall'' 3,425 times. This is what it looks like. And that doesn't even have all of those 118 new boards on it. This is just a simplified version of it. Now, does that look like something to you that gives you much choices? And second of all, talk about overhead, talk about redtape.

You know, we were thinking about, and I see my colleague has come out here with some great sort of cartoons and things, and we were thinking about turning this into a cartoon. We were going to put patients over here and doctors over here, and turn it into a place mat, and we are going to have lines like a maze, and the trick is, before your dinner is cold, to try to get the patient to the doctor. We were going to set the maze up so there wasn't any way to get there, because that is really what this tells you.

If you really want good, efficient health care, this thing here is in your way. That's the reason why a great majority of Americans don't believe that the Federal Government can take this thing over and manage it efficiently and effectively without the costs going through the roof and also without degrading health care, because the trouble is no other country has ever been able to do this.

I yield to the gentleman.

Mr. THOMPSON of Pennsylvania. Let me reflect on my experiences as someone who was a manager of health care services in a rural hospital, skilled nursing, rehabilitation service—across the board, on what this means. Because you talked about increased costs to the taxpayers of this country.

I have to tell you, what I see there is a nightmare in terms of costs for hospitals and for providers. Hospitals alone, when you look at over 1,990 pages of new text, and that is just the bill. The regulations to be promulgated as a result of over 2,000 pages of law will be—it will just take a forest to be able to print those regulations. Those regulations all need to be administered.

Here is my prediction: For those hospitals that are not bankrupt in the near future, they are going to have to add tremendous employees to deal with that bureaucracy. Those employees' only job will be to interact with all those agencies, not health care, not people providing direct care. They will have to lay off people who provide direct care to be able to afford what will be required to administer those regulations, to make those regulations work within a hospital. That is not good health care.

□ 1815

Mr. AKIN. That's overhead.

Mr. THOMPSON of Pennsylvania. That's overhead. That's the complete opposite of access to quality care. That's preventing access.

Mr. AKIN. I would like to go to my friend Dr. GINGREY. He's got another very heavy medical concept for us. I can tell. He's got it all cued up here.

Mr. GINGREY of Georgia. I thank the gentleman for yielding back to me. In fact, I would ask him to put the previous poster back up, the one that showed all those additional bureaucracies that are created by H.R. 3962. In fact, that poster was created when it was H.R. 3200 and, as the gentleman from Missouri said, a thousand pages, now 2,000 pages. But he said something about, Madam Speaker, putting that in cartoon form. Well, I've got the cartoon for my colleagues, and here it is.

When you put a gown on that chart, this is what it looks like: a bloated, bloated patient called the House health bill. And this is a cartoon actually from the San Diego Union Tribune a few days ago. And, my colleagues, look at the poor patient, and, of course, I

don't know if you can see up at the top corner, ''nip/tuck.'' And these two Senators are standing over here. I guess that may be the majority leader of the Senate, HARRY REID, and possibly the chairman of the Senate Finance Committee or the chairman of the Senate Health Committee standing next to Majority Leader REID, and the caption is, ''Hey, this might take a while'' to nip/tuck this bloated 2,000-page bureaucracy that's depicted by my colleague Representative AKIN.

It just shows you in a cartoon form, but unfortunately it's not funny, is it? It's not funny, my colleagues and Madam Speaker. This is serious business. And I hope and pray that the Senate will be the saucer that cools the drink of the hot cup that has come over from the House, because Lord help this country if we don't do a whole lot of nipping and tucking if not downright eliminating this bill, H.R. 3962.

Mr. AKIN. I appreciate your keeping it in a sort of a big picture form as to what we're talking about on cost.

Mr. GINGREY of Georgia. No pun intended, of course, about the cartoon.

Mr. AKIN. But the cost supposedly by the Congressional Budget Office was that this was going to cost a trillion dollars, so your figure over there was overweight in costing a trillion dollars. The trouble with this estimate is it's wrong because the Congressional Budget Office took some assumptions when they built it because they were told we've got to keep this thing under a trillion dollars.

The problem is, first of all, the Democrat Governor of the State of Tennessee, who has already tried this lovely idea, has taken a look at this and called it the ''monster of unfunded mandates.'' What that means is that that trillion dollars was trimmed one way, was to dump a bunch of the costs down to the various States, aside from the fact that it destroys everything that the State of Utah has set up, which is actually kind of an innovative idea. It destroys that because it says every single health insurance plan has to follow what the Federal Government says. So now they're going to define what health insurance is and that's all there is, one definition. And anybody else that doesn't follow that definition, you know what the bill says. You're going to get fined if you're offered health insurance that doesn't fit with what the government guidelines say. So this trillion dollars is wrong.

The other thing they did was they took the trillion dollars and they took the time to calculate this in such a way that the revenue was coming in but the real expenses of the program hadn't hit their peak yet. So they cheated on the two different time scales as to when the money was coming in versus when the costs were going to come. So, in fact, the trillion as the Senate has calculated it is closer to $2 trillion, which is $2 trillion we don't have.

I think the gentlewoman Congresswoman FOXX said that there was a survey done that said that Americans believe there is more probability that we're going to discover aliens in outer space than the fact that this thing is ever going to be anything other than a big budget-busting deficit, driving deficit spending. And, you know, there is a pretty good reason why Americans have that common sense, because we've tried these things before. The Federal Government has tried Medicare and Medicaid, and we see their costs are going out of control, and we're told, Trust us. Medicare and Medicaid are going out of control, so we're going to take the whole system over and run it by the government and it's not going to go out of control.

I yield to my good friend from Pennsylvania.

Mr. THOMPSON of Pennsylvania. I appreciate that, Mr. AKIN.

To that point on Medicare, because of the baby boomer generation, utilization is going up. Those costs are climbing. But just this past week we heard from the Centers for Medicare and Medicaid Services. They released their 31-page actuarial report on the Pelosi health care plan on what would this do to Medicare. You know what? You're going to have to make that poster a little larger because what the Centers for Medicare and Medicaid Services—which is the Medicare agency, and they're nonpartisan. That's not a partisan report. It comes from the people who actually run the Medicare and Medicaid systems in the country. As they looked at this bill when they scored it, they said that this would increase costs to the Medicare program over the next 10 years by $289 billion. So I'm afraid we're going to have to budget for a little larger poster, because with the Pelosi health care bill, it's going to take quite a steep climb beyond where Medicare is already on——

Mr. AKIN. So you're saying that the cost of Medicare is going to go up with this program.

Mr. THOMPSON of Pennsylvania. Absolutely, $289 billion is what the Medicare agency——

Mr. AKIN. Now, wait a minute. My understanding was that what we were cutting was 400 or $500 billion out of Medicare in order to pay for that trillion. How then is the cost of Medicare going to go up if we're cutting $500 billion? How do the mathematics work?

Mr. THOMPSON of Pennsylvania. You know what? I have asked that question many times since I came here in January, how does the math work in this Chamber, because it doesn't add up.

Mr. GINGREY of Georgia. If the gentleman from Missouri would yield.

Mr. AKIN. I yield to my good friend Dr. GINGREY.

Mr. GINGREY of Georgia. On this issue, as the gentleman from Pennsylvania just said, the actuaries of CMS, Medicare and Medicaid Services, just said exactly what he said, that over a 10-year period of time, the amount of Medicare expenditures are going to go up by something like $289 billion.

Look, colleagues, Madam Speaker, we are going to face something on this floor tomorrow, something called ''doc fix.'' I think the bill number is H.R. 3961. And I want to use my reference to my last chart to bring this home to our colleagues that this is nothing but a Trojan horse. Here's the Trojan horse with this 3961. I know, my colleagues and Madam Speaker, it's hard to see this, but it says ''Democrat doc fix,'' but what's inside that Trojan horse, of course, is the $500 billion cut to the Medicare program that the gentleman from Pennsylvania was just talking about. And also it says H.R. 3200. We now know with the Pelosi health reform act, as H.R. 3962, the poor horse is back because it's gone from a thousand pages to 2,000 pages. But that's what's inside this Trojan horse.

Make no mistake about it, my colleagues. Members back home and, yes, your physician constituents, your physician constituents are going to recognize this Trojan horse because they were promised in this massive bill, H.R. 3962, that there would be this permanent ''doc fix'' in there. But the leadership and the President got together and said, oh, no, that's going to make the cost go over $900 billion, and I promised not one dime more than $900 billion. So let's pull the doctor fix out and then we'll bring it forward as a stand-alone bill. But guess what, colleagues? It's not paid for. And the gentleman from Pennsylvania, I know that he knows this. That adds another $250 billion to the deficit.

Don't vote for this Trojan horse tomorrow, 3961.

Mr. AKIN. Reclaiming my time, you were speaking clearly except there was one word I didn't quite catch. I thought you said, was it ''doc fix'' or was it ''doc tricks''?

Mr. GINGREY of Georgia. I said ''doc fix,'' Madam Speaker. But I probably misspoke. I think the gentleman from Missouri is absolutely on target. Doc trick. Amen.

Mr. AKIN. So it's a trick to make it seem like everything is going to go right with Medicare, but, in fact, it's not. In other words, the idea was it was going to fix the formula in Medicare so that the doctors wouldn't keep having their salaries cut a certain—what was it, 5 percent a year or something like that?

Mr. GINGREY of Georgia. If my colleague would yield, and I'll yield right back to him because I know we've got another Member that wants to speak.

Mr. AKIN. I yield.

Mr. GINGREY of Georgia. It is a doc trick. And what it does is it does not

solve the problem. It just substitutes one bad formula for another. And I think, unfortunately, our doctors, if this thing passes, are going to wake up and find out that they are now working for the Federal Government and they're making far less on Medicare reimbursement than they are today.

Mr. AKIN. My friend is a medical doctor, and you're planning to vote ''no'' on the bill.

Mr. GINGREY of Georgia. In fact, the gentleman is right. I wish there was a ''heck no'' button, but I don't think there is. But I will be a definite ''no.''

Mr. AKIN. Thank you very much, Dr. GINGREY. Thank you for joining us, and I appreciate your at least trying to put somewhat of a humorous face on a very, very serious situation.

We're joined by a very good friend of mine from Louisiana. I hope you would join us here on our discussion we've got going here tonight.

I yield to the gentleman.

Mr. SCALISE. I thank the gentleman from Missouri.

You're talking about these tricks, and, of course, the American people are saying Halloween's over, we're tired of all these tricks. In fact, for most American people right now, the only treat they get is when Congress adjourns and during those times when Congress isn't trying to pass all of these policies that literally are adding millions and billions of new taxes on the backs of American families, adding billions of debt onto the backs of our children and grandchildren, and running millions of jobs out of our country. All of this happening under Speaker PELOSI's leadership. The public's had enough of the tricks, and like I said, that's the only treat they want.

But one trick that they just found out about the other day, this goes back to the stimulus bill, something that we talked about a long time ago. We opposed that pork-laden bill, that bill that massively grows the size of government, over $787 billion of money we don't have. But the White House promised the American people there would be a full accounting of the money. And now we find out, in fact, that people just in the last few days went to the White House's own Web site that was set up to track the spending in the supposed job creation, which they initially said it was going to create all these jobs and then they changed the wording and said there will be jobs created or saved, and there's no definition of a job saved. I guess every job that's out there they can try to claim they've saved. But then what we've seen is we've only had millions more jobs lost since that massive spending bill that grew the size of government.

But now talk about another trick on the American people, just Monday night when they would go to the Web site that the White House had set up, and maybe this was good news for States like yours, mine. In Louisiana, we found out, according to the White House's Web site, we had 15 congressional districts.

Mr. AKIN. How many was that, gentleman?

Mr. SCALISE. Fifteen, according to the White House. In fact, Louisiana's Eighth Congressional District, according to the White House's own Web site, created more jobs than the First Congressional District that I represent. That all sounds really good until you realize Louisiana doesn't have 15 congressional districts. Louisiana only has seven congressional districts.

So we did a little bit of research, and some people did some calling around on their own and they actually called the White House. And they said, Can you explain to us, you said there would be all this transparency. You said there would be accountability. How is it, how is it that somebody can go to the White House Web site and pull up in Louisiana Congressional District 26 or Congressional District 45? And the response from the White House was, ''Who knows, man, who really knows.''

That was Ed Pound, who is the spokesperson for the White House's recovery.gov Web site. The best he could come up with was ''who knows.'' And then he further went on to say, ''We're not certifying the accuracy of the information.'' That's the White House's spokesperson on the stimulus bill actually saying that they're not going to certify the information after they said they would be so transparent.

So when the American people say what happened to $787 billion of money that was borrowed from our children and grandchildren, money we don't have, money that surely hasn't done anything to create jobs because it was going to cap unemployment at 8 percent and now we've got unemployment at 10.2 percent, and then you go to the White House, what about that accounting that the American people deserve to know where their money is being spent, and the best the White House can say is, ''Who knows, man, who really knows,'' well, the American people have had enough.

Mr. AKIN. Reclaiming my time, I would like to take a look at your chart here. You were boggling on my poor brain here. You're the Congressman from District One, and they're saying there are 40 some congressional districts in Louisiana, which is real news to me. I suppose that was news to you, too. And you finally get ahold of the White House, and they spent millions of dollars to create this Web site to track down where we spent the $787 billion, which was guaranteed or supposed to keep us under 8 percent unemployment, and we get some guy that says, ''Who knows, man, who really knows.'' It's like Woodstock lives on.

□ 1830

And we've spent billions of dollars to get that kind of answer?

Mr. SCALISE. Right.

And what the American people are really asking is, where are the jobs and where is the accountability? And when the White House actually goes out and made these statements back months ago and they told the American people that that stimulus bill needed to be passed, we said back then it was a mistake, we shouldn't do it because it wouldn't create jobs. We proposed alternatives.

Mr. AKIN. Gentleman, you were here on the floor when we talked about this. We said, Look, all of the mathematics, all the common sense says this is wasting a lot of money that we don't have. We said, It's not going to create jobs. It didn't for Henry Morgenthau when he turned the recession into the Great Depression. We said, The reason it's not is because jobs come from businesses, particularly small businesses. You're hammering the small businesses. At least learn from the Democrats, learn from FDR, learn from Henry Morgenthau.

Instead, we've got this half-baked Web site telling us that there's 40 some congressional districts. I mean, you'd think they would at least check how many congressional districts there are in a State.

Mr. SCALISE. If this was just a mistake limited to Louisiana, maybe you could understand their excuses. But, of course, this was all across the country. I talked to a colleague of mine from Arizona where they claim there was a 99th District from Arizona.

But one final word on that. President Obama himself just yesterday said, and I'll quote another quote from the President: ''If we keep on adding to the debt, people could lose confidence in the U.S. economy in a way that could actually lead to a double dip recession.''

Now, of course, those words ring true to us. They would really ring true to the American people if it weren't for the fact that this is the same President that passed a budget just a few months ago out of Congress that doubles the national debt in the next 5 years. And yet here he is quoted just yesterday saying, If we keep on adding to the debt, people could lose confidence in the U.S. economy in a way that could actually lead to a double dip recession.

Now, I would agree with that. The only problem is, the President needs to start living up to the comments that he's actually making and pull back his bill that doubles the national debt and actually work with us to balance the budget, which is what we've said from the beginning needs to happen, not only to create stability in our economy, but actually to go out and start creating jobs as opposed to his policies that are running millions of jobs out of our country.

Mr. AKIN. Do you really think that we're going to balance the budget with a socialized medicine bill that they've

said is going to be a trillion? Do you know what the budget estimate on Medicare was when it was passed? The Congressional Budget Office, they tried to estimate it. They were off by a factor of seven times. This thing is clearly over 2 trillion when you do honest math with it. If that's off by a factor of seven, that's $14 trillion. No wonder the Chinese were giving us a lecture telling us we've got the government spending too much money. They've got some American Treasury bills. It's not like they don't mind big government, but they just don't want to see us ruin their treasuries.

I've got my good friend from New Jersey here, Congressman GARRETT. Please join us.

Mr. GARRETT of New Jersey. I appreciate the opportunity to join you, and I commend the gentleman for leading tonight and also for those very interesting quotes from the White House with regard to the Web sites that are out there.

I think the American public are asking some very basic questions—Where is the transparency? Where is the accountability? Where are the jobs?—on all this legislation that's coming through. And when they see this, when they see Web sites that you just pointed out talking about congressional Web sites that don't even exist, when they see about job creation that doesn't even exist.

You probably recall that the majority leader was on this floor back in the early part of this year when he was exclaiming that we had to vote for a seven or $800 billion stimulus bill and you had to vote for it today. Why? Because it would make or create 3 million new jobs, not next year but this year. And, of course, we now know what the facts are. What are the facts? Instead of making or saving 3 million new jobs—and I never did quite get an explanation of what is saving a job—but making or saving 3 million jobs, we, of course, have lost upwards of 3 or 4 million jobs, just the inverse of that, just the opposite of that.

So the people are asking, where is the honesty in that aspect of things? Where is the accountability with the job creation? They're also asking about, and you're talking about all the money that we're spending, the trillion dollars with regard to the health care legislation and the like. Actually, I think the number was a little bit larger than what you were saying as far as the discrepancy with the projections with regard to Medicare which was created back in the mid sixties. They said by 1990, that program would cost around 10 or $11 billion. It actually cost $112 billion, so it was off by a factor of 10.

Mr. AKIN. So seven—I was being too generous.

Mr. GARRETT of New Jersey. You were being too generous.

Mr. AKIN. So if you take the 10 factor, how much congressional budget—I mean, they're making assumptions trying to guess what something is going to be years into the future. But if you take that 10, if you put the unfunded mandates from the States and you put in the fact that they skewed the time schedule to try to keep it under a trillion, say, they're over 2 trillion, that's $20 trillion?

Mr. GARRETT of New Jersey. Those numbers are just so mind boggling you can't get your arms around it. But you know what you can get your mind around is something that's happening to everybody right now, and that is, I'm getting phone calls to my office with regard to the swine flu situation that's going across this country, and they're saying, We can't get the swine flu vaccine. This is something that's supposed to be administered by this administration, that they promised would be out there for everybody who needed it, and in my counties, my district, you can't go to a doctor or a county clinic or to a county hospital and get that. But you know who is getting it? People who work at the Federal Reserve in New York, people who work for some of the largest financial institutions in this country. And the people who absolutely need it are not getting it. The people who are in jail down at Guantanamo are getting it as well. I just use that as a real life example of the administration running a program for health care and not getting the job done.

I yield back to the gentleman as the time comes to an end.

Mr. AKIN. Looks like we're just starting to have fun and the clock has already run out. I just want to thank all of my gentleman friends here. Congressman GARRETT, thank you so much for joining us. Hearing from the east coast, that's very refreshing. From down in the South, from Louisiana, Congressman SCALISE. And also G.T., all that health care experience that you bring here to the floor managing, we appreciate that.

Thank you. Have a great evening.

COMMUNICATION FROM CHAIR OF COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE

The SPEAKER pro tempore (Ms. TITUS) laid before the House the following communication from the Chair of the Committee on Transportation and Infrastructure; which was read and, without objection, referred to the Committee on Appropriations:

HOUSE OF REPRESENTATIVES, COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC, November 18, 2009.

Hon. NANCY PELOSI,
Speaker of the House, House of Representatives, Washington, DC.

DEAR MADAM SPEAKER: On November 5, 2009, the Committee on Transportation and Infrastructure met in open session to consider 20 resolutions to authorize appropriations for the General Services Administration's (GSA) FY 2010 Capital Investment and Leasing Program, including five construction resolutions (authorizing $221.4 million) and 15 lease resolutions (authorizing $121.4 million). The Committee adopted the resolutions by voice vote with a quorum present.

Enclosed are copies of the resolutions adopted by the Committee on Transportation and Infrastructure on November 5, 2009.

Sincerely,
JAMES L. OBERSTAR, M.C.,
Chairman.

Enclosures.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

AMENDED COMMITTEE RESOLUTION

ADDITIONAL SITE AND DESIGN
U.S. LAND PORT OF ENTRY
CALEXICO, CA
PCA-BSD-CA10

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for additional site acquisition and design for the reconfiguration and expansion of the existing land port of entry in downtown Calexico, CA, at additional site costs of $3,000,000 (site acquisition costs of which $2,000,000 were previously authorized) and design costs of $6,437,000 (design costs of which $12,350,000 were previously authorized), for a combined cost of $9,437,000, a prospectus for which is attached to, and included in, this resolution. This resolution amends the Committee on Transportation and Infrastructure resolution of April 5, 2006.

Provided, that the General Services Administration (GSA) will plan, design, and construct a minimum of five privately owned vehicle (POV) southbound lanes, as recommended by the "BorderWizard" traffic simulation model used for Land Port of Entry (LPOE) studies.

Provided further, that GSA, in coordination and consultation with the U.S. Army Corps of Engineers, shall submit a report to the Committee on Transportation and Infrastructure, within 180 days of adoption of the resolution, on options to plan, design, and construct covering and or piping underground the New River, north from the International Border to Highway 98 in the City of Calexico.

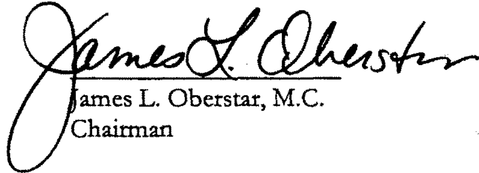
Provided further, that to the maximum extent practicable and considering life-cycle costs appropriate for the geographic area, GSA shall use energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that within 180 days of adoption of the resolution, GSA shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate a report on the planned use of energy efficient and renewable energy systems, including photovoltaic systems, for such project and if such systems are not used for the project, the specific rationale for GSA's decision.

Provided further, each alteration, design, or construction prospectus submitted by GSA shall include an

estimate of the future energy performance of the building and specific description of the use of energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

AMENDED PROSPECTUS – ADDITIONAL SITE & DESIGN
U.S. LAND PORT OF ENTRY
CALEXICO, CA

Prospectus Number: PCA-BSD-CA10
Congressional District: 51

Description

The General Services Administration (GSA) requests additional site acquisition and design for the reconfiguration and expansion of the existing land port of entry (LPOE) in downtown Calexico, CA. The project includes new pedestrian processing and privately owned vehicle (POV) inspection facilities, a new headhouse and new administration offices. The expanded facilities will occupy both the existing inspection compound and the site of the old commercial inspection facility.

Project Summary

Site Information
Government-Owned.. 13.5 acres
To be acquired.. 3 acres

Building Area
Building (including canopies)..260,410 gsf
Building (excluding canopies and inside parking)..106,605 gsf
Number of outside parking spaces..300
Number of inside secure spaces 40

Cost Information
Site Development Cost[1] $160,629,000
Building Costs (includes inspection canopies) ($308/gsf)..$80,226,000

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[1]Site development costs include grading, utilities, paving, extensive fill work for soil stabilization and demolition of existing facilities.

AMENDED PROSPECTUS – ADDITIONAL SITE & DESIGN
U.S. LAND PORT OF ENTRY
CALEXICO, CA

Prospectus Number: PCA-BSD-CA10
Congressional District: 51

Project Budget

Site Acquisition
Site Acquisition (FY 2007) $2,000,000
Additional site 3,000,000
Total Site Acquisition $5,000,000

Design
Design (FY 2007) $12,350,000
Additional design 6,437,000
Total Design $18,787,000

Estimated Construction Cost (ECC)
Phase I $65,646,000
Phase II 175,209,000
Total ECC $240,855,000

Management and Inspection (M&I)
Phase I $5,058,000
Phase II 5,299,000
Total M&I $10,357,000

Estimated Total Project Cost * $274,999,000

*Tenant agencies may fund an additional amount for emerging technologies and alterations above the standard normally provided by the GSA.

Authorization Requested

Additional Site Acquisition & Design .... $9,437,000[2]

[2]GSA has worked closely with DHS program offices responsible for developing and implementing security technology at the Land Ports of Entry (LPOE's). These programs include United States Visitor and Immigrant Status Indicator Technology (US-VISIT), Radiation Portal Monitors (RPM's) and Advanced Spectroscopic Portal (ASPs) monitors, Western Hemisphere Travel Initiative (WHTI) and Non-Intrusive Inspection (NII). This prospectus contains the funding of infrastructure requirements for each program known at the time of prospectus development since these programs are at various stages of development and implementation. Additional funding by a Reimbursable Work Authorization (RWA) may be required to provide for as yet unidentified elements of each of these programs to be implemented at this port.

AMENDED PROSPECTUS – ADDITIONAL SITE & DESIGN
U.S. LAND PORT OF ENTRY
CALEXICO, CA

Prospectus Number: PCA-BSD-CA10
Congressional District: 51

Prior Authority and Funding

- The House Committee on Transportation and Infrastructure authorized $14,350,000, including $2,000,000 for site acquisition and $12,350,000 for design, on April 5, 2006.
- The Senate Committee on Environment and Public Works authorized $14,350,000 for site acquisition and design on May 23, 2006.
- Through Public Law 110-5, GSA's Spending Plan included $14,350,000 for site acquisition and design.

Schedule	Start	End
Design	FY2007	FY2011
Construction		
Phase I	FY2011	FY2012
Phase II	FY2012	FY2014

Overview of Project

The existing LPOE is a pedestrian and vehicle inspection facility constructed in 1974. It comprises a main building and a decommissioned commercial inspection building. The project involves the creation of new pedestrian and POV inspection facilities, expanding the port onto the site of the former commercial inspection facility. The commercial inspection facility operation was moved to Calexico East in 1996. Primary POV inspection facilities will include 16 northbound lanes and three southbound lanes. There will be new administration space, a new headhouse and 32 secondary inspection stations serving northbound and southbound traffic. A total of 340 parking stalls will be provided.

The project, as originally authorized, included construction all in one phase. This prospectus proposes the project to be completed in two phases. Phase I will consist of ten northbound POV inspection lanes, a headhouse and sitework necessary to accommodate those facilities on the sloping site. Phase II will consist of the balance of the project including additional sitework, a pedestrian processing facility, administrative offices, three southbound POV inspection lanes and six additional northbound POV inspection lanes. This request for additional site acquisition and design is to address changes in requirements and the two-phased approach. The two-phased construction approach will allow additional time for site acquisition and minimize the impact to the operations of the port.

AMENDED PROSPECTUS – ADDITIONAL SITE & DESIGN
U.S. LAND PORT OF ENTRY
CALEXICO, CA

Prospectus Number: PCA-BSD-CA10
Congressional District: 51

Tenant Agencies

Defense - Joint-Mexican-U.S. Commission; Department of Homeland Security (DHS) – Animal Plan Health Inspection Service (APHIS); DHS - Customs and Border Protection (CBP); DHS - Immigration and Customs Enforcement (ICE); United States Department of Agriculture (USDA) - Food Safety and Inspection (FSIS).

Location

The site is located at the existing LPOE in Calexico, CA at 200 First Street.

Justification

On an average day, over 16,000 POVs and 20,000 pedestrians enter the U.S. through this POE. The existing facilities are undersized relative to existing traffic loads and obsolete in terms of inspection officer safety and border security. The space required for modern inspection technologies is not available in the existing facility. Current workspace is too small to accommodate additional staff, systems and equipment required at the facility following the events of September 11, 2001. The ability of DHS to accomplish its rapidly changing mission is seriously compromised by the inadequacy of the existing facilities. When completed, the project will provide the port operation with adequate operational space, reduced traffic congestion and a safe environment for port employees and visitors.

Since design was authorized, the overall square footage of the project has changed. At CBP's request, the project now includes canopy structures in the pre-primary area to protect inspectors and canines from sun, heat, and wind. Other elements of the project, such as the building footprint, have decreased due to CBP program requirements. Similarly, the number of total parking stalls increased due to program adjustment, as well as the site acreage to be acquired. Overall, the number of northbound inspection lanes remained the same while the southbound inspection lanes reduced to less than half.

Summary of Energy Compliance

The Calexico LPOE project will be designed to conform with the requirements of the Facilities Standards for the Public Buildings Service and to earn Leadership in Energy and Environmental Design (LEED) certification. It will also meet Congressionally-required energy efficiency and performance requirements in effect during design. GSA will encourage exploration of opportunities to gain increased energy efficiency above the measures achieved in the design.

AMENDED PROSPECTUS – ADDITIONAL SITE & DESIGN
U.S. LAND PORT OF ENTRY
CALEXICO, CA

Prospectus Number: PCA-BSD-CA10
Congressional District: 51

Alternatives Considered

GSA owns and maintains the existing facilities at this port of entry; thus no alternative other than Federal construction was considered.

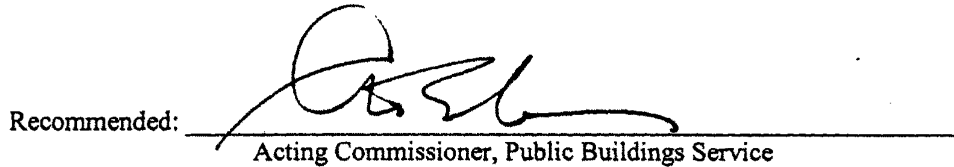
Recommendation

ADDITIONAL SITE ACQUISITION AND DESIGN

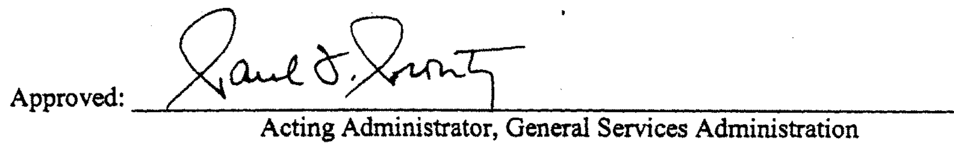
Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on July 11, 2009



Recommended: ______
Acting Commissioner, Public Buildings Service



Approved: ______
Acting Administrator, General Services Administration

Ho[illegible]sing Plan
US La[illegible]rt of Entry

PC [illegible]D-CA10
[illegible]alexico, CA

Locations	Current							Proposed						
	Personnel		*Usable Square Feet (USF)*				*RSF*	*Personnel*		*Usable Square Feet (USF)*				*RSF*
	Office	**Total**	**Office**	**Storage**	**Special**	**Total**	**Total**	**Office**	**Total**	**Office**	**Storage**	**Special**	**Total**	**Total**
US BORDER STATION														
DHS - Customs & Border Protection	155	155	31,569	31,455	10,169	73,193	98,042	277	277	30,347	506	50,875	81,728	88,471
DHS - APHIS	10	10	1,708	1,008	771	3,487	4,864	1	1	657	0	500	1,157	1,375
Department of Army	0	0	0	0	0	0	0	2	2	660	0	0	660	784
DHS - Immigration And Customs Enforcement	0	0	0	0	0	0	0	35	35	6,913	0	0	6,913	8,210
Public Bldgs Service, Field Office	0	0	0	0	0	0	0	1	1	2,157	0	0	2,157	2,562
SD Consular Affairs	0	0	0	0	0	0	0	0	0	0	0	125	125	148
Joint Use	0	0	0	0	0	0	0	0	0	0	0	720	720	855
Total:	**165**	**165**	**35,457**	**32,463**	**11,736**	**79,656**	**107,057**	**516**	**516**	**41,334**	**4,378**	**186,667**	**232,379**	**255,081**

Special Space	
Laboratory	1,600
Holding Cell	11,379
Restroom	5,136
Physical Fitness	990
Conference	3,780
ADP	1,040
Vehicle Lift	336
Inspection Canopy	153,805
Control Booth	995
Vaults	400
Interview Rooms	1,605
Break Rooms	990
Lockers	3,780
Sallyport	491
Secured Elevator	176
Hazmat Shower & Eyewash	64
Telephone Room	100
Total:	**186,667**

USF means the portion of the building available for use by a tenant's [illegible]

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

John L. Mica
Ranking Republican Member

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

James W. Coon II, Republican Chief of Staff

AMENDED COMMITTEE RESOLUTION

CONSTRUCTION
U.S. COURTHOUSE
MOBILE, AL

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for the construction of a new U.S. courthouse, up to 346,691 gross square feet, located in Mobile, AL, at additional site costs of $2,603,000, additional design costs of $6,009,000, management and inspection costs of $7,922,000, and construction costs of $173,506,000 at a proposed total cost of $190,040,000, for which a May 11, 2000 11(b) report and a fact sheet is attached to, and included in, this resolution. This resolution amends the Committee on Transportation and Infrastructure resolution of July 23, 2003.

Provided, that, to the maximum extent practicable and considering life-cycle costs appropriate for the geographic area, the General Services Administration (GSA) shall use energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that within 180 days of adoption of the resolution, GSA shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate a report on the planned use of energy efficient and renewable energy systems, including photovoltaic systems, for such project and if such systems are not used for the project, the specific rationale for GSA's decision.

Provided further, that beginning on the date of adoption of the resolution, each alteration, design, or construction prospectus submitted by GSA shall include an estimate of the future energy performance of the building and specific description of the use of energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that the Administrator of General Services shall ensure that a sharing plan approved by the Judicial Conference on September 15, 2009, for courtrooms for magistrate judges is adopted and is implemented in the design of the courthouse.

Provided further, that the Administrator of General Services shall ensure that the design provides courtroom space for senior judges for up to 10 years from eligibility for senior status, not to exceed one courtroom for every two senior judges.

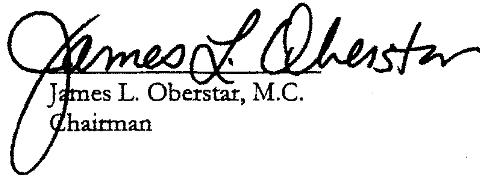
Provided further, that the Administrator of General Services shall ensure that the Mobile, Alabama

Courthouse contains no more than seven courtrooms.

Provided further, that the Administrator of General Services submit a flood plain mitigation plan to the Committee on Transportation and Infrastructure of the House of Representatives before a construction award is made.

Provided further, that the Judicial Conference of the United States shall specifically approve each departure from the *U.S. Courts Design Guide* for each U.S. courthouse construction project that results in additional estimated costs of the project (including additional rent payment obligations) and that the Judicial Conference provide a specific list of each departure and the justification and estimated costs (as supplied by the GSA) of such departure for each U.S. courthouse construction project to the GSA. Each U.S. courthouse construction prospectus submitted by GSA shall include a specific list of each departure and the justification and estimated cost (including additional rent payment obligations) of such departure and GSA's recommendation on whether the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate should approve such departure.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

Introduction
In accordance with a resolution adopted April 11, 2000 by the Committee on Transportation and Infrastructure of the House of Representatives, the General Services Administration (GSA) has investigated the feasibility and need to construct or acquire a facility to house the United States District Court for Southern AL, in Mobile, AL.

Current Housing Situation
The Administrative Office of the United States Courts (AOC) projects that within ten years, 17 judges will be in Mobile: eight district; four magistrate; three bankruptcy; and two circuit. The existing Campbell CT neither meets the United States Courts Design Guide (USCDG) standards, nor provides expansion space for future court requirements Because of the inadequate expansion space in the Campbell CT, the court currently occupies space in five leased buildings.

The Campbell CT currently has eight courtrooms. Of those eight courtrooms, only three meet the minimum USCDG for space requirements. Based on the Design Guide standards, two judges who will be eligible for senior status, will remain in two of the existing courtrooms. Three courtrooms, two of which are just below the minimum size standards, will be occupied by the bankruptcy judges. The leased space currently housing the bankruptcy court operations will be released. The remaining courtrooms will be converted to office space to accommodate increased space requirements of the U.S. Attorneys and U.S. Marshals.

The Campbell CT also provides inadequate security. For instance, separate access or egress for judicial officers or prisoners is not provided. There are no secured private corridors to courtrooms, chambers, or U.S. Marshals' areas, and there are no secure elevators in the building. Holding cells are not contiguous to the courtrooms and secured parking is not available to the courts.

Tenant Agencies
The Campbell CT and the CT-Annex will house the Judiciary, Justice, Senate and a GSA customer service center.

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

Option Based on Courtroom Sharing Model

Space Requirements of the Courts

The Five Year Courthouse Plan 2001-2005, as approved by the Judicial Conference of the United States, proposes site acquisition and design of a new court facility for Mobile for fiscal year 2001.

The CT-Annex will provide seven courtrooms and ten chambers for four district judges, two senior district judges and four magistrate judges. In addition, the CT-Annex will provide chambers for two circuit judges.

A physical connection between the CT-Annex and the existing Campbell CT will enable co-location of the entire court in a Government-owned court complex and continued utilization of the Campbell CT.

Fifty secured inside parking spaces will be incorporated into the construction of the CT-Annex and made available to judges, probation officers, pretrial officers, U.S. Marshals and U.S. Attorneys. GSA proposes buying sufficient land to enable future construction to accommodate the 30-year space requirements. In the interim, the portion of the site reserved for future expansion will be used to provide approximately 50 secured surface parking spaces for the court.

The table below outlines the current and future courts requirements.

	Current		Proposed		Number of Courtrooms		Change	
	No. of Court-rooms	No. of Judges	No. of Court-rooms	No. of Judges	No. of Existing	No. of New	No. of Court-rooms	No. of Judges
District								
- Active	2	3	4	4	0	4	2	1
- Senior	3	3	2	4	2	0	(1)	1
Magistrate	3	4	3	4	0	3	0	0
Bankruptcy	2*	2	3	3	3	0	1	1
Circuit	0	1	0	2	0	0	0	1
Total	10	13	12	17	5	7	2	4

* Bankruptcy Court is currently housed in leased space.

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

Alternatives Considered (30-year, present value costs)

Lease:	$117,171,000
New Construction:	$83,464 ,000

The 30-year, present value cost of construction is $33,707,000 less than the cost of leasing, an equivalent annual cost advantage of $2,193,000.

Project Summary

Site Information

To be purchased .... Approximately 3 acres

Building Area

Gross square feet (excluding inside parking) 278,434
Gross square feet (including inside parking) 298,434

Project Budget

Site Cost $2,895,000
Design (Annex) 4,507,000
Management and Inspection (M&I Annex) 3,543,000
Estimated Construction Cost ($195/gsf including inside parking) 58,237,000
Estimated Total Project Cost* $69,182,000

*Tenant agencies may fund an additional amount for alterations above the standard normally provided by GSA.

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

Option Based on No Departures from the U.S. Courts Design Guide

Space Requirements of the Courts
The Five Year Courthouse Plan 2001-2005, as approved by the Judicial Conference of the United States, proposes site acquisition and design of a new court facility for Mobile for fiscal year 2001.

The CT-Annex will provide eight courtrooms and ten chambers for four district judges, two senior district judges and four magistrate judges. In addition, the CT-Annex will provide chambers for two circuit judges.

A physical connection between the CT-Annex and the existing Campbell CT will enable co-location of the entire court in a Government-owned court complex and continued utilization of the Campbell CT.

Fifty secured inside parking spaces will be incorporated into the construction of the CT-Annex and made available to judges, probation officers, pretrial officers, U.S. Marshals and U.S. Attorneys. GSA proposes buying sufficient land to enable future construction to accommodate the 30-year space requirements. In the interim, the portion of the site reserved for future expansion will be used to provide approximately 50 secured surface parking spaces for the court.

The table outlines the current and future requirements of the courts.

	Current		Proposed		Number of Courtrooms		Change	
	No. of Court-rooms	No. of Judges	No. of Court-rooms	No. of Judges	No. of Existing	No. of New	No. of Court-rooms	No. of Judges
District								
- Active	2	3	4	4	0	4	2	1
- Senior	3	3	2	4	2	0	(1)	1
Magistrate	3	4	4	4	0	4	1	0
Bankruptcy	2*	2	3	3	3	0	1	1
Circuit	0	1	0	2	0	0	0	1
Total	10	13	13	17	5	8	3	4

* Bankruptcy Court is currently housed in leased space.

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

Alternatives Considered (30-year, present value costs)

Lease:	$121,623,000
New Construction:	$86,250,000

The 30-year, present value cost of construction is $35,373,000 less than the cost of leasing, an equivalent annual cost advantage of $2,301,000.

Project Summary

Site Information

To be purchased .... Approximately 3 acres

Building Area

Gross square feet (excluding inside parking) 285,361
Gross square feet (including inside parking) 305,361

Project Budget

Site Cost	$2,895,000
Design (Annex)	4,642,000
Management and Inspection (M&I Annex)	3,627,000
Estimated Construction Cost ($197/gsf including inside parking)	60,174,000
Estimated Total Project Cost*	**$71,338,000**

*Tenant agencies may fund an additional amount for alterations above the standard normally provided by GSA.

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

Option Based on Original Requirements of the U.S. Courts

Space Requirements of the Courts

The Five Year Courthouse Plan 2001-2005, as approved by the Judicial Conference of the United States, proposes site acquisition and design of a new court facility for Mobile for fiscal year 2001.

The CT-Annex will provide ten courtrooms and chambers for four district judges, two senior district judges and four magistrate judges. In addition, the CT-Annex will accommodate chambers for two circuit judges.

A physical connection between the CT-Annex and the existing Campbell CT will enable co-location of the entire Court in a Government-owned court complex and continued utilization of the Campbell CT.

Fifty secured inside parking spaces will be incorporated into the construction of the CT-Annex and made available to judges, probation officers, pretrial officers, U.S. marshals and U.S. attorneys. A 200-space deck is proposed to meet additional employee and visitor parking requirements. GSA proposes buying sufficient land to enable future construction to accommodate the 30-year space requirements. In the interim, the portion of the site reserved for future expansion will be used to provide approximately 50 secured surface parking spaces for the court.

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

The table outlines current and future requirements of the courts.

	Current		Proposed		Number of Courtrooms		Change	
	No. of Court-rooms	No. of Judges	No. of Court-rooms	No. of Judges	No. of Existing	No. of New	No. of Court-rooms	No. of Judges
District								
- Active	2	3	4	4	0	4	2	1
- Senior	3	3	4	4	2	2	1	1
Magistrate	3	4	4	4	0	4	1	0
Bankruptcy	2*	2*	3	3	3	0	1	1
Circuit	0	1	0	2	0	0	0	1
Total	10	13	15	17	5	10	5	4

* Bankruptcy Court currently housed in leased space.

Alternatives Considered (30-year, present value costs)

Lease: $124,989,000
New Construction: $91,850,000

The 30-year, present value cost of construction is $33,139,000 less than the cost of leasing, an equivalent annual cost advantage of $5,426,000.

Project Summary

Site Information

To be purchased .... Approximately 3 acres

Building Area

Gross square feet (excluding inside parking) 301,722
Gross square feet (including inside parking) 321,722

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

The table outlines current and future requirements of the courts.

	Current		Proposed		Number of Courtrooms		Change	
	No. of Court-rooms	No. of Judges	No. of Court-rooms	No. of Judges	No. of Existing	No. of New	No. of Court-rooms	No. of Judges
District								
- Active	2	3	4	4	0	4	2	1
- Senior	3	3	4	4	2	2	1	1
Magistrate	3	4	4	4	0	4	1	0
Bankruptcy	2*	2*	3	3	3	0	1	1
Circuit	0	1	0	2	0	0	0	1
Total	10	13	15	17	5	10	5	4

* Bankruptcy Court currently housed in leased space.

Alternatives Considered (30-year, present value costs)

Lease: $124,989,000
New Construction: $91,850,000

The 30-year, present value cost of construction is $33,139,000 less than the cost of leasing, an equivalent annual cost advantage of $5,426,000.

Project Summary

Site Information

To be purchased .... Approximately 3 acres

Building Area

Gross square feet (excluding inside parking) 301,722
Gross square feet (including inside parking) 321,722

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
MOBILE, AL

Report Number: BAL-01001
Congressional District: 01

Project Budget

Site Cost	$2,895,000
Design (Annex)	4,887,000
Management and Inspection (M&I Annex)	3,782,000
Estimated Construction Cost ($198/gsf including inside parking)	63,837,000
Estimated Total Project Cost*	**$75,401,000**

*Tenant agencies may fund an additional amount for alterations above the standard normally provided by GSA.

Recommendation
SITE AND DESIGN

Schedule

FY 2001	Site and Design
FY 2002	Construction
FY 2005	Occupancy

Certification of Need

New construction is the best solution to meet a validated Government need.

Submitted at Washington, DC, on May 11, 2000

Recommended Paul Chistolini
for Commissioner, Public Buildings Service

Approved Thurman M. Davis Sr.
Deputy Administrator, General Services Administration

GSA PBS

FACTSHEET
NEW U.S. COURTHOUSE
MOBILE, AL

BACKGROUND:

- Project Description: The construction of a 346,691 gsf Courthouse; including 50 inside parking spaces
- Project Justification: The CT will meet the 10-year needs of the court and court-related agencies and the site/building design is flexible enough to accommodate the 30 year needs of the court.

CURRENT STATUS:

- The design of the project is 100% complete, but storm mitigation concerns and modification to the HVAC systems now require redesign.
- The project is on hold pending receipt of additional funds for acquisition of remaining site parcels, design revision, and construction.

Site and Design	FY 2002
Construction	FY 2011
Occupancy	FY 2015

FUNDING:

The House Transportation and Infrastructure Committee authorized $97,033,000:

- $7,537,000 for site and design for a 305,361 gsf CT, including 50 inside parking spaces on 7/26/2000;
- $3,753,000 for additional site and design for a 325,452 gsf CT, including 50 inside parking spaces, on 7/18/2001; and
- $85,743,000 for additional design and for construction and management and inspection for a 342,273 gsf CT, including 50 inside parking spaces on 7/23/2003.

The Senate Environment and Public Works Committee authorized $141,861,000:

- $7,782,000 for site and design for a 321,722 gsf CT, including 50 inside parking spaces, on 7/26/2000;
- $3,753,000 for additional site and design for a 325,452 gsf CT, including 50 inside parking spaces, on 9/25/2001; and
- $141,861,000 for additional site and reduced design for construction and management and inspection for a 346,691 gsf CT, including 50 inside parking spaces on 9/13/2006.

Congress appropriated $11,290,000 for FY 2002 (Public Law 107-67).

Authorization and funding required for FY2010 is $190,400,000

Estimated Total Project Cost $201,690,000

Recent recommendations from Congress (in the ARRA conference report) concerning courtroom sharing may reduce the number of courtrooms and total space in the proposed building.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

CONSTRUCTION
U.S. COURTHOUSE ANNEX
GREENBELT, MD

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for the construction of an expansion, up to 262,579 gross square feet, of the U.S. courthouse located in Greenbelt, MD at design costs of $10,000,000, for which a February 12, 1990 11(b) report and fact sheet is attached to, and included in, this resolution.

Provided, that, to the maximum extent practicable and considering life-cycle costs appropriate for the geographic area, the General Services Administration (GSA) shall use energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that within 180 days of adoption of the resolution, GSA shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate a report on the planned use of energy efficient and renewable energy systems, including photovoltaic systems, for such project and if such systems are not used for the project, the specific rationale for GSA's decision.

Provided further, that beginning on the date of adoption of the resolution, each alteration, design, or construction prospectus submitted by GSA shall include an estimate of the future energy performance of the building and specific description of the use of energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

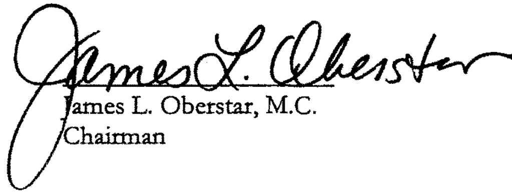
Provided further, that the Administrator of General Services shall ensure that a sharing plan approved by the Judicial Conference on September 15, 2009, for courtrooms for magistrate judges is adopted and is implemented in the design of the courthouse.

Provided further, that the Administrator of General Services shall ensure that the design provides courtroom space for senior judges for up to 10 years from eligibility for senior status, not to exceed one courtroom for every two senior judges.

Provided further, that the Administrator of General Services shall ensure that the Greenbelt, Maryland Courthouse Annex contains no more than 12 courtrooms;

Provided further, that the Judicial Conference of the United States shall specifically approve each departure from the *U.S. Courts Design Guide* for each U.S. courthouse construction project that results in additional estimated costs of the project (including additional rent payment obligations) and that the Judicial Conference provide a specific list of each departure and the justification and estimated costs (as supplied by the GSA) of such departure for each U.S. courthouse construction project to the GSA. Each U.S. courthouse construction prospectus submitted by GSA shall include a specific list of each departure and the justification and estimated cost (including additional rent payment obligations) of such departure and GSA's recommendation on whether the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate should approve such departure.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

Report Number: BMD-91W02

INTRODUCTION:

In accordance with the resolution adopted by the House Committee on Public Works and Transportation on June 22, 1989, the General Services Administration (GSA) has investigated the space requirements of all components of the U.S. Courts, as well as the U.S. Marshals Service and the U.S. Attorneys, for a courthouse to serve the newly created Southern Division of the Judicial District of Maryland. This report supports a recommendation to construct a courthouse to serve the 5 counties comprising the Southern Division - Prince George's, Montgomery, Calvert, Charles, and St. Mary's. The courthouse shall be constructed within 5 miles of the Prince George's-Montgomery County boundary.

COMMUNITY PROFILE:

The Suburban Maryland portion of the National Capital Region (NCR) encompasses 2 of these counties - Prince George's and neighboring Montgomery. Suburban Maryland is one of the three areas comprising the National Capital Region (NCR), the other two being the District of Columbia and Northern Virginia. Suburban Maryland includes Prince George's and Montgomery County. The Northern Virginia component includes the counties of Arlington, Fairfax, Loudoun, and Prince William; and the independent cities of Alexandria, Fairfax, and Falls Church.

In 1987, the population of the Suburban Maryland portion was nearly 1.4 million, up almost 10 percent from its 1980 population. Suburban Maryland accounts for well over one-third of the population of the entire Washington, DC metropolitan area, which is approximately 3.7 million. Prince George's County has less office and retail development space than Montgomery County, and is slightly less populous.

COMMERCIAL SPACE DATA:

The metropolitan area has been the focus of substantial commercial development over the past several years, although the pace has leveled off during the past year. Construction of new office space in the suburban areas has surpassed that of the District of Columbia in recent years with overbuilding occurring in some areas, causing a higher than usual vacancy rate in the suburbs. The real estate industry predicts that much of the space now being completed will not be absorbed until the mid-1990's.

Much of this commercial and retail development has occurred in Montgomery County, especially along the Interstate 270 corridor.

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REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

Report Number: BMD-91W02

COMMERCIAL SPACE DATA: (cont'd)

In addition, the extension of the Metrorail system has been critical to Montgomery County's development. Not only has substantial office and retail development already occurred along the Metrorail corridor, but additional large-scale facilities are in the planning stages. However, developmental constraints, created by traffic limitations, have recently slowed this pace.

Prince George's County, however, continues to be extremely interested in attracting new office development, both for Government agencies and private industry. Presently, Prince George's County has much less major office development than Montgomery County. Part of this difference is due to the timing of Metrorail construction. Much of the Metrorail system in Prince George's County has yet to be completed, and certain portions are not funded. As such, there has not been the opportunity for dense development along its future Metrorail corridors.

Further differences between the 2 counties are reflected by their rental and vacancy rates. Since land has been cheaper in Prince George's County, more warehouses have been built there; but there has been a recent increase in first class office space. However, the office real estate market in Prince George's County has generally reflected a lower rental rate and higher vacancy rate than in Montgomery County. During 1988, the vacancy rates have varied between 13 and 23 percent in these 2 counties.

In both counties, locations closest to DC, Metrorail, and highway access tend to command the highest rates. Rental rate estimates for first class office space in Maryland are $22 to $35 per occupiable square foot for fiscal year 1991.

FEDERAL SPACE SITUATION:

In suburban Maryland, GSA controls 2.8 million Government-owned square feet and 5.6 million leased square feet. This 8.4 million total square feet of space in Suburban Maryland is 13 percent of the region's total. By contrast, 57 percent of the total is located in DC, which houses most agency headquarters; and 30 percent is in Northern Virginia, where the Department of Defense is headquartered at the Pentagon. Northern Virginia also has the headquarters of the Patent and Trademark Office (Department of

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REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

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FEDERAL SPACE SITUATION: (cont'd)

Commerce), and major components of the Departments of Justice and Interior. The GSA space in Suburban Maryland is concentrated in the Montgomery County communities - such as Bethesda and Silver Spring - closest to Washington, DC, and along the Interstate 270 corridor between Bethesda and Germantown. Furthermore, nearly 1 million square feet will become occupied in Silver Spring during the next 2 years when the National Oceanic and Atmospheric Administration (NOAA) consolidates from several leased locations within Montgomery County.

Suburban Maryland	Gov't-owned	Leased	Total
Number of Bldgs.	27	79	106
Occupiable Sq. Ft.	2,837,702	5,455,916	8,293,618
Employees	11,282	21,406	32,688

Within Suburban Maryland, the current ratio of Government-owned space to leased space is 34:66. The current ratio of Federal employees in Government-owned space to those in leased space, in Suburban Maryland, is also 34:66.

Steady economic growth in the Washington area in recent years has resulted in a steep rise in the cost of commercial office space. Accordingly, GSA is facing a sharp increase in leasing costs over the next decade. This has been one of the catalysts for a number of the consolidation projects noted in this report.

GOVERNMENT-OWNED BUILDINGS AND SITES:

Suburban Maryland has 7 Government-owned office buildings of more than 100,000 square feet, all of which are in Prince George's County or Montgomery County. Four are in Prince George's County (all 4 are in Suitland) and 3 are in Montgomery County:

1) In Germantown (Montgomery County), the Department of Energy's largest Building, with 374,205 square feet;

2) One White Flint North (a building purchase) in North Bethesda, with 238,076 square feet occupied by the Nuclear Regulatory Commission (NRC);

3) Silver Spring Metro Center (a building purchase, and first building of the NOAA complex), with 126,441 square feet; and

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REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
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GOVERNMENT-OWNED BUILDINGS AND SITES: (cont'd)

4) In Prince George's County, the Suitland Federal Center has several major office buildings: Federal Office Buildings (FOB) 3 and 4, at 500,085 and 239,160 square feet; and Naval Intelligence Command (NIC) 1 and 2, at 146,590 and 143,785 square feet respectively. Suitland serves as the headquarters for the Bureau of the Census (Department of Commerce) as well as NIC.

In Suburban Maryland, GSA controls one major development area - the Suitland Federal Center, cited immediately above. In addition to the office buildings at Suitland, there is a 798,000 square foot Federal Records Center, plus a power plant. GSA is preparing a Master Plan to guide development for the site, including the 1989 transfer of 44 acres to the Department of Navy to construct a new building for NIC which will house elements now located in NIC 1 and 2. The Master Plan will propose a combination of new construction plus renovation of selected Government-owned buildings. Some existing buildings may be demolished to make way for new development.

In addition to space that GSA controls, there are several major installations under other agencies' purview. In Montgomery County, these include the Department of Health and Human Services' (HHS) National Institutes of Health (NIH) campus in Bethesda. NIH is adding a 500,000 square foot building to house its administrative offices. The Bethesda Naval Hospital is across the street. In Gaithersburg, the Department of Commerce has the National Institute of Standards and Technology (NIST) (formerly the National Bureau of Standards) campus.

In Prince George's County, the Department of Agriculture controls a large research facility in Beltsville, but shares its jurisdiction with the Food and Drug Administration of HHS. The National Archives and Records Administration (NARA) has received approval for a 1.4 million square foot research facility and records center in College Park. This is scheduled for completion in 1994.

LEASED SPACE:

The Government leases 8 office buildings in Suburban Maryland with more than 100,000 square feet of space:

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REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

Report Number: BMD-91W02

LEASED SPACE: (cont'd)

1. In Hyattsville, Center Building No. 1 with 220,590 square feet and Center Building No. 2 with 301,049 square feet. The Departments of Agriculture, Treasury, and Health and Human Services, are the primary tenants in these buildings;

2. The Gramax Building in Silver Spring with 159,530 square feet, which houses NOAA;

3. The Washington Science Center in Rockville with 235,280 square feet, occupied by NOAA;

4. The Parklawn Building, occupied by HHS in Rockville, with 1,317,255 square feet; and

5. In Bethesda, the Westwood Main Annex, 225,455 square feet, and Westwood Towers, 112,325 square feet. HHS and the Consumer Product Safety Commission (CPSC) are the primary tenants.

NOAA will vacate the Gramax Building and the Washington Science Center in 1990 and 1992, respectively, and relocate to Silver Spring as part of the NOAA consolidation. Ten leased locations in Maryland will be vacated as part of this consolidation.

There are numerous other leased locations in suburban Maryland which house agency functions required to be close to their headquarters. For example, there are several leased buildings near the Census Bureau at Suitland which house Census functions. Because of this constraint, there is no need to provide general office space within the proposed Courts complex discussed below.

SPACE REQUIREMENTS:

Public Law 100-487 established the new Southern Division of the Judicial District of Maryland in October 1988. Previously, the Maryland Bar Association had established a Task Force on the Organization of the United States District Court for the District of Maryland. This task force recommended the establishment of a Southern Division to better cope with the enormous growth in population, economic development, and court activity in the 5 counties comprising the Southern Division of Maryland. The Public Law states that the new courthouse shall be within 5 miles of the boundary of Prince George's and Montgomery counties.

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

Report Number: BMD-91W02

SPACE REQUIREMENTS: (cont'd)

By 1990, the Bureau of the Census projects that nearly 1.6 million residents, or almost 35 percent of the population of the entire State of Maryland, will reside in the five counties. In addition, these counties are the fastest growing in Maryland in terms of population, sales, and business development, as well as legal activity, as measured by civil, criminal, and bankruptcy court filings. Since there is not an existing courthouse in Prince George's or Montgomery counties, a new facility will have to be constructed. The Court's requirements cannot be satisfied in any existing Government-owned building or land site within Prince George's or Montgomery counties.

While there is no District Court in the 5 counties comprising the Southern Division, there are District Court functions in Prince George's and Montgomery counties. GSA leases space for Magistrates, U.S. Attorneys, and the Marshals Office in the Presidential Building in Hyattsville, and the Bankruptcy Court occupies leased space in Exchange Place in Rockville. The U.S. Marshals' space includes offices for Marshals personnel as well as holding cells for prisoners who are awaiting court appearances. A new courthouse will consolidate the existing Courts, Attorneys, and Marshals offices that are presently located in these two counties.

The elimination of constant shuttling among Court facilities by the Attorneys and Court personnel will create significant time saving as well as more efficient management of the judicial functions. Furthermore, public service will be improved by eliminating confusion about the various court locations.

The proposed facility would require a site of approximately four and a half acres to be acquired within 5 miles of the boundary of Prince George's and Montgomery counties. The courthouse should be located close to the Beltway and should be accessible to public transportation.

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REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

Report Number: BMD-91W02

SPACE REQUIREMENTS: (cont'd)

The proposed United States Courthouse will contain 96,887 occupiable square feet of space plus parking for 155 vehicles. The building will house all components of the U.S. Courts, as well as the U.S. Marshals Service and the U.S. Attorneys. There will be 7 courtrooms (three for the District Court, two for the Magistrates, and two for the Bankruptcy Court) which will meet the Court's projected requirements for the scheduled 1994 occupancy. The building will satisfy the expansion requirements of all the agencies, while consolidating them from three locations into one modern, functional, and secure facility.

The current (fiscal year 1990) commercial market rents in suburban Maryland average from $22 to $30 per square foot, fully serviced. However, due to the cost of altering leased space to accommodate courtrooms, chambers, and special facilities for handling prisoners, the rent incurred by the Government for a facility with these features would be well above these rates.

Approximately 86 percent of the nearly 12 million square feet of building space occupied by the Courts, nationwide, is in Government-owned buildings. GSA's policy to house Courts in Government-owned space, wherever practical, was reinforced by the Public Buildings Amendments of 1988. This legislation directed GSA to avoid leasing space to accommodate the U.S. Courts, in order to alleviate the high costs of alterations to commercial space.

ALTERNATIVES:

LEASE - This alternative proposes that GSA negotiate a lease to house the Courts and associated agencies in 96,887 occupiable square feet plus 155 parking spaces. The 30-year, present value cost of this alternative is $39,930,000.

CONSTRUCTION - This alternative proposes construction of a building to house the Courts and associated agencies in 96,887 occupiable square feet plus 155 parking spaces. The 30-year, present value cost of this alternative is $31,614,000.

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REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

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CONCLUSION:

The 30-year, present value of Federal construction is $8,316,000 less than the leasing alternative, or an equivalent annual cost advantage of $809,000. In addition, since it is GSA's policy to house the Courts in Government-owned buildings to alleviate the high cost of alterations to commercial space, the recommended alternative is direct Federal construction.

RECOMMENDATION:

CONSTRUCTION is recommended.

Occupants .... Multiple Agencies (Judiciary, U.S. Attorneys, U.S. Marshals)

Area
Gross .... 156,100 Square Feet
Occupiable .... 96,887 Square Feet
Parking*............................. 50 inside spaces

Site....................................... To be acquired**

Estimated Construction Cost*** $21,883,000

Authority Requested in this Prospectus $21,883,000

*In addition, there are 105 outside spaces, for an overall total of 155 spaces.

**$3,000,000 was appropriated in fiscal year 1990 for site acquisition.

***Design, management and inspection, and construction supervision are funded in a single design and construction services budget activity. For design, $1,700,000 was appropriated in fiscal year 1990. Also, it is anticipated that the agencies will fund an additional amount for space alterations above the standard normally provided by GSA.

GSA PBS

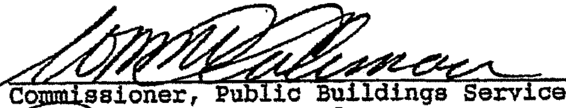
REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

Report Number: BMD-91W02

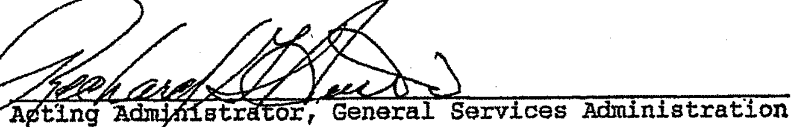
Statement of Need:

It has been determined that the above project is a Government need, and that the proposed solution is the best method to meet that need within the timeframe required.

Submitted at Washington, DC, on February 12, 1990



Recommended: Commissioner, Public Buildings Service



Approved: Acting Administrator, General Services Administration

GSA PBS

REPORT OF BUILDING PROJECT SURVEY
United States Courthouse, Southern Division of Maryland
Suburban Maryland

Report Number: BMD-91W02

ECONOMIC ANALYSIS

	CONSTRUCTION	LEASE
DATA: Term used (yrs)	30	30
Occupancy Year	1994	1993
Square feet in analysis		
Leased	-	96,887
Government-owned	96,887	-
PRESENT VALUE COSTS ($ x 1,000)		
Net, net rent	-	26,147
Construction cost	16,061	-
Design	1,451	-
Management and inspection	1,243	-
Land	2,525	-
Less: Building reversion	(4,358)	-
Land reversion	(679)	-
Interim housing	2,215	1,595
Major R&A	1,959	-
Tenant alterations	1,347	1,439
Services & utilities	6,793	7,257
Property taxes, ins.	2,264	2,419
Property management	793	605
Total Tax Benefits to Lessor	-	468
Total Present Value Cost	31,614	39,930
PROPOSAL VALUE		31,614
PRESENT VALUE COST ADVANTAGE OR		8,316
EQUIV. ANNUAL COST ADVANTAGE		809

Factors Used (10/1/89 Values):
Net Rent: $30.00/osf
Operating Cost: $6.00/osf
Construction Cost to Build a New Building: $129.69/gsf
Land Cost: $2,774,000
Discount Rate: 9.0%

Housing Plan
United States Courthouse, Southern District of Maryland
(as of November 1989)

	CURRENT						PROPOSED					
	Total OSF	Total Pers.	Office OSF	Office Wrksta.	Storage OSF	Special OSF	Total OSF	Total Pers.	Office OSF	Office Wrksta.	Storage OSF	Special* OSF
U.S. COURTS:												
Exchange Place	9,315	52	7,890	52	75	1,350						
Presidential	16,304	55	13,718	55	42	2,544						
New Courthouse	-	-	-		-	-	67,652	150	36,140	150	-	31,512
Subtotal	25,619	107	21,608	107	117	3,894	67,652	150	36,140	150	-	31,512
U.S. MARSHALS:												
Presidential	2,149	-	1,859	-	-	290						
New Courthouse	-	-	-	-	-	-	12,100	40	5,400	40	200	6,550
Subtotal	2,149	-	1,859	-	-	290	12,100	40	5,400	40	200	6,550
U.S. ATTORNEYS:												
Presidential	598	-	598	-	-	-						
One Metro Square	2,774	9	1,670	9	-	1,104						
New Courthouse	-	-	-	-	-	-	14,635	53	8,360	53	300	5,975
Subtotal	3,372	9	2,268	9	-	1,104	14,635	53	8,360	53	300	5,975
CONGRESSMAN HOYER:												
New Courthouse	-	-	-	-	-	-	1,500	-	1,500	-	-	-
Subtotal	-	-	-	-	-	-	1,500	-	1,500	-	-	-
GSA CONCESSIONS:												
New Courthouse	-	-	-	-	-	-	1,000	-	-	-	-	1,000
Subtotal	-	-	-	-	-	-	1,000	-	-	-	-	1,000
TOTAL	31,140	116	25,735	116	117	5,288	96,887	243	51,400	243	500	44,987

Current U/R (Marshals + Attorneys) = N/A (9 employees)

Proposed U/R (Marshals + Attorneys) = 148

*Special Space Includes:

Lab and clinic	1,050
Food service	1,100
Structurally changed	27,812
ADP	500
Conference/training area	12,850
Light Industrial area	1,675
Total	44,987

Parking = 155 spaces

FACT SHEET
U.S. COURTHOUSE ANNEX
GREENBELT, MD

Description

The General Services Administration (GSA) proposes expansion of the U.S. Courthous(
(CT) in Greenbelt, Maryland from 424, 816 gsf to 687,395 gsf. The 262,579 gs:
courthouse addition will be accomplished by:

1) adding a tower onto the existing half-round portion of the building to increase the functionality of the Courtrooms by adding jury deliberation suites;

2) add to the existing building District Court chambers and U.S. Marshal Service (USMS) space;

3) add other court and court-related functions such as Bankruptcy courtroom and chambers, Pretrial and Probation, U.S. Attorney's Offices, and U. S. Trustee's, and 11 inside parking spaces; and

4) expand the parking structure from 463 parking spaces to a number to be determined during design.

Project Summary

Site Information

Government-Owned........ 9.3 acres

Building Area

Existing gross square feet (including 50 inside parking spaces) 424,816
Additional gross square feet (including 11 inside parking spaces)........ 262,579
Total gross square feet (including 61 inside parking spaces) 687,395

Existing parking structure parking spaces 463
Additional parking structure parking spaces........ TBD*
Total parking structure parking spaces .... TBD

Project Budget

Design **$10,280,000**
Estimated Construction Cost (ECC) ($473/gsf including inside parking) .. **109,332,000**
Management and Inspection (M&I) **8,786,000**
Estimated Total Project Cost (ETPC) $128,398,000**

*Non court parking for the new facility will be affected by the consolidation of traffic court functions. The total number of parking spaces will be determined during design.
**Tenant agencies may fund an additional amount for alterations above the standard normally provided by the GSA.

FACT SHEET
U.S. COURTHOUSE ANNEX
GREENBELT, MD

Prior Authority and Funding

None

Overview of Project

The Greenbelt Courthouse was built in 1994. This expansion project provides:

- two additional District courtrooms with four additional chambers,
- two additional Magistrate courtrooms and chambers,
- two additional Bankruptcy courtrooms and chambers,
- additional space for the inclusion of Probation and the US Trustees (from leased space),
- expansion space for the US Attorney's Office and
- additional space for the USMS holding requirements.

Tenant Agencies

District Court; Bankruptcy Court; Federal Public Defender; Probation; Pretrial; Department of Justice – U.S. Marshals Service; Department of Justice – Office of the U.S. Attorney; Department of Justice – U.S. Trustees; U.S. House of Representatives Office

Justification

Renovation of the existing offices will provide more efficient usage of the existing facility. These additions will meet the Judiciary's 10-year need corresponding with the year 2020. The Five-Year Courthouse Project Plan for FYs 2010-2014 approved by the Judicial Conference on March 17, 2009, which reflects construction priorities approved by the Judicial Conference, includes expansion of the CT in Greenbelt, MD for site and design funding for FY 2011. (The Five-Year Courthouse Project Plan for FYs 2009-2013 approved by the Judicial Conference on March 11, 2008 included the project for site and design funding for FY 2010.)

The court's southern division has grown rapidly since the existing building opened and it needs to be expanded to accommodate current and future growth. The existing building lacks sufficient space to adequately house existing personnel and accommodate projected growth for the court and court related agencies through 2020. The existing building is structurally and functionally incapable of accommodating the projected expansion.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

AMENDED COMMITTEE RESOLUTION

CONSTRUCTION
U.S. COURTHOUSE
SAVANNAH, GA

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for the construction of a new U.S. courthouse, up to 184,955 gross square feet, located in Savannah, GA, at design costs of $7,900,000, for which a March 15, 1994 prospectus and fact sheet is attached to, and included in, this resolution. This resolution amends the Committee on Transportation and Infrastructure resolution of July 23, 2003.

Provided, that, to the maximum extent practicable and considering life-cycle costs appropriate for the geographic area, the General Services Administration (GSA) shall use energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that within 180 days of adoption of the resolution, GSA shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate a report on the planned use of energy efficient and renewable energy systems, including photovoltaic systems, for such project and if such systems are not used for the project, the specific rationale for GSA's decision.

Provided further, that beginning on the date of adoption of the resolution, each alteration, design, or construction prospectus submitted by GSA shall include an estimate of the future energy performance of the building and specific description of the use of energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that the Administrator of General Services shall ensure that a sharing plan approved by the Judicial Conference on September 15, 2009, for courtrooms for magistrate judges is adopted and is implemented in the design of the courthouse.

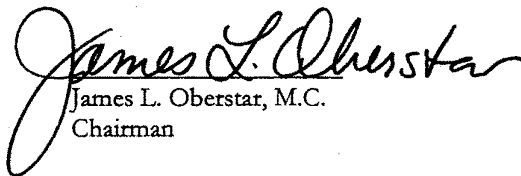
Provided further, that the Administrator of General Services shall ensure that the design provides courtroom space for senior judges for up to 10 years from eligibility for senior status, not to exceed one courtroom for every two senior judges.

Provided further, that the Administrator of General Services shall ensure that the Savannah Courthouse Annex contains no more than four courtrooms;

Provided further, that the Administrator of General Services shall prepare a feasibility report on the need for the courthouse and re-evaluate the design. The report shall be submitted to the Committee on Transportation and Infrastructure of the House of Representatives before proceeding with construction of the Savannah, Georgia Courthouse.

Provided further, that the Judicial Conference of the United States shall specifically approve each departure from the *U.S. Courts Design Guide* for each U.S. courthouse construction project that results in additional estimated costs of the project (including additional rent payment obligations) and that the Judicial Conference provide a specific list of each departure and the justification and estimated costs (as supplied by the GSA) of such departure for each U.S. courthouse construction project to the GSA. Each U.S. courthouse construction prospectus submitted by GSA shall include a specific list of each departure and the justification and estimated cost (including additional rent payment obligations) of such departure and GSA's recommendation on whether the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate should approve such departure.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

GSA PBS

PROSPECTUS - SITE AND DESIGN
U.S. Courthouse - Savannah, GA

Prospectus Number: PGA-95005
Congressional District: 1

Description:

This prospectus proposes the acquisition of a site and the design of a Courthouse (CT) in Savannah, GA. The CT will provide 233,626 gross square feet of space including 100 inside parking spaces for the U.S. Courts and court-related agencies. The proposed building will be designed to meet the 10-year needs of the courts in conjunction with the continued use of the existing Federal Building-Courthouse (FB-CT). Five new courtrooms will be provided: two district, two bankruptcy, and one magistrate. The CT will also provide offices for the U.S. attorneys, the U.S. Trustees, the U.S. marshals, and the U.S. Postal Service (USPS). The new building will house approximately 331 employees.

Currently, the courts and related activities occupy space in three locations in Savannah. There is a total of four judges: two district, one magistrate, and one bankruptcy judge. The primary location of the courts is in the Government-owned FB-CT, which was completed in 1899 and is listed on the National Register of Historic Places. It provides a total of four courtrooms, two assigned to the district court, one to the magistrate, and one to bankruptcy. Two courtrooms meet the U.S. Courts Design Guide minimum requirement of 2,000 square feet for district courtrooms. The other two courtrooms are less than 1,500 square feet and below the standard for magistrate and bankruptcy judges.

The FB-CT cannot house the total current requirements of the courts and related activities. In May 1993, the U.S. attorneys required expansion space and were relocated from the FB-CT to leased space in the nearby J.C. Penny Building. The lease expires May 27, 2003, and has termination rights after May 28, 1998. The U.S. Trustees are located in leased space in the Commerce Building, 222 West Oglethorpe Street in downtown Savannah. The lease expires October 31, 1997.

The AOC wishes to retain the FB-CT because of its significance and prominence in the heart of the Savannah historic district. The courts are aware that the proposed project will result in split court functions. A site for the proposed project has been identified adjacent to the existing FB-CT. Its convenient location will permit construction of a tunnel between the new CT and FB-CT to facilitate operations. The two district courtrooms will continue to be utilized. The two courtrooms now assigned to the magistrate judge and bankruptcy judge will be converted to office space upon completion of the proposed project. In addition, the FB-CT will continue to provide space for the Clerk of the Court, Probation, and the U.S. marshals. The USPS will relocate from the ground floor of the FB-CT to the CT to provide expansion for the Clerk of the Court. A small amount of space will be retained by executive agencies.

GSA PBS

PROSPECTUS - SITE AND DESIGN
U.S. Courthouse - Savannah, GA

Prospectus Number: PGA-95005
Congressional District: 1

Space Requirements of the U.S. Courts:

	CURRENT COURTROOMS/JUDGES		10-YEAR REQUIREMENT COURTROOMS/JUDGES			
	Courtrooms FB-CT	Judges	Courtrooms FB-CT	Courtrooms New CT	Total	Judges
Circuit Court	0	0	0	0	0	1
District	2	2	2	2	4	4
Magistrate	1*	1	0	1	1	1
Bankruptcy	1*	1	0	2	2	2
TOTAL	4	4	2	5	7	8

*These hearing rooms provide 777 and 1,200 square feet of space. They are below minimum requirement and will be converted to office space.

Time Out and Review:

After careful consideration of the client agencies' housing needs and an analysis of current market alternatives, GSA has determined that site acquisition and design of this facility should proceed. However, a review of the original estimated construction costs resulted in a $4,623,000 reduction for construction. In addition, there will be opportunities to realize savings during the design stage and procurement and execution of the construction contract through value engineering techniques. Should savings be realized, they will be made available upon completion of the construction phase of the project.

Delineated Area:

The new courthouse will be located in the CBD of Savannah, GA, on a site that has been identified adjacent to the existing FB-CT. Acquisition of this site is instrumental for the courts' consolidation and continued utilization of the existing FB-CT.

Justification:

The Administrative Office of the United States Courts (AOC) completed a Long-Range Facility Plan for the Southern District of Georgia in June 1991. Based on projections, a total of seven courtrooms will be required in the Savannah division within the next 10 years. Three additional judgeships are anticipated for Savannah: one district judgeship is currently vacant and pending appointment; one district judge is projected within 10 years; and one bankruptcy judge is projected within 5 years. In addition, it is anticipated that within the next 10 years a circuit judge will be appointed to the district. The district court will require a total of four courtrooms, the magistrate judge will require one courtroom, and bankruptcy will require two courtrooms. In accordance with the Long-Range Facility Plan and the U.S. Courts Design Guide, additional space will be required by the district court, the Circuit Court, magistrate judge, clerk of the court, bankruptcy court, U.S. attorneys, U.S. Trustees and U.S. marshals.

PROSPECTUS - SITE AND DESIGN
U.S. Courthouse - Savannah, GA

Prospectus Number: PGA-95005
Congressional District: 1

Justification (Cont'd):

The existing FB-CT cannot accommodate the increased space requirements of the U.S. courts and related agencies. Two courtrooms in the FB-CT are below the minimum standard size for both the magistrate and bankruptcy court. The proposed CT will provide the required expansion space and courtrooms that meet the minimum standard requirements. The office utilization rate will be 120 square feet per person excluding the judiciary and GSA joint-use space. The new building will be designed with ceiling heights that can accommodate the construction of six additional courtrooms, if necessary, beyond the 10-year needs because of the historic nature of Savannah and its structures and the difficulty in obtaining sites for future construction. To allow for expansion of the Judiciary, offices of related agencies such as the U.S,. attorneys and Probation, will be relocated to other space.

The proposed project includes 100 inside parking spaces consisting of 51 official, 39 employee, 5 visitor, and 5 handicapped spaces. The proposed parking will serve the needs of new CT and the existing Savannah Federal Complex that includes the FB-CT and the Juliet Gordon Low Federal Building where approximately 986 Federal employees are currently housed.

The 30-year, present value construction cost is $6,004,000 less than the cost of leasing the required space, or an equivalent annual cost advantage of $489,000.

Alternatives:

CONSTRUCTION - This alternative proposes the construction of a new courthouse facility to provide for the long-term housing of the U.S. courts and related activities. The 30-year, present value cost for this alternative is $43,626,000.

LEASE - this alternative proposes the leasing of a facility to provide for the long-term housing of the U.S. courts and related activities. The 30-year, present value cost of this alternative is $49,630,000.

Recommendation:

SITE ACQUISITION AND DESIGN are recommended.

Occupants: .... U.S. Courts and Related Agencies

Building Area:
Gross Square Feet 186,567
Gross Square Feet (including inside parking spaces) 233,626
Parking Spaces .... 100 inside

Site Information:
To be purchased .... 1.4 acres

GSA PBS

PROSPECTUS - SITE AND DESIGN
U.S. Courthouse - Savannah, GA

Prospectus Number: PGA-95005
Congressional District: 1

Cost Information:

Site	$3,211,000
Estimated Design*	2,104,000
Management and Inspection	2,065,000
Estimated Construction Cost ($126 per gsf including inside parking)**	29,587,000
Total Project Cost	$36,967,000

Authority Requested in this Prospectus (Site and Design): $5,315,000

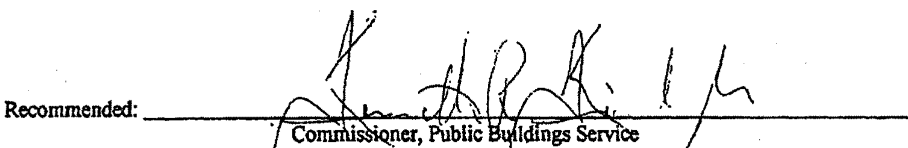
*If there are any additional design costs above the $2,104,000 due to increased project scopes that are not anticipated at this time, they will be accommodated within this line item of the new construction budget. Accordingly, GSA does not plan to request additional design authority for this project. Also, it is anticipated that the tenant agencies will fund an additional amount for the design of space alterations above the standard normally provided by GSA.

**A detailed construction prospectus will be submitted for this project with a future year construction budget request.

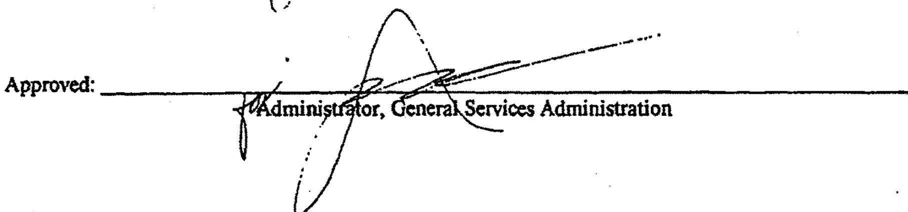
Statement of Need:

It has been determined that the above project is a Government need and that the proposed action is the most cost effective method to meet that need within the timeframe required.

Submitted at Washington, DC, on March 15, 1994



Recommended: ______________________
Commissioner, Public Buildings Service



Approved: ______________________
Administrator, General Services Administration

GSA PBS

PROSPECTUS - SITE AND DESIGN
U.S. Courthouse - Savannah, GA

Prospectus Number: PGA-95005
Congressional District: 1

ECONOMIC ANALYSIS

	CONSTRUCTION	LEASE
DATA: Term used (years)	30	30
Occupancy Year	1998	1997
PRESENT VALUE COSTS ($ x 1,000)		
Net, net rent	-	31,943
Construction cost	23,127	-
Design	1,834	
Management and Inspection	1,614	-
Land	3,091	-
Less: Building reversion	(7,860)	-
Land reversion	(1,025)	-
Interim housing	4,028	832
Major R&A	3,119	-
Tenant alterations	2,209	2,345
Services & utilities	8,431	8,951
Property taxes & insurance	2,529	2,685
Property management	2,529	2,077
Total tax benefits to lessor	-	797
Total Present Value Cost	43,626	49,630
PROPOSAL VALUE		-43,626
PRESENT VALUE COST ADVANTAGE		6,004
OR		
EQIV. ANNUAL COST ADVANTAGE		489

Net Rent: $23.50/sf
Operating Cost: $5.00/sf
Discount Rate: 7.1%

HOU: ?LAN
U.S. Courts and ..ated Activities
Savannah, GA
(As of August 1993)

CURRENT							PROPOSED					
Total OSF	Total Pers	Office OSF	Office Pers	Storage OSF	Special OSF	AGENCY/ LOCATION	Total OSF	Total Pers	Office OSF	Office Pers	Storage OSF	Special OSF
19,587	24	15,114	24	1,412	3,061	District Court	23,500	15	9,800	15	500	13,200
9,793	20	7,569	20	945	1,279	Bankruptcy	To relocate to USCT-Annex					
8,330	11	7,450	11	880	0	Probation	11,000	30	7,980	30	1,000	2,020
3,530	4	3,226	4	80	224	Clerk of Court	13,000	20	8,800	20	1,200	3,000
5,226	19	4,157	19	0	1,069	U.S. Marshals	3,500	12	1,900	12	400	1,200
900	0	900	0	0	0	U.S. Attorneys	To relocate to USCT-Annex					
7,059	8	129	8	0	6,930	USPS	To relocate to USCT-Annex					
881	6	881	6	0	0	USGS	1,000	7	900	7	100	0
3,020	15	2,766	15	254	0	Fish & Wildlife	3,000	17	2,600	17	400	0
In leased space						EEOC	3,400	14	2,200	14	200	1,000
1,339	0	0	0	705	634	Joint Use	1,265	0	0	0	560	705
59,665	107	42,192	107	4,276	13,197	SUBTOTAL	59,665	115	34,180	115	4,360	21,125
						LEASED SPACE						
3,320	25	3,320	25	0	0	U.S. Trustees	To relocate to Proposed CT					
26,050	83	22,013	83	0	4,037	U.S. Attorneys	To relocate to Proposed CT					
29,370	108	25,333	108	0	4,037	SUBTOTAL						
						PROPOSED CT**						
						District Court	29,710	13	3,270	13	300	26,140
						Magistrate	5,740	10	1,380	10	150	4,210
						Bankruptcy	25,055	60	11,410	60	2,525	11,120
						Circuit Court	2,900	6	0	6	110	2,790
						U.S. Trustees	8,200	44	6,790	44	500	910
						U.S. Attorneys	33,025	155	24,525	155	1,000	7,500
						U.S. Marshals	5,975	26	3,375	26	400	2,200
						USPS	10,000	17	2,550	17	1,000	6,450
						Joint Use	4,395	0	1,795	0	800	1,800
						SUBTOTAL	125,000	331	55,095	331	6,785	63,120
						TOTALS						
89,035	215	67,525	215	4,276	17,234	Occupiable Square Feet	184,665	446	89,275	446	11,145	22,925
8,272		6,273		397	1,601	Square Meters	17,156		8,294		1,035	2,130

Current Office Utilization Rate = 229

*FB-CT contains 59,665 sf

Proposed Office Utilization Rate = 120
(Excludes Judiciary, joint use, and 8,193 sf support space)

**Special Space in Proposed CT Includes:

Private restrooms..	2,450
Food service.......	1,140
Courtrooms/chambers	23,170
Vaults.............	250
Library............	6,800
Secured areas......	2,450
ADP................	1,200
Records storage/mai	6,250
Conference/training	19,410
TOTAL	63,120

Note: The occupiable square foot measure is used by GSA to assign space to client agencies. All rent to tenant agencies is calculated and billed on an occupiable square foot basis. The occupiable square foot measurement is defined as the actual area that is available for exclusive tenant use.

(6)

GSA PBS

FACTSHEET
U. S. COURTHOUSE ANNEX
SAVANNAH, GA

Description
This project involves the construction of a 166,955 gross square foot U.S. Courthouse Annex (Annex) in Savannah, GA. In conjunction with the renovation of the existing Federal Building-Courthouse (FB-CT), the Annex would be constructed to meet the 10-year space needs of the courts and court-related agencies. The Judiciary's Five Year Plan, which reflects priorities approved by the Judicial Conference, includes a CT Annex in Savannah, GA, for construction funding.

Project Summary

Site
Government-owned .... 1..4 acres

Building Area
Gross square feet (no inside parking) 166,955

Project Budget
Site (Demolition) (FY 1995) $3,211,000
Design (FY 1996) 2,386,000
Additional Design 668,000
Management and Inspection (M&I) 4,250,000
Estimated Construction Cost (ECC)($274/gsf) 45,818,000
Estimated Total Project Cost* $56,333,000

*Tenant agencies may fund an additional amount for alterations above the standard normally provided by GSA.

House Authorization Required (Additional Design, ECC and M&I) $50,736,000

Prior Authority and Funding
- The Senate Committee on Environment and Public Works authorized $5,315,000 for site and design on May 26,1994 and $46,462,000 for additional design, construction, management and inspection on September 23, 1998.
- The House Committee on Public Works and Transportation authorized $3,211,000 for site and $2,104,000 for design, for a combined cost of $5,315,000, on September 28, 1994.
- Through Public Law 103-329, Congress appropriated $3,000,000 for site. (FY95)
- Through Public Law 104-52, Congress appropriated $2,597,000. (FY96)

GSA PBS

FACTSHEET
U. S. COURTHOUSE ANNEX
SAVANNAH, GA

Schedule

FY 1995/1996	Site and Design
FY 2004	Construction
FY 2007	Occupancy

Overview of Project
Over the next 10 years, a total of seven courtrooms would be required in Savannah. The District Court would require a total of five courtrooms and the Bankruptcy Court would require two courtrooms. The Annex would provide two district courtrooms, one magistrate courtroom, and two bankruptcy courtrooms and would meet the ten-year expansion requirements of the courts and court-related agencies. The Annex would be designed with ceiling heights that allow for the construction of four additional courtrooms to meet the courts' long-term housing requirements. Increased ceiling heights will eliminate the need to acquire a new site, which is difficult in the Savannah Historic District. In order to accommodate future expansion of the courts, related agencies can be relocated from the building.

Tenant Agencies:
Major tenants would be the District Court, the Bankruptcy Court, U.S. Marshals Service, and U.S. Attorneys.

Delineated Area:
The site for the Annex is Federally owned and is adjacent to the existing FB-CT. Two smaller, non-historic Federal buildings will be demolished to make room for the new building.

Justification:
The Judiciary wants to retain the FB-CT due to its significance and prominence in the NHL Savannah Historic District. This historic building was not designed to accommodate more than the original number of courtrooms. Two district courtrooms in the FB-CT will continue to be utilized, while the courtrooms assigned to the magistrate judge will be converted to conference and training rooms upon completion of a future renovation project in the FB-CT. In addition, the FB-CT will continue to provide space for the District Court and the U.S. Marshals.

The existing FB-CT cannot accommodate the increased space requirements of the U.S. Courts and related agencies. Two courtrooms in the FB-CT do not meet minimum United States Courts Design Guide (USCDG) standards. Furthermore, the FB-CT requires modernization to meet the USCDG standards for operational efficiency, maximum accessibility and safety. The completion of the Annex is planned to tie in with the subsequent modernization of the FB-CT. This schedule will ensure the courts and court-related agencies adequate swing space, thus mitigating adverse impacts to these agencies' operations.

FACTSHEET
U. S. COURTHOUSE ANNEX
SAVANNAH, GA

After completion, the existing FB-CT would be retained to provide space for the District Court, U.S. Probation Office, U.S. Attorneys, U.S. Marshals Service and the U.S. Trustee. The U.S. Attorneys and the U. S. Trustees will relocate from leased space. These leases would be extended or terminated to coincide with the occupancy of the new Annex and renovated FB-CT.

Space Requirements of the U.S. Courts

	Current		10-Year		
	Courtrooms	Judges	Courtrooms FB-CT	Courtrooms Annex	Judges
District					
- Active	2	2	1	1	2
- Senior	0	1	1	1	3
- Visiting	0	2	0	0	2
Magistrate	1*	1	0	1	1
Bankruptcy	1*	1	0	2	2
Total:	4	7	2	5	10

* These courtrooms do not meet minimum USCDG standards.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

AMENDED COMMITTEE RESOLUTION

CONSTRUCTION
U.S. COURTHOUSE
SAN ANTONIO, TX

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for the construction of a new U.S. courthouse, up to 334,335 gross square feet, located in San Antonio, TX, at additional design costs of $4,000,000, for which prospectus PTX-CTSD-SA04 and a fact sheet is attached to, and included in, this resolution.

Provided, that, to the maximum extent practicable and considering life-cycle costs appropriate for the geographic area, the General Services Administration (GSA) shall use energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that within 180 days of adoption of the resolution, GSA shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate a report on the planned use of energy efficient and renewable energy systems, including photovoltaic systems, for such project and if such systems are not used for the project, the specific rationale for GSA's decision.

Provided further, that beginning on the date of adoption of the resolution, each alteration, design, or construction prospectus submitted by GSA shall include an estimate of the future energy performance of the building and specific description of the use of energy efficient and renewable energy systems, including photovoltaic systems, in carrying out the project.

Provided further, that the Administrator of General Services shall ensure that a sharing plan approved by the Judicial Conference on September 15, 2009, for courtrooms for magistrate judges is adopted within 30 days of this resolution and is implemented in the design of the courthouse.

Provided further, that the Administrator of General Services shall ensure that the design provides courtroom space for senior judges for up to 10 years from eligibility for senior status, not to exceed one courtroom for every two senior judges.

Provided, that the Administrator of General Services shall ensure that the San Antonio, Texas Courthouse contains no more than seven courtrooms;

Provided further, that the Judicial Conference of the United States shall specifically approve each

departure from the *U.S. Courts Design Guide* for each U.S. courthouse construction project that results in additional estimated costs of the project (including additional rent payment obligations) and that the Judicial Conference provide a specific list of each departure and the justification and estimated costs (as supplied by the GSA) of such departure for each U.S. courthouse construction project to the GSA. Each U.S. courthouse construction prospectus submitted by GSA shall include a specific list of each departure and the justification and estimated cost (including additional rent payment obligations) of such departure and GSA's recommendation on whether the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate should approve such departure.

Adopted: **November 5, 2009**

James L. Oberstar, M.C.
Chairman

GSA PBS

PROSPECTUS – SITE AND ADDITIONAL DESIGN
U.S. COURTHOUSE
SAN ANTONIO, TX

Prospectus Number: PTX-CTSD-SA04
Congressional District: 20

Description

The General Services Administration (GSA) proposes the acquisition of a site and the design of a 377,691 gross square foot courthouse (CT), including 37 inside parking spaces, in San Antonio, TX. The new CT would be constructed to meet the 10-year from occupancy requirements of the District Court and the U.S. Marshals Service, and the site would accommodate the 30-year from design requirements. The Judiciary's Five-Year Plan, which reflects priorities approved by the Judicial Conference, includes a new courthouse in San Antonio, TX for site and design funding.

Project Summary

Site Information

To be acquired .... Approximately 3-4 acres

Building Area

Gross square feet (excluding inside parking) 359,691
Gross square feet (including inside parking) 377,691

Project Budget

Site $18,000,000
Design 8,177,000
Management and Inspection 5,856,000
Estimated Construction Cost ($237/gsf including inside parking) 89,383,000
Estimated Total Project Cost* **$121,416,000**

*Tenant agencies may fund an additional amount for alterations above the standard normally provided by GSA.

House Authorization Requested (Site) $18,000,000
Senate Authorization Requested (Site and Additional Design) $19,251,000

GSA PBS

PROSPECTUS – SITE AND ADDITIONAL DESIGN
U.S. COURTHOUSE
SAN ANTONIO, TX

Prospectus Number: PTX-CTSD-SA04
Congressional District: 20

Prior Authority and Funding

- The House Committee on Transportation and Infrastructure authorized $6,926,000 for design for a 325,113 gross square foot Courthouse, including 37 inside parking spaces, on July 24, 2002, and $1,251,000 for additional design for a 377,691 gross square foot Courthouse, including 37 inside parking spaces, on July 23, 2003.
- The Senate Committee on Environment and Public Works authorized $6,926,000 for design for a 325,113 gross square foot Courthouse, including 37 inside parking spaces, on September 26, 2002.
- Through Public-Law 108-199, Congress appropriated $8,000,000. (FY 04)

Schedule

FY 2005	Site Selection and Design
FY 2008	Construction
FY 2011	Occupancy

Overview of the Project

The new CT will consolidate all of the District Court and U.S. Marshals Service space into one facility, thus improving efficiency of operations. The new CT will provide eight district courtrooms and five magistrate courtrooms.

Once the new CT is completed, the existing Training Center for the Administrative Office of the U. S. Courts (AOUSC) and the existing John H. Wood Jr. Courthouse (Wood CT) will be reported excess.

Tenant Agencies

The new CT will house the U.S. District Court, the U.S. Marshals Service, Probation, Pre-Trial Services, and the Public Defender.

Delineated Area

The new CT will be located in the Central Business District of San Antonio, TX.

PROSPECTUS – SITE AND ADDITIONAL DESIGN
U.S. COURTHOUSE
SAN ANTONIO, TX

Prospectus Number: PTX-CTSD-SA04
Congressional District: 20

Justification
This project is driven by the court's projection for additional judgeships within the next ten years, and by the need to consolidate their space to improve efficiency. The courts have projected a need for one additional district judgeship and two additional magistrate judgeships. Also, four district judges will be eligible for senior status in the 10-year period and require replacements. Court support functions, including the clerk's office, probation, pre-trial services, and the public defender, also require expansion space. These requirements are based on a Long-Range Facility Plan for the Western District of Texas completed by the courts in February 2000. The Wood CT cannot provide this amount of expansion space, nor provide the consolidation needed for operations.

There are currently four active district judges, one visiting district judge, and three magistrate judges in San Antonio. These judges are all housed in the Wood CT and utilize eight available courtrooms. The district court also occupies space in the Federal Building for clerks and support space, and in the Training Center for other support space. The U.S. Marshals occupy space in the Wood CT and in the Federal Building. There are two bankruptcy judges located in the PO-CT, and one circuit judge in leased space. These three judges will remain in place.

The Wood CT sits between the Training Center and the Federal Building. Upon completion of the new CT, the Wood CT and the Training Center will be reported excess. The current occupants of the Wood CT will move to the new CT. The occupants of the Training Center will move to the new CT or the PO-CT.

The Wood CT does not lend itself to the court's and marshal's special security needs. There are few instances where separate circulation exists for judges and prisoners, or for the general public. Its circular design reduces the space efficiency factor, and its lack of windows (except in the lobby area) reduces tenant satisfaction.

GSA originally planned to use the existing Government-owned site to meet the courts needs. This would have first required demolition of the Training Center to provide the site for the new CT. Subsequent to the construction and occupancy of the new CT, the Wood CT was to be demolished to provide a site for future courts expansion. Executing this plan, however, would not have met the courts security setback requirement, because continued occupancy of the Wood CT during construction of the new CT restricts initial development to the Training Center portion of the site. Consequently, GSA now proposes to acquire a new site that will meet the security requirements of the courts in San Antonio. Design of the new CT can commence once the site has been selected, with subsequent purchase of the site pending the future availability of funds.

PROSPECTUS – SITE AND ADDITIONAL DESIGN
U.S. COURTHOUSE
SAN ANTONIO, TX

Prospectus Number: PTX-CTSD-SA04
Congressional District: 20

Space Requirements of the U.S. Courts

	Current		10-Year	
	Courtrooms	Judges	Courtrooms	Judges
District				
- Active	4	4	5	5
- Senior	0	0	3	4
- Visiting	1	1	0	0
Magistrate	3	3	5	5
Total:	8	8	13	14

Alternatives Considered (30-year, present value costs)

Construction: $120,133,000
Lease: $161,682,000

Recommendation

SITE AND ADDITIONAL DESIGN

The 30 year, present value cost of construction is $41,549,000 less than the cost of leasing, an equivalent annual cost advantage of $2,954,000.

GSA PBS

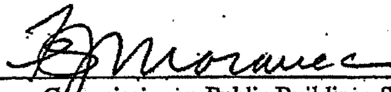
PROSPECTUS – SITE AND ADDITIONAL DESIGN
U.S. COURTHOUSE
SAN ANTONIO, TX

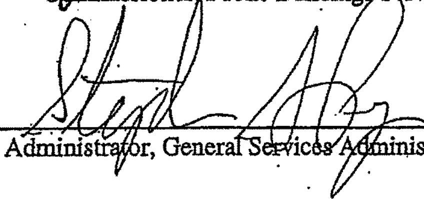
Prospectus Number: PTX-CTSD-SA04
Congressional District: 20

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, D.C. on JUN 23 2004

Recommended 
Commissioner, Public Buildings Service

Approved 
Administrator, General Services Administration

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Locations	Current							Proposed							Changes		
	Personnel		Usable Square Feet (USF)				RSF	Personnel		Usable Square Feet (USF)				RSF	Personnel	USF	RSF
	Office	Total	Office	Storage	Special	Total	Total	Office	Total	Office	Storage	Special	Total	Total	Total	Total	Total
Wood CT																	
Jud-District CT	91	91	22,605	-	41,790	64,395	97,371	-	-	-	-	-	-	-	(91)	(64,395)	(97,371)
JD-US Marshals	51	51	6,550	122	1,934	8,606	13,013	-	-	-	-	-	-	-	(51)	(8,606)	(13,013)
Jud-Ct of Appeals	0	0	1,962	-	175	2,137	3,231	-	-	-	-	-	-	-	0	(2,137)	(3,231)
Joint Use	0	0	165	219	-	384	581	-	-	-	-	-	-	-	0	(384)	(581)
Subtotal	142	142	31,282	341	43,899	75,522	114,196	-	-	-	-	-	-	-	(142)	(75,522)	(114,196)
Training Center																	
Jud-AOC	32	32	6,575	-	1,122	7,697	10,358	-	-	-	-	-	-	-	(32)	(7,697)	(10,358)
Jud-District CT	27	27	5,689	-	-	5,689	7,655	-	-	-	-	-	-	-	(27)	(5,689)	(7,655)
Subtotal	59	59	12,264	0	1,122	13,386	18,013	-	-	-	-	-	-	-	(59)	(13,386)	(18,013)
Federal Building																	
Jud-District CT	141	141	31,436	969	2,559	34,964	44,996	-	-	-	-	-	-	-	(141)	(34,964)	(44,996)
Jud-Pub Def	36	36	11,875	168	303	12,346	15,888	-	-	-	-	-	-	-	(36)	(12,346)	(15,888)
JD-US Marshals	27	27	4,091	-	941	5,032	6,476	-	-	-	-	-	-	-	(27)	(5,032)	(6,476)
Other Agencies	400	400	73,965	2,018	4,963	80,946	104,172	600	600	121,367	3,155	8,766	133,288	171,532	200	52,342	67,360
Subtotal	604	604	121,367	3,155	8,766	133,288	171,532	600	600	121,367	3,155	8,766	133,288	171,532	(4)	0	0
Total	805	805	164,913	3,496	53,787	222,196	303,741	600	600	121,367	3,155	8,766	133,288	171,532	(205)	(88,908)	(132,209)
New CT																	
Jud-District CT	-	-	-	-	-	-	-	96	96	69,450	-	70,610	140,060	161,069	96	140,060	161,069
Jud-Probation	-	-	-	-	-	-	-	165	165	36,587	-	1,015	37,602	43,242	165	37,602	43,242
Jud-Pub Def	-	-	-	-	-	-	-	39	39	12,393	-	400	12,793	14,712	39	12,793	14,712
Jud-PreTrial	-	-	-	-	-	-	-	50	50	13,577	-	785	14,362	16,516	50	14,362	16,516
JD-US Marshals	-	-	-	-	-	-	-	100	100	22,834	775	9,890	31,114	35,781	100	31,114	35,781
Joint Use	-	-	-	-	-	-	-	-	-	2,500	-	-	2,500	2,875	0	2,500	2,875
GSA	-	-	-	-	-	-	-	-	2	1,750	812	-	2,562	2,946	2	2,562	2,946
Subtotal	-	-	-	-	-	-	-	450	452	159,091	1,587	82,700	240,993	277,142	452	240,993	277,142
Total	805	805	164,913	3,496	53,787	222,196	303,741	1,050	1,052	280,458	4,742	91,466	374,281	448,674	247	152,085	144,933

	Current	Proposed	Change
	Utilization		
Rate	N/A	N/A	N/A

Special Space	USF
Toilets	4,682
Food Service	2,050
Vaults	1,920
Detention Cells	7,930
Courtrooms	29,760
Library	1,260
ADP	1,200
Judges Chambers	19,960
Conference/Training	12,738
Sallyport	1,200
TOTAL	82,700

Usable square footage means the portion of the building available for use by an tenants' personnel and furnishings and space available jointly to the occupants of the building (e.g. auditorium, health units and snack bars). Usable square footage does not include space devoted to building operations and maintenance (e.g. craft shops, gear rooms, building supply rooms, rest rooms and lobbies).

NEW U.S. COURTHOUSE
SAN ANTONIO, TX

BACKGROUND:

- Project Description: Construction of a 384,335 gsf Courthouse; including 55 inside parking spaces.
- Location: San Antonio, TX
- Project Purpose: To construct a courthouse that will include 12 courtrooms and 14 chambers to house the District Court, a Court of Appeals judge, and the U.S. Marshals Service (USMS).
- Project Justification: The project is driven by the court's projections for additional judgeships during the planning period and the need to consolidate the District Court and USMS (currently split between two buildings).

SCHEDULE:

- Design would start in October 2009.
- Construction is scheduled for FY 2012 if funded.

AUTHORIZATION AND FUNDING:

The House Transportation and Infrastructure Committee authorized $26,177,000:

- $6,926,000 for design for a 325,113 gsf Courthouse, including 37 inside parking spaces, on July 24, 2002; and
- $1,251,000 for additional design for a 377,691 gsf Courthouse, including 37 inside parking spaces on July 23, 2003; and
- $18,000,000 for site for a 377,691 gsf Courthouse, including 37 inside parking spaces on July 21, 2004.

The Senate Environment and Public Works Committee authorized $26,177,000:

- $6,926,000 for design for a 325,113 gsf Courthouse, including 37 inside parking spaces, on September 26, 2002; and
- $18,000,000 for site and $1,251,000 for additional design, or $19,251,000, for a 377,691 gsf Courthouse including 37 inside parking spaces, on June 23, 2004.

Congress appropriated $8,000,000 for FY2004 (Public Law 108-199).

Authorization and funding required for FY 2010 is $3,266,000 for additional design.

Estimated Total Project Cost: $142,612,000

Recent recommendations from Congress (in the ARRA conference report) concerning courtroom sharing may reduce the number of courtrooms and total space in the proposed building.

CONGRESSIONAL INTEREST:

Senator Kay Bailey Hutchison is a member of the Senate Committee on Appropriations.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
DEPARTMENT OF HOMELAND SECURITY
FEDERAL EMERGENCY MANAGEMENT AGENCY
WASHINGTON, D.C.
PDC-05-WA10

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a lease extension of up to 71,914 rentable square feet for the Federal Emergency Management Agency, currently located 395 E Street, SW, Washington, D.C., at a proposed total annual cost of $3,523,786 for a lease term of up to five years, a prospectus for which is attached to, and included in, this resolution.

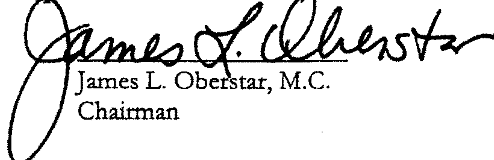
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that*, if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: November 5, 2009



James L. Oberstar, M.C.
Chairman

PROSPECTUS -LEASE
DEPARTMENT OF HOMELAND SECURITY
FEDERAL EMERGENCY MANAGEMENT AGENCY
WASHINGTON, DC

Prospectus Number: PDC-05-WA10

Project Summary

The General Services Administration (GSA) proposes a lease extension for up to 71,914 rentable square feet (rsf) for the Federal Emergency Management Agency (FEMA) currently located in the Patriots Plaza Building at 395 E Street, SW, Washington, DC.

GSA proposes to extend the current lease at Patriots Plaza to coincide with the occupancy of FEMA's new headquarters space at St. Elizabeths. Funding for design for a consolidated FEMA facility at St. Elizabeths has been requested in fiscal year 2009 and has been funded as part of the American Recovery and Reinvestment Act of 2009 (P.L.111-5). Construction funding will be requested in a future fiscal year to commence construction of the new FEMA headquarters. The space is currently scheduled to be ready for occupancy in 2014. GSA will negotiate termination rights with the current landlord to provide the flexibility needed as the occupancy date for St. Elizabeths approaches.

Description

Occupants:	FEMA
Delineated Area:	Washington, DC
Lease Type:	Extension
Justification:	Expiring lease (August 2011)
Expansion Space:	None
Parking:	None
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	5 years
Maximum Rentable Square Feet:	71,914
Current Total Annual Cost:	$3,012,192
Proposed Total Annual Cost: [1]	$3,523,786
Maximum Proposed Rental Rate: [2]	$49.00

[1] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2] This estimate is for fiscal year 2011 and may be escalated by 1.8 percent annually to the effective date of the lease to account for inflation.

PROSPECTUS -LEASE
DEPARTMENT OF HOMELAND SECURITY
FEDERAL EMERGENCY MANAGEMENT AGENCY
WASHINGTON, DC

Prospectus Number: PDC-05-WA10

Authorization

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.

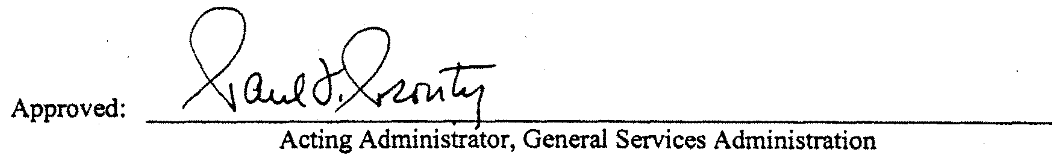
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 11, 2009

Recommended:
Acting Commissioner, Public Buildings Service

Approved: 
Acting Administrator, General Services Administration

March 2009

Housing Plan
Department of Homeland Security
Federal Emergency Management Agency

Washington, DC
PDC-05-WA10

Location	Current						Proposed					
	Personnel		Usable Square Feet (USF)				Personnel		Usable Square Feet (USF)			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
Patriots Plaza	300	300	64,071			64,071	300	300	64,071			64,071
TOTALS	**300**	**300**	**64,071**	-	-	**64,071**	**300**	**300**	**64,071**	-	-	**64,071**

	Current	Proposed	
	Utilization Rate		
	167	167	

Current UR excludes 14,096 usf of office support space
Proposed UR excludes 14,096 usf of office support space

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
U.S. ARMY CORPS OF ENGINEERS
PORTLAND, OR
POR-02-PO10

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a replacement lease of up to 126,500 rentable square feet for the U.S. Army Corps of Engineers, Portland District Office, currently located at Robert Duncan Plaza, 333 SW First Avenue, Portland, OR, at a proposed total annual cost of $5,060,000 for a lease term of up to 15 years, a prospectus for which is attached to, and included in, this resolution.

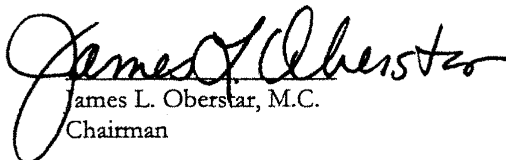
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: November 5, 2009



James L. Oberstar, M.C.
Chairman

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

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COMMITTEE RESOLUTION

LEASE
U.S. ARMY CORPS OF ENGINEERS
PORTLAND, OR
POR-02-PO10

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a replacement lease of up to 126,500 rentable square feet for the U.S. Army Corps of Engineers, Portland District Office, currently located at Robert Duncan Plaza, 333 SW First Avenue, Portland, OR, at a proposed total annual cost of $5,060,000 for a lease term of up to 15 years, a prospectus for which is attached to, and included in, this resolution.

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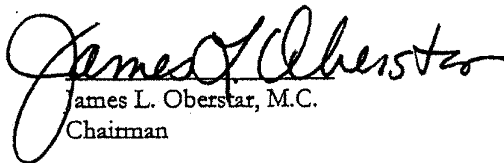
Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

PROSPECTUS - LEASE
U.S. ARMY CORPS OF ENGINEERS
PORTLAND, OR

Prospectus Number:	POR-02-PO10
Congressional District:	01, 03

Project Summary

The General Services Administration (GSA) proposes a replacement lease of 126,500 rentable square feet (rsf) of space and 25 parking spaces for the U.S. Army Corps of Engineers (USACE), Portland District Office, currently located at Robert Duncan Plaza, 333 SW First Avenue, Portland, OR.

Description

Occupants:	USACE
Delineated Area:	Portland CBD
Lease Type:	Replacement
Justification:	Expiring lease (September 17, 2011)
Number of Parking Spaces:	25
Expansion Space:	2,186 rsf
Scoring:	Operating Lease
Proposed Maximum Leasing Authority:	15 years
Maximum Rentable Square Feet:	126,500
Current Total Annual Cost:	$3,195,097
Proposed Total Annual Cost[1]:	$5,060,000
Maximum Proposed Rental Rate[2]:	$40.00 per rentable square foot

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages offerors to work with energy service providers to exceed minimum requirements set forth in the procurement.

[1]Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2]This estimate is for fiscal year 2011 and may be escalated by 1.8 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS - LEASE
U.S. ARMY CORPS OF ENGINEERS
PORTLAND, OR

Prospectus Number: POR-02-PO10
Congressional District: 01, 03

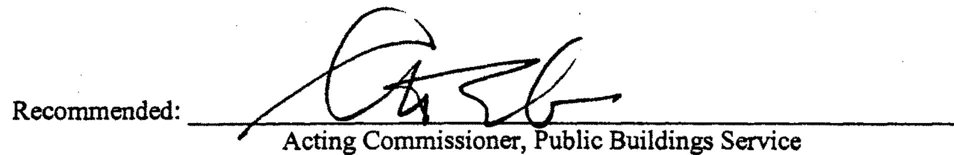
Authorizations

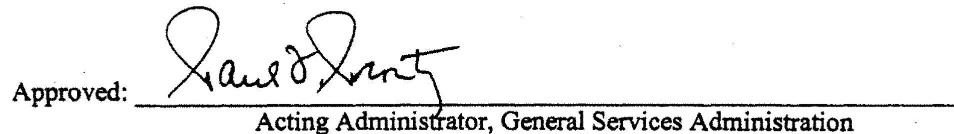
- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 11, 2009

Recommended:

Acting Commissioner, Public Buildings Service

Approved:

Acting Administrator, General Services Administration

Hor Plan

Pc d, OR

Locations	Current						Proposed					
	Personnel		*Usable Square Feet (USF)*				*Personnel*		*Usable Square Feet (USF)*			
	Office	**Total**	**Office**	**Storage**	**Special**	**Total**	**Office**	**Total**	**Office**	**Storage**	**Special**	**Total**
Robert Duncan Plaza	528	528	108,099	0	0	108,099	0	0	0	0	0	0
New Lease	0	0	0	0	0	0	549	549	98,400	0	11,600	110,000
Total:	**528**	**528**	**108,099**	**0**	**0**	**108,099**	**549**	**549**	**98,400**	**0**	**11,600**	**110,000**

	Current	Proposed
	Utilization	
Rate	160	140

Current UR excludes 23,782 USF of office support space
Proposed UR excludes 21,648 USF of office support space

Special Space	
Laboratory	662
Clinic	568
Conference	3,229
Library	5,600
ADP	491
Retail	1,050
Total:	**11,600**

USF means the portion of the building available for use by a tenant's personnel and furnishings and space available jointly to the occupants of the building.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
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John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
NATIONAL ARCHIVES AND RECORDS ADMINISTRATION
PHILADELPHIA, PA
PPA-01-PH10

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a superseding lease and space alteration of up to 345,000 rentable square feet for the National Archives and Records Administration, currently located at 14700 Townsend Road, Philadelphia, PA, at a proposed total annual cost of $3,795,000 for a lease term of up to 20 years, a prospectus for which is attached to, and included in, this resolution.

Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**

James L. Oberstar

James L. Oberstar, M.C.
Chairman

PROSPECTUS - LEASE
NATIONAL ARCHIVES AND RECORDS ADMINISTRATION
PHILADELPHIA, PA

Prospectus Number:	PPA-01-PH10
Congressional District:	08

Project Summary

The General Services Administration (GSA) proposes a superseding lease and space alterations to the National Archives and Records Administration (NARA) facility currently located at 14700 Townsend Road, Philadelphia, PA. This facility, which was occupied in 1994 under a 20 year, firm term, non-cancelable lease, provides 1.58 million cubic feet of records storage in 345,000 rentable square feet (rsf).

The proposed alteration project, to be amortized in the rent paid to the lessor, will allow the conversion of approximately 40,000 usf of soon-to-be vacant record storage bays into bays capable of housing archives and permanent records. In order to comply with NARA's 2010 archive standards as detailed in 36 CFR 1228 Subpart K, the archive and permanent records space requires more stringent paper storage conditions and requires improvements to the HVAC, filtration, humidification, and fire protection systems, and light diffusion improvements.

Approximately 40,000 usable square feet (usf) of IRS taxpayer records, currently housed at this location will be destroyed in 2009 resulting in extra storage capacity. Upon completion of the conversion, archives currently housed in two existing federal facilities, the Robert NC Nix US Post Office and Courthouse in Philadelphia, PA and the Federal Building on Varick Street in New York, NY will be transferred into this space.

Justification

The existing federal facilities cannot be upgraded economically to meet NARA's archival facility standards. The archive vaults at the Nix Post Office and Courthouse are below grade and are incapable of meeting the proposed 2010 archival standards, and it would be cost prohibitive to upgrade the Varick Street Federal Building to meet these standards. In both locations NARA will keep its offices and public contact functions. The vacated archive vaults will be marketed to Philadelphia federal tenants with basic record storage needs.

The 30-year, present value cost of a superseding lease with alterations in the NARA records center is $28,965,000 less than the cost of new construction and $12,742,000 less than the cost of a leasing new space that would meet NARA's requirements.

PROSPECTUS - LEASE
NATIONAL ARCHIVES AND RECORDS ADMINISTRATION
PHILADELPHIA, PA

Prospectus Number:	PPA-01-PH10
Congressional District:	08

Alternatives

CONSTRUCTION - This alternative proposes the construction of a new 345,000 rsf NARA facility. The 30-year, present value cost of this alternative is $123,035,000.

NEW LEASE - This alternative proposes leasing a new 345,000 rsf NARA facility. The 30-year, present value cost of this alternative is $106,812,000.

SUPERSEDING LEASE WITH SPACE ALTERATIONS - This alternative proposes alterations and a 20-year superseding lease of the existing 345,000 rsf building. The 30-year, present value cost of this alternative is $94,070,000.

Recommendation

SPACE ALTERATIONS AND SUPERSEDING LEASE are recommended.

Major Work Items

Mechanical	$2,069,000
Electrical	993,000
Interior Architectural	1,071,000
Demolition	167,000
Estimated Construction Cost (ECC)	$4,300,000
Management and Inspection Costs (M&I)	$200,000
Total Alteration Authority Requested in this Prospectus[1]:	$4,500,000

[1] Design funding in the amount of $90,000 is being provided by NARA; ECC and M&I totaling $4,500,000 will be amortized in the rent paid to the lessor.

PROSPECTUS - LEASE
NATIONAL ARCHIVES AND RECORDS ADMINISTRATION
PHILADELPHIA, PA

Prospectus Number:	PPA-01-PH10
Congressional District:	08

Description

Occupants:	National Archives And Records Administration
Delineated Area:	14700 Townsend Road Philadelphia, PA 19154
Lease Type:	Lease/Alterations in Leased Space
Justification:	Consolidation and Relocation of Government-Owned Space
Number of Parking Spaces:	0
Expansion Space:	None
Scoring:	Operating Lease
Proposed Maximum Leasing Authority:	20 years
Maximum Rentable Square Feet:	345,000
Current Total Annual Cost[2]:	$3,039,700
Proposed Total Annual Cost[3]:	$3,795,000
Maximum Proposed Rental Rate[4]:	$11.00 per RSF

Authorizations

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to alter approximately 40,000 rsf and enter into a superseding lease at the existing NARA facility.

- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

[2]Current Total Annual Cost includes $338,341 of operating costs only for the Government Owned Locations.
[3]Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[4]This estimate is for fiscal year 2010 and may be escalated by 1.8 percent annually to the effective date of the lease to account for inflation.

GSA PBS

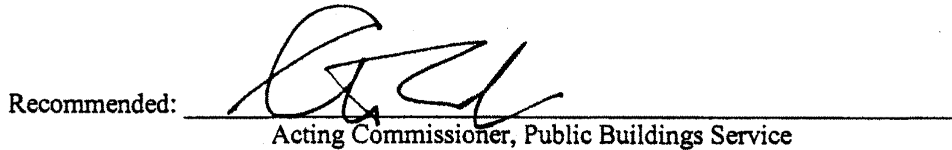
PROSPECTUS - LEASE
NATIONAL ARCHIVES AND RECORDS ADMINISTRATION
PHILADELPHIA, PA

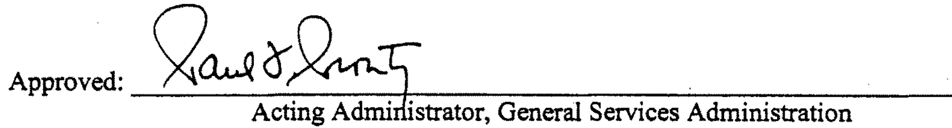
Prospectus Number: PPA-01-PH10
Congressional District: 08

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 11, 2009

Recommended: 
Acting Commissioner, Public Buildings Service

Approved: 
Acting Administrator, General Services Administration

National Records ar ·chives Administration

PF \-PH10

Locations	Current						Proposed					
	Personnel		*Usable Square Feet (USF)*				*Personnel*		*Usable Square Feet (USF)*			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
NARA RECORD STRG CTR												
NARA - Records Depositing Operations	40	40	9,000	1,200	289,800	**300,000**	40	40	9,000	1,200	289,800	**300,000**
Sub Total:	**40**	**40**	**9,000**	**1,200**	**289,800**	**300,000**	**40**	**40**	**9,000**	**1,200**	**289,800**	**300,000**
ROBT N C NIX FB USPO												
NARA	63	63	8,250	0	21,105	**29,355**	63	63	8,250	0	0	**8,250**
Sub Total:	**63**	**63**	**8,250**	**0**	**21,105**	**29,355**	**63**	**63**	**8,250**	**0**	**0**	**8,250**
FEDERAL BLDG–201 Varick Street												
NARA	10	10	14,434	0	11,000	**25,434**	10	10	14,434	0	0	**14,434**
Sub Total:	**10**	**10**	**14,434**	**0**	**11,000**	**25,434**	**10**	**10**	**14,434**	**0**	**0**	**14,434**
Total:	**113**	**113**	**31,684**	**1,200**	**321,905**	**354,789**	**113**	**113**	**31,684**	**1,200**	**289,800**	**322,684**

	Current	Proposed
Utilization		
Rate	216	216

Special Space	
Other - Record and Archive Storage	289,800
Total:	**289,800**

Current UR excludes 7,279 USF of office support space

Proposed UR excludes 7,279 USF of office support space

USF means the portion of the building available for use by a tenant's personnel and furnishings and space available jointly to the occupants of the building.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
INTERNAL REVENUE SERVICE
WASHINGTON, D.C.
PDC-07-WA09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a replacement lease of up to 100,500 rentable square feet for the Internal Revenue Service, currently located at 1750 Pennsylvania Avenue, NW, Washington, D.C., at a proposed total annual cost of $4,924,500 for a lease term of up to 10 years, a prospectus for which is attached to, and included in, this resolution.

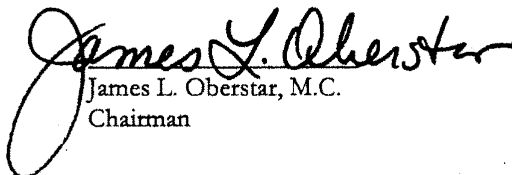
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

GSA PBS

PROSPECTUS – LEASE
INTERNAL REVENUE SERVICE
WASHINGTON, DC

Prospectus Number: PDC-07-WA09

Project Summary

The General Services Administration (GSA) proposes a replacement lease of up to 100,500 rentable square feet (rsf) for the Internal Revenue Service (IRS) currently located at 1750 Pennsylvania Avenue, NW, Washington, DC.

Description

Occupants:	IRS
Delineated Area:	Washington, DC: Central Employment Area, North of Massachusetts Avenue and Waterfront
Lease Type:	Replacement
Justification:	Expiring lease (7/31/2010)
Expansion Space:	None
Number of Parking Spaces:	None
Scoring:	Operating
Proposed Maximum Leasing Authority:	10 Years
Maximum Rentable Square Feet:	100,500
Current Total Annual Cost:	$3,167,833
Proposed Total Annual Cost:[1]	$4,924,500
Maximum Proposed Rental Rate:[2]	$49.00 per rsf

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages offerors to work with energy service providers to exceed minimum requirements set forth in the procurement.

[1] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2] This estimate is for fiscal year 2010 and may be escalated by 2.0 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS – LEASE
INTERNAL REVENUE SERVICE
WASHINGTON, DC

Prospectus Number: PDC-07-WA09

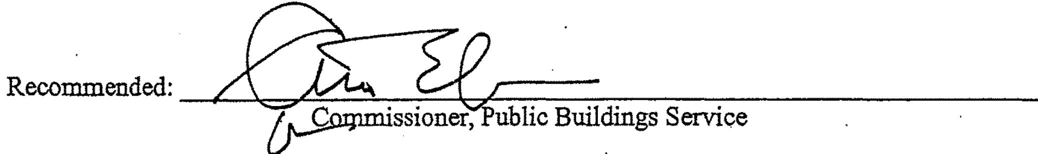
Authorization

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

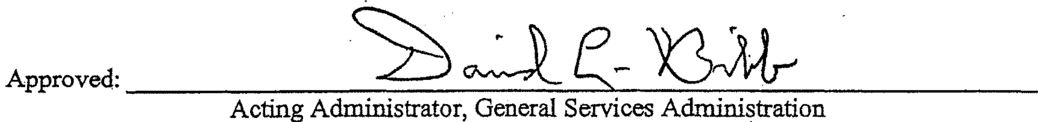
Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008



Recommended: ______________________
Commissioner, Public Buildings Service



Approved: ______________________
Acting Administrator, General Services Administration

March 2008

Housing Plan
Internal Revenue Service

Washington, DC
PDC-07-WA09

Locations	Current						Proposed					
	Personnel		Usable Square Feet (USF)				Personnel		Usable Square Feet (USF)			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
1750 Penn Ave. NW	420	420	83,026	700		83,726					-	
Proposed Lease		-					420	420	81,000	676	2,050	83,726
Total	420	420	83,026	700	-	83,726	420	420	81,000	676	2,050	83,726

Utilization	Current	Proposed
Rate	154	150

Current UR excludes 18,266 USF of office support space
Proposed UR excludes 17,820 USF of office support space

Special Space	USF
Conference	1,350
Food Service	250
Mail room	250
Copy room	200
Total	2,050

Usable square footage means the portion of the building available for use by tenants' personnel and furnishings, and space available jointly to the occupants of the building (e.g.,auditorium, health units and snack bars). Usable square footage does not include space devoted to building operations and maintenance (e.g., craft shops, gear rooms, building supply rooms, rest rooms and lobbies).

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C.
PDC-04-WA09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a replacement lease of up to 254,267 rentable square feet for the Small Business Administration (SBA), currently located at 409 Third Street, SW, Washington, D.C., at a proposed total annual cost of $12,459,083 for a lease term of up to 10 years, a prospectus for which is attached to, and included in, this resolution.

Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

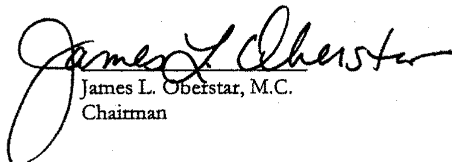
Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that within six months of the date of the resolution and prior to exercising the authority granted in the resolution, the Administrator shall provide to the Committee on Transportation and Infrastructure of the House of Representatives a draft housing plan, including Federal Government ownership options, for the SBA in the National Capital Region.

Provided further, that within two years of the date of the resolution, the Administrator shall provide to the Committee on Transportation and Infrastructure of the House of Representatives a final housing plan approved by the Office of Management and Budget that provides Federal Government ownership for the SBA in the National Capital Region.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

GSA PBS

PROSPECTUS – LEASE
SMALL BUSINESS ADMINISTRATION
WASHINGTON, DC

Prospectus Number: PDC-04-WA09

Project Summary

The General Services Administration (GSA) proposes a replacement lease for up to 254,267 rentable square feet (rsf) of space for the Small Business Administration (SBA), currently located at 409 Third Street, SW, Washington, DC.

Description

Occupants:	SBA
Delineated Area:	Washington, DC: Central Employment Area, North of Massachusetts Avenue, and Waterfront
Lease Type:	Replacement
Justification:	Expiring Lease (11/23/2010)
Expansion Space:	None
Number of Parking Spaces:	4 (Inside)
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	10 years
Maximum Rentable Square Feet:	254,267
Current Total Annual Cost:	$9,324,171
Proposed Total Annual Cost:[1]	$12,459,083
Maximum Proposed Rental Rate:[2]	$49.00

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages offerors to work with energy service providers to exceed minimum requirements set forth in the procurement.

[1] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2] This estimate is for fiscal year 2011 and may be escalated by 2.0 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS – LEASE
SMALL BUSINESS ADMINISTRATION
WASHINGTON, DC

Prospectus Number: PDC-04-WA09

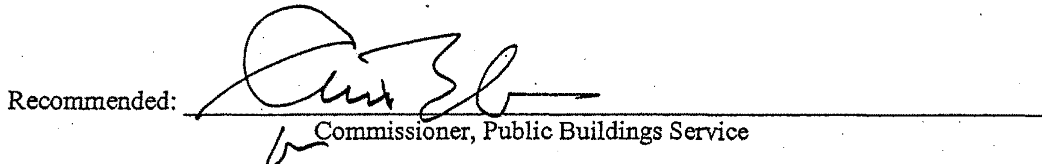
Authorization

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

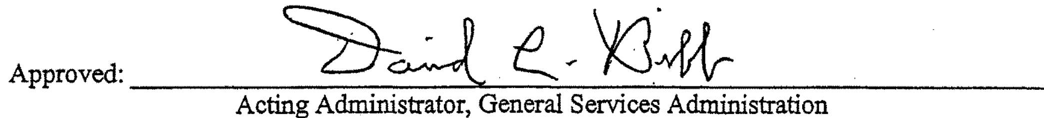
Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008



Recommended: ______________________
Commissioner, Public Buildings Service



Approved: ______________________
Acting Administrator, General Services Administration

Octobe· ·97

Ho· · Plan
Small Bus. .dministration
409 Third Street, SW

W· gton, DC
J4-WA09

Locations	Current						Proposed					
	Personnel		Usable Square Feet (USF)*				Personnel		Usable Square Feet (USF)*			
	Office	*Total*	*Office*	*Storage*	*Special*	*Total*	*Office*	*Total*	*Office*	*Storage*	*Special*	*Total*
LEASED												
409 Third Street												
Small Business Administration	636	636	184,613		27,276	211,889						
Proposed Lease			-	-	-	-	636	636	184,613	-	27,276	211,889
Total	636	636	184,613	-	27,276	211,889	636	636	184,613	-	27,276	211,889

Utilization Rate (UR)		
	Current	Proposed
Rate	226	226

Current UR excludes 40,615 USF of office support space.
Proposed UR excludes 40,615 usf of office support space.

Special Space	USF*
ADP	7,500
Auditorium	8,000
Conference	7,977
Food Service	2,799
Laboratory	1,000
Total	27,276

*Usable square footage means the portion of the building available for use by tenants' personnel and furnishings, and space available jointly to the occupants of the building (e.g.,auditorium, health units and snack bars). Usable square footage does not include space devoted to building operations and maintenance (e.g., craft shops, gear rooms, building supply rooms, rest rooms and lobbies).

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
NATIONAL INSTITUTES OF HEALTH
NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES
SUBURBAN MARYLAND
PMD-01-WA09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a succeeding lease of up to 159,731 rentable square feet for the National Institute of Allergy and Infectious Disease, currently located 6700 Rockledge Drive, Bethesda, MD, at a proposed total annual cost of $5,430,854 for a lease term of up to five years, a prospectus for which is attached to, and included in, this resolution.

Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that*, if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**

James L. Oberstar, M.C.
Chairman

PROSPECTUS – LEASE
NATIONAL INSTITUTES OF HEALTH
NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES
SUBURBAN MARYLAND

Prospectus Number: PMD-01-WA09
Congressional District: 8

Project Summary

The General Services Administration (GSA) proposes a succeeding lease of up to 159,731 rsf for the National Institute of Allergy and Infectious Diseases (NIAID) located at 6700 Rockledge Drive, Bethesda, MD.

GSA is considering a consolidation of the tenants at 6700 Rockledge Blvd with other NIAID entities in neighboring buildings and plans to extend the 6700 Rockledge Blvd lease on a short-term basis. NIH leases in neighboring buildings were acquired directly by NIH through a delegation of authority from GSA and will expire on September 30, 2011 and March 31, 2012. NIAID plans to consolidate into a single leased location by 2012 under the authority of a consolidation prospectus to be submitted in a future fiscal year program. Since the present prospectus covers a short-term requirement, GSA has determined that it is not practical to consider relocating NIAID.

Description

Occupants:	NIAID
Delineated Area:	6700 Rockledge Drive, Bethesda, MD
Lease Type:	Succeeding
Justification:	Expiring lease (5/31/2010)
Expansion Space:	None
Number of Parking Spaces:	None
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	5 years with termination rights
Maximum Rentable Square Feet:	159,731
Current Total Annual Cost:	$4,991,221
Proposed Total Annual Cost[1]:	$5,430,854
Maximum Proposed Rental Rate[2]:	$34.00

[1] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2] This estimate is for fiscal year 2010 and may be escalated by 2.0 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS – LEASE
NATIONAL INSTITUTES OF HEALTH
NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES
SUBURBAN MARYLAND

Prospectus Number: PMD-01-WA09
Congressional District: 8

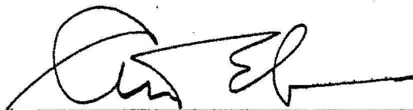
Authorization

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008

Recommended: 
Commissioner, Public Buildings Service

Approved:
Acting Administrator, General Services Administration

March 2008

Housing Plan
National Institutes of Health

Suburban Maryland
PMD-01-WA09

Locations	Current						Proposed					
	Personnel		Usable Square Feet (USF)				Personnel		Usable Square Feet (USF)			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
NIAID 6700 Rockledge	603	603	128,635		8,800	**137,435**	603	603	128,635		8,800	**137,435**
Total	**603**	**603**	**128,635**	**-**	**8,800**	**137,435**	**603**	**603**	**128,635**	**-**	**8,800**	**137,435**

Utilization Rate		
	Current	Proposed
Rate	166	166

Current UR excludes 28,300 USF of Office for support space
Proposed UR excludes 28,300 USF of office for support space

Special Space	USF
Food Service	500
ADP	1,800
Conf/Training	6,500
Total	**8,800**

Usable square footage means the portion of the building available for use by tenants' personnel and furnishings, and space available jointly to the occupants of the building (e.g.,auditorium, health units and snack bars). Usable square footage does not include space devoted to building operations and maintenance (e.g., craft shops, gear rooms, building supply rooms, rest rooms and lobbies).

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
FEDERAL EMERGENCY MANAGEMENT AGENCY
ARLINGTON, VA
PVA-01-WA09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a succeeding lease of up to 102,238 rentable square feet for the Federal Emergency Management Agency, currently located at 1800 South Bell Street, Arlington, VA, at a proposed total annual cost of $3,885,044 for a lease term of up to 10 years, a prospectus for which is attached to, and included in, this resolution.

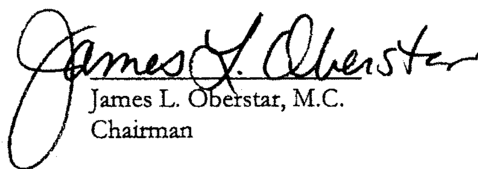
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: November 5, 2009



James L. Oberstar, M.C.
Chairman

PROSPECTUS – LEASE
FEDERAL EMERGENCY MANAGEMENT AGENCY
ARLINGTON, VA

Prospectus Number: PVA-01-WA09
Congressional District: 8

Project Summary

The General Services Administration (GSA) proposes a succeeding lease of up to 102,238 rentable square feet of space for the Federal Emergency Management Agency (FEMA), currently located at 1800 South Bell Street, Arlington, VA, known as Crystal Mall One. GSA plans to continue to house FEMA in this building until FEMA can be consolidated at St. Elizabeths West Campus. The succeeding lease term will be aligned with the date FEMA is scheduled to consolidate into the St. Elizabeths campus. The new proposed lease expiration date would coincide with the occupancy of FEMA's new headquarters space at St. Elizabeths West Campus. GSA requested a portion of design funding for a consolidated FEMA facility at St. Elizabeths in its fiscal year 2009 budget request. Construction funding will be requested in a future fiscal year. GSA will also negotiate cancellation options with the current landlord to permit flexibility should there be a change in the St Elizabeths schedule.

Description

Occupants:	FEMA
Delineated Area:	1800 South Bell Street, Arlington, VA
Lease Type:	Succeeding
Justification:	Expiring Lease (October 2010)
Expansion Space:	None
Number of Parking Spaces:	None
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	10 years with cancellation rights
Maximum Rentable Square Feet:	102,238
Current Total Annual Cost:	$3,119,281
Proposed Total Annual Cost:[1]	$3,885,044
Maximum Proposed Rental Rate:[2]	$38.00

[1] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.

[2] This estimate is for fiscal year 2011 and may be escalated by 2.0 percent annually to the effective date of the lease to account for inflation.

PROSPECTUS – LEASE
FEDERAL EMERGENCY MANAGEMENT AGENCY
ARLINGTON, VA

Prospectus Number: PVA-01-WA09
Congressional District: 8

Authorization

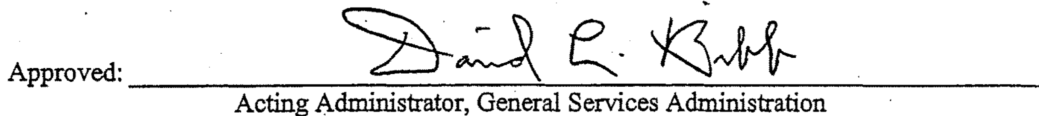
- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008

Recommended:
Commissioner, Public Buildings Service

Approved: 
Acting Administrator, General Services Administration

October 2007

HOUSING PLAN
Federal Emergency Management Agency

Northern Virginia
PVA-01-WA09

Location(s)	Current							Proposed						
Leased Space	Personnel		Usable Square Feet (USF)					Personnel		Usable Square Feet (USF)				
	Office	Total	Office	Storage	Special	Total		Office	Total	Office	Storage	Special	Total	
Crystal Mall One	400	400	83,456	-	-	83,456		400	400	83,456	-	-	83,456	
TOTALS	400	400	83,456	-	-	83,456		400	400	83,456	-	-	83,456	

Usable square footage means the portion of the building available for use by tenants' personnel and furnishings and space available jointly to the occupants of the building (e.g. auditorium, health units, and snack bars).

Utilization Rate			
	Current	Proposed	
	163	163	

Current UR excludes 18,360 usf of office support space
Proposed UR excludes 18,360 usf of office support space

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
DEPARTMENT OF DEFENSE
HOFFMAN I
NORTHERN VIRIGINA
PVA-03-WA09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a succeeding lease of up to 312,976 rentable square feet for the Department of Defense, currently located at the Hoffman I building, 2461 Eisenhower Avenue, Alexandria, VA, at a proposed total annual cost of $10,641,184 for a lease term of up to five years, a prospectus for which is attached to, and included in, this resolution.

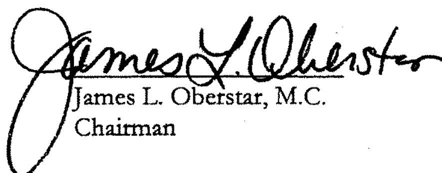
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

PROSPECTUS – LEASE
DEPARTMENT OF DEFENSE
HOFFMAN I
NORTHERN VIRGINIA

Prospectus Number: PVA-03-WA09
Congressional District: 8

Project Summary

The General Services Administration (GSA) proposes a succeeding lease of up to 312,976 rentable square feet (rsf) for the Department of Defense (DoD) located at the Hoffman I building, 2461 Eisenhower Avenue, Alexandria, VA.

The 2005 Base Realignment and Closure Act (BRAC) requires that DoD tenants in leased space relocate to DoD owned space by September 2011. The current lease expires September 30, 2010 and will need to be extended until DoD moves to owned space. Since this is a short-term requirement, GSA has determined that it is not practical to consider relocating DoD prior to their BRAC relocation date. GSA will negotiate with the lessor for termination rights.

Description

Occupants:	DoD
Delineated Area:	2461 Eisenhower Avenue Alexandria, VA
Lease Type:	Succeeding
Justification:	Expiring lease (9/30/2010)
Expansion Space:	None
Number of Parking Spaces[1]:	5 outside
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	5 years (termination rights to align with final relocation date)
Maximum Rentable Square Feet:	312,976 rsf
Current Total Annual Cost:	$7,031,741
Proposed Total Annual Cost[2]:	$10,641,184
Maximum Proposed Rental Rate[3]:	$34.00 per rsf

[1] The Department of Defense security requirements may necessitate control of the parking at the leased location. This may be accomplished as a lessor-furnished service, as a separate operating agreement with the lessor, or as part of the Government's leasehold interest in the building.
[2] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[3] This estimate is for fiscal year 2011 and may be escalated by 2.0 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS – LEASE
DEPARTMENT OF DEFENSE
HOFFMAN I
NORTHERN VIRGINIA

Prospectus Number: PVA-03-WA09
Congressional District: 8

Authorization

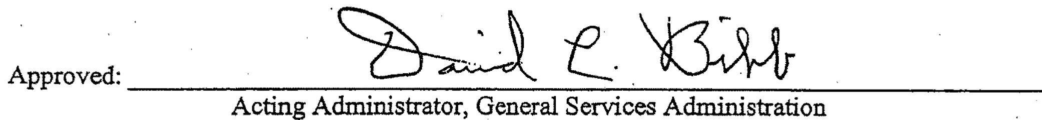
- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008

Recommended:
Commissioner, Public Buildings Service

Approved: 
Acting Administrator, General Services Administration

April 2008

Housing Plan
Department of Defense
Hoffman 1

Northern Virginia
PVA-03-WA09

Locations	Current						Proposed					
	Personnel		Usable Square Feet (USF)				Personnel		Usable Square Feet (USF)			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
Hoffman 1												
DoD	1,500	1,500	259,021		13,291	272,312	1500	1,500	259,021		13,291	272,312
Vacant *			13,024			13,024						
BRAC Swing									13,024			13,024
Total	1,500	1,500	272,045	-	13,291	285,336	1,500	1,500	272,045	-	13,291	285,336

*** Vacant space will be used to temporarily house DOD BRAC requirements moving from other locations.**

	Current	Proposed
Utilization		
Rate	141	141

Current UR excludes 59,850 USF of office support space
Proposed UR excludes 59,850 USF of office support space

Special Space	USF
Auditorium	451
Food Service	232
Loading Docks	184
Conference/Training	12,424
Total	13,291

Usable square footage means the portion of the building available for use by tenants' personnel and furnishings, and space available jointly to the occupants of the building (e.g.,auditorium, health units and snack bars). Usable square footage does not include space devoted to building operations and maintenance (e.g., craft shops, gear rooms, building supply rooms, rest rooms and lobbies).

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
DEPARTMENT OF DEFENSE
HOFFMAN II
NORTHERN VIRIGINA
PVA-04-WA09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a succeeding lease of up to 204,783 rentable square feet for the Department of Defense, currently located at the Hoffman II building, 200 Stovall Street, Alexandria, VA, at a proposed total annual cost of $6,962,622 for a lease term of up to five years, a prospectus for which is attached to, and included in, this resolution.

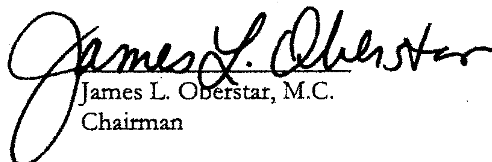
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

PROSPECTUS – LEASE
DEPARTMENT OF DEFENSE
HOFFMAN II
NORTHERN VIRGINIA

Prospectus Number: PVA-04-WA09
Congressional District: 8

Project Summary

The General Services Administration (GSA) proposes a succeeding lease of up to 204,783 rentable square feet (rsf) for the Department of Defense (DoD) located at the Hoffman II building, 200 Stovall Street, Alexandria, VA.

The 2005 Base Realignment and Closure Act (BRAC) requires that DoD tenants in leased space relocate to DoD owned space by September 2011. The current lease expires September 30, 2010 and will need to be extended until DoD moves to owned space. Since this is a short-term requirement, GSA has determined that it is not practical to consider relocating DoD prior to their BRAC relocation date. GSA will negotiate with the lessor for termination rights.

Description

Occupants:	DoD
Delineated Area:	200 Stovall Street Alexandria, VA
Lease Type:	Succeeding
Justification:	Expiring lease (3/2/2010)
Expansion Space:	None
Number of Parking Spaces[1]:	None
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	5 years (termination rights to align with final relocation date)
Maximum Rentable Square Feet:	204,783 rsf
Current Total Annual Cost:	$4,718,795
Proposed Total Annual Cost[2]:	$6,962,622
Maximum Proposed Rental Rate[3]:	$34.00 per rsf

[1] The Department of Defense security requirements may necessitate control of the parking at the leased location. This may be accomplished as a lessor-furnished service, as a separate operating agreement with the lessor, or as part of the Government's leasehold interest in the building.

[2] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.

[3] This estimate is for fiscal year 2010 and may be escalated by 2.0 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS – LEASE
DEPARTMENT OF DEFENSE
HOFFMAN II
NORTHERN VIRGINIA

Prospectus Number: PVA-04-WA09
Congressional District: 8

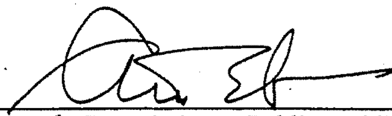
Authorization

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008

Recommended: 
Commissioner, Public Buildings Service

Approved:
Acting Administrator, General Services Administration

October 2007

Housing Plan
Department of Defense
Hoffman II

Northern Virginia
PVA-04-WA09

Locations	Current						Proposed					
	Personnel		Usable Square Feet (USF)				Personnel		Usable Square Feet (USF)			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
Hoffman II	1,000	1,000	179,355			179,355	1,000	1,000	179,355			179,355
												-
Total	1,000	1,000	179,355	-	-	179,355	1,000	1,000	179,355	-	-	179,355

	Current	Proposed
Utilization		
Rate	140	140

Current UR excludes 39,458 USF of Office for support space
Proposed UR excludes 39,458 USF of office for support space

Usable square footage means the portion of the building available for use by tenants' personnel and furnishings, and space available jointly to the occupants of the building (e.g.,auditorium, health units and snack bars). Usable square footage does not include space devoted to building operations and maintenance (e.g., craft shops, gear rooms, building supply rooms, rest rooms and lobbies).

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
FEDERAL AVIATION ADMINISTRATION
FORT WORTH, TX
PTX-02-FW09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a replacement/expansion lease of up to 530,039 rentable square feet for the Federal Aviation Administration, currently located at the 2601 Meacham Blvd., Fort Worth, TX, at a proposed total annual cost of $18,551,365 for a lease term of up to 20 years, a prospectus for which is attached to, and included in, this resolution.

Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

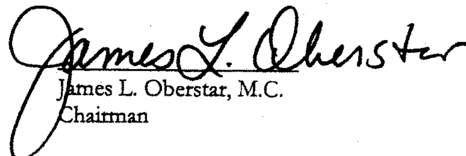
Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that any lease agreement entered into pursuant to this resolution shall include an option to purchase and obtain fee title to the facility leased to the Federal Government. The lease agreement shall provide for the exercise of the purchase option on such dates prior to the expiration of the leasehold interest and under such terms and conditions deemed by the Administrator to be in the best interest of the Federal Government.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

PROSPECTUS - LEASE
FEDERAL AVIATION ADMINISTRATION
FORT WORTH, TX

Prospectus Number:	PTX-02-FW09
Congressional District:	12

Project Summary

The GSA proposes a replacement/expansion lease for 530,039 rentable square feet (RSF) of space and 2,532 surface parking spaces for the Federal Aviation Administration (FAA) in Fort Worth, TX. FAA currently occupies 254,630 RSF at the FAA Building, 2601 Meacham Blvd., Fort Worth, TX. The current lease expires on October 28, 2013 (with termination rights in October 2011). Because the FAA has changed their business model on a national scale, they requested expansion space to meet their continuing space requirements in Fort Worth. It is anticipated that lease construction will be required to meet this need.

The FAA recently realigned their largest group, the Air Traffic Organization (ATO) from nine regions into three service areas. The ATO Central Service Area (CSA) is headquartered in Fort Worth, TX and includes the legacy Southwest, Central, and Great Lakes Regions and serves a seventeen state geographic area. Currently authorized positions are already relocating from Central ATO, Kansas City, MO and Great Lakes ATO, Chicago IL, to Fort Worth. Due to this realignment, the existing leased building no longer has adequate space to meet FAA's present and future requirements. The FAA has leased temporary space under their own authority to handle this ongoing expansion in Fort Worth, but the existing building is nevertheless overcrowded. Expansion space is needed as soon as possible to alleviate the overcrowding, and to consolidate operations. The existing GSA and FAA leases will be terminated when the new space is available.

Description

Occupants:	DOT - FAA
Delineated Area:	An area of Fort Worth, including the CBD, which is roughly bounded by Beach Street and Texas 121 on the east, IH 30 on the south, Texas 199, IH 820, and Farm Road 156 on the west, and North Tarrant Parkway on the north.
Lease Type:	Replacement/Expansion
Justification:	The FAA is consolidating operations from three regions into the Fort Worth region.
Number of Parking Spaces:	2,532 surface spaces
Expansion Space:	119,790 rsf

PROSPECTUS - LEASE
FEDERAL AVIATION ADMINISTRATION
FORT WORTH, TX

Prospectus Number: PTX-02-FW09
Congressional District: 12

Scoring:	Operating Lease
Proposed Maximum Leasing Authority:	20 years
Maximum Rentable Square Feet:	530,039
Current Total Annual Cost:	$4,866,745
Proposed Total Annual Cost[1]:	$18,551,365
Maximum Proposed Rental Rate[2]:	$35.00 per rentable square foot

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages offerors to work with energy service providers to exceed minimum requirements set forth in the procurement.

Authorizations

Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required area.

Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

[1]Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2]This estimate is for fiscal year 2012 and may be escalated by 2.1 percent annually to the effective date of the lease to account for inflation.

PROSPECTUS - LEASE
FEDERAL AVIATION ADMINISTRATION
FORT WORTH, TX

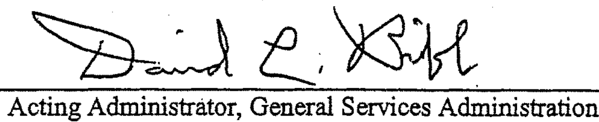
Prospectus Number: PTX-02-FW09
Congressional District: 12

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008

Recommended:
Commissioner, Public Buildings Service

Approved: 
Acting Administrator, General Services Administration

Apr'' ˉ008 | Hov˙˙g Plan | PTX˙˙˙-FW09

Federal Aviatioı .ministration (FAA)
Fort Worth, TX

Locations	Current						Proposed					
	Personnel		*Usable Square Feet (USF)*				*Personnel*		*Usable Square Feet (USF)*			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
FAA Building - 2601 Meacham Blvd.												
DOT - FAA	915	915	188,530	9,651	36,683	234,864	0	0	0	0	0	0
FAA Leases - Various Locations												
DOT - FAA	659	659	98,850	0	15,000	113,850	0	0	0	0	0	0
Replacement Lease												
DOT - FAA	0	0	0	0	0	0	1,704	1,704	305,850	12,100	132,583	450,533
Total:	1,574	1,574	287,380	9,651	51,683	348,714	1,704	1,704	305,850	12,100	132,583	450,533

	Current	Proposed
	Utilization	
Rate	156	140

Current UR excludes 41,477 USF of office support space
Proposed UR excludes 67,287 USF of office support space

Special Space	
Laboratory	1,216
Restroom	208
Physical Fitness	7,209
Conference	34,015
Auditorium	10,422
Library	1,130
ADP	12,680
Food Service	15,779
Control Booth	1,928
Vaults	2,693
Press Room	1,737
Training Room	5,159
File Storage	32,519
Command Room	5,888
Total:	132,583

USF means the portion of the building available for use by a tenant's personnel and furnishings and space available jointly to the occupants of the building.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
FEDERAL AVIATION ADMINISTRATION
RENTON AREA, WA
PWA-01-RE09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a new lease of up to 518,865 rentable square feet for the Federal Aviation Administration, currently located in multiple locations in the Renton, WA area, at a proposed total annual cost of $24,386,655 for a lease term of up to 20 years, a prospectus for which is attached to, and included in, this resolution.

Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

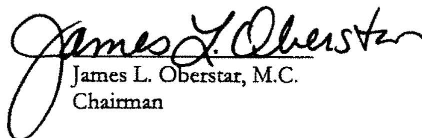
Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that,* if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that any lease agreement entered into pursuant to this resolution shall include an option to purchase and obtain fee title to the facility leased to the Federal Government. The lease agreement shall provide for the exercise of the purchase option on such dates prior to the expiration of the leasehold interest and under such terms and conditions deemed by the Administrator to be in the best interest of the Federal Government.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: November 5, 2009



James L. Oberstar, M.C.
Chairman

PROSPECTUS – LEASE
FEDERAL AVIATION ADMINISTRATION
RENTON AREA, WA

Prospectus Number:PWA-01-RE09
Congressional District: 7th, 9th

Project Summary

The General Services Administration (GSA) proposes a new lease of up to 518,865 rentable square feet (rsf) and 1,600 parking spaces to consolidate the Department of Transportation, Federal Aviation Administration (FAA) currently located in multiple locations in the Renton, WA, area.

Background

FAA's largest organization and one of their 24 Lines of Business (LOB), the Air Traffic Organization (ATO), has recently restructured from a nine (9) region to a three (3) Service Center Model. As a result of this restructuring, the Northwest Mountain regional office in the Renton area is now recognized as the Western Service Center (WSC) for the ATO LOB and consists of current FAA offices in Renton and surrounding communities as well as in California and Alaska. This reorganization is expected to spur tremendous growth in personnel for 2009 and beyond. This growth will be phased in over several years.

Currently, the FAA is scattered in over 419,000 rsf of space throughout several locations in the Renton area. FAA personnel are currently housed in 251,003 rsf of space at two separate GSA leased locations: the Federal Administration Building, 1601 Lind Avenue, and Valley Office Park, 1801 Lind Avenue; and in 115,164 rsf in three separate FAA leased locations: Seattle Manufacturing Inspection District Office (MIDO), Alaska Certificate Management Office (ACMO), Seatac City Hall 188th Street and, the Landmark Building, 1601 East Valley Road. A portion of FAA's warehouse space in GSA's facility in Auburn, WA will be moved to the proposed location and lastly, additional FAA personnel (approximately 230) will relocate to Renton from FAA and GSA leased locations in other western states (primarily CA and AK) as FAA's LOB structure evolves.

The existing FAA facilities are incapable of meeting FAA's enhanced security requirements and providing the square footage necessary to support the new expansion and consolidation requirements of the FAA. A new consolidated location will provide FAA with the space to meet the future requirements of its new functions.

PROSPECTUS – LEASE
FEDERAL AVIATION ADMINISTRATION
RENTON AREA, WA

Prospectus Number:PWA-01-RE09
Congressional District: 7th, 9th

Description

Occupant:	DOT/FAA
Delineated Area:	Cities of Renton, Tukwila, SeaTac, Des Moines and Kent
Lease Type:	New
Justification:	Consolidation/Expansion
Expansion Space:	101,398 USF
Number of Parking Spaces:	1,600 surface
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	20 years
Maximum Rentable Square Feet:	518,865 RSF
Current Total Annual Cost[1]:	$6,667,485
Proposed Total Annual Cost[2]:	$24,386,655
Maximum Proposed Rental Rate[3]:	$47.00/RSF

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages offerors to work with energy service providers to exceed minimum requirements set forth in the procurement.

[1] Current Total Annual Cost is for GSA locations only.
[2] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[3] This estimate is for fiscal year 2012 and may be escalated by 2.1 percent annually to the effective date of the lease to account for inflation.

PROSPECTUS – LEASE
FEDERAL AVIATION ADMINISTRATION
RENTON AREA, WA

Prospectus Number:PWA-01-RE09
Congressional District: 7th, 9th

Authorization

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide interim lease(s) if necessary, prior to the execution of the new lease.

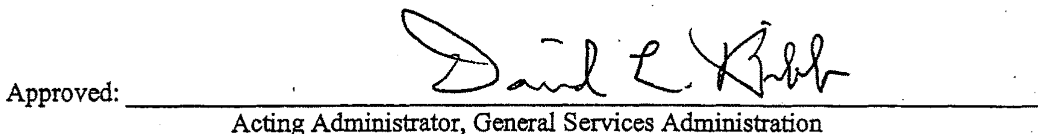
Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on June 27, 2008

Recommended:

Commissioner, Public Buildings Service

Approved:

Acting Administrator, General Services Administration

June 2008

Housing Plan
Federal Aviation Administration

Renton, WA
P... 1-RE09

Locations	Current						Proposed					
	Personnel		*Usable Square Feet (USF)*				*Personnel*		*Usable Square Feet (USF)*			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
FAA (RENTON AREA)												
GSA Leased												
1601 Lind Ave.	981	981	139,357	5,820	33,005	**178,182**	-	-	-	-	-	-
1801 Lind Ave.	300	300	50,898	0	0	**50,898**	-	-	-	-	-	-
Sub Total:	**1,281**	**1,281**	**190,255**	**5,820**	**33,005**	**229,080**	-	-	-	-	-	-
GSA Owned												
Auburn GSA Center Warehouse 5	0	0	0	44,475	0	**44,475**	-	-	-	-	-	-
Sub Total:	**0**	**0**	**0**	**44,475**	**0**	**44,475**	-	-	-	-	-	-
FAA Leased												
Seattle MIDO	15	15	3,600	0	0	3,600	-	-	-	-	-	-
Seatac City Hall on 188th St.	43	43	8,900	0	0	8,900	-	-	-	-	-	-
Landmark Bldg. on 1601 E. Valley Rd.	200	200	63,734	0	0	63,734	-	-	-	-	-	-
Sub Total:	**258**	**258**	**76,234**	**0**	**0**	**76,234**	-	-	-	-	-	-
Proposed GSA Lease												
DOT - FAA	-	-	-	-	-	-	1,950	1,950	343,533	37,000	70,654	**451,187**
Total:	**1,539**	**1,539**	**266,489**	**50,295**	**33,005**	**349,789**	**1,950**	**1,950**	**343,533**	**37,000**	**70,654**	**451,187**

	Current	Proposed
Utilization		
Rate	135	137

Current UR excludes 58,628 USF of office support space
Proposed UR excludes 75,577 USF of office support space.

Special Space	
Restroom	531
Physical Fitness	5,810
Child Care	10,000
Conference	31,704
Auditorium	3,320
ADP	9,329
Food Service	8,300
Joint Use/Retail	1,660
Total:	**70,654**

USF means the portion of the building available for use by a tenant's personnel and furnishings and space available jointly to the occupants of the building.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
PDC-03-WA09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a replacement lease of up to 136,787 rentable square feet for the U.S. Department of Agriculture (USDA), currently located at 800 9th Street, SW, Washington, D.C., at a proposed total annual cost of $6,702,563 for a lease term of up to 10 years, a prospectus for which is attached to, and included in, this resolution.

Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

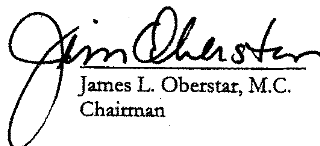
Provided further, that prior to exercising the authority granted in the resolution, the Administrator shall provide to the Committee on Transportation and Infrastructure of the House of Representatives a draft housing plan, including Federal Government ownership options, for the USDA in the National Capital Region.

Provided further, that within 60 days of the date of the resolution, the Administrator shall provide to the Committee on Transportation and Infrastructure of the House of Representatives a final housing plan approved by the Office of Management and Budget that provides Federal Government ownership for the USDA in the National Capital Region.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that*, if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

PROSPECTUS – LEASE
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, DC

Prospectus Number: PDC-03-WA09

Project Summary

The General Services Administration (GSA) proposes a replacement lease for up to 136,787 rentable square feet (rsf) of office space for the U.S. Department of Agriculture (USDA), Cooperative State Research, Education, and Extension Service (CSREES), currently located in the Waterfront Center Building at 800 9th Street, SW, in Washington, DC. CSREES is responsible for administering competitively awarded grant programs.

Description

Occupants:	USDA
Delineated Area:	Washington, DC Central Employment Area, North of Massachusetts Avenue and Southwest Waterfront
Lease Type:	Replacement
Justification:	Expiring Lease (1/17/2010)
Expansion Space:	None
Number of Parking Spaces:	None
Scoring:	Operating lease
Proposed Maximum Leasing Authority:	10 years
Maximum Rentable Square Feet:	136,787 rsf
Current Total Annual Cost:	$3,295,780
Proposed Total Annual Cost:[1]	$6,702,563
Maximum Proposed Rental Rate:[2]	$49.00

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages vendors to work with energy service providers to exceed minimum requirements set forth in the procurement.

[1] Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.

[2] This estimate is for fiscal year 2010 and may be escalated by 2.0 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS – LEASE
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, DC

Prospectus Number: PDC-03-WA09

Authorization

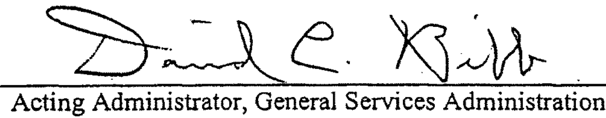
- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required rentable area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on August 20, 2008

Recommended:
Commissioner, Public Buildings Service

Approved: 
Acting Administrator, General Services Administration

June 2008

Housing Plan
U.S. Department of Agriculture

Washington, DC
PDC-03-WA09

Locations	Current						Proposed					
	Personnel		Usable Square Feet (USF)				Personnel		Usable Square Feet (USF)			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
800 9th Street	430	430	113,989			113,989						
Proposed Lease							435	435	113,989			113,989
Total	430	430	113,989			113,989	435	435	113,989			113,989

Utilization Rate		
	Current	Proposed
Rate	207	204

Current UR excludes 25,078 usf of office support space.
Proposed UR excludes 25,078 usf of office support space.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

John L. Mica
Ranking Republican Member

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
DEPARTMENT OF LABOR
SEATTLE, WA
PWA-03-SE-09

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for a consolidation lease of up to 85,608 rentable square feet for the Department of Labor, currently located at 1111 Third Avenue, and 719 Second Avenue, Seattle, WA, at a proposed total annual cost of $4,109,184 for a lease term of up to 15 years, a prospectus for which is attached to, and included in, this resolution.

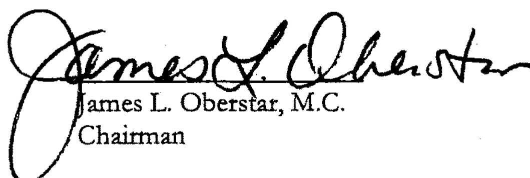
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that*, if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

GSA PBS

PROSPECTUS – LEASE
DEPARTMENT OF LABOR
SEATTLE, WA

Prospectus Number:	PWA-03-SE-09
Congressional District:	07

Project Summary

The General Services Administration (GSA) proposes a consolidation lease of up to 85,608 rentable square feet (rsf) of space for the Department of Labor (DoL) currently located at 1111 Third Avenue and 719 Second Avenue in Seattle, WA. The proposed lease will accommodate approximately eight percent growth in personnel while achieving more shared support spaces and the agency consolidation initiative.

Description

Occupants:	Department of Labor
Delineated Area:	Seattle CBD
Lease Type:	Consolidation
Justification:	Expiring leases (March 14, 2010)
Number of Parking Spaces:	25 (structured or outside)
Expansion Space:	7,561 rsf
Scoring:	Operating Lease
Proposed Maximum Leasing Authority:	15 years
Maximum Rentable Square Feet:	85,608
Current Total Annual Cost:	$2,886,600
Proposed Total Annual Cost[1]:	$4,109,184
Maximum Proposed Rental Rate[2]:	$48.00 per rentable square foot

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages offerors to work with energy service providers to exceed minimum requirements set forth in the procurement.

[1]Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2]This estimate is for fiscal year 2010 and may be escalated by 2.05 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS – LEASE
DEPARTMENT OF LABOR
SEATTLE, WA

Prospectus Number: PWA-03-SE-09
Congressional District: 07

Authorizations

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required area.

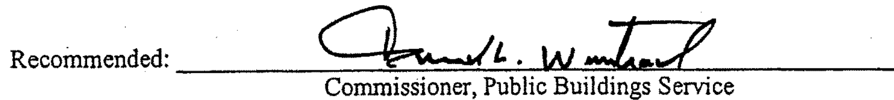
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

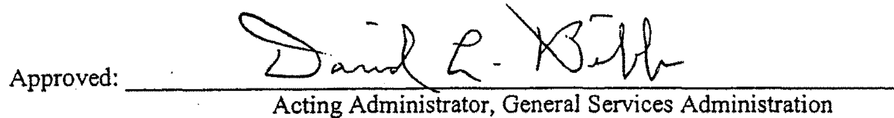
Submitted at Washington, DC, on August 20, 2008

Recommended:



Commissioner, Public Buildings Service

Approved:



Acting Administrator, General Services Administration

Ap[illegible]08 | Ho[illegible] Plan | S[illegible], WA
Depar[illegible] of Labor | PW[illegible] SE09

Locations	Current						Proposed					
	Personnel		*Usable Square Feet (USF)*				*Personnel*		*Usable Square Feet (USF)*			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
1111 Third Ave	83	83	18,889			18,889	-	-	-	-	-	-
Millenium Tower	215	215	48,784			48,784	-	-	-	-	-	-
New Lease	-	-	-	-	-	-	323	323	48,965	7,290	18,187	74,442
Total:	**298**	**298**	**67,673**	**-**	**-**	**67,673**	**323**	**323**	**48,965**	**7,290**	**18,187**	**74,442**

	Current	Proposed
	Utilization	
Rate	177	118

Current UR excludes 14,888 USF of office support space
Proposed UR excludes 10,772 SF of office support space

Special Space	
Conference	9,673
Library	3,748
ADP	1,755
Retail	3,011
Total:	**18,187**

USF means the portion of the building available for use by a tenant's personnel and furnishings and space available jointly to the occupants of the building.

U.S. House of Representatives
Committee on Transportation and Infrastructure
Washington, DC 20515

James L. Oberstar
Chairman

John L. Mica
Ranking Republican Member

David Heymsfeld, Chief of Staff
Ward W. McCarragher, Chief Counsel

James W. Coon II, Republican Chief of Staff

COMMITTEE RESOLUTION

LEASE
FEDERAL AVIATION ADMINISTRATION
DES PLAINES, IL
PIL-05-DE10

Resolved by the Committee on Transportation and Infrastructure of the House of Representatives, that, pursuant to 40 U.S.C. § 3307, appropriations are authorized for an extension/expansion lease of up to 210,000 rentable square feet for the Great Lakes Regional Office of the Federal Aviation Administration currently located at 2300 Devon Avenue in Des Plaines, IL, at a proposed total annual cost of $4,979,100 for a lease term of up to 10 years, a prospectus for which is attached to, and included in, this resolution.

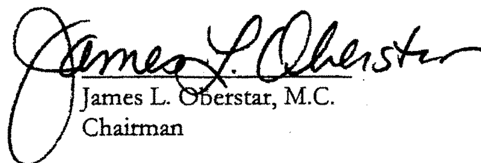
Approval of this prospectus constitutes authority to execute an interim lease for all tenants, if necessary, prior to the execution of the new lease.

Provided, that, to the maximum extent practicable, the Administrator of General Services (Administrator) shall require that the procurement includes minimum performance requirements requiring energy efficiency and the use of renewable energy.

Provided further, that the Administrator shall require that the delineated area of the procurement is identical to the delineated area included in the prospectus, *except that*, if the Administrator determines that the delineated area of the procurement should not be identical to the delineated area included in the prospectus, the Administrator shall provide an explanatory statement to the Committee on Transportation and Infrastructure of the House of Representatives prior to exercising any lease authority provided in the resolution.

Provided further, that the General Services Administration shall not delegate to any other agency the authority granted by the resolution.

Adopted: **November 5, 2009**



James L. Oberstar, M.C.
Chairman

PROSPECTUS - LEASE
FEDERAL AVIATION ADMINISTRATION
DES PLAINES, IL

Prospectus Number:	PIL-05-DE10
Congressional District:	09, 06

Project Summary

The General Services Administration (GSA) proposes an extension/expansion lease for 210,000 rentable square feet of space at 2300 Devon Avenue in Des Plaines, IL for the Great Lakes Regional Office of the Federal Aviation Administration (FAA), currently located at that address. FAA has occupied space at this location since 1972.

In 1992, Congress authorized the current lease under Prospectus No PIL-93003 for 10 years with the exercising of renewal options requiring Congressional authorization. The current lease expires October 20, 2010. It includes two 5-year options, of which one must be exercised by October 20, 2009 and the other by October 20, 2010, to extend the occupancy under the current lease.

GSA conducted a rental rate survey from which it determined that fully serviced rates on similar space in the O'Hara Airport area range from $24.59 to $30.05 per rentable square foot, while the current lease rate is $21.46 per rentable square foot, and the extensions are $22.96 and $24.46 per rentable square foot for the first and second options, respectively, for a levelized rate of $23.71 per rsf.

It is in the best interest of the Government for FAA is to stay at the current location, owing to extensive improvements that were made specifically to address its operational needs. A location near O'Hara Airport is critical to its mission, given its functions are integral with the airport's key operations.

Description

Occupants:	DOT - FAA
Delineated Area:	2300 East Devon Ave, Des Plaines, IL
Lease Type:	Extension/Expansion
Justification:	Expiring Lease (10/20/10)
Number of Parking Spaces:	760 surface
Expansion Space:	4,748 rentable square feet
Scoring:	Operating Lease
Proposed Maximum Leasing Authority:	10 years
Maximum Rentable Square Feet:	210,000
Current Total Annual Cost:	$4,404,708
Proposed Total Annual Cost[1]:	$4,979,100
Maximum Proposed Rental Rate[2]:	$23.71 per rentable sq. ft.

[1]Any new lease may contain an annual escalation clause to provide for increases or decreases in real estate taxes and operating costs.
[2]This estimate is for fiscal year 2011 and may be escalated by 1.8 percent annually to the effective date of the lease to account for inflation.

GSA PBS

PROSPECTUS - LEASE
FEDERAL AVIATION ADMINISTRATION
DES PLAINES, IL

Prospectus Number: PIL-05-DE10
Congressional District: 09, 06

Summary of Energy Compliance

GSA will incorporate energy efficiency requirements into the Solicitation for Offers and other documents related to the procurement of space for which this prospectus seeks authorization. GSA encourages landlords to work with energy service providers to exceed minimum requirements set forth in the procurement.

Authorizations

- Approval of this prospectus by the House Committee on Transportation and Infrastructure and the Senate Committee on Environment and Public Works will constitute authority to lease space in a facility that will yield the required area.
- Approval of this prospectus will constitute authority to provide an interim lease, if necessary, prior to the execution of the new lease.

Certification of Need

The proposed project is the best solution to meet a validated Government need.

Submitted at Washington, DC, on September 11, 2009

Recommended: [signature]
Commissioner, Public Buildings Service

Approved: [signature]
Acting Administrator, General Services Administration

August 2009

Housing Plan
Federal Aviation Administration

Des Plaines, IL
PIL-05-DE10

Locations	Current						Proposed					
	Personnel		*Usable Square Feet (USF)*				*Personnel*		*Usable Square Feet (USF)*			
	Office	Total	Office	Storage	Special	Total	Office	Total	Office	Storage	Special	Total
2300 E. Devon Ave, Des Plaines, IL												
DOT - Federal Aviation Administration	645	645	144,513	6,680	20,765	**171,958**						
New Lease							645	645	144,513	6,680	24,671	**175,864**
Total:	**645**	**645**	**144,513**	**6,680**	**20,765**	**171,958**	**645**	**645**	**144,513**	**6,680**	**24,671**	**175,864**

	Current	Proposed
Utilization		
Rate	175	175

Current UR excludes 31,792 USF of office support space
Proposed UR excludes 31,792 USF of office support space

Special Space	
Laboratory	110
Restroom	360
Physical Fitness	4,415
Conference	9,077
Library	970
ADP	8,799
Other - Health Space	940
Total:	**24,671**

There was no objection.

FUTURE INVOLVEMENT IN AFGHANISTAN

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Wisconsin (Mr. KAGEN) is recognized for 60 minutes.

Mr. KAGEN. Madam Speaker, I rise this evening to begin a bipartisan conversation about the future investments of our resources in both human and capital resources in the region of Afghanistan and Pakistan. Everyone will agree that we must do whatever it takes to protect America and keep hostilities from our shores. And over time, I believe we'll also come to understand that religious fundamentalism is civilization's real enemy, no matter if it is disguised in Muslim, Judeo-Christian, Hindu, Sikh or any other religious clothing.

Terrorism is not really the enemy, for violent extremists simply use terrorism as a tactic. Overcoming the violent extremists will require skilled and talented police work as coordinated between civilized nations, not only our mutual military might. And we must hunt, capture and prosecute the violent extremists wherever they seek to establish themselves, sharing the expense and doing so with our colleagues in our mutual nations overseas, our friends, particularly in NATO. Most importantly, throughout this process, we must continue to defend ourselves within the laws as established by our United States Constitution. We're still paying for the poor judgments of the previous administration which, in 2003, placed our children in the middle of a centuries' old religious civil war in Iraq, when, in fact, our invasion of Iraq was not necessary. By continuing to spend millions of our hard-earned tax dollars over there, we are unable to solve our own problems here at home.

The truth about Iraq is this: no weapons of mass destruction were present in Iraq, and al Qaeda extremists were not based there before President Bush convinced Congress to go to war. And remember this: Iraq was not involved in the attacks against America, and did not pose a risk to our national security, and it was not a danger to our national security at all.

We all have the same goal, to support our troops before, during and after they've served in harm's way, as we begin to build a better and safer and more secure Nation for all of us. Recent testimony before Congress, before the Armed Services Committee in the last several weeks, by our military leaders has made it clear: first, that they all don't agree on what we should be doing in the region, and secondly, that there is no purely military solution in either Iraq or Afghanistan, only a political one. We must, therefore, move our troops away from Iraq, focusing again upon al Qaeda.

Tonight, here on the House floor we will be discussing our ongoing involvement in Afghanistan and Pakistan, which for centuries has been the graveyard of invading empires, a place where our Nation's most precious resources, our soldiers, are presently engaged in efforts to, as President Obama has stated, ''disrupt, dismantle and defeat al Qaeda and its safe havens in Pakistan and to prevent their return to Pakistan and Afghanistan.''

I'm very grateful that President Obama has taken time to listen, taken time as well and trust that he will design a strategy that has as its first goal the safe return of all of our troops as soon as possible, for there is really no purely military solution to the complex global problems that we're all facing. And as history has proven time and time again, making war is our worst human failure.

So what are some of the numbers in Afghanistan? Suicides, post-traumatic stress disorder, a wound that we cannot see, but which our soldiers carry with them all their lives, a wound that damages not just themselves but their families and their businesses when they come home, amputations, burns, shrapnel wounds, fractured spines.

Thirty percent of our returning servicemen have PTSD, post-traumatic stress disorder. Seventy thousand of our soldiers have traumatic brain injury since 2007. In January of this year through October of this year, 1,800 have been wounded in Afghanistan, 1,000 being wounded in the last 3 months alone. And for the cause? The cause of helping, in part, to support the very fraudulent government, a government that has been formed by an election process not witnessed in our country, no matter what election you take a look at.

I will quote now from an article:

''You can't build a new political system with old politician accused of war crimes,'' said lawmaker, Ramazan Bashardost, who finished third in the country's fraud-marred August election. ''You can't have peace with warlords in control.''

Rights groups have accused soldiers and police loyal to the warlords of kidnapping, extortion, robbery and the rape of women, girls and boys. In the countryside, local commanders run their own fiefdoms with illegal militias. They intimidate people into paying them taxes, extracting bribes, steal their land, and trade drugs. They essentially rule with impunity, and no government official, no judge, no policeman can stand up to them. This is the Afghanistan world as we know it. This is the Afghanistan situation as President Karzai may soon be sworn in and give his speech in several hours in Kabul.

Earlier today, there was a newspaper report that is entitled Afghan Official Said to Take Bribe for Copper Deal. This is how business is being done in Afghanistan. $20 million bribe to a minister who gave a contract to a Chinese corporation who was coming in to mine their copper. Fraud and bribery are the rule of the day today in Afghanistan, where nearly 40 percent of the money that our taxpayers are sending into the region is taken down in bribes and plain thievery.

Well, some of the testimony that has been offered by the Armed Services Committee was put forward by people that we know and people we trust.

□ 1845

Wesley Clark finished his testimony with these words: ''But it is important to face the reality of the situation at this point: much has already been accomplished: our obligations are limited; there will never be a complete and wholly satisfactory solution, and we must focus on meeting our own—the United States' and NATO's—security needs. And the real security need in the region now is to reduce the continuing threat of al Qaeda, reportedly located principally in Pakistan. It is their decisive defeat that we must seek.'' These are the counsel and opinion of the former NATO commander, Wesley Clark.

There is somebody else that testified, Kimberly Kagan. And she spells it with an A-N, so we are not related by marriage or by genealogy. Perhaps the most interesting sentence in her publication, which is entitled—I want you to read it some day—''Why the Taliban Are Winning for Now,'' Kimberly Kagan, Foreign Policy Magazine, August 10, 2009, was ''The fact that we have not been doing the right things for the past few years in Afghanistan is actually good news at this moment.'' I don't know if that is ''Saturday Night Live'' material, but I've got to tell you, this is not something we should be sending our troops in to when we are doing the wrong thing.

Andrew Krepinevich wrote: ''Simply stated, the military foundation of our global dominance is eroding.'' That's his opinion. It's also a fact. The empire of the United States, the global reach, may be coming to an end.

And the final quote I will offer as we begin our discussions comes from Gilles Dorronsoro, who is a visiting scholar with South Asia Program, Carnegie Endowment for International Peace. And he concludes his remarks before the Armed Services Committee with this sentence: ''The only solution to this problem is a political negotiation and the awareness of what is really at stake here: the credibility of NATO as a military alliance.''

These are some of the problems that we face today, but this is not a new problem. For 2,300 years ago, 1 day after the Battle of Kalinga, in 265 B.C., where over 100,000 people perished in

the lands our Nation has sent its own children, trained in war, the then-King of Maurya dynasty, Ashoka, recorded his thoughts for our Nation's guidance today.

And Ashoka wrote: "What have I done? Is this a victory? What is a defeat then? This is a victory or a defeat. This is justice or injustice. It's gallantry or a rout. Is it a valor to kill innocent children and women? I do it to enwiden the empire or for prosperity or to destroy the other's kingdom or splendor? Someone has lost her husband, someone a father, someone a child, someone an unborn infant. What is this debris of corpses? Are these marks of victory or defeat? Are these vultures, crows, eagles, the messengers of death or evil? What have I done? What have I done?"

After he conquered the region of Afghanistan, he transformed his own personal philosophies and his kingdoms to promote peace, to promote Buddhism and a nonviolent way of solving problems.

I believe there is a better way of doing things in America; and I am convinced that by working together, we are going to be able to find it and to do that in a very bipartisan way.

I yield to my friend, my colleague, a physician and Congressman, RON PAUL of Texas.

Mr. PAUL. I thank the gentleman for yielding, and I want to express my appreciation for your getting this Special Order on this very important subject.

Of course, a lot of people in this country are asking, What should we do about Afghanistan? It's a pretty important question. It might be one of the most important questions that we are asking right now. And yet nobody seems to have an answer. I think the difficulty in finding an answer comes sometimes from not having fully understood why we got there. I just can't imagine this debate that's going on within our government today, the executive branch, the legislative branch, and with the people—can you imagine this going on during World War II? How many troops should we have? What is our exit strategy? Who is our enemy? How are we going to impose democracy? It's so far removed from what a traditional responsibility is of our government, which is to provide national security.

Now they have practically run out of excuses for why we are over in Afghanistan. The only one that is left that they seem to cling to is that we are there for national security; we want to fight the bad guys over there because we don't want to fight them over here. I will talk a little about that later; but, quite frankly, I think that's a fallacious argument and actually makes things a lot worse.

It just bewilders me about how we get trapped into these situations. I happen to believe that it's because we get ourselves involved too carelessly, too easily and we don't follow the Constitution, because under the Constitution, you're supposed to declare the war, know who your enemy is, and know when you can declare victory and bring the troops home. And we did that up until and through World War II. But since then, that hasn't been the case.

I recall a book I read in the 1980s written by Barbara Tuchman. She wrote a book called the "March of Folly," and she went back as far as Troy, all the way up through Vietnam and took very special interest in countries where they were almost obsessed or possessed with a policy, even though it was not in their interest, and the foolishness and the inability to change course. She died in 1989, but I keep thinking that if she had lived, she would probably write a history of our recent years, another "march of folly."

Just think of what has happened since the Berlin Wall came down and the Soviet system collapsed. It didn't take us long. Did we have any peace dividends? No. There were arguments for more military spending, we had more responsibility, we had to go and police the world. So it wasn't long after that, what were we doing? We were involved in the Persian Gulf war.

And then, following that, we had decades of bombing in Iraq which didn't please the Arabs and the Muslims of the world and certainly the Iraqis, but it had nothing to do with national security.

And then, of course, we continued and accelerated our support of the various puppet governments in the Middle East. In doing so, we actually went to the part of not only supporting the governments, but we started putting troops on their land. And when we had an air base in Saudi Arabia, that was rather offensive. If you understand the people over there, this is a violation of a deeply held religious view. It is considered their holy land; and foreigners, especially military foreigners, are seen as infidels. So if you're looking for a fight or a problem, just put troops on their land.

But also, as a result of the policy that we have had in the Middle East, we have been perceived as being anti-Palestinian. This has not set well either. Since that time, of course, we haven't backed off one bit. We had the Persian Gulf war, and then we had 9/11.

We know that 9/11 changed everything. We had 15 individuals from Saudi Arabia, a few from Yemen and a few from Egypt, but, aha, this is an excuse that we have got to get the bad guys. So where are the bad guys? Well, Iraq, of course. Of course, they figured, well, we can't quite do that, let's go into Afghanistan. Of course, not one single Afghani did anything to us. They said, oh, no, the al Qaeda visited there.

But I just can't quite accept the fact that the individuals that were flying those airplanes got their training by going to these training camps in Afghanistan doing push-ups and being tough and strong. What did they do? Where was the planning? The planning was done in Spain and they were accepted there in legal bases. They were done in Germany; they were accepted there. As a matter of fact, they even came to this country with legal visas. And they were accepted by the countries.

And, no, no, we said, it's the Taliban; it's the people of Afghanistan, never questioning the fact that a few years back, back in 1989 when the Soviets were wrecking the place, we were allied with the people who were friends of Osama bin Laden, and we were over there trying to support him. So he then was a freedom fighter.

And the hypocrisy of all this and the schizophrenia of it all, they were on again and off again. No wonder we get ourselves into these difficulties. And it doesn't seem to ever lead up.

The one assessment that was made after Vietnam, and I think you can apply it here, is how do we get in and why do we get bogged down? And two individuals that were talking about this, East and West, Vietnam and the United States, they sort of came to the conclusion that we, the Americans, overestimated the ominous power of our military, we could conquer anybody and everybody. And we underestimated the tenacity of people who are defending their homeland, sort of like we were defending our homeland in the Revolutionary War, and the invaders and the occupiers were the Red Coats. There's a big difference, and you can overcome all kinds of obstacles; but we have never seemed to have learned that. And unless we do, I don't think we can solve our problems.

Indeed, we have to realize that we are not the policemen of the world. We cannot nation-build. And Presidential candidates on both sides generally tell the people that's what they want, and the people say, keep our fingers crossed, hope it's true. But then, once again, our policies continue down the road, and we never seem to have the energy to back off of this.

I emphasize, once again, that I think we could keep our eye on the target, emphasize what we should be doing if we went to war a lot more cautiously, if we have an enemy that we have to fight in our national defense and then there is a declaration of war.

Mr. KAGEN. Would the gentleman yield for a moment?

Mr. PAUL. I will yield.

Mr. KAGEN. In the beginning in the formation of the United States, we had an outside observer come over here, Alexis de Tocqueville. And de Tocqueville observed that with our Republic, it would be very difficult to get this country, this Nation, to go to war. But once involved in a war, it would be

very difficult to stop it. And I think that MO, that picture, that frame is in part what is happening here. Now that we are involved in a ground game in other areas of the world, it's very difficult for our Republic to pull back.

I would like now to welcome to the floor Congressman MCGOVERN from the State of Massachusetts. And I thank you for joining us on this discussion on Afghanistan and Pakistan and where do we go from here.

Mr. MCGOVERN. Thank you very much, and I want to thank you and my other colleagues here for taking the time to come to the floor to talk about this issue. We are at war, and there is very little debate about this war. I think it is important and it is incumbent upon every Member of this House to encourage the fullest possible debate on our policy in Afghanistan.

We are told that the President any day now or any week is going to come up with a new policy. There are rumors that it will include an increase in the number of U.S. troops in Afghanistan.

That needs to be debated.

Part of our job is to be a check and balance on the executive branch. And it is our constituents who are going to war. It is our constituents who are dying over there. It is our constituents who are getting wounded over there and coming back to the United States and requiring a lifetime of care. And we need to make sure they get the care that they deserve. They have earned that.

I am very concerned about our policy in Afghanistan. I'm concerned for a whole number of reasons. I'm concerned because I don't think there is any definition to our policy. Depending on whom you talk to, you get a different answer as to what our goal is. Originally, our goal was to get al Qaeda. After September 11, I, and I think virtually every Member of this House and every Member of the Senate, voted to use force to go after al Qaeda, who were responsible for the terrible atrocities of September 11. It was the right vote then, and I think it's the right vote now.

But al Qaeda, which used to be in Afghanistan, has now moved to Pakistan. We are told by our military experts that there are no al Qaeda in Afghanistan, maybe less than 100, some say. Well, do we need 100,000 American troops to go after less than 100 members of al Qaeda? And if that is not our goal, then this is an example of mission creep where our mission has suddenly enlarged itself without any kind of input from this Congress.

Now some say we need to have more troops there to make sure that al Qaeda never comes back to Afghanistan. Well, al Qaeda has not only been in Afghanistan, they have been in Sudan, they have been in Somalia, they have been in Yemen. They have been in south Florida. Do we want to deploy more troops all over there?

I'm concerned because there is not a clearly defined mission. When I ran for Congress, I said I would never vote to send anybody to war without a clearly defined mission. That's a beginning, a middle, a transition period and an end. I have asked over and over of the previous administration and this administration, At what point does our military contribution to the political solution that you say will happen in Afghanistan, at what point does our military contribution to that political solution come to an end? And I usually get, ''Good question.'' I don't think anybody knows.

I think that that's a problem, and that's something that we need to address.

Let me just say I'm also concerned because Afghanistan is not accustomed to a centralized government. Well, we have helped give them a centralized government. And the government of Mr. Karzai is corrupt and incompetent. By conservative estimates, we are told that in the last election, 30 percent of his vote was fraudulent. Thirty percent of his vote was fraudulent. And then there was going to be a run-off election, and then the opposition candidate, I think understandably, said, I don't see how you can put together a credible election in a couple of weeks.

□ 1900

And he backed out. So here is our President by default—here's the President by default, who is about to be sworn in again, and the examples of corruption and fraud in his government, the examples of the Afghan government using American taxpayer money for things that they're not intended to be used for—basically stealing from the American taxpayer. The examples of that are too numerous to mention in this debate.

Mr. KAGEN. Will the gentleman yield for a question?

Mr. MCGOVERN. I yield to the gentleman.

Mr. KAGEN. Mr. MCGOVERN, is there any word or any sentence or phrase that the newly ''elected'' President of Afghanistan could say to convince you that the fraud is behind him, he didn't mean it?

Mr. MCGOVERN. The answer is no. He's had his chance. He blew it. I wouldn't trust that government to tell me the correct time after what they have done over the last 8 years. We have been supporting this system for 8 years. This war just didn't start. We have been there for 8 years. At some point, enough is enough. The idea of supporting a government that is corrupt and incompetent and saying that we're going to keep this government in power, we're going to help support them, our men and women are going to die for this government, and then at some point magically everything is supposed to be perfect, that we hand over everything back to this government that has stolen from the American taxpayers, this government that is guilty of fraud—I think that this is a mistake. And 57 Members of this House, bipartisan Members of this House, sent a letter to President Obama saying ''no'' to the increase in American forces there. And I think there's a lot more that feel that way. I'd like to insert this into the CONGRESSIONAL RECORD.

CONGRESS OF THE UNITED STATES,
Washington, DC, September 25, 2009.

Hon. BARACK OBAMA,
President of the United States,
The White House,
1600 Pennsylvania Avenue NW.,
Washington, DC.

DEAR MR. PRESIDENT, as you consider the latest assessment of U.S. military engagement in Afghanistan by General Stanley A. McChrystal, we urge you to reject any recommendation to increase the number of combat troops there, particularly in the absence of a well-defined military exit strategy.

We have enormous confidence in the ability of the U.S. military, but we question the effectiveness of committing our troops to a prolonged counterinsurgency war that could last ten years or more, involve hundreds of thousands of troops, and impose huge financial costs on taxpayers already saddled with trillions of dollars of government debt.

According to General Charles Krulak (retired), the 31st Commandant of the Marine Corps, the current strategy of protecting the people of Afghanistan with U.S. forces would require an escalation of several hundred thousand additional troops. He warns that our military has already been overburdened: ''Not only are our troops being run ragged but, equally important and totally off most people's radar screens, our equipment is being run ragged.'' It is unlikely that our NATO allies will be able to sustain the political support necessary for continuing such a mission placing even more of a burden on American forces and the American people.

2009 is already the deadliest year for U.S. forces since the war began eight years ago. Fifty-one of the seven hundred and thirty-eight U.S. soldiers who have lost their lives in Afghanistan were killed last month alone.

The national Afghanistan election that U.S. Ambassador Karl Eikenberry hoped would lead to a ''renewal of trust of the Afghan people for their government'' was a disaster and will almost certainly have the opposite effect. The official Electoral Complaints Commission in Afghanistan has announced that is has found ''clear and convincing evidence of fraud.'' A government already mired in allegations of widespread fraud and incompetence is now facing serious charges and compelling evidence that it has attempted to steal the national election.

A February 2009 ABC/BBC/ARD poll found that only 18 percent of Afghans support increasing the number of U.S. troops in their country. This should come as no surprise. Historically, Afghans have always forcefully resisted the presence of foreign military forces, be they British, Soviet or American. The presence of our forces strengthens the hand of Taliban recruiters. Indeed, an independent analysis early this year by the Carnegie Institute concluded that the presence of foreign troops is probably the single most important factor in the resurgence of the Taliban.

We support your administration's declared goals of defeating Al Qaeda and reducing the

global terrorist threat. But, we believe that adding even more U.S. troops to the military escalation that your administration ordered in March would be counterproductive. We urge you to consider and pursue the full range of alternative options including applying the lessons of the Cold War where we isolate and contain those who pose a threat to our national security.

Mr. President, the last thing that our nation needs as it struggles with the pain of a severe economic crisis and a mountain of debt is another military quagmire. We believe that this is why recent polls consistently show that a majority of Americans are opposed to a military escalation in Afghanistan. We urge you to reject any recommendation for a further escalation of U.S. military forces there.

Sincerely,

List of Signatures on Bipartisan Letter to President Obama Urging the Rejection to an Increase in Number of U.S. Combat Troops in Afghanistan:

James P. McGovern, Walter Jones, Ron Paul, Ed Whitfield, Neil Abercrombie, Jim McDermott, Pete Stark, Bruce Braley, Phil Hare, Raúl Grijalva, Lynn Woolsey, Lloyd Doggett, Bob Filner, John Olver, Jośe Serrano, Barbara Lee, Jerry Costello, Ben Ray Luján Alan Grayson.

Peter Welch, Kurt Schrader, Tammy Baldwin, Ed Pastor, Yvette Clarke, Sheila Jackson-Lee, John Lewis, Carolyn B. Maloney, Richard Neal, Diane Watson, John Conyers, Jr., Dennis Kucinich, Tim Johnson (IL), Steve Cohen, Keith Ellison, Donna Edwards, Laura Richardson, Michael Honda, Jan Schakowsky.

Daniel Maffei, Steve Kagen, Michael Capuano, Sam Farr, Chellie Pingree, Luis Gutierrez, Maurice Hinchey, Maxine Waters, Mazie Hirono, Jared Polis, Roscoe Bartlett, John J. Duncan, Jr., Dana Rohrabacher, Mike Michaud, Earl Blumenauer, Rush Holt, Mike Quigley, Peter DeFazio, Jerrold Nadler.

I think the American people are way ahead of us on this issue. The American people get it. They know we're getting sucked into a quagmire, they know we're getting sucked into a war that has no end, and they don't want any part of it. All I'm simply saying is, if al Qaeda is our enemy, then let's focus on al Qaeda. Let's not get bogged down in a war that has no end.

Alexander the Great found out he wasn't so great in Afghanistan. Genghis Khan couldn't do anything in Afghanistan; the British, the Soviet Union. I think we got bogged down in a war there, and I think there's a strong argument to be made that's one of the reasons the Soviet Union fell.

So we need to debate this thoroughly. We need to know what we're doing. We owe this to our constituents, we owe this to our country. So I hope that before any escalation of American forces occurs that there is a full and thorough debate in this Congress and a vote up or down on whether or not we should send more troops.

I thank the gentleman.

Mr. KAGEN. I couldn't agree more. I really appreciate your being here with your busy schedule. I align myself with your remarks.

We're also joined by WALTER JONES from North Carolina. You've had some experience in representing soldiers, haven't you?

Mr. JONES. Yes. Congressman KAGEN, I want to thank you for giving me a chance to be a small part of this debate tonight. I'm glad its a bipartisan support. Yes, I have Camp Lejeune Marine Base in my district; Cherry Point Marine Air Station; and also Seymour Johnson Air Force Base.

I want to take just a few minutes; a very few. I wanted to share with this debate tonight that this is not—as Mr. MCGOVERN said, this is an American issue. It's not a Democrat or Republican, it's not a liberal or conservative. But let me start with two conservatives.

This was written by George Will, a nationally syndicated column of September 1, 2009. George Will, "Time to Get Out of Afghanistan."

"'Yesterday,' reads the e-mail from Allen, a marine in Afghanistan, 'I gave blood because a marine, while out on patrol, stepped on a (mine's) pressure plate and lost both legs.' Then 'another marine with a bullet wound to the head was brought in. Both marines died this morning.'

'I'm sorry about the drama,' writes Allen, an enthusiastic infantryman willing to die 'so that each of you may grow old.' He says: 'I put everything in God's hands.' And: 'Semper fi!'"

George Will further writes, "Allen and others of America's finest are also in Washington's hands. This city should keep faith with them by rapidly reversing the trajectory of America's involvement in Afghanistan, where, says the Dutch commander of coalition forces in a southern province, walking through the region is 'like walking through the Old Testament.'"

Let me read from another conservative, Peggy Noonan. This was written on October 10 in The Wall Street Journal. "So far, oddly, most of the debate over Afghanistan has taken place among journalists and foreign-policy professionals. All power to them: They've been fighting it out on op-ed pages and in journals for months now, in many cases with a moral seriousness, good faith, and sense of protectiveness toward the interests of the United States that is, actually, moving. But nobody elected them. We need a truly national debate."

Those two articles, I wanted to read those parts because I want to thank you, Congressmen KAGEN, MCGOVERN, and RON PAUL and myself, WALTER JONES, for being here tonight, for this reason: Mr. MCGOVERN is exactly right, you're right, so is Mr. PAUL. This is a debate that needs to take place in the daytime with 435 Members of Congress, because our men and women in uniform will go to their death for this country, but they're worn out. There are four and five deployments to Afghanistan and Iraq. And if we don't meet our constitutional responsibility—and I agree with Mr. PAUL, we should declare war, but we don't do that any more. We just pass these resolutions to give the authority to the President. The time has come for the Congress to act on behalf of the American people and, more important, to act on behalf of our troops that we are about to break.

The last point. Today, I wrote Mr. Obama a note and thanked him for taking time to look carefully at what the options should be. And I want to say as a conservative Republican, again, thank you, Mr. Obama, for taking the time, because our boys and girls, our young men and women, they deserve the right decision as it relates to Afghanistan. Thank you.

Mr. KAGEN. I thank you for your remarks, and I align myself with everything you just said. And I want to just express for a few moments some of the experiences I've had as a physician caring for our soldiers—our soldiers who served not just in World War II, but also Korea and Vietnam and elsewhere. And having served as a physician taking care of our soldiers, I can just say it this way. You know, it's really hard to put Humpty Dumpty back together again. Once a soldier has been broken mentally and physically, it is very difficult to put him or her back into the world they came from.

More recently, one of my son's friends from his speed skating days, who was a tremendous athlete, signed up and served in Iraq. And then we got the phone call from Andy's mother that when he came back she was afraid to be in the same house with him because of his anger that would just come out. The only place he felt safe was back in theater in Iraq, guarding not just the people visiting Iraq and Congressmen and women, but the Vice President, then-Vice President Cheney.

A story about a four-star general whom I took care of in 1976, giving him his chemotherapy. I spent a lot of time with him on his way out. And he told me this about the Marines, and it stuck with me forever. The Marines, Dr. KAGEN, the Marines are a killing machine. When politicians call us into a theater, we already know before we go in, within 2 percent, how many body bags to bring. Our purpose is to destroy human life. Don't ask us to build a bridge, don't ask us to build institutions or a new financial system. Our purpose is to destroy human life. That is what the military's job is to do, from his perspective. To destroy human life.

That is the instrument of the military that is being used with a very wide swath today. I think we can do better. I am so proud of this President. And I understand, judging not only by the time that he's taking but also by the number of gray hairs he's generated on his head, that he really is taking this very seriously, trying to find a way forward.

In my view, it's incumbent upon all of us Members of the House to find a way, to help find a way to debate this issue. And I think there are going to be three questions. It's the three questions I ask myself when I look at any bill before the Congress. Number one: Will it work?

So, Mr. President, whatever strategy you're putting together, if you're listening tonight, make sure it's a strategy that's comprehensive, something that's going to work for the American people, because right now we need the help here at home. We should be building a better Nation not overseas but here at home, rebuilding our own infrastructure, the lives and families that we represent. Will it work?

Secondly, can we afford it? What's the real price, not just in dollars and cents, not just in debt accumulation, but in human cost.

The third question is: Is it the right thing to do? Is it ethical? These are the three questions.

Mr. MCGOVERN.

Mr. MCGOVERN. I agree with the gentleman. I want to again also thank our friend, Mr. KAGEN, for organizing this, and, again, my friend WALTER JONES, who's been unbelievably eloquent on the need for there to be more debate on this issue—I appreciate that—and my friend, Mr. PAUL, for all of his work.

The gentleman raises, I think, a very important point, and that is that there's a cost to this war. There's a cost in terms of human life. My friend is a doctor. He has seen firsthand the trauma that war can inflict on our soldiers. We have all been to Walter Reed Hospital. We have visited many young men and women who have been wounded in this conflict. But there's also a cost, as he mentions, in terms of dollars and cents.

I always find it somewhat ironic that we have debates on this floor about health care or child care or feeding the hungry or making sure people have adequate housing or even in terms of giving our veterans more. People always get up and say, Boy, we can't spend any more; we can't spend any more. We have to worry about our debt and our deficit.

Well, where is the outrage over the fact that we have spent all this money on these wars in Iraq and Afghanistan off budget? It's all gone on our credit card. I introduced a bill along with Mr. OBEY and Mr. MURTHA last year, a couple of years ago, saying that we should have a war tax. It got shot down in a bipartisan way. But I think that we need to understand that in these wars it is only really a tiny sliver of our country that is actually sacrificing—our soldiers and their families. The rest of us are being asked to do nothing. But understand one thing. These wars are adding incredible amounts to our deficit and our debt. People need to understand there's a cost here. And we need to have that debate.

I'll just tell you one other thing, if I can. Look, I, too, am grateful that the President is deliberating on this issue. I wish the deliberation had occurred before we had the surge that we had a few months ago, because I think it was important to have this debate before any more soldiers got sent there. But I am grateful that he is deliberating. And we don't know what his policy will be. But I'm going to tell you I am personally offended by the fact that the President of Afghanistan is openly taking on the United States, criticizing the United States, for what our motives may be and what our role may be over there when we are supporting him and he is guilty of fraud, he is guilty of corruption. If he were in this country, there would be a special investigation and he would go to jail. This is the extent of the corruption over there. And at some point you have to say that this doesn't work.

We have to ask: Why are we there while al Qaeda's in Pakistan, no longer in Afghanistan? What are we trying to do? I don't think it is worth spending the money or sacrificing the lives to defend a corrupt regime. And I think that is where we are right now.

Mr. Karzai has had 8 years to show what he is about. That's why when you asked me before whether if he adds anything to his speech about finding corruption, whether I will believe him. No, I will not, because he's had 8 years to prove what he's about. And we have had good members of our Foreign Service community who have resigned over the fact that this government is so corrupt.

So, enough. We need to develop a policy that has an exit strategy and it includes a flexible withdrawal strategy.

□ 1915

I want to help the Afghan people. I'm not against development aid. I think we should try to help them any way we can, in a way that is sustainable, in a way that works, and in a way that they want. But let's understand that there is no military solution to be had here, and expanding our military footprint will only allow the Taliban greater propaganda points for recruiting and will cost us dearly. So enough. It's time to reevaluate this policy. It is time to figure out a way to end our military involvement, and we need to do so in a sensible and thoughtful way.

Mr. KAGEN. Mr. PAUL?

Mr. PAUL. I thank you for yielding.

I want to just make a couple of points in closing. The statement at the beginning of this war was made that it's different this time. Even though the history is well known about Afghanistan—it's ancient history, but it's different this time because we're different, and it's not going to have the same result. But so far, you know, they haven't caught Osama bin Laden, and we don't have a national government, really. We don't have really honest elections. We haven't won the hearts and minds of the people. There is a lot of dissension, and it is a miserable place. It is really a total failure, let alone the cost, the cost of life and limb and money. I mean, it is just a total failure. The thought that we would pursue this and expand it and send more troops just blows my mind.

I just want to mention a couple of things that I think are bad arguments. One thing is we are involved there, we have invested too much, and, therefore, we have to save face because it would look terrible if we had to leave. But it is like in medicine. What if we, in medicine, were doing the wrong thing, made the wrong diagnosis? Would we keep doing it to prove that we are right or are we going listen to the patient and to the results?

Mr. KAGEN. You would lose your license.

Mr. PAUL. Yes, that's right. But it seems like politicians don't lose their license. Maybe they should. Maybe there will be more this year or something. But the other argument they make is, if you take a less militant viewpoint as we all do that we're not supportive of the troops. The troops don't believe that. The troops I talk to and the ones Mr. JONES talks to, they know we care about them, and they shouldn't be put in harm's way unless it is absolutely necessary.

This other argument is, well, we have got to go over there to kill them because they want to kill us. Well, like I mentioned before, it wasn't the Afghans that came over here, but if we're in their country killing them, we're going to create more terrorists. And the more people we send, the more terrorists, and the more we have to kill. And now it's spreading. That's what I'm worried about in this war.

There was one individual—I don't know his name—but they believed he was in Pakistan, so he was part of the terrorist group, the people who were opposing the occupation. So they sent 15 cruise missiles, drones, over looking for him. It took the 15th one to kill him. But 14 landed, and there was an estimate made that about 1,000 civilians were killed in this manner. How many more terrorists have we developed under those circumstances?

I do want to have 1 minute here to read a quote, and then I will yield back. This quote comes from a Russian general talking to Gorbachev, and Gorbachev went into office in 1985, and this was a year later. The general was talking to Gorbachev. Just think, Gorbachev was in office 1 year. He had the problem. He was trying to get out. He didn't get out until 1989. But the general says, ''Military actions in Afghanistan will soon be 7 years old,'' and told Mr. Gorbachev at a November

1986 Politburo session, ''There is no single piece of land in this country which has not been occupied by a Soviet soldier. Nonetheless, the majority of the territory remains in the hands of rebels.'' It reminds me of the conversation between Colonel Tu and Sumner after Vietnam. And Sumner, our colonel, says, You know, we defeated you in every battle in Vietnam. And Tu looked at him, and he said, Yes, I agree, but it was also irrelevant.

I yield back.

Mr. KAGEN. Thank you very much.

And Gorbachev also publicly said recently that there is no military solution. In his words, he said, Say ''yes'' to domestic considerations, ''no'' to war. And dialogue, he said, is best along with an international solution. Why? Because there is a dangerous concentration of terrorism and violent extremists in the Hindu Kush area. There is a concentration of violent extremists who seek to solve their problems not by dialogue, not by debate and conversation, but by vengeance and violence. There is a better way of doing things.

Mr. JONES.

Mr. JONES. Congressman, thank you very much for yielding. I will be brief.

I think what's been said by Mr. MCGOVERN, you, as well as Congressman PAUL, is that Congress needs to meet its responsibility to debate these issues. That's why I want to read from the former commandant of the Marine Corps who e-mailed me this information. I just want to read one brief paragraph.

''With all due respect to the 'COIN experts,' to execute the clear, hold and build strategy being put forth will require far more than the 40,000 to 80,000 more troops being discussed. No one who knows anything about counterinsurgency would argue that fact. I can promise you, our troops are so overextended right now that they couldn't produce the numbers needed . . . and the equipment would not be available.''

One other point. I am certainly skipping around but trying to pick out something that would be of interest to this debate. ''Finally, Afghanistan is not Iraq . . . or Vietnam . . . or Iran. It is totally different!

''This is a country (notice I don't dignify it with the term 'nation') that is totally tribal in nature. It has no real government. You cannot even imagine it as a nation-state that can be dealt with and considered an ally.''

This, again, is why we are frustrated, the four of us tonight on the floor. We have seen the pain, the hurt. You've talked about it; JIM'S talked about it; RON'S talked about it; I've talked about it. This country owes it to the families of our military to debate this on the floor of the House with 435 here on the floor of the House to be part of the debate or we're not meeting our responsibility to the men and women in uniform.

I yield back.

Mr. KAGEN. I thank you and align myself with those comments.

Mr. MCGOVERN.

Mr. MCGOVERN. Let me just say in closing, I want to associate myself with the comments of my colleague, Mr. JONES.

I also will insert in the RECORD two recent articles, one that appeared in The Washington Post, entitled ''U.S. Envoy Resists Increase in Troops: Concerns Voiced About Karzai,'' in which Ambassador Eikenberry apparently has raised many of the same issues that we have raised here, and the other from the L.A. Times, ''Ridding Afghanistan of Corruption Will Be No Easy Task,'' and it's an article that goes into great detail about the corruption that exists in Afghanistan.

[From the Washington Post, Nov. 12, 2009]

U.S. ENVOY RESISTS INCREASE IN TROOPS

(By Greg Jaffe, Scott Wilson and Karen DeYoung)

The U.S. ambassador in Kabul sent two classified cables to Washington in the past week expressing deep concerns about sending more U.S. troops to Afghanistan until President Hamid Karzai's government demonstrates that it is willing to tackle the corruption and mismanagement that has fueled the Taliban's rise, senior U.S. officials said.

Karl W. Eikenberry's memos, sent as President Obama enters the final stages of his deliberations over a new Afghanistan strategy, illustrated both the difficulty of the decision and the deepening divisions within the administration's national security team. After a top-level meeting on the issue Wednesday afternoon—Obama's eighth since early last month—the White House issued a statement that appeared to reflect Eikenberry's concerns.

''The President believes that we need to make clear to the Afghan government that our commitment is not open-ended,'' the statement said. ''After years of substantial investments by the American people, governance in Afghanistan must improve in a reasonable period of time.''

On the eve of his nine-day trip to Asia, Obama was given a series of options laid out by military planners with differing numbers of new U.S. deployments, ranging from 10,000 to 40,000 troops. None of the scenarios calls for scaling back the U.S. presence in Afghanistan or delaying the dispatch of additional troops.

But Eikenberry's last-minute interventions have highlighted the nagging undercurrent of the policy discussion: the U.S. dependence on a partnership with a Karzai government whose incompetence and corruption is a universal concern within the administration. After months of political upheaval, in the wake of widespread fraud during the August presidential election, Karzai was installed last week for a second five-year term.

In addition to placing the Karzai problem prominently on the table, the cables from Eikenberry, a retired three-star general who in 2006–2007 commanded U.S. troops in Afghanistan, have rankled his former colleagues in the Pentagon—as well as Gen. Stanley A. McChrystal, defense officials said. McChrystal, the top U.S. and NATO commander in Afghanistan, has stated that without the deployment of an additional tens of thousands of troops within the next year, the mission there ''will likely result in failure.''

Eikenberry retired from the military in April as a senior general in NATO and was sworn in as ambassador the next day. His position as a former commander of U.S. forces in Afghanistan is likely to give added weight to his concerns about sending more troops and fan growing doubts about U.S. prospects in Afghanistan among an increasingly pessimistic public and polarized Congress.

Although Eikenberry's extensive military experience and previous command in Afghanistan were the key reasons Obama chose him for the top diplomatic job there, the former general had been reluctant as ambassador to weigh in on military issues. Some officials who favor an increase in troops said they were surprised by the last-minute nature of his strongly worded cables.

In these and other communications with Washington, Eikenberry has expressed deep reservations about Karzai's erratic behavior and corruption within his government, said U.S. officials familiar with the cables. Since Karzai was officially declared reelected last week, U.S. diplomats have seen little sign that the Afghan president plans to address the problems they have raised repeatedly with him.

U.S. officials were particularly irritated by a interview this week in which a defiant Karzai said that the West has little interest in Afghanistan and that its troops are there only for self-serving reasons.

''The West is not here primarily for the sake of Afghanistan,'' Karzai told PBS's ''The NewsHour With Jim Lehrer'' program. ''It is here to fight terrorism. The United States and its allies came to Afghanistan after September 11. Afghanistan was troubled like hell before that, too. Nobody bothered about us.''

Karzai expressed indifference when asked about the withdrawal of most of the hundreds of U.N. employees from Afghanistan after a bombing late last month in Kabul. The blast killed five foreign U.N. officials.

''They may or may not return,'' he said. ''I don't think Afghanistan will notice it.''

Eikenberry also has expressed frustration with the relative paucity of funds set aside for spending on development and reconstruction this year in Afghanistan, a country wrecked by three decades of war. Earlier this summer, he asked for $2.5 billion in nonmilitary spending for 2010, a 60 percent increase over what Obama had requested from Congress, but the request has languished even as the administration has debated spending billions of dollars on new troops.

The ambassador also has worried that sending tens of thousands of additional American troops would increase the Afghan government's dependence on U.S. support at a time when its own security forces should be taking on more responsibility for fighting. Before serving as the commander of U.S. forces in Afghanistan, Eikenberry was in charge of the Afghan army training program.

Each of the four options that were presented to Obama on Wednesday were accompanied by troop figures and the estimated annual costs of the additional deployments, roughly calculated as $1 billion per thousand troops. All would draw the United States deeper into the war at a time of economic hardship and rising fiscal concerns at home.

Secretary of State Hillary Rodham Clinton and Defense Secretary Robert M. Gates have backed a major increase in U.S. forces to drive the Taliban from populated areas and provide Afghan security forces and the government the space to snuff out corruption and undertake development projects. They have argued that only a large-scale counterinsurgency effort can produce a strong Afghan government capable of preventing the

country from once again become an al-Qaeda haven.

Those views have been balanced in internal deliberations by the hard skepticism of other Obama advisers, led by Vice President Biden. They have argued for a more narrow counterterrorism strategy that would not significantly expand the U.S. combat presence.

The most ambitious option Obama received Wednesday calls for 40,000 additional U.S. troops, as outlined by McChrystal in his stark assessment of the war filed in late August.

Military planners put the additional annual cost of McChrystal's recommendation at $33 billion, although White House officials say the number is probably closer to $50 billion. The extra troops would allow U.S. forces to attempt to take back and hold several Taliban havens in the southern and eastern regions of Afghanistan.

One compromise option put forward by the Pentagon, with the backing of Gates, would deploy an additional 30,000 to 35,000 U.S. troops—fewer than McChrystal's optimal number to carry out his strategy—and rely on NATO allies to make up the 5,000- to 10,000–troop difference. The third option, known by military planners as "the hybrid," would send 20,000 additional U.S. troops to shore up security in 10 to 12 major population areas. In the rest of the country, the military would adopt a counterterrorism strategy targeting forces allied with the Taliban and al-Qaeda, primarily in the north and east, with fighter jets, Predator drones and Special Operations troops that leave a light U.S. footprint on the ground. The military puts the annual cost of that option at $22 billion.

The most modest option calls for deploying an additional 10,000 to 15,000 troops. While under consideration at the White House, the proposal holds little merit for military planners because, after building bases to accommodate 10,000 or so additional soldiers and Marines, the marginal cost of adding troops beyond that figure would rise only slightly.

[From the Los Angeles Times, Nov. 18, 2009]

RIDDING AFGHANISTAN OF CORRUPTION WILL BE NO EASY TASK

(By Alexandra Zavis)

Afghans have a name for the huge, gaudy mansions that have sprung up in Kabul's wealthy Sherpur neighborhood since 2001. They call them "poppy palaces."

The cost of building one of these homes, which are adorned with sweeping terraces and ornate columns, can run into the hundreds of thousands of dollars. Many are owned by government officials whose formal salaries are a few hundred dollars a month.

To the capital's jaded residents, there are few more potent symbols of the corruption that permeates every level of Afghan society, from the traffic policemen who shake down motorists to top government officials and their relatives who are implicated in the opium trade.

Cronyism, graft and the flourishing drug trade have destroyed public confidence in the government of President Hamid Karzai and contributed to the resurgence of the Taliban by driving disaffected Afghans to side with insurgents and protecting an important source of their funding.

With casualties mounting and a decision on military strategy looming, President Obama and other Western leaders are finding it increasingly difficult to justify sending troops to fight for a government rife with corruption.

This month, when Karzai was declared the winner of an election marred by rampant fraud, the top United Nations official in Afghanistan warned that without major reforms, the Afghan president risked losing the support of countries that supply more than 100,000 troops and have contributed billions of dollars in aid since the Taliban was toppled in 2001.

Karzai has publicly acknowledged the corruption and pledged to "make every possible effort to wipe away this stain." On Monday, the interior minister, national security director, attorney general and chief justice of the Supreme Court joined forces to announce a new crime-fighting unit to take on the problem.

But in the streets, bazaars and government offices, where almost every brush with authority is said to result in a bribe, few take the promises to tamp down corruption seriously.

"It's like a sickness," merchant Hakimullah Zada said. "Everyone is doing it."

In these tough economic times, Zada said, there's one person he can count on to visit his tannery: a city inspector.

The lanky municipal agent frowns disapprovingly when he finds Zada and five other leather workers soaking and pounding hides in the grimy Kabul River and demands his cut—the equivalent of about $40.

"He says we are polluting the river," Zada says. "So we have to pay every day. Otherwise, he will report us to the municipality, and they will close down our shops."

A 2008 survey by Integrity Watch Afghanistan found that a typical household pays about $100 a year in bribes in a country where more than half the population survives on less than $1 a day.

Government salaries start at less than $100 a month, and almost everything has its price: a business permit, police protection, even release from prison. When Zada was afraid of failing his high school exams, he handed his teacher an envelope stuffed with more than 1,500 Afghanis—about $30. He passed with flying colors.

The corruption extends to the highest government officials and their relatives. Even Karzai's brother, Ahmed Wali Karzai, has long been suspected of cooperating with drug barons, charges he denies.

Abdul Jabar Sabit, a former attorney general who between 2006 and 2008 declared a jihad, or holy war, against corruption, said he quickly learned that a class of high-ranking officials is above the law. They include members of parliament, provincial governors and Cabinet ministers.

"I wanted to tear that curtain down, but I could not do it," he said over tea in his modest sitting room at the top of a rundown apartment block.

As required by the constitution, he said, he wrote repeated letters to parliament requesting permission to investigate charges against 22 members ranging from embezzlement to murder. "Despite all my letters, the issue never made it onto the agenda of either house," he said.

Sabit estimates that he filed corruption charges against more than 300 provincial officials before he was dismissed in 2008. Few were convicted, and "none of them are in jail now," he said.

Obama and other world leaders have told Karzai that they expect him to take concrete steps to back up his promises to fight corruption. Karzai counters that donor countries share responsibility for the problem because of poor management of the funds pouring in for development projects, a concern shared by U.N. officials.

Among the practices raising alarm is the so-called flipping of contracts, which are passed along from subcontractor to subcontractor. Each one takes a cut until there is little money left for the intended project. The result is often long construction delays and shoddy workmanship.

Many foreign and local observers think Karzai can't begin to address corruption until he severs ties with former warlords who helped drive the Taliban from power in 2001 and shored up his administration when U.S. attention was focused on Iraq.

U.S. and other Western officials are pressing Karzai to form a government of competent professionals. But he will have to balance their demands against promises made to ethnic and regional strongmen who helped deliver the votes he needed for a second five-year term.

Western officials were particularly troubled by the recent return from Turkey of Abdul Rashid Dostum, a notorious former warlord who endorsed Karzai's campaign. He is accused of overseeing the deaths of up to 2,000 Taliban prisoners during the 2001 invasion, charges he denies. Karzai's two vice presidents, Mohammad Qasim Fahim and Karim Khalili, are also former warlords accused of rights abuses.

"There are also new figures who will try very hard to get their supporters in government," said Fahim Dashy, editor of the independent Kabul Weekly. "They are coming with empty pockets and they will see this as a golden opportunity to make money, either by legal or illegal ways."

Karzai has said there will be no place in his government for corrupt individuals. But his aides say that dismissals alone won't solve a pervasive and systematic problem.

An investigation by the High Office of Oversight and Anti-Corruption, set up more than a year ago to oversee the government's efforts to fight graft, found that on average it took 51 signatures to register a vehicle. Each signature had its price, for a total cost of about $400.

"It is hardly surprising if Afghans prefer to bribe policemen on a daily basis to turn a blind eye to their unregistered vehicles," said Ershad Ahmadi, the bureau's British-educated deputy director.

Ahmadi said his office helped streamline the process to four or five steps, and it requires that payments be made directly to the bank, thereby reducing the opportunities for corruption. But without the minister of transportation's cooperation, he said, his team would have been powerless.

"We do not have the necessary powers and independence to fulfill our mandate," Ahmadi said. For a start, it was never given the legal authority to investigate or prosecute corruption—only to refer cases to law enforcement agencies, themselves part of the problem.

"The police are corrupt. The prosecutors are corrupt. The judges are corrupt," Ahmadi said.

It was not clear whether the new anti-corruption unit, which was set up with the help of U.S. and British law enforcement agencies, would be more effective at pursuing individuals who indulge in corrupt practices. It is the third structure set up by Karzai's government to tackle the problem; the first was disbanded after it emerged that the head had been convicted and imprisoned in the U.S. on drug charges.

"The main problem . . . is that people have no confidence about the future," Ahmadi

said. ''That makes them make hay while the sun shines.

''We need to persuade the people of Afghanistan that there is no returning to the miseries of the past,'' he said. ''The Taliban is not coming back. The international community is not abandoning Afghanistan, and there is going to be slow but steady improvement.''

Let me just say, finally, it doesn't take a lot of guts for a Member of Congress to stand up and say, Send more troops. And certainly I guess some think it is easier, more popular to say, Let's send more troops. The more troops we send, we can appear tough on terrorism. All of us want to be tough on terrorism, but what we're arguing here is that what is happening in Afghanistan is not helping us in the war against terror. If it was, if this was a war about holding to account those who committed these terrible atrocities on September 11, I wouldn't be here questioning what we're doing.

I think we're getting sucked into a war with no end. This is a quagmire. There is no end to this. And if we're going to enlarge our military footprint, then I think it is important for the American people to know that we're going to be there for a very, very long, long time; longer than any of us will be in Congress, longer probably than we're going to be on this Earth, that is how difficult it is in Afghanistan. I think, as Mr. JONES said, that we owe it to the men and women who serve in our Armed Forces to make sure that if we're going to send them into harm's way, that we had better be sure that we are doing it because the national security interest of this country is at stake.

I don't like the Taliban. They are a bad group of people, but they are not a threat to national security of the United States. We need to help the Afghan people because they have been neglected, and they have been abused for so long by so many people. We need to figure out a way to do that, and I think we will have better luck and we will encourage more sustainable development without a large military footprint.

But I'm going to end by saying that, at a minimum, we need to know what the exit strategy is here. When the President, after his deliberation, comes up with his policy, he needs to tell us how this all comes to an end, because I think that is the responsible thing to do. We owe that to our troops. We owe that to the American people. This war has already cost us too much in terms of treasure and human life. I've been there. I think we need to change our policy dramatically, but we need to have this debate. We should not send one more American soldier over to Afghanistan without a full and thorough debate on this House floor about whether that's the right thing to do. And then every Member of this House, Republican and Democrat alike, will have to vote on it.

I am proud of this group that has gathered here today to continue to raise this issue. Mr. KAGEN, I want to thank you in particular for getting us all here tonight. This is an important issue. This is probably one of the most important issues that we're going to deal with during our service in Congress. I hope we get it right. And to me, getting it right is to change our strategy and begin a flexible exit strategy.

I thank the gentleman and yield back.

Mr. KAGEN. Thank you, Mr. MCGOVERN. There has never been a more important time in our Nation's history to get it right, to think it all the way through, and to make certain that we carry out our constitutional duties here in the House of Representatives.

Mr. PAUL.

Mr. PAUL. I would like to just make one more comment as we close the Special Order.

I opened my remarks talking about Barbara Tuchman's ''The March of Folly.'' We are on the same course. I would say it's time to march home. I'm not for sending any more troops. It is very clear in my mind that if the job isn't getting done and we don't know what we're there for, I would say, you know, it's time to come home, because I fear—and it's been brought up. Congressman MCGOVERN has brought it up, and everybody's talked about the finances of this because it is known that all great nations, when they spread themselves too thinly around the world, they go bankrupt. And that is essentially what's happened to the Soviet system. They fell apart for economic reasons.

So there are trillions of dollars spent in this operation. We're flat-out broke, a $2 trillion increase in the national debt last year, and it just won't continue. So we may not get our debate on the floor. We may not be persuasive enough to change this course, but I'll tell you what, the course will be changed. Let's hope they accept some of our suggestions, because when a Nation crumbles for financial reasons, that's much more dangerous than us taking the tough stance and saying, It's time to come home.

Mr. KAGEN. Thank you, Mr. PAUL.

Mr. JONES, go ahead, and I will wrap up afterwards.

Mr. JONES. I will be brief. I know time is getting limited. I want to thank you, Mr. MCGOVERN and Mr. PAUL for being here tonight because I've seen the pain as you mentioned earlier of PTSD, of TBI. I have seen the families when a marine came back and who needed counseling, and before it was all said and done, he killed his wife. We do not need to put these men and women under this pressure unless we know what we are trying to achieve and the end point. We need to have this debate. We will figure out some resolution that the four of us and other Members of Congress can force this House to come forward and have this debate.

Thank you for letting me be a small part of tonight.

Mr. KAGEN. I want to thank you, Mr. JONES, Mr. PAUL, Mr. MCGOVERN for this commencement of a conversation and a real discussion about what America's best interests are. I know that when we put our heads together, put our minds together, we'll find a more positive way forward in beginning to solve this problem. I will finish with a brief story.

In 1979, I was in training, in Milwaukee, at the Medical College of Wisconsin, and there training in the specialty of allergy and immunology with me was the son of a senator of Pakistan. And that was the time when Russia invaded Afghanistan. I came into the laboratory, and I said, Nassir, your country is going to be next. And he looked up at me, and he said, Oh, Steve, don't worry. It's easy to get into Afghanistan. It's very hard to get out, and when the Russians leave in 5 or 10 years, they'll be shot in the ''blank'' when they leave.

That same experience is being experienced today by our soldiers, by our Nation, by our pocketbook. So every time we hear about someone being wounded and injured, whether it's our own soldier or a civilian or an enemy, that bomb and that bullet has real echoes economically here at home. In the end, the exit strategy may be determined, as Mr. PAUL said, by our economy. The question is: Will the strategy work? Can we afford it? And is it the ethical thing to do?

At this point in time, I don't believe we can afford to stay on the current path we're on in Afghanistan and in Iraq. We have to make certain that our soldiers are safe here at home and that we have an economy that can support all of the people that we have the honor of representing.

□ 1930

AMERICA'S ROLE IN THE WORLD

The SPEAKER pro tempore (Mrs. HALVORSON). Under the Speaker's announced policy of January 6, 2009, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes.

Mr. KING of Iowa. Thank you, Madam Speaker. I appreciate being recognized to address you here on the floor of the House of Representatives.

Listening to the dialogue of the gentlemen in the previous hour, I generally have a pattern where I will discuss a bit of different viewpoints.

And returning to that subject matter, I understand their concern for military personnel and their families, for the lives and the health of all of our brave military personnel. In fact, I sympathize and support our military personnel and their families and the

entire support network that is there. I've been six times to Iraq, twice to Afghanistan; and I meet with our military personnel as often as I possibly can. And, yes, like every congressional district—and perhaps every congressional district—we've lost soldiers and we've lost airmen and we've lost marines and we've lost sailors. And that has been the case, and it's ever been thus.

So as I listened to the gentlemen who argue that we should have a debate on the floor, it seems as though they come with a common purpose of arguing that we should not be in Afghanistan.

I would make the point, Madam Speaker, that they made the same argument when we were in Iraq. And the points that they made then were very similar to the points that are being made now and that is the position that it's not worth the price. It is a legitimate position to discuss, but I believe it is the one to have that debate before we engage in a war rather than when we're in the floor of it because the dialogue from the floor of this House echoes to our enemies; and they begin to wonder whether the Americans have the resolve to persevere and bring about the sustained effort that's necessary in order to win a war, especially a war that is protracted with an amorphous enemy that is scattered throughout the mountains that has sometimes the support of the network.

The Taliban is our enemy and al Qaeda is our enemy, and there are another six or seven organizations in that part of the world who are defined organizations that are our enemies, Madam Speaker.

But the position taken by these Members back during the Iraq war was to pull out, pull out at all costs, pull out immediately. Simply leave a rear guard to try to avoid being shot in the back as our troops loaded out of Iraq. Let it collapse, if that's what it would be. But they argued it wasn't worth the price—at least some of them, and I believe all of them, that were on the floor taking this position tonight.

And yet in spite of the naysayers, in spite of the distraction, in spite of the 45 votes that were brought to the floor of this Congress and led by the Speaker of the House, NANCY PELOSI, those votes were designed to undermine, unfund, and to damage the resolve of our troops. Those votes that came to this floor—and I have a collected Excel spreadsheet that links to each one of those resolutions, each one of those votes, 45 votes and debates on the floor of this House—these Members can't argue that we didn't have the debate on Iraq. It was pushed by the Speaker of the House. And whatever the motives, it demoralized our troops and encouraged our enemies.

And the result of those resolutions and different acts that were brought to this floor was that this Congress stuck together. This Congress didn't crack. We stood with our military; we stood with our troops. We're at a time of war. And a decision was made, and this Congress made the decision to go into Iraq and to provide for the authority for the President of the United States to command the military forces to do what was necessary to protect the American people. We were operating off the best information we had at the time. That's what any nation does at any time in any crisis. And I think at any time in history if there has been a question whether it was a right decision, there's always the question of what was the information they had to work with at the time.

Regardless, the situation remains this: the people that were here on the floor that would like to pull us out of Afghanistan immediately are the ones who also predominantly were for pulling out of Iraq immediately. We know that the President of the United States, the current Commander in Chief, as a candidate for the Presidency, argued that Bush had taken his eye off the ball, that the ball was Afghanistan and the target was Osama bin Laden and that he would bring Osama bin Laden to justice. Even denigrated Senator JOHN MCCAIN for saying he would follow Osama bin Laden to the gates of hell if necessary, but not being willing to take on some of the tasks that the President thought should be taken on.

And so our current President, our current Commander in Chief, as a candidate and United States Senator, continually made the speech that President Bush had taken his eye off the ball, if the ball was Osama bin Laden and Afghanistan, and that we should immediately pull all of our troops out of Iraq without regard to those consequences, and diminished the calamity that almost certainly would have ensued.

And that calamity, just to paint that picture again, Madam Speaker, for the American people's benefit, the calamity that was pending in 2005, 2006, especially early 2007 and on into 2008, would have likely been this scenario: if we'd pulled out, the Kurds would have likely declared independence and found themselves in a two-front war: Iran on one side that had been throughout those years lobbing artillery rounds into Kurdistan, and war with the Turks on the west side who have gone in and done several raids against the Kurds there in the last few years.

So there's that open-arm conflict that exists on the east and west border of Kurdistan that likely would have swallowed up the Kurds that would not have had the help of the United States if we had pulled out of Iraq, and neither would they have had the help from Iraq because the Iraqis themselves were having significant difficulty in providing security for their own people.

Other problems that we had were militia groups that were warring against each other, Sunnis and Shias and the power vacuum that brought about this violence. There were neighborhoods that were purged and taken back over again. And we had, if not forgotten, the Mahdi militia and the other militias that had emerged within Iraq that were in the process of enforcement, and some might say ethnic cleansing and sectarian violence.

And al Qaeda was entrenched in the al Anbar province. Al Qaeda ruled al Anbar province. Al Anbar province was so bad that I could not go there during that period of time throughout all of 2006 and probably well before then. The cities of Ramadi and Fallujah had been fought over, and they needed to be fought over again before they could be liberated for the Iraqi people to take control of.

That was the scenario. And not only that, the great threat of the Iranians and their involvement and engagement in subversive activities across their border into Iraq was all part of this competition that was almost—almost—a military, political, economic conundrum.

And you have most of the oil in Iraq is over against the Straits—very, very close to the oil that's in Iran. And then in the south where you had the Shias, the Shias had some affinity to the Iranian Shias.

So that entire scenario, the worst-case scenario that I can paint for this—and it's the one that actually looked like it was the most likely it would be if the United States had pulled out of Iraq and an instantaneous sectarian violence situation where the Shias and the Sunnis would go at each other in an unrestrained way, where al Qaeda would have continued to maintain al Anbar province and expand their hold and a base camp for the world, the predictions—and they still remain true—that there are significant oil reserves in al Anbar province that would have been the wealth of that oil that could have gone into the pockets and the treasure chest of al Qaeda and funded their global operations.

The only significant refinery—I will say it this way—the most significant refinery in all of northern Iraq is in al Anbar province where Saddam put it so he could bring the Kurdish oil down and control the oil from Kurdistan for political reasons. That could have all been an al Qaeda base camp with lots of oil to fund it.

And it could have been the Shias and the Sunnis and the remaining Shias at battle with each other, and the Iranians making common cause with the Shias and taking over the oil fields in the south of Iraq where about 70 percent of the oil is and having control of both sides of the Straits of Hormuz and control of a lot more of the oil in the world, and the ability to shut off

around 40 percent of the world's oil while the Kurds find themselves in a two-front war having declared independence.

That's just part of what would have happened if we had pulled out of Iraq, Madam Speaker. That was the advice of the gentlemen on the floor that argue against our involvement in Afghanistan.

And today, today, due to a brave and difficult decision made by our then-Commander in Chief, George W. Bush, who ordered the surge, that the courageous notion of investing American might and preserving a victory that may have been achieved in March and April and May primarily in 2003 that needed to be reachieved in a number of the cities that were taken over by al Qaeda and other forces that were contrary and in opposition to the United States, that order for the surge and noble bravery of our military, of all branches of service, came together in Iraq and provided the kind of security that has allowed the Iraqis to develop their own security forces.

And those forces now exceed—by the time—if you talk all of their security forces, they meet and exceed a number in the area of 600,000 that are providing for the safety of the Iraqi people.

The stability in Iraq today? Even though there are flareups of violence and flareups of suicide bombs that take place from time to time, there is a control of that country that has been taken over by the Iraqi people exactly within the design of President Bush—but not something that the gentlemen that spoke ahead of me could actually admit to, I don't believe, the level of success in Iraq.

I did introduce a resolution in February of this year that declares that we have achieved a definable victory in Iraq, and it defines the victory and it lays out the milestones along the way. A definable victory and by measure of a civil government that can provide for safety and security for its people at a level significantly higher than it was. American casualties that went down to the point of where it was as likely that we would lose an American in Iraq due to an accident as to the enemy.

The civilian government establishments there, the distribution of the oil revenue, the list of accomplishments ratifying a Constitution far faster than we were able to do so in the United States when we established our first Constitution. The drafting and the writing and the passage and the ratification process in its entirety were quicker in Iraq than it was in the United States of America.

So of all of the milestones, of all of the benchmarks that were imposed by this Congress on the Iraqi Government and the Iraqi people and the responsibility of our President Bush at the time and the Commander in Chief of our military and our military personnel, of the 18 benchmarks, 17 of the 18 benchmarks—even as of last February—had been wholly or substantially achieved. And the 18th benchmark was an amorphous benchmark that is moving in that direction. What matters is how you define it.

That's what happened. We've achieved a definable victory in Iraq, and that accomplishment was done not because of people who wanted to pull out, that didn't have the resolve, that didn't understand the price that America pays down the line for lack of resolve in this moment of history.

I would use an example, Madam Speaker, and that would be on June 11 of 2004, I was sitting in a hotel room in Kuwait City waiting to go into Iraq the next morning. And I was watching Al-Jazeera TV. And on Al-Jazeera TV, June 11, 2004, with the English closed-caption, Moqtada al-Sadr came on—the head of the Mahdi militia who gave us so much trouble. And he said—judging by the closed caption that I read, and presumably it was in Arabic—he said, If we continue attacking Americans, they will leave Iraq the same way they left Vietnam, the same way they left Lebanon, the same way they left Mogadishu. He was predicting that the Americans would not have the resolve to achieve a victory in Iraq.

And had that been the case, if the President of the United States, if the balance of the Republicans in this Congress and some of the national security Democrats had not had resolve, today we would be seeing the calamity in Iraq that I have just laid out as the likely scenario. And we would also be listening to Osama bin Laden and perhaps Khalid Sheikh Mohammed before a courtroom in New York say, Well, the Americans left Vietnam, and they left Lebanon, they left Mogadishu, and they pulled out of Iraq. Americans don't have resolve. All it takes to defeat American might is persistence and perseverance and a willingness to fight a war of attrition and accept the casualties. And if you do that long enough, Americans will lose their patience and will lose their will. That was the message that Moqtada al-Sadr got. He said it directly into Al-Jazeera TV, June 11, 2004. It was the message that Osama bin Laden got when he was inspired to attack the United States because he didn't believe that we had the resolve to strike back or the resolve to keep the pressure on.

☐ 1945

And because America sent a weak message—Vietnam, Lebanon, Mogadishu—it inspired our enemies to take us on and challenge us because if they see a sign of weakness, that is where they would attack.

The Japanese didn't think that America had that kind of resolve when they attacked us on December 7, 1941. We did show the resolve when we were attacked, and we showed the resolve after September 11, 2001, and we need to show the resolve in Afghanistan, although it is a much more difficult nut to crack. To that extent, I will give my colleagues in the previous hour their due.

My first trip to Afghanistan, it was in the middle of the most difficult times in Iraq, when most didn't see a way out that would be victorious in Iraq. I came back and said, We will be in Afghanistan a lot longer than we will be in Iraq because Afghanistan is a lot closer to the Stone Age than Iraq. They don't have the transportation. They don't have the infrastructure. They don't have a modern education system. They are living closer to the Stone Age. There is only one highway that transfers assets across the country, and that is a highway that we turned into a paved highway. Other than that, it was a trail.

The Afghanis, many of them live up in valleys in the mountain, and that zone in a particular valley is where the tribe is. So it is much more difficult to maintain security in a country that has been at war and has been able to reject or eject any of its conquerors.

The difference is that Americans are not invaders and occupiers. We are liberators. Where we have gone, we have liberated people. And wherever American soldiers have gone, there has been a tremendous blessing that is left in the aftermath, especially if we stay and pass along American values.

Some few years ago, I was at a hotel here in downtown Washington, D.C., to hear a speech from President Arroyo of the Philippines, and I guess this was about 2004. She said, Thank you, America. Thank you for sending the Marine Corps to our islands in 1898, thank you for freeing and liberating us. Thank you for sending your priests and pastors who taught us your faith. Thank you for sending us 10,000 American teachers—and she had a Filipino name for them which I missed—and the American teachers and the priests and pastors and the soldiers.

She forgot to mention actually the Army, she said marines, they taught us the American way of life. You taught us the English language. You taught us the values, and I will summarize it in my words, not hers, the values of Western civilization. She said today, 1.6 million Filipinos leave the islands to work wherever in the world they want to go, and they send a lot of their money back to the Philippines, representing, and she gave the number, but a high percentage of the gross domestic product of the Philippines.

The benefit of having the American civilization arrive in the Philippines is evident more than 100 years later, and we are thanked for it by the President of the Philippines.

And now we look around the world and we see, is Japan better off or worse

off in the aftermath of Imperial Japan, in the aftermath of Hiroshima and Nagasaki? Is Japan better off because the Americans went into Japan and helped set up a free market capitalistic system, a system of representative government that is no longer run by the Emperor that our Commander in Chief gave a 90-degree bow before a couple of days ago?

Madam Speaker, I wasn't particularly alarmed when I heard that the President had bowed to the Emperor of Japan until I saw the videotape of the President of the United States bowing 90 degrees. It was almost a genuflection before the Emperor of Japan, so far different than it was before the ceremonies of surrender on the USS Missouri. And never in the history of the country do we have the record of a President of the United States bowing before any foreign leader, and no President of the United States should ever bow before another foreign leader. And yet we have seen this happen and we have seen this unfold around the country, around the world, a global tour of contrition that has diminished the power and the influence of the United States.

Some Nation has to be the superpower in the world. We should have adjusted to this fairly easily. It was a struggle that we were involved in. At the beginning of the Cold War, and you can pick your date on when that starts. Was it the blockade that brought about the Berlin Airlift? Was it the 1948 speech at Fulton, Missouri, when Winston Churchill laid out the identification of the Cold War when he said an Iron Curtain has descended across Europe? But some place between 1945 and 1948, the Cold War began.

The Russians and the East Germans began building their Berlin Wall in 1961, and that wall stood until November 9, 1989. That period of time clearly is Cold War time, and you can expand onto that, back it up to about 1948 or earlier, and the Cold War wasn't quite over for some months after the Berlin Wall started to come down, about the time the Soviet Union imploded, and the date I will pick on that, the specific date, would be December 31, 1990. That is about as close a date as we can get to the end of the Soviet Union.

At that period of time, we could celebrate that the Cold War was over and that the United States of America had emerged as the world's only superpower, and that this contest, this struggle, that was between this communism, hardcore socialism, militarily imposed economies with a regime that believed that the person, the individual, the human being, God's unique gift of the now six billion plus of us on this planet, that people existed for the State. That was their position. That was Karl Marx's position, and that is what has evolved in the thought process of the utopianists for 150 or more years.

And yet we saw the Soviet Union implode after we saw freedom echo across Eastern Europe in nation after nation. We just celebrated yesterday or the day before the Velvet Revolution in Czechoslovakia, where thousands and thousands of Czechs stood in the square in Prague peacefully and held their keys up, Madam Speaker, and rattled their keys for hours on end, rattling their keys for freedom. We can hear what that is like. That echoes back 20 years, and we saw Vaclav Havel step forward and become the leader of that nation, and they divided it into the two separate parts also in a peaceful way.

A little bit of violence along throughout Eastern Europe, but from the standpoint of the hundreds of millions of people who became free in the aftermath of the fall of the Berlin Wall, and part of that was the Velvet Revolution in Czechoslovakia, the maximum number of people breathe free air for the least amount of blood I believe in the history of the world, and that freedom echoed, I would argue then, all of the way across Eastern Europe, from the wall in Berlin, all of the way across Eastern Europe, all of the way across Russia, all of the way to the Pacific Ocean, at least for a time.

And the optimism that I had, and that hope, that faith, that belief that the Cold War was really over and that then the free market capitalism and the freedom that we have that the rights—our rights come from God, and they are enumerated in our Constitution, but they are God-given rights, we hold these truths to be self-evident, that the image of that, the inspiration of our freedom and the power of the free market system had set aside, had pushed away, had defeated every competing model for a civilization that had been designed by the world, Madam Speaker.

I have to characterize this another way, more succinctly in the words of another, and that was Jeanne Kirkpatrick who in the early part of the Reagan administration was the ambassador to the United Nations. Jeanne Kirkpatrick, as she stepped down as ambassador to the United Nations to pursue other endeavors, she said, What is going on in this Cold War is this: That the Soviet Union and the United States of America, these two superpowers clashing in this Cold War, are the equivalent of, the contest is the equivalent of playing chess and monopoly on the same board. With our free market economy and monopoly, and with the Soviet Union's massive buildup in military ability, she said playing chess and monopoly on the same board, and the only question is will the United States of America bankrupt the Soviet Union economically before the Soviet Union checkmates the United States militarily. Chess and monopoly on the same board. Do the Russians go bankrupt before they checkmate us with their ICBM missiles and their other military equipment and hardware, the massive military that they were developing?

We know the answer to that now. That was about 1984 that Jeanne Kirkpatrick made that statement. And November 9, 1989, and the ensuing months up until the last day in 1990 when the Soviet Union was I think officially imploded, we saw that free market capitalism, freedom, the inspiration of the rights that come from God that are enumerated in our Constitution and that flow, that the government is of, by, and for the people, and that the people grant the authority that comes from God to their legitimate elected representatives to govern them in an orderly fashion, that that system of government, our constitutional Republic prevailed, prevailed over the utopian mistake, the colossal error that cost the lives of hundreds of millions of people, Karl Marx's approach to utopianism. That is what we saw happen, Madam Speaker.

I believed then, in 1989, in the early winter of 1989 and throughout 1990, 1991, through the early part of the 1990s until the late 1990s some time, I believed that it was clear to the rest of the world that freedom had won, that free market capitalism had won. I didn't think it was arguable, and I thought somehow that those leaders in the world would realize the reality that they couldn't compete with a system that tapped into the vitality of the inspiration of every individual who had their own franchise and their own opportunity and their own rights to engage in making their lives better for themselves and their family, and to do so in a moral and ethical fashion within the framework of the rule of law. I believed the rest of the world would see that clearly.

Look at Eastern Europe, the region that so recently had won its freedom: How could they begin to think in this myopic, utopian fashion of, let's say, of Marx and Hegel and others that are part of the utopian philosophers in that part of the world. How could they think that? So they went underground for awhile and they drifted away and they became this amorphous, loosely and most often disorganized group of people who were still Marxists, they were still Communists, they were still believers in a managed society, a managed economy, a utopian world, the kind of world where liberal-thinking elitists would manage the resources of humanity and that every human being was a tool of the state and you were there to glorify the state.

And so they emerged again, Madam Speaker. And as they emerged, they began to form alliances against the United States. And those alliances that were formed brought about these alliances that we are faced with today.

I mean, it wasn't unpredictable that the Islamic fundamentalists would rise

up and begin to attack the United States. That wasn't unpredictable. In fact, it was predicted, not by me, but by other people who had an insight into human nature and history that went beyond the things that I could sense at that time at least.

And so we have seen the philosophy of ''the enemy of my enemy is my friend.'' There is a certain factor, and I will just called it national jealousy, that envy factor that comes into play. Europe had lost a lot of its glory. They had formed in the 1970s, at least, and perhaps earlier than that, the European Union. The goal of the European Union was to establish the United States of Europe, to establish the United States of Europe incrementally by a common currency and opening up borders and providing for open and free trade in the European Union.

It was designed and it was in print as a policy position and objective and a goal. And the mission statement was to shape the European Union into the United States of Europe and to provide, quote, ''a counterbalance to the United States of America,'' close quote.

You can see where Europe didn't like the idea that the United States of America—the progeny of Europe is what we have been—could become the unchallenged superpower in the world. So that resistance and objection emerged from Western Europe, the Western Europe that represents, I think, the ancestors to modern day Western civilization. But there is a little nation envy that goes on, and there is an aspiration of a wannabe in trying to make the world a better place.

In Eastern Europe they hung onto their freedom a little bit more, and I have observed that those people who have most recently achieved their freedom are the ones who protect it and guard it the most jealously. That has been the case with the Eastern Europeans who remember what it was like to live under the yoke of communism who celebrated in this month, and will celebrate every November 9 of every year from here on, the fall of the Wall, the literal crashing of the Iron Curtain and the end of the Cold War and the beginning of freedom that echoed across Eastern Europe, and by some estimations all of the way across Asia to the Pacific Ocean, until the utopianists, the control people, the dictators began to emerge and to take away the freedoms.

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We believed, I think, for some time that in Russia, the remainder of the old Soviet Union, that they had that level of freedom that the people in Russia wanted. We believed they had free elections and freedom of press and a free market economy. At least it was emerging, and people were willing to learn how to compete in a free market economy. But today we see that Putin has diminished that dramatically, that the elections are not the legitimate elections that we had hoped we would see in Russia, that free market capitalism is instead controlled often by a Russian mob, a Russian mafia, and favoritisms that take place and the payoffs that go on within indicate a corrupt society that's now run for the glorification and the power and the enrichment of the rulers. That's the case in a number of other countries in the world.

But we're unique here in the United States of America. Madam Speaker, we're a unique people. And, yes, we are the progeny of Western Europe, and we are the progeny that came from primarily Western European stock. And at the time that we received the best that Western Europe had to offer, we also received a fundamental Christian faith as the core of our moral values.

This is a Judeo-Christian Nation, Madam Speaker. The core of our moral values is embodied within the culture. Whatever church people go to or whether they go to church, wherever they worship or whether they worship, we still have the American people who, as a culture, understand Christian values and Christian principles, the Judeo-Christian values that are timeless.

So I would illustrate that, Madam Speaker, in this way. An example would be this: Let's just say if an honorable man from Texas were to pull into his driveway and his neighbor's dog had gotten loose and had run underneath the tire of his car. If you're in Texas or Iowa or most of the places in the country, if you run over your neighbor's dog, what do you do? This is how I'm going to illustrate this is a Christian Nation. You go over and knock on your neighbor's door and you say, Well, Joe, I just killed your dog. I'm sorry.

Well, there are two things that happened there. One of them is confession, I just killed your dog. I'm sorry, his repentance. The third thing you say is, Will you forgive me? I didn't mean to. It was an accident. So you would have confession, repentance, and you ask for forgiveness. And the neighbor, Joe, will say, Well, it wasn't your fault. Of course you're forgiven. And that is the path of Christian forgiveness that takes place even when we run over our neighbor's dog.

This is a Christian Nation, and the foundation of Western civilization are those kinds of values. And this is rooted going as far back as the Age of Reason in Greece where the foundations and the principles of logic and reason and science were developed, and it flows through Western civilization into the division of the Age of Enlightenment that took place, the English speaking half where we got our free enterprise and our freedom from and the non-English-speaking half of the Age of Enlightenment where we got a lot of these utopian ideas that flowed down here. And some of them have polluted the thought process, and they clearly pollute the thought process here in the United States Congress where many have suspended their ability to reason.

I recall even this week being criticized by a professor of political science who assigned me a belief system and then attacked the belief system that he assigned to me. You wouldn't have gotten by with that in front of Socrates or Milton Friedman, for example, and you shouldn't get by with that in this society either. If person after person in this Congress takes the posture that we should be legislating in part by anecdotes and by feelings and by emoting, by something sympathetic so that no one falls through anything, that we create a sieve that there are no cracks in, truthfully, Madam Speaker, society doesn't work that way. There is good and there is evil in all of us.

We're predominantly good. We have to punish the evil and reward the good. And our job in this Congress is to enhance and increase in public policy, to the extent we can, the average annual productivity of our people. And if that is brought about in a moral fashion, that improves the quality of life, the standard of living of everyone in the United States of America, and it strengthens us from a military, economic, social, and cultural standpoint. And we are being weakened by people who undermine our national security, by people who are constantly assaulting free enterprise, capitalism, by people who are constantly assaulting the rule of law. And the rule of law does apply and it applies in securing our borders.

I see my friend from Missouri has arrived on the floor, and whatever is on his heart at the time, I'd be so happy to yield to the gentleman. The gentleman from Missouri (Mr. AKIN).

Mr. AKIN. I thank my good friend from Iowa for yielding.

A number of the different words that you're using are so important to the foundation of the whole logic of how the American system works. You were talking about the idea of a rule of law, and that's one of those terms that sounds pretty straightforward. We believe in the rule of law.

What's the alternative to the rule of law? We have been seeing a whole lot of it this year. The alternative to the rule of law is special deals. If you recall, rule of law is depicted frequently by the marble statue of Lady Justice. And she has the blindfold across her eyes. She's holding up the scales. And regardless of who you are, man or woman or big or little or rich or poor, Lady Justice just simply says, Just the facts. So that's what is called the rule of law. People are equal before the law. But the alternative to that is, of course, rule by whims of mankind. It's special deals.

Mr. KING of Iowa. It could be anarchy.

Mr. AKIN. So we have the ''too big to fail'' rule. So we tax Americans, not so much Americans that live now but their grandchildren we're going to tax, and we pass these things like the porkulus bill, which is supposed to be stimulus, and we pass the Wall Street bailout. We take all this money and we give it to whom? Every small mom and pop shop that might fail? No. We give it to the ''too big to fail.'' So, therefore, you've moved from the rule of law to a special deals society. And that's the problem. Of course, that's really what socialism is. It's special deals administered by guess who, Big Brother government.

That's not what made America great. That's not what allowed our great Nation, my good friend Congressman KING, that's not what allowed us to have a list of the different nations throughout the world that Americans freed from horrible dictatorships. That's a long list. I saw it actually listed on a cartoon. It had the list of all of these countries that American GIs and that American treasure through the ages have freed. Places like Germany. Places like Japan where you have some dictator, where we went in and we freed them from that. Places like Grenada, where our sons and daughters went in and took a risk and left a free country. That's not why we were able to do that because we're another socialist Big Government-run country. It's because we're a country that was based on a different set of principles.

The thing that strikes me the most, and I don't want to overuse the welcome that you've extended to me, is this. There was a country not so many years ago, and this is how their thinking worked: They said, look, if you've got somebody and they don't have a house to stay in and it gets cold in the winter, they're going to freeze to death. And if they don't have food to eat, they're going to starve to death. And if they don't have medical care, they're going to die of some kind of medical condition. So they ought to have a right to housing, a right to food, a right to health care. And if they haven't had an education and they can't read, they ought to have a right to know how to read and to study and be educated. So that government created those rights for its citizens, and they marched forward boldly into the future until they became bankrupt and were disbanded. And it was called the Union of Soviet Socialist Republics. We call it the USSR. And we knew it wasn't a very good system because it was based on communism and socialism.

Yet here in America, we have heard, even as I have stood here on the floor with you my friend, Democrats say that you have a right to health care. So as a government, we are now saying that we're going to have the government get involved in housing. The government's going to get involved in food, in food stamps. The government is now going to take over health care. The government has now taken over most of the loans for colleges and education. And it's like how come we're repeating the same things that the Soviet Union did and anticipating that we'll get different results?

Instead, our Founders had a different concept. They said that our rights are basic things that come from God. In our Declaration of Independence, all are endowed by their Creator with certain inalienable rights. Among these are life, liberty, and the pursuit of happiness. If you'll note, those rights are not rights to something that somebody else has a claim to.

Those of you from Iowa do some farming. I think you grow some corn in Iowa. I know we do some in Missouri, but our next-door neighbor does a lot of wheat and corn. And when you have one of your Iowa farmers combine the sweat of his brow with the produce from the field, they own that corn. It is their corn because it was grown on their land. They worked hard and it belongs to them. We call that private property. We call that free enterprise. And because I'm hungry doesn't give me a right to something that belongs to someone else. That's theft. That's stealing. And if the government takes someone's corn and gives it to someone else who didn't grow it, that's called stealing, except we just call it institutionalized theft. That's socialism. You never have a right to something that's the unique property of another person.

The Founders said you have a right to your life because God gives that uniquely to an individual. You see, you have a right to liberty because God gives you just one life and you can go choose a career of your choosing. Nobody else chooses your career. You get to do it yourself. But it doesn't say you own somebody else's career and should tell them what they should do with their life. That's what the Soviet Union thought.

So our system was based on freedom, was based on limited government; limited in the sense that it was the job of government to protect just those basic rights that God gives to all men. And we have been setting aside that formula that works, instead trying to adopt something that the Europeans have never made work, and, of course, it never worked in the Soviet Union. We're going in the wrong direction, and we need to go back toward freedom.

I didn't mean to get on too long a dissertation, but those distinctions between equal before the law as opposed to special deals, that's a very big part of what we're dealing with, Congressman.

Mr. KING of Iowa. I thank the gentleman from Missouri for coming in to add that.

The components of this freedom that seem to be completely disregarded over on this side of the aisle and the debate that we've gone through on health care and the argument that there are certain freedoms in that fashion, I recall Franklin Delano Roosevelt's Four Freedoms speech. And if you go down to the memorial down here at FDR's memorial, you can walk along and look at the display. He's the longest serving President of the United States. He had some ideas. I think he was very strong in leading this country through victory in World War II. I think that his economic leadership throughout the Great Depression extended and made the Great Depression greater than it might have been if we had allowed free market capitalism to prevail.

But Franklin Delano Roosevelt gave the famous Four Freedoms speech, and the four freedoms were painted and drawn by Norman Rockwell on the cover of Life Magazine, as I recall it. And the four freedoms were freedom of speech, good. Freedom of religion, also good. Both of those are constitutional freedoms. They are protected in the Constitution specifically. Freedom of speech, freedom of religion. The other two were freedom from want and freedom from fear.

Now, if any people can be free of want, that means that they don't have any desire to get up and go do anything. They don't want for anything. We know back during the 1970s when the American people were worried about the economic juggernaut of Japan swallowing our free market up because Japan was growing so fast and they were such intense competitors and they had cash left over and they were buying into the United States and competing directly, and I remember this from being a little boy.

We first started getting products from Japan that were little New Year's toys like the little whistles and those that spring out like that when you blow it. I don't know what you call those. I think the Japanese made the Chinese handcuffs we had to play with, too, if I'm not mistaken. Little paper products that came from Japan. And then things got a little better, and I can remember about the time I was in junior high school, I had a little Toshiba transistor radio where you could listen to a radio with a battery in it and walk around. That was a pretty neat deal. And as things went on, we started to see the Japanese make optics, and so the optical equipment today is state of the art. Very good. Very good recording, a very good electronic device.

The quality of what they were doing was pretty primitive just after World War II, which one would expect, and it got better and better and better. And by the 1970s, the Japanese were doing many things better than we were here in the United States. And we were worried that Japan was going to take us

over, defeat us economically and eclipse the American economy because our production, our export markets were diminishing and theirs were increasing, and that was the first time, I think, in my lifetime we were worried about the balance of trade.

I said then and I will say today that if you wanted to destroy a culture, a free enterprise culture, a dynamic culture and civilization, the United States has a simple solution. What we would do is we would just go in and airdrop money over in Japan, and as long as they didn't work, we'd fly them in money. If you drop money down in the streets of Tokyo and if people could gather that up every day and spend it and buy what they needed, they wouldn't want for anything and they wouldn't work for anything. It would destroy the work ethic of a culture and a civilization. That's how you would do it. If you want to create a socialist state, I can tell you how to do that, too, Madam Speaker.

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And that is, go out into the middle of the Sahara Desert, where there isn't a soul, not even a camel, for 100 miles, and hang a pipe there from a sky hook—that's our expression for when you don't have anything to hang it to, you just hang it to a sky hook—and hang a pipe there and drop Federal dollars down out of that pipe, let them billow out onto the sand in the desert; and pretty soon somebody would find that money and they would go there to grab that money and somebody else would come, somebody else would come. It wouldn't be earned income. That would just be something free that comes from the sky.

Federal money comes from the sky. It's been dumped all over America by this President: $787 billion in the stimulus plan; $700 billion in the TARP fund. And when you give people something for nothing, they lose their desire, they lose their want. They have freedom from want as long as they're dependent upon the benefactor. We could create a socialist state in less than a generation in the middle of the Sahara Desert if we just dumped money out there and gave it to people, and they would become dependent upon it. That is how you destroy a culture or a civilization. We've got to have want. We've got to have desire. I think Milton Friedman talked about how greed was a good quality. As long as it is a greed that's built upon a moral foundation and aspiration. And aspiration is a good thing.

And why anybody would think that greed doesn't exist in a socialist state is amazing to me. The people that are advocating for a socialist state, don't tell me you aren't. You are. You've taken all kinds of steps to move this Nation into a socialist state. If anybody wants to step into that debate, just stand up, I will yield right now; but I don't think you believe strongly enough to take me on.

You're moving us towards a socialist state. The people in this Congress on the left side have nationalized eight large entities: three large investment banks, AIG, Fannie Mae, Freddie Mac, General Motors and Chrysler. $787 billion in the stimulus plan. They have nationalized several congressional districts in my State. They don't exist, but they must have nationalized them. They've dumped money in there now and created these jobs where districts don't exist, where jobs don't exist, but it's put out here.

The freedom of the free market system has been dramatically diminished. And the people that advocate for this socialist state, this freedom from want, simply create a dependency class in America. FDR's inspiration is not a right. You don't have a right to not wanting for something. The heart of the American people, the heart of free people, has to want for something. We've got to desire for something. We've got to desire that the next generation lives better than we do. We've got to desire that we live in a moral and virtuous and a faithful society. We've got to raise our children that way. If we tie this together, then the world is a better place, and more people succeed and more people live better. And the harder we work, and the more we produce, it raises the average annual productivity. But if we don't want, we don't produce and, therefore, our productivity diminishes, and the sun sets on the American empire. That's freedom from want's mistake.

FDR's other mistake is freedom from fear. Freedom from fear. Now, if we don't fear anything, we don't move away from anything or we don't face those fears either. How can any government guarantee that you have a right to freedom from fear? Yet the belief over here, on the ever-encroaching socialist side of the aisle, is that we have a right to be free from want, free from fear, a right to health care, a right to your own personalized health insurance program, a program that will be delivered to every American human being, probably to the chimpanzees too like they want to do in Austria and have tried, but to every American human being a health insurance policy of your very own. That's what's in the bill; for illegals as well.

Here's how it works, Mr. Speaker. It works in this fashion. They have now covered every possible scenario of someone who is illegally in the United States and made sure everybody's covered if this bill finally becomes law. First of all, they undermined the proof of citizenship requirements in the Medicaid language and did so in the SCHIP rewrite, where they expanded health insurance for children and families of four, for example, in my State, making less than $75,000 a year, and providing that health insurance at 300 percent of poverty. In that bill, which, by the way, provided health insurance premiums for families that were also paying the alternative minimum tax; they had to pay the rich man's tax, then we had to subsidize the health insurance premiums for their children. And in that same bill, they wiped out the proof of citizenship requirements, the requirements for a birth certificate and other documents that are the foundation of verification for Medicaid eligibility so we are not providing Medicaid to illegals. That got wiped out.

Now an illegal person in the United States just simply has to attest to a Social Security number. Here's a number. It's mine. Fine. Here are your benefits. There are 9.7 million people who, in the United States, don't bother to sign up. They're here in this list. I won't go into that so far, Mr. Speaker, except to say, now, here, they want to give health insurance policies to every illegal in America. I've just talked about those that now just have to sign up for Medicaid. But some of them have jobs. Those that are working, the employer will be required to give them a health insurance policy, legal or not, and prohibited from verifying whether they are legal because E-Verify doesn't allow an employer to check their current employees; only new hires.

So under these scenarios that are there, and, by the way, if they make too much money to qualify for Medicaid and the employer doesn't provide that health insurance, then the alternative is we will just cut them a check. We'll give them a refundable tax credit and say, take that and buy your health insurance, and they can go to the exchange that's created by this bill and they can buy health insurance from there. There is no scenario that can be contrived, Mr. Speaker, that an illegal in America would be denied, conceivably, a health insurance policy, much of it, we might even go so far, I'll say almost all of it, funded by the American taxpayer.

That's how far out of touch with reality the people over on this side of the aisle are. It is a lust for political power, and it's a direct assault on the rule of law in the United States of America, an assault on the producers in America, and it undermines the core of our character and who we are, and it dispirits the patriotic Americans. It undermines and erodes and corrodes our soul. That is what's at stake here.

I would yield to the gentleman from Missouri.

Mr. AKIN. I really appreciate your yielding to me.

One of the things that happens down here, as you're aware of, this legislative process gets a little bit complicated. Sometimes people pay attention to people like you and I on the floor of the Chamber of the House. People may even pay attention to what

we're voting on here on the floor. But when you talk about this Nancy Pelosi health care/socialized medicine bill, on the floor, you're not going to have an amendment that says, yeah, but the illegal immigrants can't get free health care here. They're not going to have that amendment out here because people don't want to vote that because that might not be very popular back home.

But the interesting thing is, gentleman, as you know, in various committees, they do take those votes. In fact, that very amendment was offered in one of the committees where the Pelosi health care bill was for some number of months, and they offered an amendment saying that there will be no one that's eligible for any of this insurance pool, any of these insurance pools that has not passed the eligibility of citizenship, and they spelled out what that was. That was an amendment that was offered.

The bill had said originally, we're not going to give this to illegal immigrants. But there was no enforcement mechanism. So in order to add the enforcement mechanism, that amendment was proposed. That amendment then went up for a vote in the committee. Can you guess on you how the voting went? It was supported 100 percent by Republicans and rejected by the Democrats.

So, is there a protection in the bill for illegal immigrants to be able to get health insurance? The answer is, of course they can get it, because that amendment was defeated. Now there were all sorts of protest. Oh, it's not our intent that illegal immigrants are going to get this free health care. But the fact of the matter is, if that were really the intent to protect that, there would have been an amendment in the bill to say, we don't mean for people to get this unless they pass the citizenship eligibility requirements. But that amendment was defeated by the Democrats in committee. They knew that. It came to the floor without that protection, and it passed this floor without that protection. And that says that the way the Pelosi health care bill stands now, that you've got illegal immigrants that come to this country and they're going to get health care. And guess who's going to pay for it? The U.S. taxpayers are going to pay for it, or their children or their grandchildren with the multi-trillion dollar bill that has been proposed.

It's interesting that what you're saying, a lot of people say, Well, I don't like this partisan stuff. The Democrats claim this. The Republicans claim this. Can't you all just get along? The fact of the matter is you put an amendment like that up in committee and you see there's just this polar division of opinion as to what should be in this health care bill. And what you saw was that all of the Republicans said we need to protect against illegal immigrants getting this health care. And the Democrats voted—I think there may be one or two that voted with the Republicans, but certainly clearly a great majority, so that that amendment failed, and that's the way that Pelosi health care bill is now.

And so I just thought it interesting because people don't know about what happens in committees.

Mr. KING of Iowa. I just would inject this into our discussion. This was what James Russell Lowell had to say, a contemporary of Abraham Lincoln's, by the way. This is what he had to say about compromise: Compromise makes a good umbrella but a poor roof. It is temporarily expedient, often wise in party politics, almost sure to be unwise in statesmanship. That's James Russell Lowell's statement on compromise. A good umbrella but a poor roof.

I would yield back to the gentleman from Missouri.

Mr. AKIN. Well, I think that's something we need to be paying some attention to, too. So we've got the illegal immigration question that's part of these uninsured. There were other kinds of amendments that were offered, too, in committees. I don't know if you wanted to talk about them.

I thought another one that seemed to me to be very important and, that is, what's the heart of good health care? It seems like to me that the heart of it is that when a doctor and a patient come to a decision as to what they should be doing medically, that other people shouldn't butt in and tell the doctor and the patient what should happen. That seems to be fairly fundamental to the way we work. Maybe you want to get a second opinion with another doctor to make sure what you're doing is right. But that doctor-patient relationship is something that is very important. Most of the doctors go into the field assuming that they're going to have that relationship with their patient, and so we put some emphasis on that.

Now one of the things that we don't like is when some insurance company injects themselves into that doctor-patient relationship. I've heard the Democrats complain about that. They say, Those greedy insurance companies, they get in between the doctor and the patient. As a Republican, we don't like that either. And so one of the things we did was we put in the bill, as an amendment, that no government bureaucrat would insert themselves between the doctor and the patient. That was another amendment that was passed, was offered by a Republican doctor, I think it was Dr. GINGREY if I remember, from Georgia. Again, Republicans voted for it 100 percent. The Democrats, with maybe one exception, voted against it.

And so we have this Pelosi health care bill, and it has no doctor-patient relationship protection in it at all. Now there is something, believe it or not, worse than some insurance person coming between you and your doctor, and that's when it's a bureaucrat, a Federal Government saying, No, we're sorry, STEVE. You're too old. You don't get to have this. You can take a bottle of aspirin home with you. But we're not going to do it.

Mr. KING of Iowa. I would just reclaim my time. You've inspired a recent recollection. I believe it was just yesterday when the Federal Government panel came out and said to women, You no longer need to start getting mammograms when you're 40 years old. Wait till you're 50. You no longer need to get them every year. You can wait 2 years and space them out for a 2-year period of time. This is the precursor of the panels that we're likely to see if this bill that's before this Congress becomes law.

I will put the diagram of these 111 new agencies up here just so we have a little bit of an image of what is coming at us in America if we're not able to kill this bill. In any case, the advice that came from the panel on breast cancer is the kind of advice you'll get from a death panel.

The freedoms have been dramatically diminished here in the United States of America. There's been an assault on them. The vigor and vitality of the United States is under assault from the liberal socialist left. This is socialized medicine. We've seen the nationalization of a third of our economy and we need to get it back. The President needs an exit strategy from the nationalization of our economy. We need to kill this bill, Mr. Speaker, and we need to reach out and grasp American freedom, American liberty and American vitality.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. TANNER (at the request of Mr. HOYER) for today on account of travel from the NATO Parliamentary Assembly's Fall Plenary Session on November 16 and November 17, 2009.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. LUJÁN) to revise and extend their remarks and include extraneous material:)

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. GRAYSON, for 5 minutes, today.

(The following Members (at the request of Ms. ROS-LEHTINEN) to revise and extend their remarks and include extraneous material:)

Mr. DEAL of Georgia, for 5 minutes, today.

Mr. PITTS, for 5 minutes, today.

Mr. STEARNS, for 5 minutes, today.

(The following Member (at his request) to revise and extend his remarks and include extraneous material:)

Mr. GRIFFITH, for 5 minutes, today.

ADJOURNMENT

Mr. KING of Iowa. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 8 o'clock and 30 minutes p.m.), the House adjourned until tomorrow, Thursday, November 19, 2009, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

4688. A letter from the Assistant Secretary of Defense, Department of Defense, transmitting proposed changes to the U.S. Army Reserve Fiscal Year 2008 National Guard and Reserve Equipment Appropriation; to the Committee on Appropriations.

4689. A letter from the Director, Office of National Drug Control Policy, Executive Office of the President, transmitting the final plan for the allocation of the Fiscal Year (FY) 2009 HIDTA discretionary funds; to the Committee on Appropriations.

4690. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Suspension of Community Eligibility [Docket ID: FEMA-2008-0020; Internal Agency Docket No. FEMA-8089] received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

4691. A letter from the Program and Regulatory Affairs Branch, Department of Agriculture, transmitting the Department's final rule — School Food Safety Inspections [FNS-2005-0002] (RIN: 0584-AD64) received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

4692. A letter from the Secretary, Department of Health and Human Services, transmitting renewal of the July 26, 2009 determination of a public health emergency existing nationwide involving Swine Influenza A (now called 2009 — H1N1 flu), pursuant to 42 U.S.C. 247d(a) Public Law 107-188, section 144(a); to the Committee on Energy and Commerce.

4693. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Air Quality Designations for the 2006 24-Hour Fine Particle (PM2.5) National Ambient Air Quality Standards [EPA-HQ-OAR-2007-0562; FRL-8969-2] (RIN: 2060-AP27) received October 15, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4694. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of Air Quality Implementation Plans; South Carolina; Clean Air Interstate Rule [EPA-R04-OAR-2009-0455(a); FRL-8969-9] received October 15, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4695. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Revisions to the California State Implementation Plan, San Joaquin Valley Unified Air Pollution Control District [EPA-R09-OAR-2009-0384; FRL-8959-7] received October 15, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4696. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of Air Quality Implementation Plans; Indiana [EPA-R05-OAR-2008-0783; FRL-8971-9] received November 5, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4697. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Revisions to the Arizona State Implementation Plan, Maricopa County Air Quality Department and Maricopa County [EPA-R09-OAR-2009-0042; FRL-8902-6] received November 5, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4698. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Revisions to the Arizona State PM-10 Implementation Plan; Maricopa County Air Quality Department [EPA-R09-OAR-2009-0558; FRL-8975-06] received November 5, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4699. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Revisions to the California State Implementation Plan, San Joaquin Valley Unified Air Pollution Control District and South Coast Air Quality Management District [EPA-R09-OAR-2009-0272; FRL-8970-4] received November 5, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4700. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Significant New Use Rules on Certain Chemical Substances; Technical Amendment [EPA-HQ-OPPT-2008-0251; FRL-8438-5] (RIN: 2070-AB27) received November 5, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4701. A letter from the Acting Chief, Competition Policy Division, Wireline Competition Bureau, Federal Communications Commission, transmitting the Commission's final rule — Petition to Establish Procedural Requirements to Govern Proceedings for Forbearance Under Section 10 of the Communications Act of 1934, as amended [WC Docket No.: 07-267] received November 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4702. A letter from the Deputy Bureau Chief, PSHSB, Federal Communications Commission, transmitting the Commission's final rule — Improving Public Safety Communications in the 800 MHz Band [WT Docket No.: 02-55] received November 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4703. A letter from the Program Analyst, OMD-FO, Federal Communications Commission, transmitting the Commission's final rule — Assessment and Collection of Regulatory Fees for Fiscal Year 2009 [MD Docket No.: 09-65] Assessment and Collection of Regulatory Fees for Fiscal Year 2008 [MD Docket No.: 08-65] received November 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4704. A letter from the Secretary of the Commission, Federal Trade Commission, transmitting the Commission's final rule — Rules of Practice received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4705. A letter from the Chairman, Federal Reserve System, transmitting the System's Semiannual Report to Congress for the six-month period ending September 30, 2009, as required by the Inspector General Act of 1978, as amended; to the Committee on Oversight and Government Reform.

4706. A letter from the Chair, Council on Environmental Quality, Executive Office of the President, transmitting notifying Congress that the report due under Section 5 of the Oceans Act will be delayed until the spring of 2010; to the Committee on Natural Resources.

4707. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric, transmitting the Adminstration's final rule — Fisheries of the Economic Exclusive Zone Off Alaska; Pacific Cod by Vessels Subject to Amendment 80 Sideboard Limits in the Western Regulatory Area of the Alaska [Docket No.: 0910091344-9056-02] (RIN:0648-XR37) received October 29, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4708. A letter from the Deputy Assistant Administrator of Regulatory Programs, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Endangered and Threatened Species; Designation of Critical Habitat for Atlantic Salmon (Salmo salar) Gulf of Maine District Population Segement; Final Rule [Docket No.: 0808061060-91139-03] (RIN: 0648-AW77), pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4709. A letter from the Deputy Assistant Administrator for Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Endangered and Threatened Species; Critical Habitat for the Endangered Distinct Population Segment of Smalltooth Sawfish [Docket No.: 0707017355-91122-02] (RIN: 0648-AV74) received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4710. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Ocianic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Atka Mackerel in the Bering Sea and Aleutian Islands Management Area [Docket No.: 0810141351-9087-02] (RIN: 0648-XR36) received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4711. A letter from the Federal Liaison Officer, Department of Commerce, transmitting the Department's final rule — Changes in Requirements for Signature of Documents, Recognition of Representatives, and Establishing and Changing the Correspondence Address in Trademark Cases [Docket No.: PTO-T-2008-0021] (RIN: 0651-AC26) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

4712. A letter from the Federal Register Certifying Officer, Department of the Treasury, transmitting the Department's final

rule — Administrative Offset Under Reciprocal Agreements with States (RIN: 1510-AB23) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

4713. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Arbitration for Public Assistance Determinations Related to Hurricanes Katrina and Rita (Disasters DR-1603, DR-1604, DR-1605, DR-1606, and DR-1607) [Docket ID: FEMA-2009-0006] (RIN: 1660-AA63) received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4714. A letter from the Under Secretary of Defense, Department of Defense, transmitting notification to Congress on Transfer Authorities Used in Fiscal Year 2009; jointly to the Committees on Armed Services and Appropriations.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. CONYERS: Committee on the Judiciary. House Resolution 871. Resolution directing the Attorney General to transmit to the House of Representatives certain documents, records, memos, correspondence, and other communications regarding medical malpractice reform (Rept. 111–341). Referred to the House Calendar.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Ms. KILROY (for herself, Mr. BLUMENAUER, Mr. AL GREEN of Texas, Ms. HIRONO, Mr. ISRAEL, Mr. MOORE of Kansas, Mr. PERRIELLO, Mr. TONKO, Mr. WU, and Mr. SESTAK):

H.R. 4099. A bill to establish incentives to increase the energy efficiency of federally assisted housing; to the Committee on Financial Services.

By Mr. BROUN of Georgia (for himself, Mr. GOHMERT, Mr. HALL of Texas, Ms. GRANGER, Mr. COLE, Mr. FRANKS of Arizona, Mr. SHADEGG, Mr. BISHOP of Utah, Mr. MARCHANT, and Mr. POSEY):

H.R. 4100. A bill to amend the Internal Revenue Code of 1986 to provide individual and corporate income tax relief, to reduce the employee share of payroll taxes, and to rescind unobligated stimulus funds, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Appropriations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. MCDERMOTT:

H.R. 4101. A bill to amend the African Growth and Opportunity Act and the Trade Act of 1974 to provide improved duty-free treatment for certain articles from certain least-developed countries, and for other purposes; to the Committee on Ways and Means.

By Ms. ROS-LEHTINEN (for herself, Ms. BERKLEY, Mr. GINGREY of Georgia, Mr. LINCOLN DIAZ-BALART of Florida, Mr. MINNICK, Mr. ROYCE, Mr. ROSS, and Mr. BURTON of Indiana):

H.R. 4102. A bill to require the Secretary of State, in consultation with the Secretary of Defense, to provide detailed briefings to Congress on any recent discussions conducted between United States Government and the Government of Taiwan and any potential transfer of defense articles or defense services to the Government of Taiwan, and for other purposes; to the Committee on Foreign Affairs.

By Mr. KLINE of Minnesota (for himself, Mr. GUTHRIE, Mr. MCKEON, Mr. HOEKSTRA, Mr. SOUDER, Mr. WILSON of South Carolina, Mrs. MCMORRIS RODGERS, Mr. CASSIDY, Mr. ROE of Tennessee, Mr. THOMPSON of Pennsylvania, and Mr. EHLERS):

H.R. 4103. A bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes; to the Committee on Education and Labor.

By Mr. ELLSWORTH:

H.R. 4104. A bill to direct the Secretary of Transportation to establish and carry out a highway emergency responders safety grant program, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. ENGEL:

H.R. 4105. A bill to prohibit smoking near executive, legislative, and judicial branch entryways; to the Committee on Transportation and Infrastructure, and in addition to the Committees on House Administration, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HIMES (for himself, Mr. WELCH, and Mr. OLVER):

H.R. 4106. A bill to authorize the Secretary of Housing and Urban Development to make grants and loans to owners of federally assisted housing projects for costs of making green retrofit improvements to such projects; to the Committee on Financial Services.

By Mr. KING of Iowa:

H.R. 4107. A bill to preserve and protect the free choice of individual employees to form, join, or assist labor organizations, or to refrain from such activities; to the Committee on Education and Labor.

By Mr. MCCLINTOCK:

H.R. 4108. A bill to authorize the Secretary of the Interior to acquire the Gold Hill Ranch in Coloma, California; to the Committee on Natural Resources.

By Mr. PASCRELL:

H.R. 4109. A bill to amend the Internal Revenue Code of 1986 to allow the low income housing credit to be carried back 5 years, and for other purposes; to the Committee on Ways and Means.

By Mr. PAULSEN (for himself, Mr. WILSON of South Carolina, Mr. MCCARTHY of California, Mr. LEE of New York, Mr. PRICE of Georgia, Mr. LANCE, Mr. BURGESS, Mr. NEUGEBAUER, Mrs. BACHMANN, Mr. BACHUS, Mr. KLINE of Minnesota, Mr. BARRETT of South Carolina, Mr. BARTLETT, Mrs. SCHMIDT, Mr. ROE of Tennessee, Ms. FALLIN, Mr. GARRETT of New Jersey, Mr. THOMPSON of Pennsylvania, Mr. AKIN, Mr. CARTER, Mr. POSEY, Mr. MARCHANT, Mr. LAMBORN, Mr. KING of Iowa, Mr. ROONEY, Mr. SHADEGG, Mr. FRANKS of Arizona, Mr. CONAWAY, Mr. COLE, Ms. GRANGER, Mr. HALL of Texas, Mr. GOHMERT, Mr. SHIMKUS, Mr. HENSARLING, Mr. CHAFFETZ, Ms. JENKINS, Mr. HARPER, Mr. LUCAS, Mr. TERRY, Mr. MANZULLO, Mrs. CAPITO, Mr. HELLER, Mrs. LUMMIS, Mrs. BIGGERT, Mr. BRADY of Texas, Mr. MCCLINTOCK, Mr. GARY G. MILLER of California, Mr. CASTLE, Mr. FLEMING, Mr. MCHENRY, Mr. PUTNAM, Mr. SMITH of Nebraska, Mr. TIAHRT, Mr. GUTHRIE, Mr. HUNTER, Mr. CAO, and Mr. PAUL):

H.R. 4110. A bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program; to the Committee on Financial Services.

By Mr. TIAHRT:

H.R. 4111. A bill to prohibit the prosecution of unprivileged enemy combatants by the Department of Justice; to the Committee on the Judiciary.

By Mr. YARMUTH (for himself, Mr. ROE of Tennessee, Mr. MOLLOHAN, Mr. GORDON of Tennessee, Mr. CHANDLER, Mr. TANNER, Mr. DAVIS of Tennessee, and Mr. MOORE of Kansas):

H.R. 4112. A bill to amend the Internal Revenue Code of 1986 to modify the requirements for windows, doors, and skylights to be eligible for the credit for nonbusiness energy property; to the Committee on Ways and Means.

By Ms. PINGREE of Maine:

H. Con. Res. 214. Concurrent resolution providing for an adjournment or recess of the two Houses; considered and agreed to.

By Mr. EHLERS:

H. Res. 911. A resolution requesting the Attorney General to appoint a special counsel to investigate allegations regarding the organization ACORN; to the Committee on the Judiciary.

By Ms. RICHARDSON (for herself, Mr. ROHRABACHER, Mr. THOMPSON of California, and Mr. CALVERT):

H. Res. 912. A resolution recognizing the Aquarium of the Pacific for winning the Super Nova Star of Energy and Efficiency Award and for providing national leadership in marine education, and for other purposes; to the Committee on Natural Resources.

By Mr. BUTTERFIELD (for himself and Mr. ROGERS of Michigan):

H. Res. 913. A resolution recognizing and commending the American Speech-Language-Hearing Association on the 40th anniversary of the establishment of the Office of Multicultural Affairs; to the Committee on Energy and Commerce.

By Ms. DEGETTE (for herself, Mr. SMITH of Washington, Mr. AL GREEN of Texas, Mr. CRENSHAW, Ms. ESHOO, Mr. WEINER, Ms. LEE of California, Mr. HILL, Mr. GORDON of Tennessee, Mr. CHANDLER, Ms. SUTTON, Mr. DELAHUNT, Mr. FOSTER, Mr. ETHERIDGE, Mr. RUSH, Mr. ELLSWORTH, Mr. BRALEY of Iowa, Ms. SHEA-PORTER, Mrs. MCCARTHY of New York, Mrs. MCMORRIS RODGERS, Mr. GONZALEZ, Mr. DENT, Mr. MELANCON, Mr. CARNEY, Mrs. LUMMIS, Mr. MAFFEI, Mr. LIPINSKI, Mr. ISSA, Mr. CAMP, Mr. PRICE of North Carolina, Mr. SCOTT of Georgia, Mr. WU, Mr. MANZULLO, Ms. EDWARDS of Maryland, Mr. BLUMENAUER, Mr. MARKEY of Massachusetts, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. ENGEL, Mr. FALEOMAVAEGA, Mr. LOBIONDO, Mr. PALLONE, Mr. UPTON, Mr. GENE GREEN of Texas, Mr. GEORGE MILLER of California, Mr. JOHNSON of Georgia, Ms. ROS-LEHTINEN, Mr. LANGEVIN, Ms. SCHAKOWSKY, Mr. INSLEE,

Mr. LEWIS of California, Mr. MATHESON, Mr. MCDERMOTT, Mr. MCGOVERN, Mr. BONNER, Mr. WILSON of South Carolina, Mr. BARROW, Mr. CULBERSON, Mr. DINGELL, Mr. TIERNEY, Mr. KLINE of Minnesota, Mr. LEWIS of Georgia, Mr. OLVER, Mr. SALAZAR, Mr. SHADEGG, Mr. SHIMKUS, Mr. SPRATT, Mr. TANNER, Mr. PITTS, Mr. SESTAK, Ms. CASTOR of Florida, Mrs. DAHLKEMPER, Mr. BOSWELL, Mr. LANCE, Mr. DOGGETT, Ms. BORDALLO, Mr. KIRK, Mrs. BLACKBURN, Mrs. BONO MACK, Ms. WATERS, Mr. BURGESS, Mr. CASTLE, Mr. HONDA, Mr. MCMAHON, Mr. DOYLE, Mr. MCINTYRE, Mr. ROSS, Mr. ABERCROMBIE, Mr. GRIFFITH, Mr. GINGREY of Georgia, Mr. NEAL of Massachusetts, Mr. ALEXANDER, Mr. NEUGEBAUER, Mr. KLEIN of Florida, Mr. BLUNT, Mr. HINOJOSA, Mr. BISHOP of Georgia, Ms. JACKSON-LEE of Texas, Ms. BERKLEY, Ms. HERSETH SANDLIN, Mr. BUYER, Mrs. MYRICK, Ms. KOSMAS, Ms. BALDWIN, Mr. POE of Texas, Mr. MCCOTTER, Mr. WALZ, Mr. TIAHRT, Mr. COLE, Mr. CHILDERS, Ms. FOXX, Mr. CLAY, Mr. BECERRA, Mr. SPACE, Mr. WAMP, Ms. ZOE LOFGREN of California, Mr. PRICE of Georgia, Mr. KAGEN, Mr. WAXMAN, Mr. TIM MURPHY of Pennsylvania, Mr. STEARNS, Mr. WALDEN, Mr. BARTON of Texas, Mr. LOEBSACK, Mr. CLYBURN, Mr. KRATOVIL, Mr. PERRIELLO, Mr. NYE, Mr. HINCHEY, Mr. POMEROY, and Ms. KILPATRICK of Michigan):

H. Res. 914. A resolution supporting the observance of National Diabetes Month; to the Committee on Energy and Commerce.

By Mr. DONNELLY of Indiana (for himself, Mr. PENCE, Mr. HILL, Mr. BURTON of Indiana, Mr. ELLSWORTH, Mr. SOUDER, and Mr. CARSON of Indiana):

H. Res. 915. A resolution encouraging the Republic of Hungary to respect the rule of law, treat foreign investors fairly, and promote a free and independent press; to the Committee on Foreign Affairs.

By Mr. RODRIGUEZ (for himself, Mr. SMITH of Texas, Mr. GONZALEZ, and Mr. CUELLAR):

H. Res. 916. A resolution recognizing the significant contributions of the Fort Sam Houston Memorial Services Detachment to the veterans of the United States Armed Forces; to the Committee on Veterans' Affairs.

By Ms. ROS-LEHTINEN (for herself, Mr. BUCHANAN, Mr. ROONEY, Mr. CRENSHAW, Mr. MEEK of Florida, Mr. PUTNAM, Mr. MARIO DIAZ-BALART of Florida, Mr. KLEIN of Florida, Mr. MACK, Ms. WASSERMAN SCHULTZ, Ms. CASTOR of Florida, Mr. YOUNG of Florida, Ms. CORRINE BROWN of Florida, Ms. GINNY BROWN-WAITE of Florida, Mr. WEXLER, Mr. LINCOLN DIAZ-BALART of Florida, Mr. BOYD, Mr. MICA, Mr. MILLER of Florida, Ms. KOSMAS, Mr. GRAYSON, Mr. BILIRAKIS, Mr. STEARNS, and Mr. POSEY):

H. Res. 917. A resolution recognizing the Florida Keys Scenic Highway on the occasion of its designation as an All-American Road by the U.S. Department of Transportation; to the Committee on Transportation and Infrastructure.

By Mr. SESTAK (for himself, Mr. DENT, Mr. GERLACH, and Mr. DOYLE):

H. Res. 918. A resolution recognizing the 60th Anniversary of Chuck Bednarik's debut in the National Football League and the contributions of all Slovak-Americans; to the Committee on Oversight and Government Reform.

By Mr. STEARNS (for himself and Mr. LEWIS of Georgia):

H. Res. 919. A resolution supporting the goals and ideals of Chronic Obstructive Pulmonary Disease Awareness Month; to the Committee on Oversight and Government Reform.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 24: Mr. CUELLAR, Mr. MARKEY of Massachusetts, Mr. THOMPSON of Pennsylvania, Mr. SMITH of Nebraska, and Mr. JORDAN of Ohio.

H.R. 116: Mr. GALLEGLY.

H.R. 197: Mr. ROGERS of Kentucky and Mr. GALLEGLY.

H.R. 211: Ms. TSONGAS and Mr. RUPPERSBERGER.

H.R. 270: Mr. POSEY.

H.R. 313: Mr. KING of New York.

H.R. 330: Mr. SCOTT of Virginia.

H.R. 503: Mr. POLIS of Colorado, Mr. GRAYSON, Ms. SLAUGHTER, Mr. ALTMIRE, Mr. JACKSON of Illinois, and Mr. BUCHANAN.

H.R. 558: Mr. BOCCIERI.

H.R. 571: Mr. FATTAH and Mr. POSEY.

H.R. 678: Mr. DOGGETT, Mr. LEWIS of Georgia, Ms. CORRINE BROWN of Florida, Mr. ROGERS of Alabama, and Mr. KILDEE.

H.R. 734: Mr. HOLT, Mr. SPACE, Ms. BEAN, Mr. SCHOCK, Mrs. CAPITO, and Mr. BUTTERFIELD.

H.R. 775: Mr. SESSIONS, Mr. MEEKS of New York, Mrs. MCCARTHY of New York, and Mr. MCCOTTER.

H.R. 886: Mr. MARKEY of Massachusetts, Mr. BRADY of Pennsylvania, and Mr. MCNERNEY.

H.R. 948: Mr. HALL of New York.

H.R. 1066: Mr. GARAMENDI.

H.R. 1074: Mr. GALLEGLY.

H.R. 1084: Mr. ANDREWS, Mr. BARROW, Mr. BLUMENAUER, Ms. BORDALLO, Mr. BRALEY of Iowa, Mr. KENNEDY, Mr. MCINTYRE, and Mr. NYE.

H.R. 1126: Mr. HEINRICH.

H.R. 1177: Mr. BARTLETT.

H.R. 1203: Mr. TURNER and Mr. ALEXANDER.

H.R. 1230: Mr. CARNAHAN.

H.R. 1361: Mr. JACKSON of Illinois and Mr. COHEN.

H.R. 1443: Mr. SCHAUER.

H.R. 1454: Mr. LUETKEMEYER.

H.R. 1523: Ms. SLAUGHTER.

H.R. 1547: Mr. MAFFEI.

H.R. 1585: Mr. BOCCIERI.

H.R. 1613: Mr. KISSELL and Mr. PERRIELLO.

H.R. 1778: Mr. CONYERS, Mr. MAFFEI, Mr. JOHNSON of Georgia, Mr. HASTINGS of Florida, Mr. LOEBSACK, and Mr. DOGGETT.

H.R. 1831: Mr. RAHALL, Mr. COFFMAN of Colorado, and Mr. SCHRADER.

H.R. 1835: Mr. THOMPSON of Pennsylvania.

H.R. 1869: Ms. PINGREE of Maine.

H.R. 1873: Ms. NORTON.

H.R. 1897: Mr. TIM MURPHY of Pennsylvania.

H.R. 1956: Mr. COFFMAN of Colorado and Ms. MARKEY of Colorado.

H.R. 1964: Ms. CORRINE BROWN of Florida and Mr. JACKSON of Illinois.

H.R. 1995: Ms. FUDGE.

H.R. 2000: Mr. HEINRICH, Mr. MCCAUL, and Mr. ADLER of New Jersey.

H.R. 2026: Mr. POSEY.

H.R. 2102: Mrs. DAVIS of California, Mr. ROTHMAN of New Jersey, Mr. WALZ, Mr. CARSON of Indiana, and Ms. JACKSON-LEE of Texas.

H.R. 2112: Mr. MCINTYRE, Mr. NEAL of Massachusetts, and Mr. VAN HOLLEN.

H.R. 2142: Mr. BOSWELL, Mr. DAVIS of Tennessee, Mr. SHULER, Mr. CHANDLER, Mr. TAYLOR, Mr. HOLDEN, Mrs. DAHLKEMPER, and Mr. BACA.

H.R. 2160: Mr. SCHOCK.

H.R. 2254: Mr. GENE GREEN of Texas, Mr. AL GREEN of Texas, and Mr. LEWIS of Georgia.

H.R. 2296: Mrs. KIRKPATRICK of Arizona.

H.R. 2413: Mr. ORTIZ, Mr. CASSIDY, Mr. KILDEE, and Mr. CROWLEY.

H.R. 2425: Mr. LEWIS of Georgia.

H.R. 2426: Mr. PAYNE and Ms. SLAUGHTER.

H.R. 2460: Mr. HEINRICH, Mr. ACKERMAN, Mr. TONKO, Mr. SCOTT of Virginia, and Ms. RICHARDSON.

H.R. 2478: Mr. KILDEE, Mr. ROTHMAN of New Jersey, Mr. SCHIFF, Ms. JENKINS, and Mr. CLEAVER.

H.R. 2480: Mr. HASTINGS of Florida, Mr. CAMPBELL, and Mr. WU.

H.R. 2493: Ms. KOSMAS and Mr. MELANCON.

H.R. 2517: Mr. BACA, Mr. RUSH, Mr. SMITH of Washington, Mr. HALL of New York, Mr. PAYNE, Mr. DAVIS of Illinois, Mr. Luján, and Ms. TITUS.

H.R. 2560: Ms. BERKLEY.

H.R. 2579: Mr. COHEN, Ms. NORTON, and Mr. JACKSON of Illinois.

H.R. 2712: Mr. SCHOCK.

H.R. 2733: Ms. KILROY and Mr. HARPER.

H.R. 2766: Ms. MCCOLLUM.

H.R. 2811: Ms. JACKSON-LEE of Texas, Mr. POSEY, and Mr. BLUMENAUER.

H.R. 2866: Mr. SESTAK.

H.R. 2897: Mr. MOLLOHAN.

H.R. 2906: Mr. CLEAVER.

H.R. 2946: Mr. ABERCROMBIE.

H.R. 3017: Ms. FUDGE and Ms. TITUS.

H.R. 3020: Mr. MITCHELL and Mr. ADLER of New Jersey.

H.R. 3101: Mrs. NAPOLITANO, Mr. BLUMENAUER, Ms. PINGREE of Maine, and Ms. Bordallo.

H.R. 3107: Mr. MCCOTTER.

H.R. 3129: Mr. MCCOTTER.

H.R. 3185: Mrs. NAPOLITANO.

H.R. 3202: Mr. MCDERMOTT.

H.R. 3227: Mr. SPACE, Mr. PERRIELLO, and Mr. GUTHRIE.

H.R. 3245: Mrs. CAPPS.

H.R. 3248: Mr. POLIS of Colorado.

H.R. 3421: Mr. BERMAN.

H.R. 3439: Ms. SPEIER.

H.R. 3457: Mr. KAGEN and Mr. SCHAUER.

H.R. 3458: Ms. SCHAKOWSKY.

H.R. 3464: Mr. CARTER.

H.R. 3480: Mr. KILDEE.

H.R. 3485: Ms. SCHWARTZ and Mr. LANCE.

H.R. 3488: Mr. HALL of New York.

H.R. 3497: Mr. LEWIS of Georgia.

H.R. 3524: Mr. LUCAS and Mr. GALLEGLY.

H.R. 3535: Mr. PLATTS.

H.R. 3554: Mr. BOUCHER.

H.R. 3564: Ms. LINDA T. SÁNCHEZ of California.

H.R. 3569: Mr. INGLIS.

H.R. 3589: Mr. PASCRELL, Mr. SESTAK, Mr. PALLONE, and Mr. ROTHMAN of New Jersey.

H.R. 3604: Ms. SCHAKOWSKY.

H.R. 3644: Mr. POLIS of Colorado and Mr. FILNER.

H.R. 3646: Mrs. CAPPS.

H.R. 3652: Mr. CARNAHAN.

H.R. 3668: Mr. ELLISON, Ms. EDWARDS of Maryland, Mr. CALVERT, and Mr. CLEAVER.

H.R. 3695: Mr. GORDON of Tennessee.

H.R. 3711: Mr. SERRANO.

H.R. 3731: Mr. BRALEY of Iowa.

H.R. 3734: Mr. CONNOLLY of Virginia and Mr. SALAZAR.

H.R. 3749: Mr. LATTA.
H.R. 3781: Mrs. KIRKPATRICK of Arizona.
H.R. 3787: Mr. TIM MURPHY of Pennsylvania.
H.R. 3789: Mr. LATTA.
H.R. 3838: Ms. NORTON.
H.R. 3905: Mrs. EMERSON, Mr. COSTA, Mr. HALL of New York, and Mr. LUCAS.
H.R. 3910: Mr. REICHERT.
H.R. 3922: Mr. LAMBORN.
H.R. 3924: Ms. JENKINS.
H.R. 3927: Mr. CUMMINGS, Ms. ROS-LEHTINEN, and Mr. AL GREEN of Texas.
H.R. 3931: Ms. LEE of California, Mr. GARAMENDI, Mr. CARDOZA, and Ms. LORETTA SANCHEZ of California.
H.R. 3942: Mr. MICHAUD and Mr. MANZULLO.
H.R. 3943: Mr. CASTLE, Mr. PIERLUISI, Mr. CARSON of Indiana, Mr. SHERMAN, Mr. BERMAN, and Mr. CUELLAR.
H.R. 3963: Ms. RICHARDSON.
H.R. 3980: Ms. RICHARDSON.
H.R. 3985: Mr. THOMPSON of California.
H.R. 3995: Mr. CUMMINGS, Mr. DOGGETT, and Mr. KUCINICH.
H.R. 4022: Mr. PUTNAM.
H.R. 4045: Mr. BACA and Mr. COURTNEY.
H.R. 4046: Mr. NADLER of New York, Mr. BURTON of Indiana, Mr. MCCOTTER, Mr. KAGEN, Mr. BUCHANAN, and Mr. FILNER.
H.R. 4060: Mr. FILNER and Mr. SIMPSON.
H.R. 4073: Mr. GRIJALVA.
H.R. 4088: Mr. CRENSHAW, Mrs. KIRKPATRICK of Arizona, Mr. LUETKEMEYER, Mr. NUNES, Mr. TEAGUE, Mr. BROWN of South Carolina, Mr. CUELLAR, Mr. MORAN of Kansas, Mr. WILSON of South Carolina, Mr. OLVER, Mr. SOUDER, Mr. GRIFFITH, Mr. MCHENRY, Mr. HALL of Texas, Mr. BISHOP of Utah, Mr. LATTA, Mr. ORTIZ, Mr. ROONEY, Mr. LATHAM, Mr. BUCHANAN, Mr. POSEY, Mr. KLINE of Minnesota, Mr. SHADEGG, and Mr. MARCHANT.
H.R. 4089: Mr. TIAHRT, Mr. LATOURETTE, and Mr. CARDOZA.
H. Con. Res. 42: Mr. GUTIERREZ, Mr. MEEKS of New York, and Ms. LEE of California.
H. Con. Res. 43: Mr. GUTIERREZ, Mr. MEEKS of New York, and Ms. LEE of California.
H. Con. Res. 98: Mr. MOORE of Kansas and Mrs. MALONEY.
H. Con. Res. 200: Mr. MCHENRY.
H. Con. Res. 212: Mr. SESTAK and Mr. MCCOTTER.
H. Con. Res. 213: Mr. MCGOVERN, Mr. PIERLUISI, Mr. BURTON of Indiana, and Mr. ENGEL.
H. Res. 150: Mr. JACKSON of Illinois.
H. Res. 278: Mr. OBERSTAR, Mr. HOLT, Mr. RANGEL, and Mr. HONDA.
H. Res. 521: Mr. RUSH.
H. Res. 704: Mr. ISSA, Mrs. BONO MACK, Mr. SHERMAN, Mrs. BLACKBURN, Mr. EDWARDS of Texas, Mr. NEUGEBAUER, Mr. BRADY of Pennsylvania, Mr. GUTIERREZ, Mr. MILLER of North Carolina, Mr. GARRETT of New Jersey, Mr. HONDA, and Mr. MARKEY of Massachusetts.
H. Res. 812: Mr. ROTHMAN of New Jersey.
H. Res. 840: Mr. GALLEGLY and Mr. MCCOTTER.
H. Res. 852: Mr. BUCHANAN and Ms. FOXX.
H. Res. 874: Mr. INGLIS.
H. Res. 879: Mr. MCNERNEY, Mr. SCHIFF, Mr. SHULER, Mr. SHERMAN, Mr. DENT, Mr. MANZULLO, Mr. GRIJALVA, Mr. MCINTYRE, and Mr. PETERSON.
H. Res. 888: Mr. LAMBORN, Mr. MCCOTTER, and Mr. LATTA.
H. Res. 890: Mr. SCHIFF, Mr. CARSON of Indiana, Mr. FILNER, Mr. TOWNS, Mr. SNYDER, and Mr. FALEOMAVAEGA.
H. Res. 901: Ms. CLARKE, Mr. SERRANO, Ms. LEE of California, Mr. COHEN, Mr. YARMUTH, Mr. SARBANES, Ms. EDWARDS of Maryland, Ms. RICHARDSON, Mr. HODES, Mr. CROWLEY, and Mr. BISHOP of New York.
H. Res. 910: Mr. FRANK of Massachusetts, Mr. GRIJALVA, Mr. MCGOVERN, Ms. LEE of California, and Mr. PAYNE.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:

H.R. 874: Mr. LATOURETTE.
H. Res. 648: Mr. TERRY and Mr. COHEN.

PETITIONS, ETC.

Under clause 1 of rule XXII, petitions and papers were laid on the clerk's desk and referred as follows:

81. The SPEAKER presented a petition of American Bar Association, Chicago, Illinois, relative to Resolution 301 supporting the enactment of federal legislation, and adoption of regulations and other governmental measures, designed to improve the regulation of financial institutions and markets in the United States; to the Committee on Financial Services.

82. Also, a petition of American Bar Association, Chicago, Illinois, relative to Resolution 300 supporting federal, state or territorial legislation, regulations, or court rules that promote the use of mediation to assist in resolving disputes that could lead to forclosure of mortagees on residential real property; to the Committee on the Judiciary.

83. Also, a petition of American Bar Association, Chicago, Illinios, relative to Resolution 111B supporting the enactment of legislation that would provide for a national study of the state of criminal justice in the United States; to the Committee on the Judiciary.

EXTENSIONS OF REMARKS

HONORING TECHNICAL SERGEANT ROBERT HORNER UPON HIS RETIREMENT

HON. TIM RYAN

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. RYAN of Ohio. Madam Speaker, it is my great honor to stand before you today in recognition of Technical Sergeant Robert E. Horner. Robert will retire this December after more than 34 years of service to our country.

Robert enlisted with the U.S. Navy in September 1975. He served aboard the USS *John F. Kennedy* as an Aircraft Bosun Mate in the Atlantic Theater. In October 1979 he transferred to the U.S. Navy Reserve. He continued with the Navy Reserve until he transferred to the Air Force Reserve as a Propulsion Mechanic in 1983, at the 911th Air Force Reserve, Pittsburgh, Pennsylvania. His service to our country continued through the gulf war and the war on terrorism; from 1995 through the present he served as Propulsion Mechanic before moving to the Aerial Spray Maintenance with the 910th Airlift Wing, Youngstown, Ohio. Robert continued his military service even through heart surgery in 1992. His distinguished career is punctuated by over a dozen awards and decorations, including the Meritorious Service Medal, the Air Force Achievement Medal, the Humanitarian Service Medal, and the Military Outstanding Volunteer Service Ribbon.

Robert demonstrates an exemplary commitment to his community even aside from his military service. In 1993 he accepted a commission for the West Farmington Police Department, and served the village of West Farmington for 8 years. In 2002 he was made Police Chief, and he continues at this post today.

Robert's current responsibilities as Technical Sergeant with the 910th Airlift Wing includes supervision of 12 reservists in the maintenance and operation of the Modular Aerial Spray System, the only full-time, fixed-wing aerial spray unit within the Defense Department.

Madam Speaker, Technical Sergeant Robert Horner has dedicated his life to serving his country and his community. In recognition of his many efforts on behalf of the American people, I ask that you and all of my distinguished colleagues join me in commending him for his lifetime of service and dedication.

INTRODUCING THE ENERGY EFFICIENT MODERNIZATION ACT

HON. MARY JO KILROY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Ms. KILROY. Madam Speaker, I am introducing the "Energy Efficiency Modernization Act of 2009," to establish market incentives so that federally assisted housing can become more energy efficient.

Federally assisted housing programs provide real opportunities for green improvements. However, existing rules and regulations make it difficult for owners of federally assisted housing to maximize efforts and decrease our Nation's energy bill.

A 2008 study by the Government Accountability Office found that the Department of Housing and Urban Development spends an estimated $5 billion annually on energy costs to pay for roughly 6 million units of housing, representing almost 17 percent of the Nation's rental housing stock.

Improving the energy efficiency of federally assisted housing by 25 to 40 percent would result in savings for HUD at roughly $1 billion to $1.5 billion annually, making the long-term cost savings for the Federal Government—and, most importantly, taxpayers—substantial.

Furthermore, energy efficiency improvements will provide stimulus to the economy in terms of capital projects and "green collar" jobs, create best practices for the industry on the whole and fulfill the mandate of HUD.

COMMEMORATING THE 175TH ANNIVERSARY OF ST. JOSEPH'S VILLA IN RICHMOND, VIRGINIA

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. CANTOR. Madam Speaker, I rise today to commemorate the 175th anniversary of St. Joseph's Villa in Richmond, Virginia.

St. Joseph's Villa has been serving the Richmond community since 1834 when it was established by the Daughters of Charity as an orphanage. It is now a nonsectarian organization and is the oldest and largest operating children's nonprofit in metropolitan Richmond.

Currently, the Villa works with more than 600 children and families on a daily basis. The mission of St. Joseph's Villa is to provide children with special needs, as well as their families, the opportunity to succeed through innovative and effective programs. To accomplish this mission, St. Joseph's Villa works with local school systems and parents to provide a variety of educational, residential and day programs to children and families dealing with autism, homelessness or physical and mental disabilities or other behaviors that classify the child as being "at risk." These programs include, to name just a few, the Dooley School at St. Joseph's Villa, for middle- and high-school students with learning disabilities and behavioral issues, the Dooley Center for Alternative Education, for students who have been suspended or expelled from their local high school, and the Dooley School at Cherokee Road, an elementary-school program for students with a variety of learning disabilities. Each program contains both academic and behavioral components and their goal is to prepare the child for returning to his or her local school.

St. Joseph's Villa employs more than 300 full and part-time employees who are integral in making this organization a success. The Villa is committed to staff-development, involvement, and effective teamwork that respect the individuals they serve. I commend them on the services they have rendered to the Richmond community over the years.

Madam Speaker, I ask you to join me in recognizing St. Joseph's Villa as it celebrates its anniversary and wishing the students and staff the best in their future endeavors.

HONORING CALEB MATHER

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Caleb Mather, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 75, and in earning the most prestigious award of Eagle Scout.

Caleb has been very active with his troop participating in many Scout activities. Over the many years Caleb has been involved with Scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Caleb Mather for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

RECOGNIZING BREAST CANCER AWARENESS MONTH

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. RANGEL. Madam Speaker, I rise today to recognize Breast Cancer Awareness Month.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

As the month draws to a close, it is important that we acknowledge the impact that breast cancer has had on both women and men in our country. This October marks the 25th anniversary of the inaugural National Breast Cancer Awareness Month, celebrating a quarter century of awareness, education, and empowerment.

Each year, approximately 200,000 women and 1,700 men are diagnosed with breast cancer and more than 40,000 women and 450 men die from it. Breast cancer is sadly the most common cancer in women in the United States, but fortunately, there are about 2.5 million breast cancer survivors living in the United States today. This disease affects the lives of so many women and their loved ones, and it is of the utmost importance that the public is aware of current information and treatment options.

I commend organizations like Susan G. Komen for the Cure, and others, for its dedication to educating the citizens of our community and keeping them updated on the status of relevant research. I appreciate its commitment to providing more opportunities for individuals to learn about the disease, by spreading the message of prevention and awareness to wider audiences. In order to prevent breast cancer, we must increase our awareness, which makes research, early detection, and treatment all the more important as a woman's best defenses in the fight against this deadly disease.

In acknowledging and honoring Breast Cancer Awareness Month, doing so, we will educate our loved ones across the Nation—many mothers, sisters, and friends—on the importance of early detection, so that we may prevent as many women from dying as possible.

HONORING LEE MYERS, MAYOR OF MATTHEWS, NORTH CAROLINA

HON. SUE WILKINS MYRICK

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mrs. MYRICK. Madam Speaker, I rise today to acknowledge the great work of one of my constituents, R. Lee Myers, mayor of Matthews, North Carolina. Mayor Myers has recently completed his ninth term in office. Lee is a wonderful public servant—he's given over 20 years of his life to serve the citizens of Matthew—as mayor and as a town commissioner. During this time, he's overseen the rapid development of Matthews into one of the fastest growing metropolitan areas in the Nation.

Born in Mecklenburg County, North Carolina, in 1951, Mayor Myers graduated from East Mecklenburg High School, received a B.A from East Carolina University in 1973, and received a law degree from Oklahoma City University School of Law in 1976. Mayor Myers and his wife Lucinda have two children, Matthew and Amanda. He currently practices law alongside his son, Matthew, at the Myers Law Firm, PLLC.

Mayor Myers' civic activities also include serving on the Mecklenburg-Union Metropolitan Planning Organization from 1989 until the present, having served as chairman from 1997 to 2005. He has also been the Matthews representative to the Metropolitan Transit Commission since its formation.

Today, I join the nearly 30,000 residents of Matthews in thanking Mayor Myers for his two decades of outstanding service to them and to Mecklenburg County. His dedication is to be commended, and I wish him and his family all the best.

RECOGNIZING HARRY STATHAM FOR HIS 1,000TH VICTORY AS THE MEN'S BASKETBALL COACH AT McKENDREE UNIVERSITY IN LEBANON, ILLINOIS

HON. JERRY F. COSTELLO

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. COSTELLO. Madam Speaker, I rise today to ask my colleagues to join me in recognizing Harry Statham who, on November 13, 2009, posted his 1,000th victory as coach of the McKendree Bearcats, the first coach of a men's 4-year college basketball program to reach that mark.

Harry Statham began his career at McKendree College in 1966 after 5 years as a high school coach. Forty-four years later, coaching in the basketball court that bears his name, Coach Statham is still at McKendree, now McKendree University, and has built an impressive program on the guiding principle of, "You win games by getting the right kids." And Harry Statham's criteria for "the right kids" should be a model for other coaches in all sports. "We want good people, good students and good basketball players—in that order," he says.

Harry Statham has been the career wins leader for a 4-year men's basketball program since passing Dean Smith with his 880th victory in 2004. His record, after the 79–49 win over East-West University on November 13, was 1000–318.

Harry Statham's career is not marked solely by an impressive number of victories. He was named the 2001–02 NAIA Men's Basketball Coach of the Year and has received the AMC Coach of the Year award eight different times. He was a six-time recipient of the NAIA District 20 Coach of the Year, has been named the NAIA-Illinois Basketball Coaches Association Men's Basketball Coach of the Year 12 times, was the recipient of the National Association of Basketball Coaches, NABC, Guardians of the Game Leadership Award and received the Distinguished Service Award from the United States Sports Academy.

Madam Speaker, I ask my colleagues to join me in congratulating Harry Statham on his milestone 1,000th victory as the men's basketball coach at McKendree University and to thank him for his many contributions to his sport, his university and his community.

TRIBUTE TO MAJOR TOBY D. PATTERSON

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. SKELTON. Madam Speaker, let me take this moment to recognize and honor MAJ Toby D. Patterson, United States Marine Corps, for his service to the U.S. House of Representatives as he prepares to depart Capitol Hill. After serving over 2½ years as a liaison officer and the Deputy Director of the United States Marine Corps Liaison Office in the U.S. House of Representatives, he will be attending the Australian Command and Staff College in Canberra, Australia.

While serving in the Liaison office, Major Patterson developed and executed a legislative strategy for the United States Marine Corps that was instrumental in training and equipping the Marine Corps and ensuring their success on the battlefield. By engaging members of Congress and their staffs, Major Patterson directly facilitated an increased emphasis on improving Congressional relationships, which is a cornerstone of the Corps' strategic vision.

During his time on Capitol Hill, Major Patterson successfully planned, coordinated and escorted over 50 international and domestic Congressional and Staff Delegations. His attention to detail and anticipation of requirements allowed my fellow members of the House to focus on fact-finding and gleaning new insights that informed critical decisions to support the people of the United States. Due to his professionalism, dedication and knowledge, Major Patterson became a highly sought after military escort for delegations traveling into Combat and Post Conflict Zones. The time he has spent supporting members of the House has been truly noteworthy.

Major Patterson has distinguished himself as a man of many talents. While working in a challenging environment, he earned a Master's degree from the University of Oklahoma, completed the Marine Corps Non-Resident Command and Staff College, and succeeded as an accomplished athlete having run two Marine Corps Marathons and completing a full Ironman Triathlon.

Madam Speaker, as Chairman of the House Armed Services Committee, I have benefitted personally from Major Patterson's invaluable insights and hold great appreciation for the caliber of his work. He sets a high standard for others to emulate, and our Nation benefits from his outstanding dedication and leadership. I am certain that the members of the House will join me in wishing Major Patterson and his wife, Lindsey, continued success in their future endeavors.

PERSONAL EXPLANATION

HON. MARY JO KILROY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Ms. KILROY. Madam Speaker, on the legislative day of Monday, November 16, 2009, I

was unable to cast votes on a number of rollcall votes. Had I been present, I would have voted "yea" on rollcall votes 889 and 890, and "aye" on rollcall vote 891.

BANK OVERDRAFT POLICIES

HON. KENDRICK B. MEEK
OF FLORIDA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. MEEK of Florida. Madam Speaker, today I rise on behalf of American consumers who have contacted me about their discontent regarding bank overdraft fee policies. Most, if not all, of these individuals are everyday Americans who regularly monitor their spending and account usage. Unfortunately, many of these individuals are victims of unfair and excessive overdraft fees charged by banks.

In light of these many concerns, I believed that it was imperative to speak to citizens directly in an open forum about their worries and how Congress should act on their behalf. I hosted an online chat session this past week where American consumers had the opportunity to share their stories with me. This issue was first raised on a local level by Mike Holfeld, an investigative reporter at WKMG in Orlando.

If the Speaker would allow, I would like to relay a few of their stories:

Kathryn McCarrey is a 32-year-old mother of two from Groveland, Florida who has been a customer with Bank of America since 2005. She complained that she has been unfairly charged hundreds of dollars in overdraft fees over the past 2 years. She stated, "Just last week I printed my screen with [my] bank balance 3 days in a row to prove that the bank was charging erroneous fees . . . I cannot afford to continue giving money to the bank!"

Lauren Fant is a University of Central Florida student and customer at SunTrust Bank. She was fined three consecutive overdraft charges of $39 in August for three transactions that only went through a week after she made them. Although her overdraft amount was only $12, her fees totaled $117.

David Spatzer, also from Orlando, was hit with over $700 worth of charges in the past 2 months. When he went to his bank for help, he was told to take out a loan at 12 percent interest. He collects monthly Social Security checks while also working at Disney World. His checking account, however, approves transactions even when he does not have enough of a balance in his account.

Floridians and individuals throughout our Nation are currently going through similar circumstances as Kathyrn, Lauren and David. Congress needs to institute proper notification features at the point of transaction in cases of possible overdraft.

Madam Speaker, on behalf of the consumers mentioned above and the numerous others who reached out to me about their concerns on bank overdraft fee policies, I implore all members of this esteemed legislative body to work toward providing consumers with the safeguards necessary to make educated financial decisions without being charged exorbitant and unfair bank overdraft fees by their banks.

HONORING ERIC SIGMAN

HON. SAM GRAVES
OF MISSOURI
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Eric Sigman, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 75, and in earning the most prestigious award of Eagle Scout.

Eric has been very active with his troop participating in many Scout activities. Over the many years Eric has been involved with Scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Eric Sigman for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

HONORING THE COMMISSIONING OF THE USS "NEW YORK," LPD 21

HON. JOE COURTNEY
OF CONNECTICUT
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. COURTNEY. Madam Speaker, I rise today to celebrate the commissioning of the USS *New York*, LPD 21. On October 22, 2009, the House passed H.R. 856 to congratulate the captain and commissioning crew for the vessel entering the service of the U.S. Navy. The USS *New York* honors those who lost their lives at the World Trade Center, the Pentagon, and Shanksville, Pennsylvania, on September 11, 2001, and adds to our Navy's capabilities to protect our Nation.

With its hull constructed using steel from the World Trade Center, the ship will serve as a memorial to September 11. The ship's main passageway was dubbed "Broadway" and features an insignia with references to the Statue of Liberty, the Twin Towers, the New York City Police Department, and the New York City Fire Department. Its galley hosts a pre-September 11 neon outline of New York City. It is the newest entry to the U.S. Navy's fleet of *San Antonio*-class amphibious transport dock ships and will be deployed to provide amphibious assault capability anywhere in the world. CDR F. Curtis Jones, USN, a New York native, captains the ship.

I also want to take a moment to recognize an important connection between the USS *New York* and my State. RSL Fiber Systems, LLC of East Hartford, Connecticut was proud to be a part of this project, manufacturing the signal and navigation lights used on board the vessel. The ship contains five RSL lighting systems, which boast the breakthrough technology of fiber optic illumination systems. The Connecticut based company was selected to provide remote source lighting and the lighting control systems to the U.S. Navy for shipboard use on the LPD 17 class, the Navy Experimental Craft *Seafighter*, and the DDG 1000 class ships.

The ship's motto is, "Strength Forged Through Sacrifice. Never Forget," serving as a powerful symbol of September 11. The vessel pays tribute to those who lost their lives and reaffirms Congress's commitment to fighting terrorism and recognizing those men and women who risk their lives and fight for our freedom every day. I ask all of my colleagues to join with me in congratulating those who helped build the ship, and honoring those who defend our Nation every day.

TRIBUTE TO THOMAS J. GRAFF

HON. GEORGE MILLER
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. GEORGE MILLER of California. Madam Speaker, I rise today to pay tribute to one of the great icons of modern environmentalism, Thomas J. Graff, who passed away last week at the age of 65.

Tom Graff founded Environmental Defense Fund's California office in 1971, and over the ensuing decades, he built a record of accomplishment that includes landmark reforms to the way we use water and energy.

It was my great honor and pleasure to have worked with Tom for many years, and my staff and I often relied on his counsel and insights. His ability to think strategically about policy and politics was unmatched, and there are very few facets of California environmental policy over the last four decades that did not feel Tom's influence.

Tom Graff's negotiating prowess and his wisdom were critical to the passage of legislation that I authored in 1992 to protect the Bay-Delta of California: the Central Valley Project Improvement Act. And his work on California energy policy since the 1970's helped lead to the state's pioneering global warming bill, AB 32, signed into law in 2006.

Over his remarkable career, Tom Graff did an enormous amount of good for his fellow Californians—and for the planet and all its inhabitants. But Tom's unique legacy may be the partnerships and friendships that he formed on the way to his many accomplishments. Tom was always able to find a way to work together with those on the other side of the table, and even though his communications skills were incomparable, he knew that long-term solutions were always more important than soundbites.

In closing, I want to express my deep condolences to Tom's loving family, to his colleagues at EDF, and all of those who knew and worked with him—his passing leaves an incredible void. We will miss his insights, his creativity, his unmatched ability to find solutions, and most of all, his warmth and good humor.

I am submitting for the record several articles remembering Tom's life, and I ask my colleagues to join me in recognizing the life and legacy of a great friend and environmental champion, Thomas J. Graff.

[From the Sacramento Bee, Nov. 15, 2009]

A WATER WARRIOR WHO WON RESPECT FROM ALL SIDES

(By Stuart Leavenworth)

A lion of California's environmental movement died Thursday. Tom Graff, who helped

lead the 1980s fight against the peripheral canal and blocked the East Bay from diverting water from the American River, finally succumbed to the cancer that snuck up on him two years ago.

I feel fortunate to have known Graff for as long as I did. When I returned to California a decade ago, Graff was one of many people who helped school me on my home state and its Byzantine water politics.

Graff, a Harvard-educated lawyer with a degree from the London School of Economics, was not a native Californian. (He was born in Honduras, the son of Jewish parents who had fled Nazi Germany). But he knew more about my home state than almost anyone you could imagine.

I soon learned that Graff was a hero for Sacramento residents who care about the American River. In 1971, he founded the California office of the Environmental Defense Fund in an attic in Berkeley. When the East Bay Municipal Utility District attempted to tap water from the American River, Graff was asked by local residents to file a lawsuit. After 17 years, they eventually triumphed, prompting EBMUD to reach a 2001 settlement with Sacramento County on a joint water-withdrawal project further downstream, on the Sacramento River. He also helped pass California's climate legislation, AB 32, and spark a campaign to restore Hetch Hetchy, the valley in Yosemite National Park that is submerged by San Francisco's water supply.

Graff will be known for battles he won and lost, but he never was just a "stopper." Throughout his career, he advised his peers to go beyond mere obstruction. He wanted the environmental movement to understand the circumstances that led to projects they might oppose, and offer reasonable solutions.

His lifelong crusade was for rational (i.e. market-based) uses of water. By trading water, he argued, water districts could collectively cope with shortages without building new dams. While this idea was anathema to many environmentalists (those who see markets as evil), it sparked a needed debate in California on the essential value of water and the waste that can occur when it is priced cheaply.

I spent a day with Graff last April at his home in the East Bay, after it was clear his cancer couldn't be cured. His voice was barely audible, yet he still exuded the good spirit and humor that drew people to him throughout his career.

Graff and I spent most of the afternoon talking about California politics, the general dysfunction at the Capitol and new plans for a canal to divert water around the Sacramento-San Joaquin Delta.

We had lunch at Zackary's Pizza in Oakland, where he impressed me with his appetite. Graff helped kill the peripheral canal project at the ballot box in 1982, going head-to-head with some of his fellow environmentalists and then-Gov. Jerry Brown. At the time, Graff wasn't convinced that the canal would be operated properly, with adequate safeguards for the Delta and its upstream tributaries.

When I talked to him in April, Graff seemed to have turned a page on that old fight. "We'd be willing to go there, to a canal outcome," he told me. "But we would want to know as much of the terms as possible."

In particular, Graff said, he'd want to know key details of how water would be conveyed in such a facility, in wet periods and dry ones. There would have to be long-term assurances built into the project's operations so that a change in the governor's office didn't spell doom for the Delta and upstream water users.

We exchanged e-mails and phone calls, but I didn't get a chance to spend time with Graff after that long afternoon. So I have no idea where he stood on the legislative water package the governor finished signing the day that he died.

My guess is that Graff, with his expertise in economics, would be distraught the state is seeking to borrow $11.1 billion from taxpayers for various water projects, including new dams. As he told me in April, such projects should be largely paid "by water users, instead of taxpayers."

On the other hand, I know that Graff would be proud of a little-noticed part of policy package—one that requires the state to assess the needs of the Delta as a public trust resource.

Graff had sought this assessment for years, especially as various fish species of the Delta went into deep decline. The new law means that, before any new studies are launched on a canal or other alternatives, the state must evaluate how much water the Delta ecosystem needs in various years and in various climate scenarios.

Those needs, for the first time, will then become part of an overall management system for the Delta, its ecosystem and its various communities.

As for the canal itself, Graff would likely want to reserve judgment on the project until he could closely examine its details. How would it be designed, operated and financed?

He'd pay close attention to the new Delta Stewardship Council that the new law creates. Appointees to this council could determine if the public trust needs of the Delta are married with the operational details of a canal, or some other form of conveyance to move Delta water to the south.

While Graff's views on the water package are intriguing to speculate about, his views on life are more important.

In his final years and months, at age 65, Graff displayed more courage than anyone I've known with a terminal disease. He was never bitter, and always encouraging. He stayed in touch with friends, devoted himself to his family and managed to keep track of his life's work.

You'll probably hear more in the weeks ahead about Graff's legacy—both from old friends and adversaries. He died having the respect of both.

In the world of California water, that's an achievement in itself.

[From the Washington Post, Nov. 16, 2009]

GROUNDBREAKER IN U.S. WATER POLICY

(By Juliet Eilperin)

Thomas J. Graff, 65, who helped transform the nation's water policy as the longtime regional office director in California for the Environmental Defense Fund, died Nov. 12 at a hospital in Oakland after battling thyroid cancer for more than two years.

Mr. Graff founded the advocacy group's California office in 1971 in the attic of a University of California at Berkeley fraternity house. He changed the way federal and state governments managed water in the West by providing market incentives for farmers and other water rights holders to conserve resources and direct them toward urban areas and environmental purposes for a profit.

Marcia Aronoff, the Environmental Defense Fund's senior vice president for programs, said Mr. Graff was responsible "for putting together the first major change in water law and federal policy in modern times."

The idea of upending the principle of "use it or lose it" when it came to water rights was radical when Mr. Graff suggested it in the 1980s, but he persuaded lawmakers in Washington and Sacramento to let farmers save water and then sell it to supply urban consumers and critical ecosystems.

Mr. Graff helped codify these incentives through the 1990 Truckee-Carson-Pyramid Lake Water Rights Settlement Act and the 1992 Central Valley Project Improvement Act. "Water policy had been a socialized system based entirely on subsidies and political considerations," said Tom Jensen, who got to know Mr. Graff while serving as the chief water lawyer for the Senate Energy and Natural Resources subcommittee on water and power under Bill Bradley (D–N.J.) in the late 1980s and early 1990s.

Mr. Graff's ability to influence the legislative process—he was dubbed "the Godfather" by California Lawyer magazine—stemmed from his impressive analytical ability, array of contacts and listening skills, and a willingness to use tough legal and public relations tactics when needed.

"He was subtle and strategic. He could play at every level of the game," Jensen said. "He could be a spotlight-grabbing advocate or he could be utterly invisible, insidious and influential."

Mr. Graff was known for writing concise, one- or two-paragraph missives that crystallized key policy questions. He once ghostwrote a letter for a member of Congress that ultimately prodded the Interior Department to release water from Arizona's Glen Canyon Dam in order to allow the Colorado River to flow more freely through the Grand Canyon.

Thomas Jacob Graff was born Jan. 20, 1944, in Honduras to German Jews who had fled Nazi Germany. He grew up in Syracuse, N.Y., and graduated from Harvard College in 1965 and from Harvard Law School in 1967.

He attended the London School of Economics, was a legislative assistant for New York Mayor John V. Lindsay and an associate at a law firm in San Francisco before opening the defense fund's California office. Defense fund head Fred Krupp once said Mr. Graff joined the organization because of the affinity the young lawyer felt "for an organization whose informal motto back then was 'sue the bastards.' "

His marriage to Joan Messing Graff ended in divorce. Survivors include his wife of 31 years, Sharona Barzilay of Oakland; a daughter from the first marriage, Samantha Graff of Oakland; two children from his second marriage, Rebecca Graff of Cambridge, Mass., and Benjamin Graff of San Jose, Calif.; a sister; and two grandsons.

A fan of the Oakland Athletics, Mr. Graff liked to say that not only had he managed to tutor his children in how to score baseball games with precision but that this training proved to be invaluable when his daughter Rebecca chose to pursue a doctorate in statistics at Harvard.

A number of prominent politicians mourned Mr. Graff's death, including Bradley, who said the lawyer's "good sense and judgment guided" the federal 1992 water law. California Gov. Arnold Schwarzenegger (R), speaking at the signing ceremony Thursday for a California water reform law, lamented the fact that Mr. Graff was not in the audience.

"The reason why I wanted to mention him is because he was a great environmentalist," Schwarzenegger said, "someone that was very heavily working for 30 years on preservation, conservation and protecting the environment, protecting the [Sacramento-San

Joaquin River Delta] and who was very instrumental to get us where we are here today.''

[From the Contra Costa Times, Nov. 12, 2009]

TOM GRAFF, CALIFORNIA ENVIRONMENTAL WATER PIONEER, DIES AT 65

(By Mike Taugher)

Thomas J. Graff, the Harvard-educated lawyer who was among the most influential environmentalists in California water policy during the last 30 years, died Thursday morning after a long battle with cancer. He was 65.

Graff, of Oakland, gave up a career at a prestigious San Francisco law firm to open the California office of the Environmental Defense Fund in the attic of a UC Berkeley fraternity house in 1971, helping the organization grow in the following decades into one of the most powerful voices on environmental issues ranging from climate change to oceans to water policy.

Friends and colleagues recalled Graff as exceptionally smart, interested in the views of others, a master negotiator and an energetic and forward thinker. He was devoted to his family and a good friend and mentor to many colleagues, friends said.

''He was one of the earliest environmentalists to advocate (that) if water could be marketed and moved more freely, it would be used more efficiently and we wouldn't need more dams,'' said Laura King Moon, assistant general manager for the State Water Contractors, a water industry group.

''You could be arguing violently with him one minute and hugging him goodbye a half-hour later. He was a lion in the water environmental movement over the last three decades,'' King Moon added.

Graff was born Jan. 20, 1944, in Honduras to German Jews who had fled Nazi Germany. He grew up in Syracuse, N.Y., and later attended Harvard College, Harvard Law School and the London School of Economics.

At the Environmental Defense Fund, he was a champion of the idea of using market forces to improve the environment by pushing for water marketing in California, and for plans to cap-and-trade sulfur dioxide emissions in the eastern states to combat acid rain. ''He was a great listener,'' recalled Spreck Rosekrans, a water policy analyst at the organization. ''He always got along with people.''

He was also a driving force behind the Central Valley Project Improvement Act, the 1992 law that reworked one of California's biggest water projects and perhaps the most important piece of environmental legislation in the career of Rep. George Miller, D-Martinez.

''One of Tom's great insights was in advocating for, and helping to develop, the water-marketing agreements that helped bring the business world and the urban water community on board,'' Miller said last year in a speech to Congress.

Graff was a leader in the political fights against construction of a Peripheral Canal around the Delta. When the Sierra Club was debating whether to accept a compromise that would allow the canal to be built, Graff argued that the canal would allow San Joaquin Valley farmers and Southern California to take too much water out of the estuary. He sued the East Bay Municipal Utility District to block plans to tap into the American River, starting a 17-year legal battle over the health of the river and the Oakland-based district's contract rights to water. The utility eventually gave up its plans to build an intake on the American River and reached an agreement with environmentalists and Sacramento interests to move the intake downstream to the Sacramento River.

Graff is survived by his wife, Sharona Barzilay, the assistant head at the College Preparatory School of Oakland; sister Claudia Bial of Fort Lee, N.J.; daughter Samantha, son-in-law Miguel Helft, and grandchildren Avi and Rafael Helft of Oakland; son Benjamin of San Jose; and daughter Rebecca of Cambridge, Mass.

A private memorial is scheduled this weekend. A public service will be scheduled in the coming weeks.

RECOGNIZING THE CENTENNIAL ANNIVERSARY OF SAM HOUSTON ELEMENTARY SCHOOL

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I rise today to recognize the 100th anniversary of Sam Houston Elementary School in the Oak Lawn neighborhood of northern Dallas.

On December 6, 1909, the Oak Lawn School opened its doors to roughly 200 students under the leadership of Principal Mary Spears. The school included eight classrooms, five of which were used for academic purposes, and was located near the corner of Throckmorton Street and Dickason Avenue. Within a year, a petition was filed with the Texas Board of Education to begin a kindergarten program in the unused rooms of the school, and in March 1910 the first free kindergarten under the control of the Dallas School Board opened with an attendance of 25 students. Shortly thereafter, the Oak Lawn School changed its name to the Sam Houston School in honor of the 75th Anniversary of the Battle of San Jacinto.

Today, Sam Houston Elementary School stands as the oldest school in the Dallas Independent School District to continue to operate in its original building. For 100 years, the faculty and staff of this institution have educated young people in North Texas to become responsible and productive members of society. Through their hard work, Sam Houston Elementary has developed a legacy of excellence, and I am so proud to have this school within my District in Texas.

Madam Speaker, I ask my fellow colleagues to join me today in celebrating the success of this institution's century of existence and to recognize the faculty and staff's hard work and continued determination to ensure a quality education for children in north Texas.

HONORING JONATHAN ROBERT HUBBS

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Jonathan Robert Hubbs, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 900, and in earning the most prestigious award of Eagle Scout.

Jonathan has been very active with his troop participating in many Scout activities. Over the many years Jonathan has been involved with Scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Jonathan Robert Hubbs for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

HONORING SUTTER LAKESIDE HOSPITAL OF LAKE COUNTY, CALIFORNIA

HON. MIKE THOMPSON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. THOMPSON of California. Madam Speaker, I rise today to honor Sutter Lakeside Hospital of Lake County, California. On November 19th, 2009, Sutter Lakeside will be hosting a ribbon cutting ceremony for their new Mobile Health Services Unit.

The Mobile Health Services Unit project began over 2 years ago. Twenty percent of Lake County's residents and 31 percent of its children are living below the poverty line. This fact, combined with the county's rural nature, means an unacceptably high number of residents have no access to basic health care services. The Mobile Health Services Unit will ensure that these underserved populations receive the care they need, where they need it.

The entire Mobile Health Services Unit team at Sutter Lakeside deserves our thanks for their efforts in making this project a reality. In particular, a debt of gratitude is owed to Charlie Melo, owner of American Custom Coach, who provided the expertise and leadership that made this all possible. He was also so kind as to donate the unit's solar panels.

Madam Speaker, it is appropriate at this time that we honor Sutter Lakeside Hospital and thank them for their contributions to the citizens of Lake County. The new Mobile Health Services Unit is an invaluable addition to the community and all involved in making this happen are to be commended for their efforts.

HONORING THE LIFE AND MEMORY OF BILL BOYD

HON. SAM JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. SAM JOHNSON of Texas. Madam Speaker, I invite my colleagues to join me in honoring the life and memory of my friend, Bill Boyd. Enclosed they may read a profile piece in the Dallas Morning News featuring Bill's distinguished life of service, love of Texas, and devotion to family.

[From the Dallas Morning News, Aug. 31, 2009]

WILLIAM M. "BILL" BOYD: STORIED DALLAS ATTORNEY DEFENDED TEX WATSON, POLICE CHIEF

(By Rudolph Bush)

William M. "Bill" Boyd, 71, a storied attorney who gave up a career in politics to build up a successful McKinney law firm founded by his father, died Saturday of heart failure. Mr. Boyd of Dallas was well known in Texas' political and legal circles for his sharp mind, constant optimism and kindness. His career spanned five decades and countless cases.

A 1963 graduate of Southern Methodist University Law School, he was elected Collin County district attorney in 1964, before he had even passed the bar. As the son of attorney Roland Boyd—a close adviser to House Speaker Sam Rayburn and a friend of President Lyndon Johnson—Mr. Boyd might easily have built his early success into a lifelong political vocation, friends said.

"He would have done well in politics, but he loved the law. He loved legal practice," said Kent Hance, chancellor of Texas Tech University and a former U.S. representative. Mr. Boyd served four years as district attorney before returning to Boyd Veigel, where he practiced until his death.

From the earliest years of his career, Mr. Boyd was involved in high-profile cases. When Manson family member Charles "Tex" Watson was arrested in connection with the murders of actress Sharon Tate and others, Mr. Boyd fought his extradition from Texas to California all the way to the U.S. Supreme Court.

"He did everything he could to keep him over here because Watson had already been convicted in the papers over there. He didn't feel like Watson could get a fair trial," said John Stooksberry, a longtime partner of Mr. Boyd.

Though ultimately unsuccessful at blocking Watson's extradition, Mr. Boyd did see many legal victories. In 1991, he successfully defended former Dallas Police Chief Mack Vines against a perjury charge, calling a slew of witnesses, including former U.S. Attorney General Edwin Meese, to the stand.

At the time of his death, Mr. Boyd was leading a long-standing lawsuit pitting Dallas police officers and firefighters against the city in a dispute over back pay. Elements of that case, which could involve hundreds of millions of dollars in potential damages, are now before the state Supreme Court.

Mr. Boyd's wife, Barbara White Boyd, recalled her husband's passion for the law and for politics as grounded in a keen intelligence and attention to detail.

"He always managed to put things in such an eloquent and kind way, even when he was critical. He was the most open and honest person," she said.

He was loyal, too. In conservative Collin County, he never wavered from his commitment to Democratic politics.

"After I changed parties in the '80s, he told me, 'I still love you even though you're a Republican.' " Mr. Hance said. "He had friends on both sides, and he never took his politics so personal it affected his friendship with anyone."

Mr. Boyd's mark on law in Collin County is clear from a visit to the county courthouse, where he has placed two works of art, a sculpture of Alamo hero William Barret Travis and a portrait print of decorated World War II soldier Audie Murphy.

Mr. Boyd had said the sculpture of Travis represented what he believed in when it came to the law.

"It stands for courage, and that's what you need in a lawyer. You need someone that will stand up against the state, against powerful forces that you may be, as an individual, up against," he said.

In addition to his wife, Mr. Boyd's survivors include his sons, William Bradley Boyd of New Orleans and Blake Edward Boyd of Los Angeles; his sister, Betty Skelton of Houston; and three grandchildren. He was preceded in death by his first wife, Betty Boyd.

His body will lie in repose from 2 to 5 p.m. Wednesday at Turrentine Jackson Morrow Funeral Home, 2525 N. Central Expressway in Allen. Visitation will be from 5 to 8 p.m. Wednesday at the funeral home.

Services are scheduled for 10 a.m. Thursday at First Baptist Church of McKinney, 1615 W. Louisiana St. Burial at Lake View Cemetery in Lavon will follow.

IN HONOR OF THE RETIREMENT OF MIAMI-DADE COUNTY POLICE DIRECTOR ROBERT PARKER

HON. DEBBIE WASSERMAN SCHULTZ

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Ms. WASSERMAN SCHULTZ. Madam Speaker, I rise today to recognize the retirement of Police Director Robert Parker from the Miami-Dade County Police Department.

Director Parker has 33 years of distinguished service for the eighth largest police department in the country and for the last five years Mr. Parker has served as Director of the force, overseeing more than 4,700 dedicated sworn and non-sworn personnel.

Director Parker joined the Miami-Dade Police Department in 1976 where he was quickly promoted through all the civil service ranks. He has diverse experience in police management and operations, including posts as Assistant Director of Police Services, Division Chief of the North Operations Division and the Special Investigations Division, and Police Bureau Commander. In 2004, he made history when he was appointed as the first African American Director of Police for Miami-Dade County.

Known as a gifted leader in his community and in the Department, Director Parker was appointed by the Governor of Florida to serve as Co-Chair of the Southeast Regional Domestic Security Task Force. He also served as President of the Dade County Association of Chiefs of Police from 2006–2007, presiding over more than 35 municipal police departments as well as other state and federal law enforcement member agencies.

With Director Parker at the helm, the Department became known nationally as a leader in law enforcement. The Miami-Dade County Police Department holds accreditation from two agencies, the Commission of Accreditation for Law Enforcement Agencies (CALEA), and the Commission for Florida Law Enforcement Accreditation (CFA), documenting its commitment to the highest level of service.

I am proud today to honor Director Parker's distinguished career and leadership in the South Florida community and wish him and his family well on their future endeavors.

U.S. SENATOR ROBERT C. BYRD

HON. NICK J. RAHALL II

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. RAHALL. Madam Speaker, I rise today to honor the achievement of U.S. Senator ROBERT C. BYRD on becoming the longest serving Member in the history of the United States Congress.

Senator ROBERT C. BYRD has made a career of setting the standard for his fellow Members of Congress to emulate and today, he has, again, set the bar of Congressional service one notch higher.

This is a history-making day. But Senator BYRD's record-setting achievement is not gauged best by the number of years, days, and hours he has spent in office—though he could tell us to the minute. It is, instead, more correctly measured by the wealth of hope his work has generated, the vast number of lives his efforts have touched and improved, and the multiple generations of citizens his struggles from virtual orphan to the heights of political power have inspired.

His work, in short, has been monumental. His efforts have provided for public services and fundamental structures—modern highways, safer bridges, veterans centers, clean water systems—but these fall far short of the greatest and most lasting monument that he has given the people of West Virginia, his devotion and tireless work to make their lives richer.

I am proud and awed—though not in the least surprised—to be able to congratulate West Virginia's senior Senator on becoming the longest serving Member in the history of the U.S. Congress. And I look forward to many more record-breaking years of ROBERT C. BYRD serving in the U.S. Senate and setting a wise and fruitful course for the future of West Virginia and the Nation.

HONORING VINCENT PAUL WHITAKER

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Vincent Paul Whitaker, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 900, and in earning the most prestigious award of Eagle Scout.

Vincent has been very active with his troop participating in many Scout activities. Over the many years Vincent has been involved with Scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Vincent Paul Whitaker for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

ON THE OCCASION OF THE 85TH BIRTHDAY OF ROSEMARY McCANN

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Ms. ESHOO. Madam Speaker, it is with great pride that I rise today to honor an outstanding American and a great public servant who will celebrate her 85th birthday on November 20, 2009. Rosemary McCann has served her country with an unyielding sense of determination, and she has cared well for so many people through her distinguished and long career as a nurse.

After raising two exceptional children, Rosemary's caring nature led her to begin a career in nursing. She served for more than a decade as the occupational health nurse in Tiffany & Company's medical department. During her tenure, she served approximately 900 employees and provided emergency care and follow-up for the injured. She also helped to implement important safety and health education programs, which no doubt prevented future injuries from occurring on the job.

After her time at Tiffany & Company, Rosemary's desire to serve her country guided her to become the medical officer aboard the USNS *Silas Bent* and later with the U.S. Merchant Marine. During her service, she cared for sick or injured crewmembers and technicians on world-wide voyages, from the North Atlantic to the Indian Ocean. She also maintained the on-board medical inventory, oversaw food sanitation, and ensured that sailors had potable water to drink.

Her humor and compassion were a comfort to sailors away from home and she made sure that they stayed in contact with their families while at sea. Early one May, as Mother's Day was approaching, bad weather kept the USNS *Silas Bent* away from port. Always an expert at handling emergency situations, Rosemary passed out her supply of handmade cards to sailors to send home to their mothers. The cards made it home just in time.

Today, well past the customary age of retirement, Rosemary continues to touch people's lives as a relief nurse for numerous agencies and companies, including the U.S. Public Health Service, Time Warner, and Tiffany & Company.

Throughout her career, Rosemary has consistently demonstrated her intelligence, compassion and desire to serve others. Her determination has garnered the admiration of her co-workers and the respect of her patients.

It is a special privilege to honor Rosemary McCann because I know firsthand what a remarkable human being she is. I also have the privilege of knowing her daughter Leonore Horowitz and her family, and can say with great confidence that Rosemary McCann's values live on. I ask my colleagues to join me in celebrating her 85th birthday and thank her for her decades of service to our nation. She has made her family strong, and her community and country better by all she has done.

20TH ANNIVERSARY OF THE FALL OF THE BERLIN WALL

HON. LAMAR SMITH

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. SMITH of Texas. Madam Speaker, last week marked the 20th anniversary of one of the greatest triumphs of freedom and democracy in history—the fall of the Berlin Wall.

But two decades ago, the national media gave Americans a biased account of the issues surrounding this historic event, according to a new report by the Media Research Center, titled "Better off Red?"

MRC found that many in the national media failed to portray the evils of communism and suggested that free-market capitalism was somehow worse.

Furthermore, the media's coverage often tipped in favor of the oppressors—not the oppressed—and frequently criticized those who were fighting communism rather than those who were perpetuating it.

It is just as important today as it was 20 years ago that the national media give Americans the facts, not tell them what to think.

ON THE PASSING OF EUNICE KENNEDY SHRIVER, THE CREATOR OF THE SPECIAL OLYMPICS

HON. JAMES P. McGOVERN

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. MCGOVERN. Madam Speaker, I rise today to honor the passing of a Great American, Eunice Kennedy Shriver. Her life and her times were a lesson to us all about a life well lived. From mother to matriarch, hers was a life of love, nurturing and giving. The creator of the Special Olympics. A woman who led by example, and of great faith, who ever throughout her lifetime, asked the question, "Have you done enough?" I ask that this poem penned by Albert Caswell in honor of her be placed in the RECORD.

BUT, HAVE WE DONE ENOUGH?

Sunrise, Sunset . . .
All in these, the days of our lives that we have left!
All in these the moments, that which so race . . . of which lie before us in our life's face . . .
Only, so much time to find . . . all in one's lifetime, that which our world to grace!
To give to this our world, all in what we have done . . .
To make our lives burn bright, burn bright like the morning sun!
To ask that question, "have we done enough?"
A Mother, A Wife, A Sister, A Matriarch . . .
A Champion for others, as was Eunice's most splendid part!
For she was such a woman of faith!
Such a woman of heart!
As to all of these, Eunice could not so give enough, her art!
As to all she so asked as such!
But, have you done enough?
As a Champion For Children, as her heart was so filled in!
Creating The Special Olympics, a work of art to help all hearts mend!
For from a beautiful Rose, once came a flower so beautiful to help hearts win . . .
So bright, a giver of light . . . a true lover of life!
As above great American Women she so towers, as we look back upon her hours . . .
For she never asked more, than what she was willing to give herself . . .
For in all hearts, she always saw good . . . as how a life should be lived as felt!
As someone, who so came from such heartache and pain . . .
And yet, somehow in her fine heart . . .
Her Profiles In Courage . . . still remained!
Showing us all, her light!
But, have we done enough?
To make our world burn bright?
To Heaven now our sweet child, rise . . . looking into our Lord's eyes . . .
But, have we done enough?

CONGRATULATING SHARK TOWN MICRO COMMUNITY

HON. RON PAUL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. PAUL. Madam Speaker, Monday, November 23, in Port Lavaca, Texas, IBC Bank and HJM Elementary School will co-host the Shark Town Micro Community Grand Opening. Shark Town Micro Community is an innovative education program that gives HJM Elementary students the opportunity to learn "real world" business and financial skills. I am pleased to extend my best wishes to the people of IBC Bank, HJM Elementary, and all the businesses, educators, and, especially, students participating in this program.

The Shark Town Micro Community is a small community within the school run by the students. The HJM Elementary student council serves as the Shark Town council, and the student council president serves as the mayor of Shark Town. HJM Elementary students named the community after their school's mascot, a shark.

Students may choose to work at any of a variety of business, including an IBC Bank, Wal-Mart, and HEB grocery store. Students can also work at Shark Town's branch of the IRS, student workers have to pay taxes, one of Shark Town's utility companies, the post office, the local newspaper, the safety patrol, or the recycling center. Students may also train to be future teachers.

Local Port Lavaca businesses sponsor their Shark Town counterparts. The businesses provide their Shark Town counterparts with signs, badges, and shirts for their employees. Local businesses also provide funds for the Shark Town companies. Employees of the local businesses also periodically visit the school to offer assistance to their counterpart businesses.

Students receive salaries based on their jobs and their work performance. In order to participate in Shark Town, students must submit job applications and be interviewed. Payment is in the form of "sand dollars." Students may use their sand dollars to pay their taxes and utility bills as well as to shop at Shark Town's stores.

Madam Speaker, the Shark Town Micro Community program represents an innovative means of providing students with a unique opportunity to learn about how businesses operate as well as develop work and financial management habits that will serve them well throughout their lives. It is my pleasure to again congratulate all those participating in the Shark Town Micro Community project.

COPD AWARENESS MONTH

HON. CLIFF STEARNS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. STEARNS. Madam Speaker, today is World Chronic Obstructive Pulmonary Disease Awareness, COPD, Day. COPD is the fourth leading cause of death in the United States.

COPD includes many conditions such as chronic bronchitis, emphysema, refractory asthma and bronchiectasis. It is preventable and treatable. However, it is also progressive and there are millions of Americans that do not detect COPD in the early stages.

There are over 12 million Americans diagnosed with COPD and that number is growing. It is estimated that COPD will be the third leading cause of death worldwide by 2020. Despite all this, there is lack of awareness of COPD.

That is why, as one of the founders of the COPD Caucus, I've worked to highlight the problem of COPD and am introducing today, a Resolution, with my friend and colleague, JOHN LEWIS of Georgia, designating COPD Awareness Month.

OUR UNCONSCIONABLE NATIONAL DEBT

HON. MIKE COFFMAN

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. COFFMAN of Colorado. Madam Speaker, this morning our national debt was $12,039,319,107,488.80. I should note this week is the first time our debt has broken the 12 trillion level. We have added $8,019,921,198.73 to the national debt since yesterday.

On January 6, 2009, the start of the 111th Congress, the national debt was $10,638,425,746,293.80.

The national debt has increased by $1,400,893,361,195 so far this year.

According to the non-partisan Congressional Budget Office, the forecast deficit for this year is $1.6 trillion. That means that so far this year, we borrowed and spent $4.4 billion a day more than we have collected, passing that debt and its interest payments to our children and all future Americans.

COMMENDING THE WATER REPLENISHMENT DISTRICT OF SOUTHERN CALIFORNIA

HON. LINDA T. SÁNCHEZ

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Ms. LINDA T. SÁNCHEZ of California. Madam Speaker, I rise today to commend the Water Replenishment District of Southern California on the occasion of its 50th anniversary.

The Water Replenishment District of Southern California was created by the voters of California on November 17, 1959.

The successful election and creation of the Water Replenishment District was the culmination of a 17-year effort by groundwater producers in the Central and West Coast Basins to devise a system to finance and manage the restoration of dangerously depleted basins, retard and reverse the intrusion of sea water, institute a program of annual replenishment, and adjudicate and protect the rights of groundwater producers.

For five decades, the Water Replenishment District of Southern California has pursued this mission, assuring the continued beneficial use of the basins for groundwater production.

The programs and projects of the Water Replenishment District have included the pioneering use of recycled water and the capture and use of storm water for replenishment, multiple groundwater contamination cleanup projects in the Central Basin, desalination of brackish water in the West Coast Basin, and the supply of water to the sea water barrier wells in both basins. These successful programs have resulted in the steady reduction of reliance on the expensive and uncertain supply of imported water and a steady increase in the use of locally-developed water.

The goal of the Water Replenishment District of Southern California is to eliminate the use of imported water for replenishment by 2015. On the occasion of its 50th anniversary, I want to commend the district for a job well done and to recognize the crucial role the Water Replenishment district plays in the daily lives of Southern California residents.

HONORING MAX AND MARION VOLTERRA

HON. JAMES P. McGOVERN

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. MCGOVERN. Madam Speaker, I rise today in honor and recognition of Max and Marion Volterra of Attleboro, Massachusetts. Max and Marion Volterra are pillars of their community. Their dedication and service to the betterment of the city of Attleboro is inspiring. In acknowledgement of their many contributions to the good and welfare of their community, they have been selected to receive the United Regional Chamber of Commerce's "2009 Persons of the Year" award.

Max Volterra has devoted the better part of his life to ensure the success and prosperity of the city of Attleboro. He served as a City Councilor and as City Solicitor prior to launching a successful campaign for State Representative. He then represented the city of Attleboro in the State Legislature until he was tapped to serve as Chief Legal Counsel to Governor Michael Dukakis in 1978.

Leaving state politics to return to his law practice in Attleboro, Max focused his attention on bringing a formerly vital and prosperous downtown back to life. He personally invested in the downtown by purchasing a vacant train station and converting it to office space for his law firm and other offices. He was one of the founding members of an organization called Friends of Attleboro Interested in Revitalization and served as a member and past chairman of the Attleboro Redevelopment Authority that was responsible for several successful economic development projects. He volunteered countless hours for the purpose of ensuring that Attleboro would once again become a vibrant place to work and raise a family.

Marion Volterra's many accomplishments parallel those of her husband. She embodies the concept that a truly successful community must provide opportunities for people of all ages and ethnicities to experience art and culture in order to produce well-rounded citizens. Marion has volunteered with the Attleboro Arts Museum for so many years that no one has any idea how long it has actually been. With her support and guidance, the museum has become an oasis in the center of the city, welcoming all to participate in its educational and cultural opportunities. In her spare time, Marion volunteers as a mentor to students at Attleboro High School and serves on the Board of Directors of the YMCA.

Together Max and Marion Volterra accomplish far more than the sum of their individual efforts, and do so with enthusiasm and dedication. In tribute to their outstanding service to the city of Attleboro, I congratulate Max and Marion Volterra on receiving this award. I know all my colleagues will join me in paying tribute to them today.

HONORING JACOB OWENS

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Jacob Owens, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 75, and in earning the most prestigious award of Eagle Scout.

Jacob has been very active with his troop participating in many Scout activities. Over the many years Jacob has been involved with Scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Jacob Owens for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

RECOGNIZING WNY AMERICORPS, PUSH BUFFALO, AND BUFFALO REUSE

HON. BRIAN HIGGINS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. HIGGINS. Madam Speaker, most are familiar with ABC's Extreme Makeover: Home Edition program which embarks on the monumental task of building a new home from the ground up in just one week for a deserving family. Last week WNY AmeriCorps, People United for Sustainable Housing (PUSH) Buffalo and Buffalo ReUse, organizations in my hometown, took on that job.

On a visit to the site I was expecting to see the team's progress on the Powell family home on Massachusetts Avenue but what I witnessed far exceeded expectations.

The extreme team, which comprised of WNY AmeriCorps, PUSH Buffalo and Buffalo ReUse, in partnership with David Homes and many more from the community stepping up to help, went house to house patching roofs, fixing porches, planting shrubs, painting siding and more.

Hailed by producers as unlike any community effort they've seen in the show's history, the organizations worked in perfect synchronization, Buffalo ReUse deconstructing and recycling building materials, AmeriCorps donating and managing volunteers by the thousands and PUSH Buffalo working throughout the neighborhood, all operating around the clock for one week improving over 50 homes. But it didn't stop there. Their generosity inspired others, prompting food and blood drives and the construction of a community garden.

Madam Speaker, today I am honored to recognize WNY AmeriCorps, PUSH Buffalo and Buffalo ReUse for taking on the assignment to develop a home and turning it into an opportunity to develop hope—hope for a family, a neighborhood and an entire city. While the spotlight highlighted their efforts last week, these organizations work quietly each and every day building a better future for the Western New York Community and for that we are deeply grateful.

CONGRATULATING SENATOR ROBERT C. BYRD

HON. ALAN B. MOLLOHAN

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. MOLLOHAN. Madam Speaker, Senator ROBERT C. BYRD today becomes the longest-serving Member of Congress in our nation's history. I join my fellow West Virginians and, indeed, citizens from across the country in congratulating Senator BYRD for this historic record.

We mark Senator BYRD's longevity today, but that longevity is not what captures his greatness. I have worked with Senator BYRD for more than a quarter of a century—barely half of his tenure in the Senate—and I have known him for most of my life. His greatness is built on three pillars.

First is his personal story and the way that it has always informed his career. ROBERT C. BYRD grew up as the adopted son of a miner, graduated as class valedictorian in the depths of the Great Depression. Unable to afford college, he worked where he could find employment—pumping gas, selling produce, cutting meat, welding metal in shipyards. He courted, married, and relied for almost 70 years on his beloved wife, Erma. He earned a law degree even while serving as a Member of Congress. The qualities of discipline, industry, integrity, and commitment underlying that personal history would define greatness in any man no matter his station in life.

Second is his profound connection to the people of West Virginia. Senator BYRD is of the people and he is for the people. He has given West Virginians a lifetime of commitment and faithful service, and the people in turn have given him an unbreakable bond of trust, respect, and deep affection. I cannot imagine ROBERT C. BYRD representing any state other than West Virginia—and I cannot imagine West Virginia without the decades of service Senator BYRD has given it.

Finally, Senator BYRD's greatness derives from his devotion to the Senate and reverence for the Constitution that established it. As that other icon of the Senate, Ted Kennedy, put it, "Bob Byrd personifies what our founding fathers were thinking about when they were thinking about a United States Senate. He brings the kind of qualities that the founding fathers believed were so important for service to the nation."

Madam Speaker, even as we congratulate Senator BYRD for his years of service to his state and his country, we also recognize that it is not the number of those years we are celebrating but the content of those years. That content demands that for as long as there are people who care about the history of this nation, the name ROBERT C. BYRD will be mentioned in the same breath as Daniel Webster, Robert La Follette, Henry Clay, Edward Kennedy—the half dozen or so true giants of the Senate.

HONORING 90 WORLD WAR II VETERANS FROM SOUTH CAROLINA

HON. JOHN M. SPRATT, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. SPRATT. Madam Speaker, today, I am proud to honor a group of 90 World War II veterans from South Carolina who will make their way on November 21st to Washington, DC, in order to visit the World War II Memorial among other national monuments. Their visit will include the Korean, Vietnam and Lincoln Memorials, along with the National Cemetery at Arlington.

The veterans who make the journey to Washington represent all four branches of service, and they fought in all of the major theaters of the war. They fought in Europe in places like France, Italy, and Germany, and in the Pacific in islands like Guadalcanal and Okinawa. Represented in this group are veterans who saw service in pivotal battles such as D-Day, the Battle of the Bulge, and Tarawa.

WWII was a time when America was at her best. Our nation met the threats of tyranny and fascism and came to the aid of our allies. The valor of our veterans never shone more brightly, and the sacrifice borne by these veterans should never be forgotten.

We can never forget that WWII was a time of triumph and tragedy. Sixty million people worldwide were killed, including 40 million civilians, and more than 400,000 American servicemembers were slain during the war.

In South Carolina, the war was a time of special sacrifice. 166,119 servicemembers from our state participated in the war. 4,153 lost their lives. We prize our WWII veterans in South Carolina and their tales of victory over tyranny.

Accompanying these veterans and representing the future leaders of our military and our next generation of veterans are students from Andrew Jackson High School's Reserve Officers Training Corps. These young leaders will benefit from the mentoring and guidance provided by the WWII veterans during this trip.

I would like to thank the volunteers from the Honor Flight of South Carolina. This group, ably led by Bill Dukes, Lt. Gov. Andre Bauer and Medal of Honor winner Charles Murray are to be commended for ensuring that these veterans have the opportunity to see the memorial dedicated to them.

I ask the House of Representatives to join with me in honoring these 90 veterans who make this memorable visit to Washington, and pay tribute to their service and sacrifice.

RECOGNIZING NORTHERN WASCO COUNTY PUD AND PUBLIC POWER UTILITES

HON. GREG WALDEN

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. WALDEN. Madam Speaker, I rise today to recognize the rich history of Oregon's People's Utility Districts, PUD, and the efforts of Northern Wasco County PUD, the lone PUD in Oregon's Second Congressional District. Last month, Northern Wasco County PUD joined Oregon's numerous Municipal Electrical Utilities and Rural Electrical Cooperatives to celebrate the 23rd anniversary of Public Power Week and to recognize over seven decades of public power generated by the clean and renewable federal hydropower system in the Pacific Northwest. I commend Northern Wasco County PUD for their continued commitment to the utilization of clean renewable power in Wasco County, as well as their exemplary efforts in energy efficiency and conservation.

On September 28, 1937, President Franklin Roosevelt stood on Oregon soil as he dedicated the newly constructed Bonneville Dam, which became one of the first in a series of dams to be installed along the Columbia River as part of the President's vision to improve economic opportunities, flood control and, more importantly, provide electricity to communities throughout the Pacific Northwest. Since that day, public power utilities across Oregon,

including Northern Wasco County PUD, have harnessed the renewable power of the region's hydroelectric dams to provide clean renewable electricity to Oregon's communities and deliver steady supplies of power to small and large businesses. By providing some of the lowest-cost power to businesses in the Nation, public power utilities play a major role in maintaining thousands of jobs throughout rural and urban Oregon.

Besides delivering reliable hydropower, public power utilities and their ratepayers' across the West have invested a tremendous amount of financial resources in energy conservation and renewable energy projects. Since Congress passed the 1980 Pacific Northwest Electric Power Planning and Conservation Act, Oregon, Washington, Idaho and Montana have conserved a combined 3,700 average-megawatts of energy. This savings is equal to the annual combined energy needs of Idaho and western Montana, or the output of seven 500-megawatt coal-fired power plants. These conservation efforts have also resulted in a reduction of 13.5 million tons of CO_2 emissions and nearly $2 billion in consumer savings per year.

Over the years, Northern Wasco County PUD customers have invested $27 million in two hydroelectric projects, both of which allow for enhanced fish passage and an increased supply of renewable power. These projects include a five-megawatt generator located at The Dalles Dam and a 10-megawatt generator at the McNary Dam. Both projects generate clean power with no emissions and enhance the survival of listed fish along the main stem of the Columbia River.

In addition, Northern Wasco County PUD is developing a methane gas capture energy project in partnership with the The Dalles, Oregon at the city's wastewater treatment plant as well as a micro-hydroelectric generation installation on the city's water mainline. Furthermore, Northern Wasco County PUD is exploring a U.S. Department of Energy grant for potential geothermal generation in cooperation with a group of other northwest utilities. From my conversations with Northern Wasco County PUD officials, I know they are most proud of their commitment to providing their residential and industrial customers with adequate and predictable supplies of energy at affordable prices, especially in light of the difficult economic circumstances facing rural Oregon.

I also know that the commitment of public power utilities to providing clean renewable energy options for customers is strong. In fact, many now offer their residential, commercial and industrial customers the option of purchasing up to 100 percent renewable electricity produced from resources such as solar, wind, geothermal, biogas, biomass and low-impact hydro.

Madam Speaker, as the debate continues about how to best address climate change, energy independence, and our smarter energy future, it is imperative that entities providing public power in the Pacific Northwest, like Northern Wasco County PUD, receive credit for the work and investments they have already made in protecting our environment through the responsible use of the renewable energy hydropower system and through energy conservation. I commend them for these efforts.

IN MEMORY OF KEITH ROMAINE

HON. TIMOTHY H. BISHOP
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. BISHOP of New York. Madam Speaker, I rise today to celebrate the life and accomplishments of Brookhaven Town Councilman Keith Romaine. Tragically, Councilman Romaine's life was cut far too short on November 14 at the age of 36.

Keith Romaine devoted himself to family and to the community he loved. Like his father, Keith believed in putting public service first. He served as a Congressional aide and small business owner before his election in 2007 to the Brookhaven Town Board. Although Keith could have simply run on his strong family name, he worked hard to establish his own identity and accomplishments.

He served as President of the Moriches Bay Civic Association where he was a tireless advocate for this community.

On the Brookhaven Town Board he worked equally as hard, serving as a full-time representative for his community. Among his accomplishments in just one term were closing the composting facility on Papermill Road in Manorville, working with other levels of government to establish a skate park, and legislation to reduce unnecessary vehicle expenses which will save Brookhaven residents millions of dollars.

Shortly after his election to the Town Council, Keith sat down with me during some of my Community Office Hours and we discussed issues where we could work together. I saw his passion for his community and so did the people he represented.

In one of his last interviews, when Councilman Romaine was asked why he wanted to serve in Town government, he gave a simple, but telling answer, ''You're the closest to the people.''

Keith Romaine's career was only beginning and the Town of Brookhaven and Long Island will be worse off without him. My heart goes out to Keith's father Ed, his brother Kevin, his grandfather Edward, and the entire Romaine family on this tragic loss.

HONORING THE LIFE OF KEITH ROMAINE

HON. STEVE ISRAEL
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. ISRAEL. Madam Speaker, I rise today to pay special tribute to the life and legacy of Keith Romaine, Brookhaven Councilman who we lost too soon on November 14, 2009 at the age of 36.

Keith will be remembered by family, friends, and constituents as a devoted public servant who worked tirelessly to improve his neighborhood and community. I offer my support to his family and friends upon the loss of a bright, intelligent, and dedicated community leader who will be sorely missed by the people of Long Island.

HONORING VENERINI ACADEMY, WORCHESTER, MA

HON. JAMES P. McGOVERN
OF MASSACHUSETTS
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. MCGOVERN. Madam Speaker, I rise today in honor of an incredible school, Venerini Academy, located in my district of Worcester, Massachusetts. The mission of the Venerini Sisters in Worcester celebrates its 100th anniversary this year, and I am proud to recognize its many contributions to the community over the last century.

The school's and order's founder Rosa Venerini was born in Viterbo, Italy in 1656. She started the first public school for girls there, marking a milestone in the evolution of the education of women. Rosa knew the barriers women faced when life choices were limited often to marriage and the convent. Her father instilled in her a great respect for education and she wanted the same for future women. Rosa came to adopt the maxim, ''educate to liberate''.

In 1713, Rosa opened a school in Rome and Pope Clement XI paid her the honor of a visit. The Pope stayed the whole morning in the school listening to the class of catechism and asking the students questions. At the end of the visit, he called Rosa and her companions; he thanked her for their precious work, and said to them: ''I desire that these schools spread to all of our cities.'' Within a short time the schools opened everywhere, teaching young women to read and other life skills such as sewing. By the time of her death in 1728, Rosa Venerini opened 40 schools across the world.

In 1909, the movement she started came to the United States, establishing its first mission outside Italy on Edward Street in Worcester, Massachusetts. Venerini Academy's hallmarks of dedicated educators and rigorous programs would become a vital part of the community and a model for many other successful missions in countries across the globe.

Madam Speaker, I am certain that the entire House of Representatives joins me in honoring and thanking the Venerini Sisters and the Venerini Academy for their contributions to our community and the education of our children, as well as expressing our hope and confidence in an even more accomplished second hundred years.

RECOGNIZING DAVID STAPLETON

HON. BRIAN HIGGINS
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. HIGGINS. Madam Speaker, most are familiar with ABC's Extreme Makeover: Home Edition program which embarks on the monumental task of building a new home from the ground up in just one week for a deserving family. Last week in my hometown David Stapleton, owner of David Homes took on that job.

On a visit to the site I was expecting to see the construction team's progress on the Powell family's home on Massachusetts Avenue

but what I witnessed far exceeded expectations.

Under David's leadership volunteers by the thousands were transforming not one home but an entire neighborhood on Buffalo's West Side. With local organizations including WNY AmeriCorps, PUSH Buffalo and Buffalo ReUse as partners and many more from the community stepping up to help, the extreme team went house to house patching roofs, fixing porches, planting shrubs, painting siding and more.

Hailed by producers as unlike any community effort they've seen in the show's history, David's team managed 4,500 volunteers working around the clock for one week improving over 50 homes. But it didn't stop there. Their generosity inspired others, prompting food and blood drives and the construction of a community garden.

David agreed to this project knowing he could not simply go into this neighborhood and build one home. Producers feared he would lose focus but he knew he would have to do better and that he did.

Madam Speaker, today I am honored to recognize David Stapleton for taking on the assignment to develop a home and turning it into an opportunity to develop hope—hope for a family, a neighborhood and an entire city. What David Stapleton built last week is a better future for the Western New York Community and for that we are grateful.

HONORING COACH VERNON GLASS

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. POE of Texas. Madam Speaker, The Lamar University Cardinals in Beaumont, Texas lost one of it's legends in December 2005 with the passing of former head football Coach Vernon Glass. In an effort to keep Vernon's presence in the football program alive, The University recently renamed it's newly renovated practice field The Coach Vernon Glass Field of Champions.

Glass served as Lamar's head coach from 1963 through 1975. His 1964, 1965, 1966, and 1971 Cardinal teams won Southland Conference Championships and he finished his career with a 63–68–1 record. He was recognized as the NCAA College Division Coach of the year in 1964 and 1965. One of Coach Glass' former students called him 'a true champion and a great legend'. Therefore, it is only fitting for the university to recognize him by naming the practice field the ''Field of Champions''.

Madam Speaker, it is truly remarkable when one human being can touch so many lives. Coach Vernon Glass did just that during his years as a football Coach at Lamar University. The Second District of Texas recognizes Coach Glass for his years of dedication and service to the University and to improving the lives of the many players who played on the field under his leadership.

EARMARK DECLARATION

HON. LOUIE GOHMERT

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. GOHMERT. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding funding received in my district as part of H.R. 2996, the Interior, Environment, and Related Agencies Appropriations Act, 2010.

City of Lufkin Water Project. STAG Water and Wastewater Infrastructure Project, the City of Lufkin, P.O. Drawer 190, Lufkin, Texas 75902, $400,000 to help the city purchase the water production and transmission facilities owned by a local, but long-idle and deteriorating paper mill in danger of becoming an environmental hazard with long-term national implications. The funding will be used to develop infrastructure for the storage and treatment of 17 million gallons of water per day from the Angelina River and Kurth Lake, helping meet the increasing residential, commercial and industrial demands for potable water in a growing region of the state, which is relied on repeatedly by evacuating hurricane victims.

PERSONAL EXPLANATION

HON. TOM COLE

OF OKLAHOMA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. COLE. Madam Speaker, on Monday, November 16, 2009, I missed the last vote in a series of three votes. I missed rollcall vote No. 891. Had I been present and voting, I would have voted as follows: rollcall vote No. 891: ''aye'' (On agreeing to H.R. 3767).

RECOGNIZING THE LEADERSHIP OF THE SLE LUPUS FOUNDATION AND THE LUPUS COOPERATIVES OF NY FOR BEING LEADERS IN THE FIGHT AGAINST LUPUS

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. RANGEL. Madam Speaker, I rise today to recognize the SLE Lupus Foundation and the Lupus Cooperatives of New York for their contributions to help people with lupus and for fighting gender and racial disparities in the treatment of lupus for almost 40 years.

Systemic lupus erythematosus, SLE, commonly called lupus, is a chronic and potentially fatal autoimmune disorder. It is one of the Nation's least recognized major diseases, and it disproportionately affects women, particularly women of color. In lupus, the body's immune system forms antibodies that can attack virtually any healthy organ or tissue, from the kidneys to the brain, heart, lungs, skin, joints and blood. Lupus is a leading cause of cardiovascular disease, kidney disease, and stroke in young women. No major new treatments for lupus have been approved in 50 years.

The SLE Lupus Foundation, headquartered in New York City with a West Coast division in Los Angeles, was founded in 1970. It is a nonprofit organization that provides direct patient services, education, public awareness, and funding for novel lupus research on the national level. The Foundation deals with the predominance and severity of such lupus complications as kidney and cardiac disease in Blacks, Hispanics, Asians and people of other racial and ethnic backgrounds.

Madam Speaker, in 1998, the SLE Lupus Foundation opened the first Lupus Cooperative of New York in East Harlem. The Lupus Cooperative programs ensure that people of lupus receive the medical treatment, emotional care and practical assistance needed to live with this chronic disease, no matter their gender, or ethnic and socioeconomic backgrounds. Over the past decade, the Lupus Cooperatives have focused on communities characterized by high poverty rates, large numbers of uninsured residents, numerous single-parent families and a population at highrisk for lupus. They have worked actively to address gender and racial health disparities by demonstrating a collaborative model for the management of chronic illness among young, inner-city minority women.

The SLE Lupus Foundation is a member organization of the Lupus Research Institute National Coalition, which has affiliate organizations nationwide. Through the Lupus Research Institute National Coalition, the SLE Lupus Foundation has created visibility for the needs of underserved populations through awareness-building, advocacy and direct education programs on a national, state and local level.

Highlights of accomplishments include:

''Invisible No More'' forum on race and lupus at the Congressional Black Caucus Annual Legislative Conference in 2004;

Educational panel on heart disease and lupus presented at the Congressional Black Caucus Annual Legislative Conference in 2005;

Spanish language public awareness campaign to alert Hispanic women to the dangers of lupus in 2005;

Congressional briefing on racial disparity in lupus to the Congressional Hispanic Caucus in 2006;

Five-City series on the increased risk of heart disease in people with lupus, particularly young women and African-American women. That was presented in conjunction with the Association of Black Cardiologists in 2007. The series was held in New York City, San Francisco, Chicago, Los Angeles, and Detroit;

National Lupus Health Education for Physicians and Health Care Providers—in partnership with the Office of Minority Health and Human Services.

Madam Speaker, the SLE Lupus Foundation has accomplished and will continue to accomplish great things for people with lupus. I am grateful to the SLE Foundation and the Lupus Cooperative of New York for the work that they do to help people with lupus nationwide.

HONORING SHIRLEY COELHO AND CHERYL NIMIROSKI

HON. JAMES P. McGOVERN

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. MCGOVERN. Madam Speaker, I rise today to recognize and congratulate New Hope Board Members Shirley Coelho and Cheryl Nimiroski for their many years of dedicated service to this inspiring organization. New Hope is a non-profit agency serving communities in Central and Southeastern Massachusetts that is committed to ending domestic violence by helping people live safer lives.

Ms. Coelho and Ms. Nimiroski have worked tirelessly over the past 20 and 15 years respectively to provide individuals and families with the resources they need to identify, overcome and prevent domestic violence. Not only have their efforts improved the lives of those they have worked with directly, but they have also made the lives of countless individuals in their greater communities safer.

At New Hope's annual meeting on October 29, 2009, Shirley and Cheryl were specially honored with the creation of the "Coelho-Nimiroski Volunteer of the Year Award" which will be awarded to an outstanding volunteer who embodies the values of and shows dedication to the mission of New Hope. The creation of this award ensures that Shirley and Cheryl's work will continue to inspire future volunteers for years to come.

Madam Speaker, domestic violence affects us all and sadly, it still exists in communities across the United States. The care, compassion and commitment to ending domestic violence shown by devoted individuals like Shirley Coelho and Cheryl Nimiroski is truly exemplary. We should all be inspired by their invaluable work.

I respectfully ask the entire U.S. House of Representatives to join me in commending Shirley Coelho and Cheryl Nimiroski for their years of service to New Hope and for their dedication to ending domestic violence.

HONORING MEL AUST OF LAKE COUNTY, CALIFORNIA

HON. MIKE THOMPSON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. THOMPSON of California. Madam Speaker, I rise today to recognize my dear friend Mel Aust, General Manager of the Hidden Valley Lake Community Services District in Lake County, California. Mel is being honored this evening on the occasion of his 20th anniversary with the district.

Mel's contributions to the people of Lake County and California over the years are immeasurable. Mel was the driving force behind the water reclamation treatment plant and wastewater treatment plant to sustain build-out of the Hidden Valley Lake community. In 2001, his Community Services District helped build a ballpark at Coyote Valley Elementary School. He also secured $250,000 in labor grants to clean up Coyote Creek, Gallagher Creek and drainage ditches throughout the Hidden Valley Lake subdivision. He played a key role in crafting a letter that secured essential federal funding for the training and technical assistance HVLCSD offers to water and wastewater systems all over California.

The list of boards and commissions on which Mel has served is equally impressive. Locally, he serves on the Lake County Business Outreach Team, the Board of Directors of the South Lake County Fire District and the Board of Directors of the Toys for Kids program. Statewide, he served on the Association of California Water Agencies Federal Affairs committee and the California Department of Water Resources Drought Preparedness Committee. Mel also serves as California's representative at the National Rural Water Association and is on NRWA's Asset Development, Legislative and Conference Committees.

Mel is known across the state for his immense knowledge of complex water issues and his public speaking ability. He frequently lobbies in Sacramento and on Capitol Hill for the Association of California Water Agencies, American Water Works Association, California Rural Water Association and National Rural Water Association. He is the go-to speaker for these organizations when needed, often speaking to audiences of thousands with ease.

Madam Speaker, it is my distinct privilege to recognize Mel Aust for his many years of service to the people of California and to thank him for his many contributions on behalf of our country and our community. I am proud to call him a friend. I join his wife, Connie, and all of our colleagues in congratulating him on this milestone.

CONGRATULATING KATHLEEN HODGES OF GARLAND'S WALNUT GLEN ACADEMY

HON. SAM JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. SAM JOHNSON of Texas. Madam Speaker, last week I visited Garland's Walnut Glen Academy to congratulate Kathleen Hodges for winning the Outstanding Teaching of the Humanities Award 2008–2009. The Outstanding Teaching of the Humanities Awards recognize eleven exemplary K–12 humanities teachers in the Lone Star State. The exceptional Rowlett resident stands head and shoulders above her peers for her role as a terrific humanities teacher making a difference in the lives of young Texans.

Humanities Texas, formerly the Texas Council for the Humanities, is the state affiliate of the National Endowment for the Humanities. Humanities Texas conducts and supports public programs in history, literature, philosophy, and other humanities disciplines.

I wish my colleagues could have seen the heartwarming patriotic celebration that coincided with this wonderful announcement heralding Kathleen's accolade. On Veterans' Day, Walnut Glen Academy rolled out the red carpet for patriots young and old. The faculty and students at Walnut Glen Academy went to great lengths to stress the importance of service before self—and pointed a shining example of that—Kathleen's tireless work on behalf of young people. It was truly inspiring. Most important, Kathleen received the special recognition and her time in the sun for her tremendous achievement she so truly deserves.

After spending the day at her school, it is easy to see why Kathleen considers her proudest accomplishment the art program she has helped establish at Walnut Glen Academy. Congratulations are in order for Kathleen Hodges and the students and faculty at Walnut Glen Academy. God bless you and I salute you.

EARMARK DECLARATION

HON. LOUIE GOHMERT

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. GOHMERT. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding funding received in my district as part of H.R. 2996, the Interior, Environment, and Related Agencies Appropriations Act, 2010.

Lanana Creek Water Initiative. STAG Water and Wastewater Infrastructure Project, the City of Nacogdoches, P.O. Box 635030, Nacogdoches, Texas 75963, $500,000 for regional detention ponds to complete a storm water mitigation initiative at Lanana Creek, Nacogdoches, Texas, which will prevent submergence of a number of bridges by keeping Lanana Creek at a low water level. This will allow for full access of emergency personnel to areas south of the North Loop 224 bridge at all times, and dealing with untenable wetland issues.

CELEBRATING THE MONTH OF NOVEMBER AS NATIVE AMERICAN INDIAN HERITAGE MONTH

HON. MICHAEL M. HONDA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 18, 2009

Mr. HONDA. Madam Speaker, I rise today to celebrate the month of November as Native American Indian Heritage Month, and to express my support for the Native American Business Development Enhancement Act of 2009.

Over 562 Native American tribes have made extraordinary professional, educational, and cultural contributions to our community. After centuries of gross mistreatment at the hands of the U.S. government and generations of unequal, exploitative policies that have worked to effectively rob Native Americans of their land, culture, and livelihood, it is a privilege to honor the many accomplishments that these groups are making today. Their rich ancestry and surviving traditions are a living testament of the strength and unyielding spirit shared by many great tribal nations across this land, and their

legacy will continue to be a major part of the ethnic fabric of American society.

Since its inception in 1990, Native American Indian Heritage Month has sought to promote recognition for the significant contributions the first Americans made to the establishment and growth of the United States, and increase awareness of the tragedies and discrimination these groups have experienced throughout history. This year's theme, Pride in Our Heritage, Honor to our Ancestors, reflects the importance of remembering the rich and diverse cultural legacy of our Native American communities.

In the spirit of recognizing the longstanding social and economic inequalities facing Native American tribes, it is crucial that we take steps to ensure that Native American communities achieve equal access to public services, government funding, employment, business and educational opportunities. Individually and as distinct nations, Native Americans have made distinguished and significant achievements in the fields of agriculture, business, medicine, music, language, and art. I have every confidence that they will continue to distinguish themselves in those arenas as well as in government, as entrepreneurs, athletes, and scholars in the years and decades to come.

As we proceed to strengthen America's economic and social infrastructure, it is imperative that we target existing inequalities and discriminatory policies and make an active, nationwide effort to include Native Americans in future programs through forward-thinking legislation, such as the Native American Business Development Enhancement Act of 2009.

I strongly support H.R. 1834, the Native American Business Development Enhancement Act of 2009, which will be considered by the House today. This legislation, introduced by my colleague Rep. ANN KIRKPATRICK, will establish the Office of Native American Affairs within the Small Business Administration. This effort will increase Native American entrepreneurship and engage tribes in the small business arena.

In this vein, I have been working to further Native American business and economic development by supporting the elevation and funding of the Office of Native American Business Development, ONABD, at the Department of Commerce. I believe the ONABD should be more independent and receive an increase of funds in order to expand its activities, and fulfill its duties to expand business development, trade promotion and tourism opportunities for Native American tribes and their enterprises.

In closing, Madam Speaker, celebrating Native American Indian Heritage Month and supporting our Native American community is an important milestone to increase public awareness of their role in American history and recognize their cultural legacies that enrich our everyday lives.

HONORING THE LYONS TOWNSHIP HIGH SCHOOL MEN'S SOCCER TEAM ON WINNING THE ILLINOIS 3A STATE CHAMPIONSHIP

HON. DANIEL LIPINSKI
OF ILLINOIS
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. LIPINSKI. Madam Speaker, I rise today to honor the Lyons Township men's soccer team on its victory in the Illinois 3A State Championship match on November 7 in Naperville, IL.

Lyons Township enjoyed immense success this season, posting a record of 26 wins and only three losses. This year marked LT's sixth appearance in the state tournament. But after five previous trips ended in early exits, this year's team was determined to come home with a different result, and displayed resilience and skill all the way to the end.

Finishing the season on a 15-game winning streak, LT was playing its best soccer coming into the tournament, and that momentum carried over into the playoffs. With excellent coaching and strong senior leadership, LT put together a playoff run that included coming from behind, defeating an opponent that had twice beaten it in the regular season, and knocking off the defending state champions. All this set the table for an intense championship match against Lake Zurich High School. Ninety minutes proved insufficient, as it took overtime for Lyons Township to close out a hard-fought 2-1 victory.

I ask you to join me in honoring the members of the Lyons Township men's soccer team for achieving what every high school athlete strives for—a State Championship.

THE BENEFITS OF BUYING LOCAL

HON. HARRY E. MITCHELL
OF ARIZONA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, November 18, 2009

Mr. MITCHELL. Madam Speaker, as the holiday shopping season approaches, I want to urge my colleagues to consider the benefits of buying local, and join me in sharing your support for strengthening our local economies, creating local jobs, and ensuring local, sustainable economic development in our communities.

Buying locally strengthens the viability and competitiveness of local businesses. For every $100 in consumer spending, the total local economic impact is only $13 when goods and services are purchased at a national chain store.

The same amount spent with a local merchant, small business, or retailer yields more than three times the local impact, nearly $45 for every $100 spent.

Buying locally benefits small businesses, retailers and merchants who maintain a healthy and competitive marketplace for goods and services. Doing so ensures choice, diversity and competition in the marketplace for goods and services.

Moreover, as a former Mayor, I know that buying locally from independent businesses raises the standard of living in local neighborhoods because they take their profits and buy products and services from other local businesses in the area. As a result, local jobs are created in the community and the unique character of our neighborhoods and towns is preserved.

I want to recognize the work of Local Arizona First, a non-profit organization consisting of independent businesses, in making Arizona communities aware of the economic impact independent businesses have on local economies. Their mission is to promote, support, and celebrate a vibrant and sustainable Arizona economy by educating citizens about local business ownership, social equity, cultural diversity, environmental kinship, and collaboration.

On Friday, November 27, 2009, Local Arizona First will be launching their "Buy Local Week" in Arizona. I applaud their work and wholeheartedly support their efforts in showcasing the economic benefits of buying locally in our community.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, November 19, 2009 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

NOVEMBER 20

10 a.m.
Finance
To hold hearings to examine the nominations of Mary John Miller, of Maryland, to be Assistant Secretary, and Charles Collyns, of Maryland, to be Deputy Under Secretary, both of the Department of the Treasury.
SD–215

DECEMBER 2

10 a.m.
Energy and Natural Resources
To hold hearings to examine policy options for reducing greenhouse gas emissions.
SD–366

2:30 p.m.
Homeland Security and Governmental Affairs
Disaster Recovery Subcommittee
To hold hearings to examine disaster case management, focusing on developing a comprehensive national program focused on outcomes.
SD–342

DECEMBER 10

10 a.m.
Energy and Natural Resources
To hold hearings to examine the role of grid-scale energy storage in meeting our energy and climate goals.
SD–366

HOUSE OF REPRESENTATIVES—*Thursday, November 19, 2009*

The House met at 10 a.m. and was called to order by the Speaker pro tempore (Mr. PASTOR of Arizona).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
November 19, 2009.

I hereby appoint the Honorable ED PASTOR to act as Speaker pro tempore on this day.

NANCY PELOSI,
Speaker of the House of Representatives.

PRAYER

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

Lord God, architect divine and the definer of measured change, help us to seize the present moment and accept our place in Your loving plan for us and for this Nation.

By Your grace, enable us to notice all the love that surrounds us and the unconditional love that comes from You alone. Fill us with gracious thanksgiving for all our many blessings, so the joy of gratitude may be shared with everyone who has a place at our table of life.

To You be praise and thanks, Almighty God, both now and forever.

Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

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

PLEDGE OF ALLEGIANCE

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

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

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain up to 10 requests for 1-minute speeches on each side of the aisle.

TAKING CARE OF OUR FIRST RESPONDERS

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

Mr. ARCURI. Mr. Speaker, very often Members stand before this body and talk about the fact that we should never forget 9/11. Yesterday, I had an opportunity to stand with those first responders who responded to 9/11, not just the first responders themselves, but many of the family members of those who have passed away as a result of their service. And it's sad to hear their comments that, in fact, we have forgotten about 9/11, certainly the people that responded first. They are in desperate need of health care benefits as a result of the service that they rendered on that day at the World Trade Center site.

I think, when all is said and done, the quality of a society is not measured by its ability to wage war but, rather, by its ability to take care of those in its society who need it most. These individuals need the help of Congress to pass legislation to ensure that the health benefits that they need as a result of their service to this country are taken care of.

I strongly urge Congress to pass legislation to ensure that our first responders are taken care of.

WHERE ARE THE JOBS?

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

Mr. WILSON of South Carolina. Mr. Speaker, two nights ago, America learned that recovery.gov, the official administration Web site, was full of fake stimulus jobs in fake congressional districts. Last night, even ABC News broke that the Government Accountability Office says that one out of every 10 jobs created by the stimulus are also fake. When asked about the inconsistencies, the spokesman for recovery.gov replied, Who knows, man? Who really knows?

One thing is certain—Americans need real jobs. I call on my colleagues to listen to Republican plans to promote real jobs. Where are the jobs?

The Economic Recovery and Middle-Class Relief Act of 2009, which I support, unleashes the potential of American small businesses. It reduces the burden that government places on employers and employees.

In conclusion, God bless our troops, and we will never forget September the 11th in the global war on terrorism.

FIRE GRANTS REAUTHORIZATION

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

Ms. SCHWARTZ. I rise today to recognize the importance of the Fire Grants Reauthorization Act. These grants are a prominent demonstration of the Federal support for our Nation's first responders by enhancing their ability to protect the public from fire and related hazards. The Assistance to Firefighters and SAFER grants included in the act will help ensure that our first responders get the critically needed personnel, equipment, protective gear, emergency vehicles, training, and upgraded facilities they need to protect the public and the emergency personnel from fire and related hazards.

Every day our Nation's firefighters risk their lives to keep our communities safe. From 30,000 fire departments in the United States, a firefighter responds to a fire every 20 seconds. Philadelphia is home to one of the oldest fire companies in the country, dating back to 1736. The Philadelphia Fire Department is one of the busiest emergency management systems in the country, handling 260,000 responses in 2006.

Throughout my time in office, I have fought to ensure that our firefighters receive the respect and resources they so keenly require. I am proud to support the reauthorization of these grants and to support our firefighters in the efforts to support our communities and families.

BLUE RIBBON BLUNDER

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

Mr. COBLE. Mr. Speaker, it's not uncommon for Presidents' administrations to commit blunders, but of the several blunders that have been forthcoming from this administration, the one that stands out most prominently is the decision to authorize prosecution of the 9/11 terrorists in New York City.

This decision, Mr. Speaker, violates reason and common sense. The costs will be overwhelming, the risk not insignificant, and the defendants will enthusiastically embrace the circus atmosphere to espouse their radical

□This symbol represents the time of day during the House proceedings, e.g., □1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

views. I hope it is not too late to rescind this flawed decision and conduct the prosecutions before military tribunals.

Of the several blunders committed, this one must be awarded the ultimate blue ribbon. Mr. Speaker, let's hope it's not too late to rescind it and move forward.

ILLEGAL SUBSIDIES FOR AIRBUS

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

Mr. INSLEE. Mr. Speaker, today in the days of 10 percent unemployment, it is particularly important to be fair to the American worker. And right now, there is a gross inequity to the American worker pending in the contract to acquire a new aerial fuel tanker by the U.S. Air Force.

Right now, we know that one of the bidders, the Airbus company, has received grossly unfair multibillion dollar subsidies from the European Union countries. It is absolutely necessary for the United States Air Force to factor into this bid the illegal subsidies that Airbus consortium has received.

It is inconceivable that one agency of the U.S. Government has found illegal subsidies by this bidder, and another agency may award a bid without taking into consideration the illegal subsidies found by the WTO.

We are calling for the Air Force and the President to factor in these illegal subsidies so the American worker gets fairness. And that is what we deserve.

THE DRUG CARTEL ARMY

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

Mr. POE of Texas. Mr. Speaker, The Washington Times recently reported that Mexico's two most deadly drug cartels have more than 100,000 foot soldiers in their criminal cartel armies. That massive firepower does battle with each other and battle with our Border Patrol and our border sheriffs. They fight for control over the drug and human smuggling routes into America.

The killing is rampant in Mexico, with over 7,000 murders this year. Law and order are absent in parts of that nation.

The two biggest and most violent criminal cartels control territory along the border at Laredo, Texas. Now, they are considering combining their criminal enterprises. These two groups, the Zetas and the Federation, if they unite, their 100,000-man army will be almost as big as the entire Mexican Army.

The threat keeps building at our southern border. Mexico is our border neighbor, and we had better be as concerned about the stability of that government and the security of our mutual border as we are about the stability and the borders of Iraq and Afghanistan.

And that's just the way it is.

SETTING THE RECORD STRAIGHT WITH SENIORS

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

Mrs. DAHLKEMPER. Mr. Speaker, it's time to set the record straight. Too many people are trying to scare our senior citizens with misinformation.

The truth is that the Affordable Health Care for America Act will strengthen Medicare for seniors and extend the life of the Medicare Trust Fund by 5 years. Without reform, the Medicare Trust Fund will be exhausted within the decade. What will happen to our seniors then? It is for our seniors that we must enact health care reform now.

Our health care reform plan will eliminate copayments for preventative health services in Medicare. It will close the prescription drug doughnut hole and make lifesaving medications affordable for our seniors. And it will make Medicare more efficient and affordable for all seniors.

We owe our seniors the truth. That's why I'm proud to support health care reform that improves Medicare for seniors and health care for all in our country.

ILLEGAL SUBSIDIES IN THE TANKER COMPETITION

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

Ms. JENKINS. Mr. Speaker, in September, the World Trade Organization confirmed that the European Union doled out billions in illegal subsidies to prop up the development of large aircraft. Those subsidies forced companies here in the United States to close their doors and sent Kansans to the unemployment lines.

Rather than continuing to ignore the WTO ruling, it's time for the Department of Defense to do the right thing, to take into consideration the WTO ruling as they finalize the tanker competition. At a time when the American people are struggling, this decision has the potential to create jobs and help our Nation's economy. The Department of Defense must base its decision on a fair and level playing field.

I am proud to stand with a bipartisan, bicameral group fighting for American workers and fighting for the American tanker.

I urge all of my colleagues to join us in this fight.

LEGAL AID FOR VETERANS

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

Mr. KLEIN of Florida. Mr. Speaker, I rise today to congratulate the Legal Aid Society of Palm Beach County for launching a new innovative Armed Services Advocacy Project. This new service will provide civil legal assistance to Armed Forces members who have served in Iraq or Afghanistan and their families. With over 1,200 veterans of these ongoing conflicts residing in our community, the need for these services is tremendous.

The legal services provided by Legal Aid will be free of charge to Active Duty servicemembers, veterans and their families, and will cover a range of issues, most importantly, helping to improve access to veterans benefits.

I believe that every person who puts on the uniform of this country must have access to the full range of benefits they have earned. And this new Legal Aid project brings us one step closer to meeting this commitment in south Florida.

I would like to thank Robert Bertisch, Executive Director of the Legal Aid Society of Palm Beach County, and Elaine Martens of the Armed Forces Advocacy Project, as well as all members of the society for their dedication to serving those who have served our country.

WORKSITE ENFORCEMENT IN FREE FALL

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

Mr. SMITH of Texas. Mr. Speaker, workplace immigration enforcement is in a free fall. We will discuss this free fall and other ways illegal immigration adversely impacts jobs at a Republican forum today at 1:00 p.m. in 2237 Rayburn House Office Building.

Workforce enforcement has dropped across the board from 2008 to 2009. Administrative arrests fell 68 percent. Criminal arrests fell 60 percent. Criminal indictments fell 58 percent. Criminal convictions fell 63 percent.

It's hard to conceive of a worse time to cut worksite enforcement efforts by more than half. There are 16 million Americans out of work, and yet the administration has chosen to ignore the fact that there are nearly 8 million illegal immigrants in the workforce.

Those stolen jobs should be returned to out-of-work citizens and legal immigrants. The Obama administration should put citizens and legal immigrants first.

INDIRECT LAND USE CHANGE

(Mrs. HALVORSON asked and was given permission to address the House

for 1 minute and to revise and extend her remarks.)

Mrs. HALVORSON. Mr. Speaker, I rise today to talk about an important issue, indirect land use change, which affects many of my domestic ethanol producers. It assumes that biofuel production displaces other crops which are then grown in other parts of the world, leading to deforestation, and that American biofuel producers should be penalized for that indirect release of carbon due to the unrelated actions of foreign countries.

The facts are that deforestation, particularly in the Amazon, has decreased, while domestic biofuel production has doubled over the same period. The House included a provision in the Energy bill that prevents EPA from implementing this rule for 6 years while it is studied to see whether the theory is scientifically sound.

Meanwhile, EPA is slated to release a rule in December which would presumably include this theory. This provision could have harmful effects on our ethanol producers, and I urge EPA to refrain from implementing ILUC until proper science can support it.

□ 1015

WHO KNOWS, MAN

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

Mr. MCCLINTOCK. Mr. Speaker, the unfolding scandal of phony or inflated job claims from the so-called stimulus bill should shock the conscience of the Nation and permanently stain the reputation of this Congress and this President.

But it gets even worse if we take them at their word. As of this morning, the administration claims that in my Fourth Congressional District of California, the brain trust at the Treasury has spent $182 million to save or create all of 168 jobs. That is $1.1 million per job. They claim to have saved or created 110,000 jobs in California. But 75,000 of those 110,000 jobs occur in a single ZIP code, 95814. What's 95814? That's the ZIP code that encompasses the State capitol building and the State bureaucracies.

Stimulating the economy? Mr. Speaker, all we're stimulating is government at the expense of the economy.

ILLEGAL LAUNCH AID SUBSIDY

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

Mr. DICKS. Mr. Speaker, I'm concerned about the Air Force's approach to acquiring the next generation of air refueling tankers because the draft RFP the Air Force has published has ignored an important element in the competition. The U.S. Government in 2004 filed a complaint with the WTO that European governments had illegally subsidized EADS/Airbus in the development of commercial aircraft, allowing Airbus to steal market share and U.S. aerospace jobs. Now the WTO panel reviewing the matter has rendered an interim decision that these subsidies were improper and caused adverse effects to the interests of the United States.

Now the Airbus/Northrop Grumman team wants to use the A–330 platform, which received $5.7 billion in direct launch aid subsidy, as the airframe for the Air Force's refueling tanker. In soliciting bidders for the tanker, we simply must insist that the Department of Defense/Air Force take into account the illegal launch subsidy, without which the A–330 might never have been built.

MEANINGFUL HEALTH CARE REFORMS

(Mr. LEE of New York asked and was given permission to address the House for 1 minute.)

Mr. LEE of New York. A recent report by the Obama administration confirmed that Speaker PELOSI's health care bill will cut seniors' Medicare benefits and, in particular, Medicare Advantage. The report from the nonpartisan Centers for Medicare and Medicaid Services said that Speaker PELOSI's bill would slash Medicare and Medicare Advantage by more than $500 billion. According to The Washington Post, these massive cuts ''would sharply reduce benefits from some senior citizens and could jeopardize access to care for millions of others.''

My district in western New York has the greatest number of Medicare Advantage enrollees in New York State. Medicare Advantage provides seniors a comprehensive health care plan that they can afford, yet Speaker PELOSI's bill will all but destroy this program.

It's important that Congress enact meaningful reforms to our health care system to improve affordability and accessibility, but we should not financing these reforms on the backs of seniors.

EXTENDING FIRST-TIME HOMEBUYER TAX CREDIT TO MILITARY FAMILIES

(Mr. HALL of New York asked and was given permission to address the House for 1 minute.)

Mr. HALL of New York. Thank you, Mr. Speaker, for the opportunity to speak today about a very important issue for our Nation's military families. On November 6, President Obama signed into law the Worker, Homeownership, and Business Assistance Act of 2009, which included an extension of the $8,000 first-time homebuyer tax credit. This credit offers a special rule for servicemembers who have served on extended overseas duties since the end of 2008.

Those serving on extended duty outside the United States for at least 90 days between December 31, 2008, and May 1, 2010, qualify for an additional 1-year extension through May 1, 2011, of the $8,000 first-time homebuyer credit. We should not penalize those serving our country overseas. I was proud to cosponsor and vote for this provision in the House of Representatives.

Extending this credit gives our servicemembers abroad the latitude necessary to take advantage of this important provision while readjusting to civilian life back here in the United States.

LEVEL THE PLAYING FIELD

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

Mr. TIAHRT. Mr. Speaker, we need an American air refueling tanker built by an American company with American workers. And we need it now more than ever. With unemployment at over 10.2, it's unbelievable that the Pentagon would consider outsourcing this key national security asset to the French. But not only is the Department of Defense considering this; they are bending over backwards to ensure that EADS, the French company, can compete.

The Department of Defense is turning a blind eye to the World Trade Organization's ruling that found EADS guilty—guilty of receiving billions of dollars in illegal subsidies. This distorts the marketplace and gives EADS a clearly unfair advantage in the competition. The Department of Defense is also waiving five expensive regulations for the French company, but not for the American workers. This makes the American tanker more expensive and less competitive.

The Pentagon should develop a fair level playing field for the air refueling tanker competition, and this can only happen when these illegal subsidies are considered and all regulations are equally applied to both competitors.

WINNERS AND LOSERS

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

Mr. LARSEN of Washington. Mr. Speaker, I rise today to express my concern about the illegal subsidies that have been given to Airbus by the European governments. It's been widely reported that the World Trade Organization found the EU guilty of providing Airbus with billions of dollars in illegal and improper subsidies. These subsidies

gave Airbus an unfair advantage for years, costing good-paying American jobs. At the same time we're fighting Europeans over their illegal subsidies, our Nation is considering buying $35 billion worth of Airbus aerial refueling tankers.

Now who wins if we ignore these subsidies? European taxpayers will get a huge return on their illegal investment in subsidies for Airbus and European workers who are designing and building the Airbus airplanes.

Who loses? U.S. workers, who will lose their jobs, and I think our men and women in uniform, who might get an illegally subsidized tanker instead of the best tanker for their mission.

Airbus' history of subsidies should not be ignored in this tanker competition.

GITMO

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

Mr. SAM JOHNSON of Texas. Well, the administration announced it would hold civilian trials in New York for the 9/11 mastermind and other terrorists. I suspect the administration hopes this move will hasten the closure of Guantanamo.

The administration's announcement is exasperating, irresponsible, and absurd. Terrorists just do not deserve the same right to trial as Americans. Moving terrorists to New York will give those who wish to harm us constitutional rights that they do not deserve. Also, it will expose our intelligence-gathering methods to the world.

For the safety of all Americans, the trial should be held in military courts in Guantanamo. The administration should never put the rights of terrorists above the rights of Americans.

God bless America.

MORE OF THE SAME FROM DRUG MANUFACTURERS

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

Mr. OLVER. Mr. Speaker, amidst one of the worst recessions in our Nation's history, as Americans are tightening their budgets, our friendly drugmakers are flying high. While promising to support the health care overhaul by cutting $8 billion per year from our Nation's prescription drug costs, they're busy raising the prices of brand-name drugs by 9 percent. That will add more than $10 billion per year to prescription drug costs.

While the Consumer Price Index has fallen, the drugmakers are creating the highest annual rate of inflation for drug prices since 1992. It was only 3 years ago, in 2006, as the new Medicare part D program was going into effect, our prescription drugmakers raised their prices by four times the general inflation rate for the first quarter of that year.

America, we have foxes in our hen house. Drugmakers are up to the same old tricks again, gouging America's senior citizens while pretending to work cooperatively with us on the health reform effort. Their profit margins are their only concern. How could we have expected anything else?

GIVE AMERICA A FAIR SHAKE

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

Mr. REICHERT. I raise my voice loudly today on behalf of more than 22,000 Boeing workers in my district and all those thousands of workers across the State of Washington. The Department of Defense has pledged a fair and transparent process when it comes to awarding a new tanker contract for the Air Force. It must take a long, hard look at every angle when dealing with these decisions about the manufacturing of critical military equipment.

Billions of dollars of European ''launch aid'' subsidizes Airbus and gives them a grossly unfair competitive advantage in the global marketplace. This must not be ignored in awarding a tanker contract.

This is about fairness, it's about common sense, and has serious implications for our economy and our national security. Boeing workers produce the best planes in the world. They represent a long tradition of excellence and innovation. Let's give America a fair shake. Let's let the people of Boeing build this airplane.

PROVIDING FOR CONSIDERATION OF H.R. 2781, MOLALLA RIVER WILD AND SCENIC RIVERS ACT

Mr. CARDOZA. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 908 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 908

Resolved, That upon the adoption of this resolution it shall be in order to consider in the House the bill (H.R. 2781) to amend the Wild and Scenic Rivers Act to designate segments of the Molalla River in Oregon, as components of the National Wild and Scenic Rivers System, and for other purposes. All points of order against consideration of the bill are waived except those arising under clause 9 or 10 of rule XXI. The amendment in the nature of a substitute recommended by the Committee on Natural Resources now printed in the bill shall be considered as adopted. The bill, as amended, shall be considered as read. All points of order against provisions in the bill, as amended, are waived. The previous question shall be considered as ordered on the bill, as amended, to final passage without intervening motion except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Natural Resources; and (2) one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentleman from California is recognized for 1 hour.

Mr. CARDOZA. Mr. Speaker, for the purposes of debate only, I yield the customary 30 minutes to the gentlewoman from North Carolina (Ms. FOXX). All time yielded during consideration of the rule is for debate only.

GENERAL LEAVE

Mr. CARDOZA. I ask unanimous consent that all Members have 5 legislative days within which to revise and extend their remarks on House Resolution 908.

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

There was no objection.

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

Mr. Speaker, House Resolution 908 provides for consideration of H.R. 2781, a bill to amend the Wild and Scenic Rivers Act to designate segments of the Molalla River in Oregon as components of the National Wild and Scenic Rivers System, under a closed rule.

□ 1030

The rule provides for 1 hour of general debate, equally divided and controlled by the chairman and ranking minority member of the Committee on Natural Resources. The rule waives all points of order against consideration of the bill except for clauses 9 and 10 of rule XXI. The rule provides that the amendment in the nature of a substitute, recommended by the Committee on Natural Resources, now printed in the bill, shall be considered as adopted. The bill, as amended, shall be considered as read. The rule waives all points of order against the bill, as amended. Finally, the rule provides for one motion to recommit with or without instructions.

Mr. Speaker, the bill before us today, H.R. 2781, would add two segments of the Molalla River totaling 21.3 miles in northwestern Oregon to the National Wild and Scenic Rivers System. The two segments, 15.1 miles on the main stem of the Molalla River, and 6.2 of the Table Rock Fork, would be designated as a recreational river.

The Molalla rises in the Cascade Range, east of Salem. From its headwaters above the Table Rock Wilderness Area, the river flows through cedar, hemlock and old-growth Douglas fir forests, and basalt rock canyons until it meets the Willamette River near Canby. The Molalla River is an essential wildlife area for the pileated woodpecker and both golden and bald eagles. It is also within an hour's drive of the Portland and Salem metropolitan areas and provides significant recreational opportunities for fishing,

hunting, canoeing, kayaking, whitewater rafting, mountain biking, horseback riding, hiking, camping, picnicking, swimming and diving, all wonderful, great traditional American recreational activities.

These opportunities and a 20-mile hiking, mountain biking area and equestrian trail system draw over 65,000 visitors annually. I would add that the Molalla River also served as both a trail for indigenous Molalla Indians and as a vital trade route between pioneers in Oregon. The river is also where the cities of Molalla and Canby derive their drinking water.

In earlier planning analyses, the Bureau of Land Management determined that most of the river and the Table Rock Fork should be considered for designation as wild and scenic rivers. In testimony before the House Natural Resources Committee, BLM stated, ''the designation called for in H.R. 2781 would be largely consistent with management currently in place, and would cause few changes to BLM's current administration.''

Mr. Speaker, I would like to commend the gentleman from Arizona (Mr. GRIJALVA) and the gentleman from Oregon (Mr. SCHRADER) for bringing this legislation to the floor today so we can ensure America's beauty and natural wonderment is preserved both now and for future generations.

Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I yield myself such time as I may resume.

I want to thank my colleague from California for yielding me time. I am opposed to the rule and the underlying bill for reasons that I will make clear and that my colleagues will make clear.

At this time, I would like to recognize my colleague from Utah (Mr. BISHOP) for 5 minutes.

Mr. BISHOP of Utah. Mr. Speaker, I am opposed to the rule because an amendment that was under my name was not admitted in the rule by the Rules Committee. However, the issue at hand in both that amendment and the underlying bill is very small. It's 400 acres in Oregon. That is truly, in the scope of things, an insignificant number. What is significant, though, is the concept behind it, because it represents a larger, more pernicious issue that simply the leaders of this Congress are failing to address or even acknowledge.

Now, I have to admit that the fact that I am an old public schoolteacher is part of the problem. I spent 16 years in the Utah Legislature serving on the Public Education Subcommittee. I understand how difficult it is for those of us who are in the West, Mr. Speaker, the gentleman from the other side, how difficult it is for us to fund our public education system. And part of it is from the example that I have before me.

This chart simply shows the amount of Federal land that is owned in each State. As you notice, there is a somewhat disproportionate amount in the West. The Speaker's State of Arizona has a great deal; my State does; the State of Oregon, a little bit less. But nonetheless, there is a significant amount of land that is controlled by the Federal Government.

Many of our friends in the East who don't have that same opportunity have a hard time understanding what it's like to be a public land State. However, the second one, perhaps the more difficult one, is this chart which simply shows the number of States in red are the ones that have the most difficult time funding their public education system. These are the States whose growth in public education funding is the slowest, the most difficult.

You will notice that there is a unique correlation to the amount of Federal land that is owned and the inability of States to fund their public education system. It's almost a one-to-one relationship that happens to be there. So the 400 acres that would be taken out, the potential timberland that would be taken out of potential production in this particular bill, actually is land that no longer produces timber today. That's part of the problem.

It's one of the reasons why we received a letter from California and Oregon county officials who have what's called O&C land. O&C land is land that is dedicated for timber production. This 400 acres is not considered O&C, but it is the same concept. It is land that could be used for timber production.

What this bill will do in taking this small amount of land is to finalize and put in statute the bad administrative decisions of the past which have taken it out of production so it no longer can produce the revenue that we desperately need in these States to try to fund public education. The sponsor of this piece of legislation understood that. He got it right. When he came before the committee in our hearing, he simply used this statement when he asked the ranking member and the chairman to find an offset so that they did not lose the value of this small amount, 400 acres.

Unfortunately, we did not find an offset, and that was the crux of my amendment, both in committee as well as before the Rules Committee. There needs to be some kind of offset.

It says something even more disgusting as well, that if the Interior Department—of all the vast acreage of land that the Federal Government owns, 1 out of every 3 acres in this Nation—cannot find 400 acres as an offset for the State of Oregon, there is something terribly wrong in the mindset of the Interior Department here in Washington.

The issue is schoolkids. Are we going to try to help States fund their education system or not? I recognize that my amendment was ruled nongermane. Our germaneness rule is used more in its absence than in its regulation. But the issue at hand is simply, the gentleman from Oregon was right in the hearing—he got it right when he wanted an offset. The leadership of this Congress was wrong when they decided not to heed his warning and not to give his request. Today it's 400 acres. Tomorrow it may be 16,000 acres in another bill or 9.8 million acres in another bill.

It simply says, our kids are props for political purposes around here, but we really don't care about trying to find a long-term funding solution. The Rules Committee made this amendment out of order. I recognize that they can justify that on the grounds of germaneness. They could have just as easily incorporated the amendment without that as well. We do it all the time.

The SPEAKER pro tempore. The time of the gentleman has expired.

Ms. FOXX. I yield the gentleman 1 additional minute.

Mr. BISHOP of Utah. We justify those kinds of decisions all the time. I recognize that the Rules Committee will take its orders from leadership. That has to happen. They cannot ignore those things. But at the same time, had the Rules Committee followed the wishes of the gentleman from Oregon, we could actually be setting a precedent to help kids. When the Rules Committee failed to heed the request of the gentleman from Oregon, the sponsor of this piece of legislation, when he was justified and correct in coming before our hearing, what it simply said was that we put kids at a lesser priority than other protected kinds of issues.

Once again, this is the problem. It is this amount of land that causes the difficulty of Western States—all of our Western States on a State level—to provide for their needs. And that's what our amendment could solve. That amendment was not made in order. That is simply wrong. Please vote down the rule so that we can put this amendment back in place.

Mr. CARDOZA. In response to the gentleman from Utah, I would say the following. Two of the amendments that the gentleman offered to the Rules Committee on H.R. 2781—one amendment was nothing more than political talking points with zero substance. The second, the other amendment, was both nongermane and a violation of PAYGO under the House rules.

Further, I would add in response to the questions with regard to the Obama administration that, on November 13, the Obama administration reiterated in a letter to Chairman GRIJALVA, stating, ''There are no timber contracts within the Federal lands proposed for designation under H.R. 2781.'' I would like to insert into the RECORD a letter from the department indicating that to the chairman.

DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington, DC, November 13, 2009.

Hon. RAÚL GRIJALVA,
Chairman, Subcommittee on National Parks, Forests, and Public Lands, House Committee on Natural Resources, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Enclosed are responses prepared by the Bureau of Land Management to questions submitted following the Subcommittee's Thursday, October 1, 2009, hearing on, H.R. 2781, "Molalla River: National Wild and Scenic River System."

Thank you for the opportunity to provide this material to the Subcommittee on National Parks, Forests, and public Lands."

Sincerely,

CHRISTOPHER P. SALOTTI,
Legislative Counsel, Office of Congressional and Legislative Affairs.

Enclosure.

QUESTIONS FOR ROBERT ABBEY, DIRECTOR, BUREAU OF LAND MANAGEMENT, DEPARTMENT OF THE INTERIOR.

Questions from Representative Grijalva:

1. How does BLM usually manage private land within wild and scenic river corridors?

Answer. Under the Wild and Scenic Rivers Act, the Federal government has no authority to manage private lands within wild and scenic river corridors.

2. Are there any timber contracts within the corridor of the proposed designation for the Molalla?

Answer. The BLM in Oregon informs me that there are no timber contracts within the Federal lands proposed for designation under H.R. 2781, which designates segments of the Molalla River in Oregon as components of the National Wild and Scenic River System.

Third, with regard to Mr. SCHRADER's comments, the gentleman said that we should have heeded Mr. SCHRADER's comments. Well, guess what. Representative SCHRADER, who represents this area, expressed a concern, as the gentleman indicated, about this issue at the Natural Resources Committee hearing in October. He also states in a letter to us, that I will have inserted in the RECORD, that since that time he has investigated this concern with the agencies on the ground and wrote the committee on November 10 to say that he was totally satisfied that the bill will not remove trees from the timber stock because there are no timber contracts planned in the area, and there are none now, and there are none planned. So I would like to submit for the RECORD Mr. SCHRADER's letter.

HOUSE OF REPRESENTATIVES,
Washington, DC, November 10, 2009.

Hon. NICK RAHALL
Chairman, House Committee on Natural Resources, Longworth House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: I write to express my support for the committee's amendments to my bill, H.R. 2781, to designate segments of the Molalla River in Oregon as components of the National Wild and Scenic Rivers System.

At the October 28th markup of H.R. 2781, mention was made of a statement in my testimony regarding 420 acres of timber management, or "matrix," lands that will be within the river corridor when my bill is enacted. Since the October 1st hearing before the National Parks, Forests and Public Lands Subcommittee at which I testified, I have consulted both the Bureau of Land Management and committee staff about those matrix lands. I am satisfied that this designation will not remove trees from the timber stock: there are no timber contracts in that area, and no timber sales are planned.

I reserve the right to offset logging acreage in future bills I might introduce, but I see no need to add such language to H.R. 2781 at this time. Thank you for your support of this legislation which has overwhelming support within my district and thank you for all your work you do as Chairman of the Natural Resources Committee.

Sincerely,

KURT SCHRADER,
Member of Congress.

I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I yield 1 minute to the gentleman from Utah.

Mr. BISHOP of Utah. I appreciate the comments made by the gentleman from California, and I think I tried to state those comments earlier on.

The letter we received from the Association of O&C Counties—that's Oregon and California—concerned about this particular issue does include and specifically mentions these 411 acres in this National Wild and Scenic Rivers bill. I also recognize that the gentleman from Oregon, who is the sponsor of this bill, has since sent a letter that says that it does not have an impact. It does not have an impact because of bad administrative decisions made earlier that have already taken this out of timber production.

What we are doing with this bill is now putting that in statute so that we cannot at some time reverse that with the ease with which we took them out in the first place. We have made bad decisions time after time after time, which has impacted the timber industry in these States and has impacted their ability to fund their local governments and especially their education system. That was the fundamental reason it was ruled out of order. It violated PAYGO because, if you actually did put that, those funds would have to be shared with the local States.

Mr. CARDOZA. Mr. Speaker, I yield 5 minutes to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. I appreciate the gentleman's courtesy in permitting me to speak on this, as I appreciate his clarity in moving it forward. It is my privilege to represent part of Clackamas County in my congressional district. Now while I don't actually have the area in question, I have worked very hard with my colleague Congressman SCHRADER to make sure that the interests of this diverse county are, in fact, represented. And if one came from Mars and listened to the debate, they might be a little confused on this point.

First, the land in question is not O&C land. It is BLM land. There is no fiscal impact here. There is no timber that is involved. I worked very closely with this county and have for decades. The county commissioners now, as they have in the past, have been very careful to heed the balance of resource protection, economic development, the environment, and tourism in the broad range of areas. I have worked with them on wilderness legislation, in wild and scenic legislation, including the one signed into law by President Obama at the beginning of this year.

I have had times when they have been hesitant because they have had questions about whether the benefits of economic development of tourism, of wilderness protections, would offset potential loss of timber production. The county has gone through the process here yet again. It is their judgment, and one that I strongly support, that the resource protections to have this stretch of the Molalla River being granted Wild and Scenic protection is well worth it.

There is a minuscule amount of land that would not be removed from potential harvest, but it's not going to be harvested now. It's not going to be harvested in the future. If the gentleman would come with me to Clackamas County, Congressman SCHRADER and I would be pleased to show him this precious resource and why there was never any question that this would not be harvested.

So people can go on and confuse BLM land with O&C land. They can talk about their disputes with this administration and past administrations about timber practices. That's fair game. And they will battle that. Frankly, the American public supports wilderness protection. The American public wants the protection not just of Wild and Scenic Rivers but of our precious watersheds where half the people in my State get their water from national timberland. As my friend from California knows, this is a very sensitive issue these days.

□ 1045

Mr. Speaker, I am proud to support this rule. I am proud to support this underlying legislation. It has been carefully crafted by my friend, the gentleman from Clackamas County. He lives in this county not very far from the river that would be so designated. It is a testament to his quick assimilation into the ways of the House of Representatives, to be able to move forward with significant wild and scenic legislation, to be able to work with the local environmentalists, work with the county commission, to come forward with something that not only will protect a natural resource for years to come, but it is also going to enhance the local economy.

This will in fact deal with the future of the children of Clackamas County because the economic development potential that will be generated by people

who use this waterway, you come year round and not just in high water times, people navigate these waters in Clackamas County. It is a growing and thriving area of economic development, of recreation for people young and old, and for the character of a unique county in our State and in our Nation.

Mr. Speaker, I am proud to speak in support of the rule, the underlying legislation, and I look forward to passage of both.

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

You know, Republicans are getting very tired of being accused of not being sensitive to our environment. We are very sensitive to the environment. We want to protect water everywhere. We have been very, very vocal on that issue, especially this session, especially as it has related to the West, and my colleague on the Rules Committee knows that.

However, we are also concerned about jobs for the American people. We know that the unemployment rate has recently reached a record high of 10.2 percent, the highest unemployment rate our country has in 26 years, and aptly described in a Wall Street Journal editorial this week, ''It is no wonder Americans seem to have only three things on their mind right now: jobs, jobs, and jobs.''

If nothing else, the Federal Government should do no harm to the job market—that is common sense—but that is exactly what the Democrats in charge are doing with this legislation today. They are going to be harming American families by increasing unemployment.

Mr. Speaker, I yield 5 minutes to the gentleman from Utah (Mr. BISHOP), who is going to deal with some of the issues that our colleague from Oregon has raised on this issue.

Mr. BISHOP of Utah. Mr. Speaker, I appreciate the time.

I am sorry that the gentleman from Oregon came in late during the discussion and has left that side of the aisle. I want to make it very clear, when I was making my first statements, I did not say that these 400 acres were O&C lands—I made that very clear—but they are treated like O&C lands, which is why the local leaders from Oregon and California sent the letter and specifically asked any kind of lands taken out of the ability to be used for timber production be offset. They specifically requested in a number of other areas this particular area that will be made wild and scenic. This is the request that comes from the local leaders in California and Oregon which recognizes what happens when these lands are taken out of production, and they clearly, as I do, understand that there is economic development from tourism. There is also economic development from manufacturing and there is also economic development from timber harvest, and they each have a different role to play. And each have a different amount of money they do to help kids.

These local leaders recognize that fact which is why they supported what the sponsor of this bill originally wanted to do. Unfortunately, the House leadership has not recognized what his wishes were and has not done what the sponsor originally wanted to do. Though he has now changed his mind, he says these lands are not now producing timber, that is not the issue. The issue is will they ever be useful in that particular effort. That is what we are trying to do with the amendment which should have been made in order. It should have been part of the original bill that came out of the committee. There is no reason why it should not have been.

Now, I recognize there is a significant issue, Mr. Speaker, and let me do just one thing very quickly, because what these local leaders are talking about is specifically allowing them to have some kind of control over their own destiny. We see that played out in bill after bill and issue after issue on this floor.

The other week we passed a small bill, maybe some of you have read about it in the papers, about health care. One of the issues of that bill is it stops local, creative, alternative approaches.

The State of Utah started a local approach for health care reform. They got it right. It was based on empowerment of individuals by employers who would now have a common understanding of what they would have to spend on health care, to be able to give that to their employees, so the employers go to a State index where they have presently 66 options from which to choose. It was an effort to empower individuals. It is an effort of States to solve their own problems because States understand the unique demographic needs that they have in those particular States. Unfortunately, the bill that was passed, if it were to go all of the way through the system, stops the States dead in their tracks from actually implementing their own local reforms, just like this would stop the local areas from implementing their own local reforms.

Now, I hope we understand how significant it is that you can't get enough experts here in one particular room to solve all of the problems in the world, and we should look at the concept of States and local governments having their own ability to experiment and their own ability to meet their local demographic's needs and their own ability to come up with unique and clear ideas, and we should be empowering local governments to make those decisions, not restricting them with a one-size-fits-all mentality or telling them what they will and will not do on the local level.

Mr. CARDOZA. Mr. Speaker, as part of the course of debate, the gentlewoman from North Carolina indicated that they have been very supportive of the environment, and she has indicated that they are getting a bad rap, as it were, for not being supportive of the environment. I would like to ask the gentlelady how many wild and scenic bills have they supported on the floor this session of Congress. I know we have had a number, and I don't recall a one that they have supported.

Mr. Speaker, at this time I yield to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. I thank the gentleman.

Ms. FOXX. Would the gentleman yield?

Mr. DEFAZIO. I yield to the gentlelady.

Ms. FOXX. I thank the gentleman from Oregon for yielding.

We have voted for all of the wild and scenic bills that have met the proper definition of wild and scenic rivers.

Mr. DEFAZIO. Okay. That would raise a further interrogatory with me: How many did you deem in your opinion met the proper definition?

I yield.

Ms. FOXX. Not the one in Massachusetts, the Taunton River, and not this one.

Mr. DEFAZIO. Thank you.

Reclaiming my time, it is interesting to me, and I represent one of the districts most impacted by changes in Federal forest policy and suffering some of the highest rates of unemployment in the United States, and it is interesting to hear the gentleman from Utah now come before us as such a tremendous advocate for local governments with revenues created or shared from Federal lands, because when we were in a crisis, the Bush administration having made no changes in Federal forest policy and still limping along during the 6 years that the Republicans controlled the House, the White House and the Senate, the guarantees that had been put in place to ameliorate the impact of the Clinton forest plan, which I opposed, expired. They just expired while George Bush was in the White House and the Republicans controlled the House and the Senate.

Now I wonder about that tremendous concern. At that time when they controlled everything, they had an opportunity to continue a program that would fund sheriffs and would maintain our jail space and would fund our roads, bridges, and highways on the county system, would help fund schools, they just walked away from it. They let it die. And it took the Democrats 5 months to pass, after we took control from the Republicans, despite the objections of the Republicans and the Bush administration, to pass legislation to give emergency payments for

1 year, and then yet again the Democrats in the last Congress extended the program for 4 years with a phasedown.

I actually did bring my bill for authorizing programs to the floor of the House last year on June 5, 2008. It was brought up under a suspension of the rules, unfortunately. Because of Republican opposition to the bill, it was deemed it would have to come up under suspension of the rules. We got 218 positive votes; 16 of those were Republican, 16, but it was not the gentleman from Utah. He opposed my proposal.

Suddenly, now, over a little 400 acres of land, which does not have any potential to produce any large amount of money, if any, under the current forest management, he wants to block this bill. But last year when the opportunity to vote to extend funding to all of the counties and school districts in America, and his State would have been one of the greatest beneficiaries outside of Oregon and California, he voted ''no.''

So sometimes around here, I think the proof is in the pudding on how you vote. I think it is an objection of convenience on the part of the gentleman, this sudden, newfound concern for local governments and schools for the nonexistent revenue from this very small parcel of land as opposed to the benefits that would accrue to that area by the protection of this. The local governments and all of the other officials in that area support the legislation. They aren't concerned about some theoretical, infinitesimal loss of money. They are more concerned about protecting the resource and developing that area into a recreation corridor that will attract people from around the State and perhaps from around the Nation to that area. That is part of their local economic development strategy, and that is what the local governments want. That is what the Representative for that district wants. That is what I support, and I will just say that any specious argument that somehow this hurts local government, hurts schoolkids, hurts public safety, coming from someone who opposed an opportunity to give robust funding for public safety, schoolkids all across America, to all of these distressed counties, is a little bit out of line.

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

You know, from almost the very first day when I came here, I heard my colleague from Oregon blaming George Bush for everything insufficient in this country. That started in 2005 and he is still doing that, just like many of our colleagues here. But the Democrats in charge can't hide from the fact that they now control the House, the Senate, and the White House, and what are they doing to solve the problems? Very little.

I want to say that the sponsor of the bill actually brought up this issue that our friends across the aisle are trying to say now is our issue, but unfortunately the sponsor of the bill has been helped to change his mind on the issue by the Democrats in charge because it suits their purposes more.

And actually, the GOP has been the leader in starting good environmental programs in this country, just as we were the people who passed the civil rights bills back in the sixties without very much help from our colleagues across the aisle. They love to engage in revisionist history.

□ 1100

Mr. Speaker, I would like to say that this bill could have been brought to the floor under an open rule, and we could have been debating amendments. But it's been brought in a closed rule. Actually, this bill is probably going to pass, the rule and the bill will pass overwhelmingly; and the real reason that we're doing this today is to kill time again. We've been voting on a lot of things we haven't really needed to vote on with a recorded vote because the majority wants to, again, kill time in order to be dealing with problems where their majority is not going to hold very well.

What we are going to be voting on a little later today, we think, is a bill which our colleagues across the aisle call the ''doc fix'' but we call the ''doc trick.'' It's really a Trojan horse. Supposedly it is going to take care of the reimbursements for physicians in our country that are scheduled to be cut next year by 20 percent.

But this ''doc trick,'' as I said, is really a Trojan horse because it is not deficit neutral, and it is a bill that is going to increase spending by at least $209 billion plus another $70 billion that's hidden in administrative actions by the Department of Health and Human Services. So it's going to really cost $279 billion. When you take the ''doc trick'' in combination with the health care bill, the combination increases the deficit by $100 billion.

This is unconscionable in a time when we have the largest deficit ever in the history of this country, which is the biggest concern of the people in this country. They are not as concerned about health care as they are about jobs and about the horrible debt that we are incurring not only for ourselves but for our children and our grandchildren.

Republicans have made a commitment that if we take back the majority next year, we will fix this reimbursement for physicians permanently. But that's not what's going to happen with the ''doc trick'' shell game that is being brought to us. And what they're going to do is say that it's going to be compliant with PAYGO.

You know, every time I hear the term ''PAYGO,'' we know, and the American people are beginning to notice, that it is a big joke. It's been talked about as a joke by almost every editorial in the country. The Washington Post has called it a shell game, budgetary smoke and mirrors. It's going to add billions to the deficit even though President Obama promised, ''If you're a taxpayer concerned about deficits, I want to reassure you that I am too. That's why I have pledged I will not sign health insurance reform that adds even one dime to our deficit over the next decade and I mean it.'' This was said by President Obama in Shaker Heights, Ohio, on the 23rd of July.

We also know that the Senate has already rejected a bill almost exactly the same as the one that's going to be voted on today. Thirteen Democrat Senators opposed it. Senator KENT CONRAD said, ''I don't agree with just adding that amount to the debt.'' He happens to be a Democrat from North Dakota. Senator EVAN BAYH, a Democrat in Indiana, said he couldn't support it at a time when we are hemorrhaging red ink. Senator JOE LIEBERMAN, independent, but caucusing with the Democrats said, ''Out of nowhere we're asked to provide $250 billion to cover services without any payment for it, increasing the debt by that amount.'' He added that if lawmakers pass health care reform that includes a public option, the debt crisis will only worsen.

This is the wrong direction to be going in this country, Mr. Speaker, because we're adding debt; and, as I say again, the bill that's going to be presented today is a Trojan horse. It is not going to help our physicians dealing with reimbursements. It is a trick to say that it is being taken care of. It was taken out of the major health care bill.

Those are the kinds of things that we should be dealing with on this floor. We should have open rules, and they should not be doing their best to fool the American people on what is really happening with our debt and with costs.

Mr. Speaker, I reserve the balance of my time.

Mr. CARDOZA. Mr. Speaker, in the 7 years that I have been here and the years that I have watched this Congress beforehand, I sometimes watch the floor and I can't believe what I'm hearing. I can't believe my ears. Today what I'm hearing on the floor really takes the cake.

The gentlewoman from North Carolina in her statement just now indicated that the Republican GOP had passed the Civil Rights Act legislation with almost no help from the Democrats. I can't believe my ears. It was the Kennedy and Johnson administrations where we passed that Great Society legislation. It was over the objections of people like Jesse Helms from the gentlewoman's State that we passed that civil rights legislation.

JOHN LEWIS, a Member of this House, was beaten on the Edmund Pettus Bridge to get that civil rights legislation passed. Tell JOHN LEWIS that he wasn't part of getting that legislation passed.

I sometimes cannot believe what I hear on this House floor. And I will tell you today that I will stand by these statements, and I am very proud of what my party has done to advance civil rights legislation in the United States of America.

Mr. Speaker, I reserve the balance of my time.

Ms. FOXX. Mr. Speaker, I'd just like to point out to the gentleman from California that Senator Helms was not elected to the United States Senate until 1972 and was not in the Congress when the civil rights legislation was passed in the 1960s.

Mr. Speaker, if this legislation passes as it's written right now, 420 acres of timberland will be lost and along with it local jobs and funding for local schools. As Mr. BISHOP has suggested with an amendment he offered in the Rules Committee on Tuesday, a better name for this bill would be the ''School Children and Jobs Left Behind Act.''

Even worse, Oregon's unemployment level in September 2009, the latest on record, was 11.5 percent, up almost double from 6.8 percent in the same month last year.

Most of Oregon's economic output depends on the State's timber industry. Valuable revenue needed to fund schools has been lost as well. According to the Pew Center on the States, Oregon has lost 19 percent of its revenue in the last year and faces a budget gap of 14.5 percent in fiscal year 2010. According to the U.S. General Services Administration, the Federal Government already owns 53 percent of the State of Oregon, 53 percent. Apparently that's not enough to satisfy special interest groups to which the Democrats are beholden. This bill will lock up 420 more acres that could be used to produce much-needed revenue for the State while at the same time refusing to open up an equal amount of Federal land to offset more job losses during a recession.

As Ranking Member HASTINGS described to the Rules Committee, it's longstanding tradition that the Natural Resources Committee be respectful of the views of those elected to represent a district and show deference when a Member opposes an action that's proposed in the district that Member was elected to represent.

In his testimony to the subcommittee, Mr. SCHRADER specifically asked that as this bill moves forward, work be done to ensure that there will be no net loss of acres available for timber management as a result of this legislation. However, Democrats on the Natural Resources Committee blocked an amendment offered by Mr. BISHOP to ensure the lost timberlands were offset and the health of the local economy be maintained. Mr. BISHOP again offered an amendment to provide an offset for lost timberlands, but it was rejected by the Democrats on the Rules Committee.

In fact, the rule we have before us today is a closed rule, as I said earlier. No amendments were allowed by Democrats in charge of the Rules Committee. By choosing to operate in this way, the majority has again cut off the minority and their own colleagues from having appropriate input in the legislative process.

By choosing to stifle debate, the Democrats in charge have denied their colleagues on both sides of the aisle the ability to do the job they have been elected to do: offer ideas that represent and serve their constituents. They are denying Members the ability to offer improvements to this legislation, and this is an injustice to their colleagues on both sides of the aisle.

Our colleagues across the aisle are limiting what ideas can be debated on the floor and which constituents can be adequately represented in the House. Our constituents in both Republican and Democrat districts are struggling to make ends meet, are facing unemployment, and yet are simultaneously being cut out of participating in a debate over how their hard-earned taxpayer dollars are being spent by the Federal Government.

Why is the majority blocking debate on such important legislation? Are they afraid of debate? Are they protecting their Members from tough votes? Are they afraid of the democratic process?

Mr. Speaker, it's troubling to me we're debating this legislation today when my constituents and all Americans are confronted with dire economic hardships that remain unaddressed. Families all over the country are struggling to find jobs to provide for their children and keep food on their tables. Yet while Rome burns, this Congress is wasting the day talking about whether or not a river should be designated as ''wild and scenic'' and trying to pass a policy that will do even more harm to the economy.

We cannot afford to lose more jobs. The U.S. national debt is currently $12 trillion. With over 300 billion people in the United States today, each citizen's share of this debt right now is $38,800. The national debt has continued to increase at an average of $3.88 billion per day since September 28, 2007.

We can no longer blame the deficit and the economic difficulties today on the previous administration. As I said earlier, the Congress and the administration are now controlled by Democrats. They continue to borrow money, and it's being spent by Speaker PELOSI and the Obama administration; and as a result, the unemployment rate continues to rise and the deficit continues to rise.

Since the Democrats took control of Congress on January 4, 2007, the national debt has increased by $3.282 trillion. Since President Obama was inaugurated just 10 months ago in January, the national debt has increased by $1.325 trillion. Almost 1 year after President Obama was elected and 3 years since the Democrats took majorities in Congress, the Department of Treasury has reported that under the Democrats' control, 2009 was the worst fiscal year in this Nation's history. The results get more disastrous with each passing day.

I have opposed all these efforts to raise the debt limit, and we're going to be facing that again very shortly. According to analysis by the Heritage Foundation, the White House projects $10.6 trillion dollars in new deficits over the next decade. That is nearly $80,000 per household in new borrowing. It's beyond time to stop digging. The new budget estimates, including an estimated total national debt of $24.5 trillion in 2019 under President Obama's budget, are alarming and unsustainable. The result will be the highest level of spending and debt in American history.

Mr. Speaker, we need to be dealing with this. We need to be putting people back to work. We don't need to be increasing the debt with every passing day by passing bills that will do that and playing a shell game with the American people.

One of the best things that's happened this year is that the American people are paying much closer attention to what is going on in the Congress. They've learned they can read the bills if the bills are ever put out for them to read. They spoke in New Jersey, they spoke in Virginia in the election earlier this year, and our colleagues on the other side of the aisle need to start paying attention, as we have been paying attention all year long.

Mr. Speaker, I reserve the balance of my time.

Mr. CARDOZA. Mr. Speaker, I would like to respond to the gentlewoman's statement where she talked at great length about the fact that the House is being closed down, that the debate is being stifled. And I would like to remind the House of an earlier statement that I made that there were only two amendments submitted to the Rules Committee on H.R. 2781.

One of the amendments was nothing more than a change of the title which consisted of political talking points, added zero substance to the bill. The other amendment was both nongermane and a violation of the PAYGO requirements of this House, two of the most important rules that are part of the conducting of debates in this House.

So the gentlewoman is advocating that we break the House rules and agree to an amendment that is really de minimis to the grander aspect of what we're trying to do here.

□ 1115

The local community has asked for this designation, the local Congressman. In fact, you've heard today that three Members of Congress from Oregon all advocate for this bill. I'm sure there are more. The reality is that the local folks have determined that this is the best way to create economic development, and the 420 acres that are being so grandly discussed by the other side as reason to oppose this bill, that are going to cause economic devastation for both this area and the country—well, the local folks don't believe it, and neither does anybody else.

This is a good bill, Mr. Speaker.

I'd like to now yield 5 minutes to my colleague from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, the gentlelady's concerned about two things, the deficit and jobs. I share those concerns. But again, we have a little problem with consistency. When she was offered an opportunity, just in September, to extend the national surface transportation investment, fully paid for through user fees, gas tax and other fees, fully paid for, a program that creates millions of jobs, construction jobs, she voted ''no.'' She voted to end all funding for investment in our national transportation infrastructure, an extraordinary vote, unbelievable for someone who cares about jobs and cares about the deficit, because it was paid for and it creates millions of jobs.

And on October 1 that program was going down, and tens of thousands of people across the United States of America would have been unemployed, private sector people, construction workers who are already hard-hit in this recession. If the Republicans and she had their way, that program would have ended on October 1.

Now, it's pretty hard to justify that vote. I don't quite understand it. But she also has the same consistency problem as the gentleman from Utah; that is, when there was an opportunity to help those school districts, those local communities fund critical public safety, sheriffs and jail beds, she voted ''no'' along with a large majority of Republicans against my legislation last May.

Now, there's this suddenly newfound interest in a community that doesn't want her interest. They want self-determination. They support this legislation. The elected Representative supports this legislation. But, no, the Republicans from elsewhere around the country, they know better than the people of Oregon. They know better what would help the people of Oregon.

Except, again, back to the Bush administration and the Republicans running Congress, when the Bush administration had an opportunity to continue payments to those counties, or change the forest policy, they did neither. They didn't change the Clinton forest plan, which I opposed, which has devastated communities. And they allowed the legislation signed by President Bill Clinton to give assistance to those counties impacted by his forest policies assistance—they allowed that to expire, too, when they were in charge. And the gentlelady said nothing at that time. She didn't help support us in that effort. She didn't support that. She didn't support it last year when I offered it.

So let's not have a false debate here about what's better for the people of Oregon, coming from even a near neighbor in Washington State, or from the gentleman in Utah, or a woman from back East. Let's respect the local will of the people.

When DON YOUNG chaired the Resources Committee, we kind of had a rule. We didn't mess around in each other's districts. I kind of liked that rule. We're messing around in someone else's district here. We're messing around with the local will. And let's not have newfound sympathy for my constituents who've been hit so hard when you didn't lift a finger to help them when you ran everything.

Mr. HASTINGS of Washington. Will the gentleman yield?

Mr. DEFAZIO. I will yield.

Mr. HASTINGS of Washington. I appreciate the gentleman yielding. Let me just reiterate his last point. I agree with that. In fact, I made that observation when we were in committee on this. I just have a problem with wild and scenic designations that I've pointed out.

But I just wanted to correct a little bit because you and I worked very hard on the rural school issue. I was on the Rules Committee at that time, and I know my friend from California heard me over and over on that. Let's just go back in history. It was a Forest Policy Act that caused that to happen. It was a Republican Congress that put the rural school program in place. So, you know, finger-pointing is not going to get us anywhere.

I know that when you took over, the Senate, for example, had passed the rural school bill, something like 92–3. I forget the exact figure, but it was overwhelming, and it was never taken up by your House leadership. Now, it eventually got done, but it does have a date, and we're going to have to come back and revisit it. The point of all of this debate is that the end result, this is only a very small acreage, but we are going to forever take it out of potential logging. That is what the issue is.

And so I appreciate the gentleman yielding. I just wanted to clarify that particular point because he and I did work on that rural school problem along with our colleague from Oregon (Mr. WALDEN). He is very much involved with that.

So I appreciate the gentleman yielding. We will have more discussion on this issue when, if, this rule passed. I certainly hope it doesn't pass because then we can, you know, go and do the right thing. But, at any rate, I appreciate the gentleman yielding.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. CARDOZA. I yield the gentleman from Oregon 1 additional minute.

Mr. DEFAZIO. The gentleman is correct, and he did work hard to help with the renewal of the county schools, and my colleague from Oregon, GREG WALDEN, was a partner in that effort. But the fact is that, you know, when you controlled everything, it died. The program died. And we were so desperate that at the end of the Congress GREG and I came and sat here on the floor till 2 o'clock in the morning, so at the end of that Congress we could offer a unanimous consent request to move that program forward and fund it, and the objection came from your side of the aisle again.

So, unfortunately, you know, there are some hard facts here. You are right. The original legislation was passed when the Republicans controlled the House. Bill Clinton was President. We had a bipartisan agreement to help the counties, but when there was a later opportunity, nothing happened.

Ms. FOXX. Mr. Speaker, you said I had 3 minutes. There's so much to say in so little time.

I do want to point out—and it's in the RECORD, it's easy for people to check out—that the Democrat-controlled Rules Committee in the 1960s defeated bringing up civil rights legislation until the Speaker of the House increased the membership on the Rules Committee, so that the increased Democrats could vote with the Republicans to bring the civil rights legislation to the floor.

Mr. Speaker, I urge my colleagues to defeat the previous question so an amendment can be added to the rule. The amendment to the rule would provide for separate consideration of H. Res. 554, a resolution to require that legislation and conference reports be posted on the Internet for 72 hours prior to consideration by the House. It does not affect the bill made in order by the rule. The amendment to the rule provides that the House will debate the issue of reading the bill within three legislative days. It does not disrupt the schedule.

This is not a partisan issue, Mr. Speaker. As Members of Congress, we ought to agree that, regardless of the legislation brought before us, we should always have the opportunity to read and understand the legislation before we vote. The American public

agrees with this commonsense position. A recent survey by Rasmussen Reports found that 83 percent of Americans say legislation should be posted online and available for everyone to read before Congress votes on it. The poll also found that this is not a partisan issue; 85 percent of Republicans, 76 percent of Democrats, and 92 percent of unaffiliated voters, favor posting legislation online prior to it being voted on.

Mr. Speaker, we're elected to Congress to represent our constituents. How are we supposed to determine what's right for our fellow Americans if we have to vote on something before we even have time to read it?

I urge my colleagues to defeat the previous question so we can have this debate and do the right thing for the American people.

Mr. Speaker, I ask unanimous consent to have the text of the amendment and extraneous material inserted into the RECORD prior to the vote on the previous question.

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

There was no objection.

Ms. FOXX. I urge my colleagues to vote ''no'' on the previous question and the rule, and I yield back the balance of my time.

Mr. CARDOZA. Mr. Speaker, we've heard quite a debate today. The debate was about designating a wild and scenic river in Oregon. But it has gone far, far afield from there. We've heard about the deficit. We've heard about jobs. We've heard about the Civil Rights Act and who was responsible for passing the legislation that did that historic. We've heard quite a lot that doesn't have anything to do with the reason we are here today, and that, Mr. Speaker, is designating the Molalla River as part of the Wild and Scenic Rivers System, which will help ensure that social, cultural, and economic benefits of the area will be preserved.

For several years, an alliance of over 45 organizations has been dedicated to river restoration efforts and protecting the area from destructive acts. And the local community around the Molalla has asked for this designation. It is now up to Congress to act on behalf of the citizens and the communities at hand to preserve the river's historic, scenic, and recreational values; to protect the river's water quality and its free-flowing character; and ensure that Americans and Oregonians can enjoy the original character of this river for generations to come.

Mr. Speaker, I think it's a good bill. The bill deserves strong support of my colleagues on both sides of the aisle, and I ask for that support. Mr. Speaker, I urge a ''yes'' vote on the rule and on the previous question.

The material previously referred to by Ms. FOXX is as follows:

AMENDMENT TO H. RES. 908 OFFERED BY MS. FOX OF NORTH CAROLINA

At the end of the resolution, insert the following new section:

SEC. 2. On the third legislative day after the adoption of this resolution, immediately after the third daily order of business under clause 1 of rule XIV and without intervention of any point of order, the House shall proceed to the consideration of the resolution (H. Res. 554) amending the Rules of the House of Representatives to require that legislation and conference reports be available on the Internet for 72 hours before consideration by the House, and for other purposes. The resolution shall be considered as read. The previous question shall be considered as ordered on the resolution and any amendment thereto to final adoption without intervening motion or demand for division of the question except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Rules; (2) an amendment, if offered by the Minority Leader or his designee and if printed in that portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII at least one legislative day prior to its consideration, which shall be in order without intervention of any point of order or demand for division of the question, shall be considered as read and shall be separately debatable for twenty minutes equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit which shall not contain instructions. Clause 1(c) of rule XIX shall not apply to the consideration of House Resolution 554.

(The information contained herein was provided by Democratic Minority on multiple occasions throughout the 109th Congress)

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not merely a procedural vote. A vote against ordering the previous question is a vote against the Democratic majority agenda and a vote to allow the opposition, at least for the moment, to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's Precedents of the House of Representatives, (VI, 308–311) describes the vote on the previous question on the rule as ''a motion to direct or control the consideration of the subject before the House being made by the Member in charge.'' To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's ruling of January 13, 1920, to the effect that ''the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition'' in order to offer an amendment. On March 15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R-Illinois) said: ''The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition.''

Because the vote today may look bad for the Democratic majority they will say ''the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever.'' But that is not what they have always said. Listen to the definition of the previous question used in the Floor Procedures Manual published by the Rules Committee in the 109th Congress, (page 56). Here's how the Rules Committee described the rule using information form Congressional Quarterly's ''American Congressional Dictionary'': ''If the previous question is defeated, control of debate shifts to the leading opposition member (usually the minority Floor Manager) who then manages an hour of debate and may offer a germane amendment to the pending business.''

Deschler's Procedure in the U.S. House of Representatives, the subchapter titled ''Amending Special Rules'' states: ''a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate.'' (Chapter 21, section 21.2) Section 21.3 continues: Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon.''

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Democratic majority's agenda and allows those with alternative views the opportunity to offer an alternative plan.

Mr. CARDOZA. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

ELECTING MEMBERS TO CERTAIN STANDING COMMITTEES OF THE HOUSE OF REPRESENTATIVES

Mr. LARSON of Connecticut. Mr. Speaker, by direction of the Democratic Caucus, I offer a privileged resolution and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 921

Resolved, That the following named Members be and are hereby elected to the following standing committees of the House of Representatives:

(1) COMMITTEE ON ARMED SERVICES.—Mr. Owens (to rank immediately after Mr. Murphy of New York).

(2) COMMITTEE ON HOMELAND SECURITY.—Mr. Owens (to rank immediately after Mr. Luján).

(3) COMMITTEE ON SCIENCE AND TECHNOLOGY.—Mr. Garamendi (to rank immediately after Mr. Griffith).

(4) COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE.—Mr. Garamendi.

Mr. LARSON of Connecticut (during the reading). Mr. Speaker, I ask unanimous consent that the resolution be considered as read and printed in the RECORD.

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

There was no objection.

The resolution was agreed to.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on questions previously postponed.

Votes will be taken in the following order: Ordering the previous question on House Resolution 908; adopting House Resolution 908, if ordered; and suspending the rules on S. 1599.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

PROVIDING FOR CONSIDERATION OF H.R. 2781, MOLALLA RIVER WILD AND SCENIC RIVERS ACT

The SPEAKER pro tempore. The unfinished business is the vote on ordering the previous question on House Resolution 908, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The vote was taken by electronic device, and there were—yeas 241, nays 176, not voting 17, as follows:

[Roll No. 902]

YEAS—241

Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Butterfield
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Chu
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Yarmuth

NAYS—176

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Baird
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Brady (TX)
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Cassidy
Castle
Chaffetz
Childers
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Donnelly (IN)
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOT VOTING—17

Abercrombie
Boustany
Brown (SC)
Burgess
Capuano
Carter
Clarke
Engel
Gohmert
Lewis (GA)
McCaul
McDermott
Miller, George
Moran (VA)
Nadler (NY)
Skelton
Wu

□ 1153

Messrs. BAIRD and HALL of Texas changed their vote from ''yea'' to ''nay.''

Mr. THOMPSON of California changed his vote from ''nay'' to ''yea.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Ms. FOXX. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 244, noes 176, not voting 14, as follows:

[Roll No. 903]

AYES—244

Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Butterfield
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Castle
Castor (FL)
Chandler
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono

Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOES—176

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Brady (TX)
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Campbell
Cantor
Cao
Capito
Cassidy
Chaffetz
Childers
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Donnelly (IN)
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuler
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOT VOTING—14

Abercrombie
Boustany
Brown (SC)
Camp
Capuano
Carter
Gutierrez
Kennedy
Lewis (GA)
McCaul
McDermott
Miller, George
Moran (VA)
Watt

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1201

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

RESERVE OFFICERS ASSOCIATION MODERNIZATION ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill, S. 1599, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from California (Ms. CHU) that the House suspend the rules and pass the bill, S. 1599.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 425, nays 0, not voting 9, as follows:

[Roll No. 904]

YEAS—425

Ackerman
Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton

Slaughter	Thompson (MS)	Wasserman Schultz
Smith (NE)	Thompson (PA)	Waters
Smith (NJ)	Thornberry	Watson
Smith (WA)	Tiahrt	Watt
Snyder	Tiberi	Waxman
Souder	Tierney	Weiner
Space	Titus	Welch
Speier	Tonko	Westmoreland
Spratt	Towns	Wexler
Stark	Tsongas	Whitfield
Stearns	Turner	Wilson (SC)
Stupak	Upton	Wittman
Sullivan	Van Hollen	Wolf
Sutton	Velázquez	Woolsey
Tanner	Visclosky	Wu
Taylor	Walden	Yarmuth
Teague	Walz	Young (AK)
Terry	Wamp	Young (FL)
Thompson (CA)		

NOT VOTING—9

Abercrombie	Carter	Moran (VA)
Brown (SC)	McCaul	Smith (TX)
Capuano	Miller, George	Wilson (OH)

□ 1209

So (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MOLALLA RIVER WILD AND SCENIC RIVERS ACT

Mr. GRIJALVA. Mr. Speaker, pursuant to House Resolution 908, I call up the bill (H.R. 2781) to amend the Wild and Scenic Rivers Act to designate segments of the Molalla River in Oregon, as components of the National Wild and Scenic Rivers System, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. HOLDEN). Pursuant to House Resolution 908, the amendment in the nature of a substitute recommended by the Committee on Natural Resources printed in the bill is adopted and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 2781

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

SECTION 1. DESIGNATION OF WILD AND SCENIC RIVER SEGMENTS.

Section 3(a) of the Wild and Scenic Rivers Act (16 U.S.C. 1274(a)) is amended by adding at the end the following:

''(______) MOLALLA RIVER, OREGON.—The following segments in the State of Oregon, to be administered by the Secretary of the Interior as a recreational river:

''(A) MOLALLA RIVER.—The approximately 15.1 miles from the southern boundary line of section 19, Township 7 south, Range 4 east downstream to the edge of the Bureau of Land Management boundary in section 7, Township 6 south, Range 3 east.

''(B) TABLE ROCK FORK MOLALLA RIVER.—The approximately 6.2 miles from the easternmost Bureau of Land Management boundary line in the northeast quarter of section 4, Township 7 south, Range 4 east downstream to the confluence with the Molalla River.''.

The SPEAKER pro tempore. The gentleman from Arizona (Mr. GRIJALVA) and the gentleman from Washington (Mr. HASTINGS) each will control 30 minutes.

The Chair recognizes the gentleman from Arizona.

GENERAL LEAVE

Mr. GRIJALVA. I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on H.R. 2781.

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

There was no objection.

Mr. GRIJALVA. Mr. Speaker, I rise in strong support of H.R. 2781, introduced by our friend and colleague, a new Member of this House, Representative KURT SCHRADER of Oregon. H.R. 2781 would add just over 21 miles of the Molalla River in northwestern Oregon to the Wild and Scenic Rivers System. This beautiful mountain river rises in the Cascade Range east of Salem. It flows through old-growth forests and deep-rock canyons until it meets the Willamette River near the town of Canby, Oregon.

More than 20,000 people in the towns of Canby and Molalla draw drinking water from the river. The Molalla is a short drive from Portland and is a popular destination for thousands of people who recreate along the river every year. Steelhead, salmon, and cutthroat trout rely on the river for crucial spawning and nursery habitat.

The river corridor served as a trail for indigenous tribes long before European settlers reached its banks, and early pioneers found the river a vital source of drinking water for homesteading, as well as an important trade route.

In more recent times, however, the river was the victim of neglect, with illegal dumping and other activities degrading the water quality. This degradation prompted creation of a broad-based coalition of more than 45 nonprofit, civic and conservation groups; local, regional, State, and Federal agencies; numerous waters users; and property owners dedicated to protecting and preserving the Molalla River.

The alliance is a leading supporter of Representative SCHRADER's bill, as well as the city of Molalla and Clackamas County. They believe the designation will help keep the Molalla clean and free-flowing, while attracting more visitors to the river corridor. More visitors, more fishermen, more kayakers, more campers, and more hikers mean more meals at local restaurants, more stays at local hotels, more customers for outfitters and guides, and more economic development for the local communities.

Mr. Speaker, the bill before us today designates two segments of the Molalla River: 15.1 miles on the main stem and 6.2 miles on the Table Rock Floor. These designations are consistent with recommendations from the Bureau of Land Management, and the administration supports this legislation.

When Representative SCHRADER testified before the Natural Resources Committee on this bill, he asked the committee to consider whether this ''wild and scenic'' designation would have any impact on roughly 400 acres of timberland included in the corridor. As my colleagues are well aware, this is a significant issue in Oregon because the revenue generated by harvesting Federal timber is used to fund public education in the State.

Since the hearing, both Representative SCHRADER and the committee have clarified two important points: the Wild and Scenic Rivers Act does not prohibit logging, and there are no logging contracts in place or planned for the river corridor anyway. We were pleased to be able to resolve the concerns of the bill's sponsor.

□ 1215

Mr. Speaker, Congress created the Wild and Scenic Rivers System in 1968 to preserve rivers with outstanding natural, cultural and recreational values in their free-flowing state. The Molalla is a worthy addition to that system. I commend Congressman SCHRADER for his hard work in crafting the bill and helping the committee prepare the bill for consideration by the House today.

I urge my colleagues to support H.R. 2781.

I reserve the balance of my time.

Mr. HASTINGS of Washington. Mr. Speaker, I yield myself as much time as I may consume.

Mr. Speaker, I reluctantly rise to oppose this legislation, and I do so with a degree of conflicting views. Let me explain. On the one hand, I have fundamental concern with the impacts that wild and scenic river designations can have on surrounding property owners, river users, either upstream or downstream, and the restrictions that such designations can have on private citizens. Most importantly, such designations preclude the ability to make future decisions without—I say, Mr. Speaker—without an act of Congress. There are many ways to protect and manage our rivers without imposing such absolute, permanent, and inflexible mandates that do not allow us to adapt to new circumstances, evolving environmental science, and changing public needs and views.

On the other hand, Mr. Speaker, I am sympathetic when a Member of the House proposes legislation that directly affects the district that he represents. I believe that we must be respectful of the views of those who are elected to represent a district, and this, Mr. Speaker, is a two-way street. It means affording a level of deference when a Member has a proposal that affects just his district, and it means an

even stronger degree of respect and deference when a Member opposes an action that is proposed in the district he was elected to represent.

It is very troubling to me, Mr. Speaker, to see bills introduced and referred to the Natural Resources Committee, as an example, that would have extensive and often drastic negative impacts on the economic livelihoods of local communities, workers, and their families in the Western part of the United States, but that are authored and sponsored by Members from the east coast and the Nation's biggest cities.

Mr. Speaker, this lack of respect on these issues is very troubling to me. Therefore, while I generally do not support such inflexible and restrictive river designations, I do have respect for the fact that Mr. SCHRADER of Oregon is a sponsor of this bill, and it directly affects his district.

At the same time, I must agree with the position clearly stated by Mr. SCHRADER during his testimony at the subcommittee hearing on this bill. At that hearing, Mr. SCHRADER said that he was sensitive to the fact that this river designation would impact over 400 acres of timber matrix lands. When timber is responsibly and sustainably harvested on these matrix lands, funds that come from these harvestings are provided directly to the local schools and communities in that area. This is a way of partially compensating areas of the West that are home to high percentages of Federal land for Federal policies that limit economic development. These timber matrix lands are a commitment that's been made, and they're critical to the ability of hundreds of schools to properly educate their children and for the communities in these areas to provide essential services.

Mr. SCHRADER, to his credit, said he was sensitive to this harm that his bill would have on these lands and the schools and communities that depend on these lands. In his October 1 testimony, Mr. SCHRADER specifically stated, ''I would ask the chairman and ranking member to work with me and my staff to ensure there will be no net loss of the acres available for timber management as a result of this legislation.''

Mr. Speaker, no such provision or protection or offset has been included in this bill despite the honest recognition and explicit request from Mr. SCHRADER that action needed to be taken to protect the lands important to the schools and communities in his district. Several efforts to amend the bill to simply provide that the lands be identified elsewhere to replace the 400-plus acres locked up under this river designation bill have been blocked.

The first blockage was in the Natural Resources Committee markup. On Tuesday, it was blocked by a Democrat majority on the Rules Committee. So it's been blocked two times. The need to address the loss of these timber matrix lands and the schools that depend on such lands was clearly identified and then ignored.

Now, Mr. Speaker, we learned on Tuesday, the day before yesterday, that 7 days earlier, on November 10, Mr. SCHRADER had sent a letter to the Natural Resources Committee chairman that appears to shift away from his subcommittee testimony that clearly asked for help in ensuring that the loss of timber lands be addressed in this legislation. This letter states, ''I am satisfied that this designation will not remove trees from the timber stock: there are no timber contracts in that area, and no timber sales are planned.''

Mr. SCHRADER's letter further states that on the question of offsetting logging acreage, which he alluded to in his statement before the subcommittee, he says, ''I see no need to add such language to H.R. 2781 at this time.'' This letter of November 10 appears to directly contradict the gentleman from Oregon's public testimony on October 1.

Was the statement made in his testimony a mistake made in understanding the bill that he authored? Or is the position taken in his letter a reversal of his request for help on fixing the timber matrix land issue? When he states that language is not needed at this time, does he mean that his view on the need for offsetting the acreage may change in the future?

Mr. SCHRADER later implies that there is no reason to offset these lands because no current timber contract exists, nor are there logging plans at the current time. So this begs the question, Mr. Speaker: is the concern for school funding only today and not what will happen tomorrow or in the future?

Of course there are no logging jobs at this moment. It is well-known throughout the Northwest that timber harvest is at a standstill due to the struggling economy and the sharp drop in housing starts. In fact, just yesterday the Natural Resources Committee approved a bill to allow for existing Federal logging contracts to be extended due to the poor economic conditions. I think that's a good idea.

So yesterday, just to put this into perspective, the bad timber market is used to push legislation to ensure existing contracts can be carried forward, but today the bad market is used as an excuse for legislation that will lock up hundreds of acres, not just until the market turns around but forever.

Mr. Speaker, these are not insignificant questions, and I think that there needs to be some clarification of that. So I hope very much that we have an opportunity to resolve this apparent discrepancy as this debate continues.

Again and again, this Congress acts to remove more and more land from the West from active, sustainable timber management. It is our schoolchildren that are paying the highest price, as school budgets are squeezed even tighter due to the actions of the Federal budget. You can't advocate for these schools and for wiser timber and forest management to ensure jobs in towns across the Northwest while at the same time advancing legislation that makes the problem permanently worse, and that's exactly what this bill does.

Some may say, well, it's only 400 acres. Yet if that was such a small amount, then why the resistance to offsetting these lands? The offset ought to be easy if this issue is just a small acreage. The fact of the matter is is that this 400 acres comes on top of thousands and thousands of acres that have been locked up in recent years. Excusing these 400 acres today feeds the notion that tomorrow or next week perhaps we can excuse taking another 6,000 acres away from helping schools and rural communities.

I believe that Congress must take responsibility for its actions and the impact that it's having. It's time to demand that schoolchildren in small towns don't pay the price for the unwillingness of those in Congress to provide offsets for their actions. So it's for these reasons, Mr. Speaker—again, with deference to the gentleman who sponsored this bill, affecting only his district—that I must oppose this bill.

With that, Mr. Speaker, I reserve the balance of my time.

Mr. GRIJALVA. Mr. Speaker, I will yield as much time as he may consume to the sponsor of the legislation, Congressman SCHRADER, who did a magnificent job and had a collaborative effort with communities and agencies in bringing this legislation forward.

Mr. SCHRADER. I appreciate the opportunity to testify on this bill. It is really tremendously exciting to the good citizens of Molalla and Clackamas County, Oregon, that we have this bill to vote on today. I'm sorry to have some of the discussion we've been hearing so far. It's basically irrelevant to the bill.

The idea here is to designate the Molalla River as a recreation river under the Wild and Scenic Rivers Act that was initiated by a small gathering of folks a few years ago, local river stewards and Molalla residents who were looking to preserve and protect their river and aid their local economy by increasing tourism. They came to me earlier this year with the idea. Our team liked it, and we introduced the bill. It immediately garnered major support in Molalla and Clackamas County. And as of now, this bill is supported by the city of Molalla, the Clackamas County Board of Commissioners, the Oregon Department of Fish and Wildlife, and over 40 Oregon-based

environmental, recreational, and public safety groups. All recognize the social, economic, and cultural benefits of this bill.

In particular, I want to personally thank the many people who worked so tirelessly on this bill. This includes the president of the Molalla River Alliance, Mike Moody; the mayor of Molalla, Mike Clarke; Molalla City Manager John Atkins; Police Chief Gerald Giger; the executive director of Molalla River Watch, Kay Patterson; the president of Molalla Community Planning Organization, Jim Gilbert; and, frankly, Oregon river enthusiasts like Kavita Heyn and Erik Fernandez.

I also want to personally acknowledge Ryan Morgan, a lifelong Molalla resident and member of the Molalla City Council who tragically died earlier this year. Ryan was a river enthusiast and a strong supporter of this legislation. I would like to think he is looking down on us right now with pride over the vote and this particular piece of legislation that he worked so hard to get on the House floor.

Mr. Speaker, the Molalla River is a national treasure in my State. Historically, it serves as both the trail for indigenous Molalla Indians and as a trade route between pioneers in the Willamette Valley and residents of eastern Oregon. Its Table Rock Trail, which is also known as ''Huckleberry Trail,'' was used by members of the Warm Springs tribe in search of huckleberry- and salmonberry-picking areas in the early days. Early settlers used its fertile lands and drinking water for homesteading, and its Ogle Mountain mine attracted migrants during the gold rush.

Today the Molalla River is known for its many recreational purposes, including hiking, diving, fishing, kayaking, white-water rafting, picnicking, mountain biking and horseback riding. It's also nationally recognized for its beautiful and scenic wildlife. It provides spawning beds for threatened steelhead trout and Chinook salmon and is an essential wildlife area for the pileated woodpecker, red tree vole, red-legged frog, northern spotted owl, Pacific giant salamander, and both golden and bald eagles.

Designating the Molalla River as recreational under the National Wild and Scenic Rivers System would have tremendous economic, cultural, and environmental benefits for the region. Economically, we need jobs. It would attract more tourism and create tons of new jobs in a very, very difficult environment in Molalla, something the State of Oregon desperately needs in its rural communities. Environmentally, it will protect the character of the river, preserving it so future generations can recognize its rich cultural, historical, social, and economic benefits.

I want to thank Chairman RAHALL and Subcommittee Chair GRIJALVA for their support and efforts on this bill. I also want to thank their staff, and in particular Leslie Duncan, for all of their hard work.

A lot of focus has been around the comments the gentleman from Washington referenced that I made in committee. My goal there as a lifelong friend of the timber industry, particularly in my legislative arena, was to make sure that if there was impact on logging in this area, in my county, in my State so desperately in need of economic energy, that we'd investigate that. The committee—I appreciate the work they've done—and I and my office checked into whether or not these matrix lands were going to impact the timber harvest or any of the land in that area.

And I am pleased to report back, as has been reported, that the BLM has told us again and again that there are no timber sales in that area, and there have never been any timber sales planned in that area. So I guess I'm a little concerned that as I step up and try to make sure that the concerns of the gentleman from Washington are addressed, and we bring this topic up, which I hope we will bring up in any of the legislation that comes from his State and other States, that it seems like it's turned against one.

□ 1230

I don't feel in any way that I have changed my view on the need to make sure that if there is an issue, we have offsetting lands for harvest if it is going to affect local communities.

But no private landowner, I want to make this very clear, no private landowner in this area, including Weyerhaeuser, including some of the big timber companies and the small woodlot owners, is objecting to this bill. I go to the gentleman from Washington's earlier comments that if this is a bill brought forward by a Member who represents the State, and more particularly represents the local district in which this wild and scenic river designation is to be had, that generally he votes in favor of these things. So I ask him politely to consider changing his viewpoint and voting for the bill since such a Member has done the work that he asked to do in the first of all.

Mr. HASTINGS of Washington. Would the gentleman from Oregon yield?

Mr. SCHRADER. I yield to the gentleman.

Mr. HASTINGS of Washington. I thank very much the gentleman yielding.

As I mentioned in my opening statement, I am very sensitive to Members of Congress who have projects or issues within their districts to be able to do them. I just, as I mentioned in the committee and as I mentioned on the floor, I just have a general problem with the wild and scenic designation. It is on that principle that I rise to oppose this.

But I do want a clarification because I spent extensive time in my opening statement talking about your testimony in front of the subcommittee on this issue where you said very specifically that you recognized this as timber matrix land, and you wanted to work with the chairman and the ranking member, myself and Mr. RAHALL, so there would be no net loss, meaning you would be open to transfer of lands or whatever the case may be. We attempted to accommodate you with an amendment that we had that unfortunately was ruled nongermane, and so we didn't get a chance to address that. The second chance we had at that was in the Rules Committee where they can waive the rules, and they decided not to.

I would like to ask the question, it appears to me that now you have reversed your position because you have said that there is no potential timber harvest, and I would like you to clarify what you mean by that.

Mr. SCHRADER. I would like to reclaim my time.

I appreciate the gentleman from Washington's concern. As I said before, it is very explicit in my testimony and testimony from the chairman, and others who have spoken in favor of this bill, that we have investigated it. I am a full supporter of making sure that if there is a problem in the timber harvest or management area that is going to impact the economics of my community, that I will be there.

Right now, this bill is an economic driver for this community, sir. We actually have to make sure that this bill passes because the tourism that is going to happen in this bill is the big economic driver in this community. Right now we actually have serious drug issues in our State and, frankly, in this area where, if we have the opportunity to make sure that law enforcement has the ability to get special protection and maybe special opportunities, we can make sure that this area stays drug free. We can make sure that we actually have a better chance to make sure that this community is going to be economically advantaged. The men and women in my State and in my district are hurting, so I want to make sure we have economic opportunities.

Frankly, I would just like to say in my final comment, at this time this State faces tremendous economic hardship. We are one of the most heavily hit States in the Nation. We are an income tax State, and we are hurting. We are hurting bad in this economy.

I urge my colleagues to pass H.R. 2781. Aid the good people of Molalla and Clackamas County. They need your help. This will attract tourism to the river, more business for river guides,

anglers, more stops at the local restaurants, hotels, and shops that preserve the character of the river so future generations can enjoy its cultural, historic, and recreational benefits. I really urge my colleagues to support this bill.

Mr. HASTINGS of Washington. Mr. Speaker, I yield myself such time as I may consume.

I just wish the gentleman would have yielded to me because he did not acknowledge his change of view of his testimony where these matrix lands are potential revenue if in fact they are harvested. He just simply said there will be no harvesting. But by passing this bill, you will forever, you will forever, Mr. Speaker, take those 400 acres out of ever being harvested. So that begs the question, if there is no logging now, what about in the future if the market turns around and there is a higher demand, how do we go back and get these 400 acres or potentially 6,000 acres in the future? That is the question, and that is always the fundamental question on these issues.

Keep in mind, our national forest lands and our Federal lands were designed to be for multiple purpose, and that means commercial purposes. On timberland, that obviously means logging activity which benefits local communities.

And in this bill, I acknowledged in my opening statement, it is a small sector of land. Nevertheless, it is the principle. And the gentleman, unfortunately, did not respond to that particular issue. He just simply said the government when he said the bureau, but he didn't talk about the impact it would potentially have on local communities because of the lack of potential harvesting in the future.

I think a land transfer and trade would have been very easy to do, and that could have been accomplished if we had adopted the amendments that we offered in committee, and the amendment that was denied to be even debated on this floor, which seems to be a pattern, but that is another story. So these potential 400 acres will now be gone forever if this bill were ever to become law. The drip, drip, drip of acreage being taken away leads to other issues.

So while I respect the gentleman, and he talked very clearly about the potential benefits, I suspect that there will be a time in the future, if this bill were to become law, that there will be an ensuing lawsuit that will probably tie up some of the activity that he hopes to preserve for future tourism. Why do I say that? Because that has been a pattern, unfortunately, in many parts of the West.

I have always felt that Federal lands ought to be multiple use, and when you put restrictions on them, you put restrictions not only on commercial activity but on recreational activity. That is where this goes. But this issue here is very simple. The communities that depend on the revenue coming from commercial activities on these lands are, under this bill, denied forever in the future from getting any revenue from those lands.

With that, I reserve the balance of my time.

Mr. GRIJALVA. Mr. Speaker, in reference to the drip, drip, drip, the current BLM management plan for this area was begun by the Bush administration. And what's more, the Wild and Scenic Rivers Act does not prohibit logging. It says it must be done carefully.

I yield to the gentleman from Illinois (Mr. QUIGLEY) for his comments, sir.

Mr. QUIGLEY. Mr. Speaker, I rise in support of the Molalla River Wild and Scenic Rivers Act. I came to Congress, like many others, to continue work on conservation efforts with similar-minded legislators from across the country.

But today, we have heard concerns that increased regulation would negatively affect industry and private landowners. This is simply not true.

On November 5, 2009, the Congressional Budget Office reported, ''The affected segments, which total about 21 miles, are already protected for wilderness values, and the proposed designation would not significantly affect the way they are administered.''

We protect these beautiful, powerful, and spiritual landmarks for our children so they may know the great lands of our lifetime. Indeed, our legacy is what we leave behind for our children's children. If we dare disrupt these natural treasures, we will forget why we have protected them in the first place.

I want to thank the sponsor for his efforts to move this legislation forward.

Mr. HASTINGS of Washington. Mr. Speaker, I yield myself 1 minute.

In response to my friend from Arizona, the subcommittee chairman, he said that logging, or commercial activity, could happen on these lands, specifically logging. But there is a proviso in there, as long as there is, and I will paraphrase, nondegradation of the existing area.

Now, Mr. Speaker, we have been around this business long enough to know that when there is a term like that and someone is opposed to some action or commercial activity, boom, you go to court right away, which means the costs go up, and, therefore, there are no contracts. And so you have de facto locked up these lands from any commercial activity. I think that is wrong.

I reserve the balance of my time.

Mr. GRIJALVA. Mr. Speaker, I yield such time as he may consume to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Mr. Speaker, I appreciate the courtesy and the leadership of my friend from Arizona in permitting me to speak on this bill.

It is my honor to share the representation of Clackamas County, Oregon, with my friend and colleague, Congressman SCHRADER. While I don't represent this particular area, it is an area that is known to me and one that I am pleased that he has been able to assemble a broad coalition at home to have meaningful legislation literally within a few months of his joining this body.

This is an area that should never be logged. That is one of the reasons he has been able to assemble a broad coalition of interests in our community to make sure that it is given the wild and scenic designation.

I have worked for years with the Clackamas County Commission, a group of men and women that is very sensitive to the dynamics of forest resources, agriculture, and industry. Clackamas County is a very diverse area that represents Oregon itself. I have worked with them on a number of wilderness provisions, and I will tell you that the agreement of the Clackamas County Commission does not come easily. They want to make sure that they know what they are getting into. They want to make sure that they are protecting the economic resource base. They are well aware that some of the revenues that come from our national forest lands find their way into local communities, particularly education. That is why it took us years to work on legislation that President Obama signed into law in his first weeks in office with the National Wilderness Act.

The homework has been done here. This is an area, as the chairman mentioned, as the sponsor mentioned, that is not affecting any, any, land that will be harvested now or, frankly, into the future. You ask the people in that community whether they would like to, at some point, risk this precious resource and they will tell you no.

This is an area, however, that is going to generate a great deal of economic activity. The gentleman from Canby referenced the proximity to the metropolitan area, that people who are kayakers, hikers, fishermen, other recreationalists already flock to this year-round. The designation and the protection of the Wild and Scenic Act is going to enhance that.

Now ours is a State, unlike my friend from the State of Washington, that has protected far more of their forest resources. Oregon doesn't protect that much. In fact, that is why we are working to provide a greater array of protections for recreation, for water resources. This is an important step.

I would like to express my appreciation to the sponsor for zeroing in on this early, for assembling an unprecedented coalition in Clackamas County

of people who understand this is important today and in the future. I appreciate his being clear that his county would not be at risk economically, raising the question and working with the committee and the administration to make sure that that is dealt with. And anybody who has watched the career of this gentleman over a decade in the State of Oregon knows that he is in tune with the district and their needs. He has a long record of working with the natural resource industries, most particularly the timber industry. Whether or not they happen to agree on any particular item, he has enjoyed the support and respect from the timber industry because he does his job right.

□ 1245

And the committee and the sponsor have done their job right with this piece of legislation. It's going to make a difference for the county that we both represent and the State of Oregon for generations to come.

I salute his leadership, and look forward to supporting it and hope that this is another signing ceremony that we can share at the White House.

Mr. HASTINGS of Washington. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, if the gentleman would hang around, I will be more than happy to interact with him. He made a point I would like to elaborate on, and I will yield to him to follow up.

He said two things in his remarks. He said, I believe, that this is an area that should never be logged. Listen, I respect the fact that he has that position. He's very straightforward. I mean, I have no problem with that position. I may disagree with it, but I certainly have no problem with that position. But if that is the case and that is the argument and the fact is that this land is never going to be lost, then for goodness sakes why didn't we take into consideration the fact that there are 400-plus acres that could have easily been transferred in a land transfer to someplace else to keep at least the economic viability in hand? That was not done. The gentleman from Oregon, the sponsor of this bill, asked for that. I was certainly willing to accommodate that, and we did that in our amendment.

Now, if the idea is that you're going to lock up these lands forever, at least that's being straightforward. But that certainly isn't how this has been talked about and debated here on the floor today.

Secondly, the gentleman from Oregon, again, the one from downtown Portland, made this observation: he said that Washington has more lands that are designated like this than Oregon, the implication meaning that maybe they want to catch up.

Let me offer maybe a little different twist on that because I stated, based on my experience in my State that when you have designations like this, you restrict the access to those areas. Now, hopefully that doesn't happen. Hope springs eternal. Every time we have this sort of activity in Washington State, this issue is brought up and don't worry, and then you look in the future and it happens. It happened with a particular part of my district, for example, that was designated a wilderness area 20-some years ago, and we're having a dickens of a time just trying to get the road to that area opened. Why? Because of the restrictions.

So I will just tell my friends from Oregon that if they want to catch up with Washington, then you'd better watch out what you're trying to catch up to, because what you're catching up to is more restrictive activity.

Now, it's 10 minutes to 10 back in the Pacific time zone. I am sure there are a lot of interested folks that are affected by this. I hope that they would take that part into consideration, and I hope they would take that part into consideration that, yes, these lands could be potentially logged as long as there was no degradation. Look at that word ''degradation'' and connect the dots as to how that would end up in court if, in fact, there were a contract.

All of these things are real, Mr. Speaker, and so I just bring them up.

Mr. Speaker, I am very pleased to yield such time as he may consume to my friend from Oregon (Mr. WALDEN).

Mr. WALDEN. I thank the gentleman, and I thank him for his leadership.

Mr. Speaker, I stand up today on this bill, and I actually intend to support it because I think I may differ with my colleague from Washington about some things. But the fundamental issue that I'm upset about is the notion that we can protect lands somehow by never doing anything again on them. And certainly there are areas and I've supported some of these new wilderness designations. I've tried to do it in a bipartisan way and tried to help. But doggone it, there are a whole bunch of other lands. The majority of lands in our State are Federal forested lands that are completely out of balance with nature, that cry out for good stewardship and balanced management. And I hope Washington never has to catch up to Oregon when it comes to unemployment.

You get out in parts of my district in eastern Oregon, and we are pushing 20 percent unemployment in county after county. And all too often the biggest economic activity that occurs in the summer is not the harvesting of dead trees; it's the making of lunches for firefighters as catastrophic wildfire takes over.

Now, my colleague from Oregon, Mr. SCHRADER, and I are working on legislation with others, Mr. HASTINGS and others, that will allow us to go out into the forest and treat these lands. It is a crying shame and I think absolutely erroneous to argue that the only way you protect is to lock up and ignore.

This Congress, under Democrat leadership and with the good chairman who took the gavel I used to have when I chaired the Forestry Subcommittee, I hope will actually give us a hearing on our legislation after it's introduced and will actually give it due consideration, as in give us a hearing, give us a markup, let us put it into law.

Let's take the Healthy Forests Restoration Act that passed in an overwhelming bipartisan manner by both Houses of this Congress and was signed into law in 2003 that has been very successful around our urban interface areas and wildland urban interface, where we can go in and thin out the brush, work with the communities in collaboration and reduce the threat of catastrophic wildfire. Let's take those authorities that are now proven and workable and save taxpayer money because they're efficient and expand those out so we can protect watersheds, so that we can get ahead of these bug infestations that are killing off enormous swaths of Federal forest.

And I don't sense that the chairman—and I'd love to know if he'll take this up—I don't know if he supported the Healthy Forests Restoration Act when it was before the House, but it just so frustrates the people I represent and others that we may argue over a river here or something there and meantime the whole forest is dying, not just in the Northwest and on the east side, pine forest, but you get in Colorado and look at the damage there.

Members of both sides of the aisle in Colorado have called for special initiatives to allow thinning there to get ahead of that bug infestation that's killing the pine. You look, frankly, at what has happened across the border in Canada. These are enormous infestations. And if you're concerned about climate change, then you have to have understood that if temperature is rising, the forests can't keep pace with the change.

So if you want to do something to protect the forests for the future, then you need to thin them out now to be able to get out of drought and further stress and further bug infestation. And in doing so, we can reduce the cost to the taxpayers because we will get the forests back into balance; and when they catch fire, it will burn naturally and actually be fine.

And, by the way, we can put people to work; and that's what this ought to be about. This House should be addressing how you actually use the resources we have in a manageable and responsible way to put people back to work, whether you're in John Day or you're in Prineville or you're in Baker City or out in Wallowa County.

It's amazing the policies that have been put in place that restrict our access to our own forests, that even are so tight, so restrictive, you can't even cut a burned dead tree while it still has value and run it through a mill and make a productive wood out of it, lumber out of it.

No, we'd rather have some other country do that and then we'll import it, while our stuff stands there and rots. Then, oh, by the way, that becomes the breeding ground for some next expansion of some bug infestation that will take the next healthy forest. You drive around Suttle Lake in central Oregon and tell me we couldn't have prevented the fire that destroyed things there.

I can show you where when the Forest Service was given the ability to thin before this enormous fire a couple of years ago, the trees that they thinned around lived. Where they were denied access to go in and do forest recovery work, it destroyed everything. Oh, it will recover. None of us will probably be alive to see it. We might be. But, you know, it shouldn't be that way. It doesn't have to be that way.

So while we debate this bill here today on the Molalla River and the Willamette Valley, there's a bigger issue we should be bringing to this floor, and it is about how we are entrusted with the stewardship of America's great forests, those reserved and set aside beginning in 1935 by Theodore Roosevelt, who, by the way, when he did that speech in Utah, said the great purpose of forest reserves is, first, water for agriculture and, second, home-building. Now most people don't attribute that to Theodore Roosevelt, and you can go look up his speech in Utah, but that's what it was for.

Now, obviously there are things that we need to do in our forests for other purposes than those two; but, clearly, protecting watersheds is an essential stewardship obligation that this Congress for too long has not done enough to deal with. And part of it, sure, we can add more money here and more money there and that can be good and we can debate how much, but the real issue is the underlying law that needs to be fixed so that our forest managers who are trained professionals can go out to do what they were trained to do.

Can you imagine, let's say, if you were a veterinarian, and I don't know if there are any on the floor, maybe Mr. SCHRADER, but if you were a veterinarian and you had to go through the process a forester has to go through to treat an animal, you might as well shoot it in the head because it's never going to survive long enough to get the treatment you know you need to prescribe.

So let's be reasonable about these things. We've done it before in a bipartisan way. We can do it again before America's great forest reserves go up in smoke and are destroyed. You go back to that Colorado example when the Hayman fire occurred and that whole watershed, the pictures of the mud coming into their drinking water and the dead fish. We don't have to live that way.

But simply making the argument, as one of my friends made, that, well, we're just behind the next State in terms how much we set aside and don't ever do anything with and ignore is the wrong argument in my book, and so I would respectfully disagree with my friend from Oregon who made that argument because I don't think that's the measurement of good stewardship.

The measurement of good stewardship is how you take care of it for the future, what you leave for the next generation, and that doesn't mean you never touch it again. It means active management where it's appropriate. It means saving our watersheds and habitat for all God's creatures; and it means, by the way, in doing so, we can figure out a way to turn biomass into energy and turn our natural resources into jobs. That's what we need. And it can be hand in hand, and it can be responsibly done.

Mr. GRIJALVA. Mr. Speaker, let me tell my friend from Oregon, Mr. WALDEN, that his comments are appreciated.

I agree with you. There is a universal question about balance, restoration, and protection of our great forests, and I look forward to discussing those.

Mr. Speaker, I yield such time as he may consume to the sponsor of the legislation, Mr. SCHRADER.

Mr. SCHRADER. Mr. Speaker, I just want to thank my colleague from the eastern part of the great State of Oregon for supporting this bill. He's an acknowledged forest policy expert in his caucus; and if he thinks the bill has merit, I would hope that the rest of his colleagues would, too.

Mr. HASTINGS of Washington. Mr. Speaker, I yield myself the balance of my time.

I really appreciate my friend from Oregon, Mr. WALDEN, making his statement because this is just a very, very small part of the complex issues surrounding our national forest lands, and I thought he put it very much into perspective.

I too in my State in the last several years have suffered from a number of forest fires. And it gets very, very frustrating that after the fire is put out that the potential harvestable leftover there is subject to litigation and you can never harvest it, which simply means that that timber becomes fuel for the next fire, and yet that is our policy.

How that relates to this bill is that the focus, at least on my part, and I acknowledge that it is a very small portion and it's only 400 acres, but we are forever taking those 400 acres out of potential commercial activity.

□ 1300

And it just seems to me that this is one part of it that we ought to be at least working and dealing cautiously with, because it's symptomatic of the larger issue of timber management in this country, as so eloquently stated by the gentleman from Oregon (Mr. WALDEN).

So, Mr. Speaker, I am going to reserve my time at this point.

Mr. GRIJALVA. Mr. Speaker, let me yield 3 minutes to my friend, Congressman WU.

Mr. WU. Mr. Speaker, I rise in strong support of this legislation to designate about 21 miles of the Molalla River in Clackamas County, Oregon, as ''wild and scenic.'' It is a Federal designation that will help preserve the Oregon character of this beautiful river. The Molalla is a prime example of accessible, valued natural settings that Oregonians cherish as an essential component of our living standard. Beyond the essential function of supplying water to communities in Clackamas County, each year the river attracts thousands of boaters, hikers, and fishermen from up and down the Willamette Valley, from around Oregon, including eastern and central Oregon, and indeed, from around the country. I, myself, have floated this river, have fished this river, and appreciate its wild splendor, whether it's osprey fishing for trout themselves, or beaver and other animals swimming through the rivers.

It's also true that in these very tough economic times the protection of special natural spaces like the Molalla supports Oregon's vibrant and crucial outdoor recreation industry, an industry which supplies 73,000 jobs and injects $5.8 billion into Oregon's economy each year. That is why this bill has the support of diverse community leaders and groups, not just environmental groups, not just recreation groups, but economic leaders and community leaders, elected and appointed.

From cities to counties, neighborhood associations, to recreational groups, sportsmen groups to environmental organizations, we all appreciate the pragmatic protection of our rivers and natural areas in a comprehensive, inclusive and fair way. This bill will ensure that Oregonians will always be able to enjoy what the Molalla River has to offer.

I want to commend my good friend and colleague from Oregon, Congressman SCHRADER, for bringing this important bill before this body. I thank him, and ask for everyone to support this legislation.

Mr. HASTINGS of Washington. Mr. Speaker, I inquired a moment ago how much time. How much time again? And if I could inquire of my friend from Arizona again if there's any speakers. I noted that the gentleman from Oregon came down, and that's why I reserved.

And I just wonder if the gentleman has any more speakers.

Mr. GRIJALVA. There are no additional speakers.

The SPEAKER pro tempore (Mr. JACKSON of Illinois). The gentleman from Washington has 4½ minutes remaining. The gentleman from Arizona has 7 minutes remaining.

Mr. HASTINGS of Washington. Mr. Speaker, I yield myself the balance of the time.

Mr. Speaker, I made reference several times in my remarks of the unintended consequences, or alluded to unintended consequences, that happen with legislation like this. And let me give you a real-life example, and again, I alluded to it in my remarks.

I'm talking specifically about the Stehekin town at the end of Lake Chelan in my district. This is a town that has no roads going into it. The only way you can get there is by boat, up the Lake Chelan, or by an airplane that can land on the lake. This is a gateway to a wilderness area, and this wilderness designation was made some 20 years ago. There's a road that goes back about 20 miles to hit the wilderness area. This is an economic driver for the town of Stehekin.

Well, unfortunately, the road is in a wilderness area, and this is the unintended consequence, because you get a lot of snowfall in the Cascades, and this road gets washed out occasionally. It got completely washed out several years ago, and the obvious solution to that is to repair the road so that you can still have access to the wilderness area. But you have the one problem in this particular case, and that is, the road is in a wilderness area, which means there's no wiggle room. And so, it is literally taking an act of Congress, Mr. Speaker, to rebuild a dirt road to give access to a wilderness area.

Now, I'm sure that that wasn't intended when this bill was passed by the Congress before I got here in the late 1980s. I'm sure that that was not the case, and yet, we passed the bill out of the House, I'm very pleased, in a bipartisan note. But just think about this principle. This is a road that gives you access to a wilderness area, but it happens to be on wilderness land. An act of nature washes out that land, and it takes an act of Congress, for goodness sakes, to make it whole again so you have economic activity.

Several Members, several of my colleagues from Oregon have talked about the great economic activity that this designation is going to have. I hope they're right. But they should take into account a real life example in a small part of a State just north of them, namely, what's happened to the community of Stehekin at the top end of Lake Chelan in my district, because these are the real-life happenings and the unintended consequences that happen when you give total authority to the Federal Government.

I hope it doesn't happen on the Molalla River, I truly don't. But I suspect, as I said earlier in my remarks, that that very well may be the case. And so I think that story is worth retelling, Mr. Speaker, because it's not told enough. The town of Stehekin is a very small town, and the issue isn't done yet. That bill is in the Senate. I certainly hope it passes.

But I might mention one other irony. Those that are opposed, that were opposed to rebuilding that road, they don't live in Washington State. They live in other areas of the country. Why? Because you cannot damage wilderness. Even though this happens to be an economic lifeline, I'm sure it was the unintended consequences that they're talking about.

So, Mr. Speaker, I reluctantly rise, as I said in my opening remarks, to oppose this designation, not because the gentleman from Oregon, the sponsor of the bill, is doing what he thinks his constituents want. I respect that. I really do. I just have experienced firsthand enough in my time in Congress to see that this leads to unintended consequences, and there are better ways to management and probably to provide economic activity surrounding the Molalla River than going this far.

The second point is, we could have accommodated the gentleman from Oregon's concern about taking this timber matrix out with a simple land exchange. We're only talking about 400 acres. Yet, it was denied twice: once in committee and once by the Rules Committee. So those 400 acres, albeit small, are locked up forever. But, as I said, 400 acres today, maybe it will be 6,000 acres in the future. There's certainly been thousands of acres in the past.

So with that, Mr. Speaker, I rise reluctantly to oppose this bill.

I yield back my time.

Mr. GRIJALVA. Mr. Speaker, during the course of this debate, we interchanged "wilderness" for "wild and scenic river" designations throughout. But I think the point that Mr. HASTINGS made was an important one. And all of us were happy to work with Mr. HASTINGS to address the wilderness road issue that it raised. It was in his district. He wanted it. He wanted to get it fixed, and so it was done.

This is Mr. SCHRADER's district, and he wants it so we should respect that as well. I want to also congratulate him on the fine work. This was a participatory process, stakeholders at the table. It was a process that everybody has an investment in, and the consequence of that process, and the fine work done by Mr. SCHRADER, is that we have buy-in, and we have tremendous support for it.

Part of what we were talking about today as well were the claims. First, it was claims that this would stop logging. We pointed out that there was no logging on the land due to a management prerogative by the Bush administration. Then it was claimed, well, this might stop logging in the future. We pointed out that the wild and scenic rivers designation and the act does not stop logging in the future. So, then it was claimed, well, litigation might stop logging. Well, as the claims and the discussion changes, the argument keeps changing. I think this is a good piece of legislation. I urge all my colleagues to support it.

I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to House Resolution 908, the previous question is ordered on the bill, as amended.

The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. HASTINGS of Washington. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clause 8 of rule XX, this 15-minute vote on passage of H.R. 2781 will be followed by a 5-minute vote on suspending the rules and agreeing to H. Con. Res. 212.

The vote was taken by electronic device, and there were—yeas 292, nays 133, not voting 9, as follows:

[Roll No. 905]

YEAS—292

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bartlett
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Bono Mack
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Butterfield
Camp
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Castle
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Fortenberry
Foster
Frank (MA)
Frelinghuysen
Fudge
Garamendi
Gerlach
Giffords
Gonzalez
Goodlatte
Gordon (TN)
Grayson
Green, Al

Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inglis
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larsen (WA)
Larson (CT)
LaTourette
Lee (CA)
Levin
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McCotter
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (MI)
Miller (NC)
Minnick
Mitchell
Mollohan
Moore (KS)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paulsen
Payne
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Platts
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reichert
Reyes
Richardson
Rodriguez
Rogers (KY)
Rogers (MI)
Ros-Lehtinen
Roskam
Ross
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Simpson
Sires
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Whitfield
Wilson (OH)
Wittman
Wolf
Woolsey
Wu
Yarmuth

NAYS—133

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Barton (TX)
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Boozman
Boustany
Brady (TX)
Broun (GA)
Burgess
Burton (IN)
Buyer
Calvert
Campbell
Cantor
Cao
Capito
Cassidy
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Emerson
Fallin
Flake
Fleming
Forbes
Foxx
Franks (AZ)
Gallegly
Garrett (NJ)
Gingrey (GA)
Gohmert
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Issa
Jenkins
Johnson, Sam
Jordan (OH)
King (IA)
King (NY)
Kingston
Kline (MN)
Lamborn
Latham
Latta
Lee (NY)
Lewis (CA)
Linder
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McClintock
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Myrick
Neugebauer
Nunes
Olson
Paul
Pence
Pitts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Roe (TN)
Rogers (AL)
Rohrabacher
Rooney
Royce
Ryan (WI)
Scalise
Schmidt
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Smith (NE)
Smith (TX)
Souder
Stearns
Sullivan
Thompson (PA)
Thornberry
Tiahrt
Turner
Wamp
Westmoreland
Wilson (SC)
Young (AK)
Young (FL)

NOT VOTING—9

Brown (SC)
Capuano
Carter
McCaul
Melancon
Miller, George
Moore (WI)
Murphy, Tim
Rothman (NJ)

□ 1337

Messrs. CRENSHAW and SULLIVAN changed their vote from ‘‘yea’’ to ‘‘nay.’’

Messrs. DENT, VAN HOLLEN and WOLF changed their vote from ‘‘nay’’ to ‘‘yea.’’

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

RECOGNIZING ANNIVERSARY OF THE VELVET REVOLUTION IN CZECHOSLOVAKIA

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the concurrent resolution, H. Con. Res. 212, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. ACKERMAN) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 212, as amended.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 426, nays 0, not voting 8, as follows:

[Roll No. 906]

YEAS—426

Abercrombie
Ackerman
Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Minnick
Mitchell
Mollohan
Moore (KS)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer

Schiff	Souder	Van Hollen
Schmidt	Space	Velázquez
Schock	Speier	Visclosky
Schrader	Spratt	Walden
Schwartz	Stark	Walz
Scott (GA)	Stearns	Wamp
Scott (VA)	Stupak	Wasserman Schultz
Sensenbrenner	Sullivan	Waters
Serrano	Sutton	Watson
Sessions	Tanner	Watt
Sestak	Taylor	Waxman
Shadegg	Teague	Weiner
Shea-Porter	Terry	Welch
Sherman	Thompson (CA)	Westmoreland
Shimkus	Thompson (MS)	Wexler
Shuler	Thompson (PA)	Whitfield
Shuster	Thornberry	Wilson (OH)
Simpson	Tiahrt	Wilson (SC)
Sires	Tiberi	Wittman
Skelton	Tierney	Wolf
Slaughter	Titus	Woolsey
Smith (NE)	Tonko	Wu
Smith (NJ)	Towns	Yarmuth
Smith (TX)	Tsongas	Young (AK)
Smith (WA)	Turner	Young (FL)
Snyder	Upton	

NOT VOTING—8

Brown (SC)	Melancon	Murtha
Carter	Miller, George	Rothman (NJ)
McCaul	Moore (WI)	

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1344

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

The result of the vote was announced as above recorded.

The title was amended so as to read: ''Concurrent resolution expressing the sense of Congress on the occasion of the 20th anniversary of historic events in Central and Eastern Europe, particularly the Velvet Revolution in Czechoslovakia, and reaffirming the bonds of friendship and cooperation between the United States and the Slovak Republic and the Czech Republic.''.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. ROTHMAN of New Jersey. Mr. Speaker, Wednesday, November 18, 2009, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 896: Passage of H. Con Res. 214. Had I been present, I would have voted "yes."

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 897: Motion on Ordering the Previous Question on the Rule for H.R. 3791. Had I been present, I would have voted "yes."

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 898: Passage of H. Res. 909. Had I been present, I would have voted "yes."

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 899: On agreeing to the Perlmutter (CO) Amendment. Had I been present, I would have voted "yes."

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 900: On agreeing to the Flake (AZ) Amendment. Had I been present, I would have voted "no."

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 901: On Passage of H.R. 3791. Had I been present, I would have voted "yes."

Mr. Speaker, on Thursday, November 19, 2009, due to my required participation in a classified national security meeting, I was unable to vote on rollcall No. 905: On Passage of H.R. 2781. Had I been present, I would have voted "yes."

Mr. Speaker, due to my required participation in a classified national security meeting, I was unable to vote on rollcall No. 906: On Passage of H. Con. Res. 212. Had I been present, I would have voted "yes."

MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 2009

Mr. WAXMAN. Mr. Speaker, pursuant to House Resolution 903, I call up the bill (H.R. 3961) to amend title XVIII of the Social Security Act to reform the Medicare SGR payment system for physicians, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. SALAZAR). Pursuant to House Resolution 903, the bill is considered read.

The text of the bill is as follows:

H.R. 3961

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Physician Payment Reform Act of 2009''.

SEC. 2. MEDICARE SUSTAINABLE GROWTH RATE REFORM.

(a) TRANSITIONAL UPDATE FOR 2010.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(10) UPDATE FOR 2010.—The update to the single conversion factor established in paragraph (1)(C) for 2010 shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.''.

(b) REBASING SGR USING 2009; LIMITATION ON CUMULATIVE ADJUSTMENT PERIOD.—Section 1848(d)(4) of such Act (42 U.S.C. 1395w–4(d)(4)) is amended—

(1) in subparagraph (B), by striking ''subparagraph (D)'' and inserting ''subparagraphs (D) and (G)''; and

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

''(G) REBASING USING 2009 FOR FUTURE UPDATE ADJUSTMENTS.—In determining the update adjustment factor under subparagraph (B) for 2011 and subsequent years—

''(i) the allowed expenditures for 2009 shall be equal to the amount of the actual expenditures for physicians' services during 2009; and

''(ii) the reference in subparagraph (B)(ii)(I) to 'April 1, 1996' shall be treated as a reference to 'January 1, 2009 (or, if later, the first day of the fifth year before the year involved)'.''.

(c) LIMITATION ON PHYSICIANS' SERVICES INCLUDED IN TARGET GROWTH RATE COMPUTATION TO SERVICES COVERED UNDER PHYSICIAN FEE SCHEDULE.—Effective for services furnished on or after January 1, 2009, section 1848(f)(4)(A) of such Act is amended by striking ''(such as clinical'' and all that follows through ''in a physician's office'' and inserting ''for which payment under this part is made under the fee schedule under this section, for services for practitioners described in section 1842(b)(18)(C) on a basis related to such fee schedule, or for services described in section 1861(p) (other than such services when furnished in the facility of a provider of services)''.

(d) ESTABLISHMENT OF SEPARATE TARGET GROWTH RATES FOR CATEGORIES OF SERVICES.—

(1) ESTABLISHMENT OF SERVICE CATEGORIES.—Subsection (j) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraph:

''(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2009, each of the following categories of physicians' services (as defined in paragraph (3)) shall be treated as a separate 'service category':

''(A) Evaluation and management services that are procedure codes (for services covered under this title) for—

''(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under subsection (c)(5) as of December 31, 2009, and as subsequently modified by the Secretary); and

''(ii) preventive services (as defined in section 1861(iii)) for which payment is made under this section.

''(B) All other services not described in subparagraph (A).

Service categories established under this paragraph shall apply without regard to the specialty of the physician furnishing the service.''.

(2) ESTABLISHMENT OF SEPARATE CONVERSION FACTORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subparagraph (A)—

(i) by designating the sentence beginning ''The conversion factor'' as clause (i) with the heading ''APPLICATION OF SINGLE CONVERSION FACTOR.—'' and with appropriate indentation;

(ii) by striking ''The conversion factor'' and inserting ''Subject to clause (ii), the conversion factor''; and

(iii) by adding at the end the following new clause:

''(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2011.—

''(I) IN GENERAL.—In applying clause (i) for years beginning with 2011, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

''(II) INITIAL CONVERSION FACTORS.—Such factors for 2011 shall be based upon the single conversion factor for the previous year multiplied by the update established under paragraph (11) for such category for 2011.

''(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update established for such category under paragraph (11) for the year involved.''; and

(B) in subparagraph (D), by striking ''other physicians' services'' and inserting ''for physicians' services described in the service category described in subsection (j)(5)(B)''.

(3) ESTABLISHING UPDATES FOR CONVERSION FACTORS FOR SERVICE CATEGORIES.—Section

1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)), as amended by subsection (a), is amended—

(A) in paragraph (4)(C)(iii), by striking ''The allowed'' and inserting ''Subject to paragraph (11)(B), the allowed''; and

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

''(11) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2011.—

''(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2011, the following rules apply:

''(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

''(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

''(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

''(II) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

''(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2010, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

''(i) FOR 2010.—For 2010:

''(I) TOTAL 2009 ACTUAL EXPENDITURES FOR ALL SERVICES INCLUDED IN SGR COMPUTATION FOR EACH SERVICE CATEGORY.—Compute total actual expenditures for physicians' services (as defined in subsection (f)(4)(A)) for 2009 for each service category.

''(II) INCREASE BY GROWTH RATE TO OBTAIN 2010 ALLOWED EXPENDITURES FOR SERVICE CATEGORY.—Compute allowed expenditures for the service category for 2010 by increasing the allowed expenditures for the service category for 2009 computed under subclause (I) by the target growth rate for such service category under subsection (f) for 2010.

''(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.''.

(4) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH CATEGORY.—

(A) IN GENERAL.—Section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f)) is amended by adding at the end the following new paragraph:

''(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2010.—The target growth rate for a year beginning with 2010 shall be computed and applied separately under this subsection for each service category (as defined in subsection (j)(5)) and shall be computed using the same method for computing the target growth rate except that the factor described in paragraph (2)(C) for—

''(A) the service category described in subsection (j)(5)(A) shall be increased by 0.02; and

''(B) the service category described in subsection (j)(5)(B) shall be increased by 0.01.''.

(B) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(i) in subsection (d)—

(I) in paragraph (1)(E)(ii), by inserting ''or target'' after ''sustainable''; and

(II) in paragraph (4)(B)(ii)(II), by inserting ''or target'' after ''sustainable'';

(ii) in the heading of subsection (f), by inserting ''AND TARGET GROWTH RATE'' after ''SUSTAINABLE GROWTH RATE'';

(iii) in subsection (f)(1)—

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

(II) in subparagraph (B), by inserting ''before 2010'' after ''each succeeding year'' and by striking the period at the end and inserting ''; and''; and

(III) by adding at the end the following new subparagraph:

''(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years.''; and

(iv) in subsection (f)(2), in the matter before subparagraph (A), by inserting after ''beginning with 2000'' the following: ''and ending with 2009''.

(e) APPLICATION TO HEALTH CARE GROUP DEMONSTRATION PROGRAM AND SUCCESSOR ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.—In applying the target growth rate under subsections (d) and (f) of section 1848 of the Social Security Act to services furnished by a practitioner to beneficiaries who are attributable to a health care group under the demonstration program provided under section 1886A of such Act (or to an accountable care organization under a pilot program that is a succcessor to such demonstration program under a section of such Act), the Secretary of Health and Human Services shall develop, not later than January 1, 2012, for application beginning with 2012, a method that—

(1) allows each such group or organization to have its own expenditure targets and updates for such practitioners, with respect to beneficiaries who are attributable to that group or organization, that are consistent with the methodologies described in such subsection (f); and

(2) provides that the target growth rate applicable to other physicians shall not apply to such physicians to the extent that the physicians' services are furnished through the group or organization.

In applying paragraph (1), the Secretary of Health and Human Services may apply the difference in the update under such paragraph on a claim-by-claim or lump sum basis and such a payment shall be taken into account under the demonstration or pilot program.

The SPEAKER pro tempore. The gentleman from California (Mr. WAXMAN) and the gentleman from Texas (Mr. BARTON) each will control 30 minutes.

The Chair recognizes the gentleman from California.

Mr. WAXMAN. Mr. Speaker, I yield myself 3 minutes.

Today, we consider legislation that will maintain and strengthen Medicare for seniors and individuals with disabilities. A law passed in 1997 set a limit on payments to Medicare physicians. The idea was to save money, but the limit was set too low and required draconian cuts, forcing Congress to intervene with temporary fixes.

In 2004, the law required a 4.5 percent cut. In 2008, it was a 10.1 percent cut. This year, doctors face a 21 percent cut. These are unsustainable cuts that would bring about havoc in the Medicare program. Congress has responded by enacting temporary 1-year fixes. These temporary fixes only make the problem worse the next year. The result has been a cycle of ever increasing cuts followed by ever costlier fixes.

This is not a problem of mere budget or fiscal discipline; it is a kitchen table problem for America's seniors and for the physicians who are partners in the Medicare program. Medicare's ability to guarantee health care for seniors would be eliminated if these cuts went into effect.

We are rightly asking much of the health care providers in health reform. We are demanding they provide care more efficiently, that they improve the quality of care, and that they give taxpayers good value for their dollars. In return, we need to pay them fairly for their efforts and to be an honest partner. We have two basic choices. We can solve this problem permanently or we can enact another 1-year Band-Aid. This legislation says that we will finally enact a lasting reform.

The House recognized in our budget that honest accounting means facing this problem squarely and finding a way to address it. This legislation meets that call, replacing the sustainable growth rate for physicians, or SGR, which Congress enacted in 1997, with a more responsible and stable system for the future. We must be honest about this problem and address it responsibly and immediately. We can take that step today by passing this bill and combining it with statutory PAYGO, which will help restore fiscal discipline.

I urge Members to support adoption of this bill and reserve the balance of my time.

Mr. BARTON of Texas. I ask unanimous consent that of the 30 minutes that I control, the ranking member of the Ways and Means Committee, the gentleman from Michigan (Mr. CAMP), control 15 of those minutes.

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

There was no objection.

Mr. BARTON of Texas. I would yield myself 1 minute.

Mr. Speaker, the only fix that's in this bill before us is ''the fix is in.'' This is nothing more than a repayment to the American Medical Association for endorsing the larger health care bill that was on the floor several weeks ago. There is not one dime of pay-for in this bill. It is a wave the magic wand, erase the accumulated deficit of the last 10 years or so in the SGR formula, and let's kick the can on down the road.

The bill is so narrowly construed that we couldn't offer in the motion to recommit a real pay-for because this bill doesn't have a pay-for. This is nothing more than a political payoff to the American Medical Association. Republicans support really fixing the SGR system, but we think it ought to be done all at the same time. So we would hope that we would vote against this sham today.

I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this point to yield 1 minute to the distinguished majority leader to speak on the legislation, the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. I thank the distinguished chairman for yielding, and I rise in strong support of this legislation. I want to say to my friend who has just spoken, the ranking member of the committee who chaired the committee, who said they wanted to pay for things, what this bill does is put statutory PAYGO into law. He's right. But what he didn't say to you is when their side controlled the Presidency, the House, and the Senate, they jettisoned paying for things. They did away with statutory PAYGO, they did away with PAYGO generally, and what happened? We went from substantial surpluses under the Clinton administration to substantial deficits under the Bush administration.

Now we were told those substantial deficits and deficits that were being created would create economic growth in our country. In point of fact, however, after 8 years of that economic policy where they jettisoned PAYGO, a PAYGO which provided $5.6 trillion of surplus available in March 2001, according to President Bush; but they abandoned PAYGO, which is in this bill.

This is not a question of payoff to anybody. This was in the President's budget when he sent it down here earlier this year. It was in our budget that passed the House and the Senate. We said we were going to do this. Why? Because it's the right thing to do. Today, we have the chance to vote for health care our seniors can count on and a fiscal future for all Americans that they can have faith in.

Very frankly, my friend also said, We on the Republican side want to fix this. My question is simply: Why didn't you? Why do we still have this issue that confronts us year after year after year because we didn't have the courage to face it? I'm going to talk about the deficit, because this adds to the deficit. I will lament that, but there is not an option, as you added to the deficit every time you fixed it one year at a time. Doctors couldn't rely on it. More importantly, seniors couldn't rely on the fact that their doctors wouldn't have a big cut and push them out. I'm going to talk about that as well. We can do it by stopping a massive Medicare payment cut and by committing future policies to the tested principle of pay-as-you-go.

Now my friends on the other side of the aisle don't like pay-as-you-go because it constrained them in cutting revenues over a trillion dollars, which is one of the reasons we have such a large deficit, because they didn't pay for what they bought. Interestingly enough, my friends, they bought at a rate twice the growth in spending that occurred during the 1990s, in the 2000s, which was about 3½ percent per year. It was 7 percent a year when my friends on the other side of the aisle controlled all of the levers of power. So they decreased revenue and increased spending, and we had large deficits and the biggest recession we have faced since the 1930s were inherited by this administration and, frankly, by this Congress.

Now going back to the pay-as-you-go. First, the Medicare payment rate cut, if we do nothing, payments to doctors treating Medicare patients will drop by 21 percent in the new year with more cuts in the years to come. If we allow that to take place, many seniors will find their doctors no longer available to treat them.

So this is not only about compensating doctors for the services that are vitally important and we want them to give, but it is also protecting seniors' access to doctors. That will mean less access to health care, longer waiting lists, and serious conditions going untreated and.

In sum, if we do not act on this bill, it will mean sicker seniors. That's why it's essential that we stop these cuts before they're allowed to take effect. The cuts, of course, will occur on January 1 of this year, approximately 1 month from today.

It is important to remember that this bill would simply prevent cuts, not increase payments to doctors. But it is true that ensuring our seniors' access to their doctors will add to our deficit, just as extending any of the Bush tax cuts that are set to expire next year would do. Because seniors' health is at stake in this bill, I believe that stopping these payment cuts is worth the cost.

It's also worth pointing out that this bill represents a new honesty in budgeting. As far as Democrats are concerned, the days of pretending that the costs of the ''doctor fix'' will be made up by even deeper cuts next year are over. That, of course, is a policy we followed in the first 8 years of this decade. We pretended that somehow we'd fix it later, and we never did. Indeed, most of the costs associated with this bill are the result of stopping the gimmicks that were used for years and cleaning up the mess created by those gimmicks. The first step to getting out of debt is being honest about the debt we're in. It is too deep, it is dangerous, and we need to address it.

So let's be honest. Our country is in a deep fiscal hole for reasons that go far beyond Medicare payments. In fact, there's no one reason for our record national debt. It's bipartisan in nature, not exclusively Republican or Democrat.

The causes include the previous administration's debt financed tax cuts, which I've spoken of, for America's essentially wealthier citizens who got most of the tax cuts; the cost of two wars, which we did not pay for; our escalating entitlements programs, which all of us have supported; the recession that we have confronted and that started in the seventh year of the previous administration's term; and the deficit spending—and we need to clean up that economic mess; spending that economists tell us is necessary to stimulate demand and recession.

In other words, we needed to spend the money to preclude a depression, not just a deep recession that we're in, and almost every economist, including Marty Feldstein, said that that was necessary.

A recent New York Times analysis tells us that 90 percent of our deficit has been brought about by the policies of the previous administration and the extension of its policies and the economic crisis that it left behind.

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No one step will get us out of our fiscal hole, but the most important immediate step we can take is to commit ourselves to the principle that in new policies of our country, we will pay for what we buy. That is the principle of pay-as-you-go, or PAYGO, which was in place in the 1990s as we went from deep debt into surplus and that $5.6 trillion surplus that President Bush inherited in 2001. In the 1990s, President Clinton used it to turn huge deficits into a record surplus, and when President Bush abandoned PAYGO, and my friends on the other side of the aisle abandoned PAYGO, record deficits returned.

When Democrats took back the House majority in 2006, we demonstrated our commitment to fiscal responsibility by making PAYGO a part of the House rules. It's sometimes been difficult. And now with the support from President Obama and both Chambers of Congress, we have a real chance to give PAYGO the force of law by passing this bill. Under PAYGO, Congress will be forced to offset all new policies reducing revenues or expanding entitlements, so that they add nothing to our deficit.

In essence, we will be forced to make the hard budgeting choices that are so tempting to avoid. We are avoiding them today. We ought to admit that very honestly. Why are we doing it? Because as a practical matter, in the deep recession that we're in, we cannot pay for it without depressing the economy further.

That is not an acceptable alternative. If we want to cut taxes, we'll have to explain which programs will suffer cuts. If we want to expand entitlements, we'll have to spell out how we are going to pay for it. And no matter which party is in power, we'll be forced to distinguish wasteful spending and subsidies from the long-term priorities that really matter to our country.

Some have explained that statutory PAYGO would not apply to extensions of some existing policies that have bipartisan support, one of which is the one we're talking about today. Policies on the alternative minimum tax, which we've already done. And by the way, I am one of those—wasn't in the majority—who voted against extending the alternative minimum tax if we did not pay for it. In addition to that, Medicare doctor payments, which we're talking about today, and the estate and middle-income tax cuts passed in 2001 and 2003.

I sympathize with their concerns. They are not specious concerns. I have said repeatedly that I would fight to pay for all of these policies. Hear me, if the Senate sends this back paid for, I will support it. I challenge all of you on that side of the aisle and all of you on this side of the aisle to do the same. That stands in contrast, frankly, to the first 8 years of this decade, when repeatedly it was stated that they do not believe that extensions of tax cuts need to be paid for.

Unfortunately, it's a political reality that the votes to pay for extensions of the Bush policies are most likely not there. A PAYGO law that ignored that fact would be waived for those policies and then again and again. I prefer a law that we can enforce consistently. And very frankly, that is supported by some of the most consistent voters for fiscal responsibility on this floor.

Mr. Speaker, in our country's economic meltdown last year, we all saw the damage that deep debt can do. It's time for our Federal Government to learn that lesson and act on it. If we fail to act, liberal and conservative, Democratic and Republican, priorities will suffer alike. We can still prevent that outcome, ladies and gentlemen of this House. We cannot get back to fiscal health in one afternoon's vote, and we will not, perhaps not in this President's term or the next, but we must start. We must take a step toward that end.

This bill does that. It supports not only ensuring our seniors access to quality medical services but also ensures that we, again, adopt the policy that brought us $5.6 trillion in surplus.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Parliamentary inquiry.

The SPEAKER pro tempore (Mr. SALAZAR). The gentleman will state his parliamentary inquiry.

Mr. BARTON of Texas. Under the rules that we operate where we alternate back and forth, is it allowable for myself to make a rebuttal and then recognize the gentleman from Indiana? Or do I have to do one or the other?

The SPEAKER pro tempore. The Chair may exercise his discretion in recognition in that fashion.

Mr. BARTON of Texas. I am going to recognize myself for 1 minute to comment on my friend from Maryland's comments. Then hopefully the Chair will let me recognize the gentleman from Indiana (Mr. PENCE) for 3 minutes.

Mr. Speaker, first of all, under Republican control, every bill that we brought to the floor, except one bill, was paid for either in that bill or in our budget resolution. There was one exception to that where we did not pay for it. So that is answer number one. Answer number two, this is not paid for. Under a bill that my friends in the majority passed in July, they say we're going to start pay-for, but it doesn't count for the doctors fix, it doesn't count for the alternative minimum tax, and it doesn't count for the estate tax.

But once we do all that without paying for it, then the pay for will kick in. So in that sense, my good friend from Maryland is accurate. But in the sense of this bill, he is totally inaccurate. This bill is not paid for.

Now, Mr. Speaker, if I am allowed to, I yield 3 minutes to my good friend from Indiana (Mr. PENCE).

Mr. PENCE. I thank the gentleman for yielding and for his leadership on this critical issue.

Mr. Speaker, I rise in opposition to H.R. 3961, which, rightly understood, is just the latest deficit-spending bill championed by my Democrat colleagues here on Capitol Hill. It is, in a very real sense, an addendum to the government takeover of health care that was rammed through this House just 2 short weeks ago with a pricetag in excess of $1.3 trillion.

You know, the President of the United States just said in China, If we keep adding to the debt even in the midst of this recovery, people could lose confidence in the U.S. economy. Maybe it would help if the President said that in America instead of China. Then maybe his party would get the message. Two days ago, we learned the national debt just pushed past $12 trillion. That means every man, woman and child in this country bears the burden of more than $38,000 in Federal Government debt.

In October alone, the deficit reached $176.4 billion and now comes one more deficit-spending bill to facilitate passage of a government takeover of health care. Under the guise of helping doctors and seniors, this will cost the taxpayers of future generations $200 billion, and it all goes straight to deficits and debt. One analysis by the Heritage Foundation estimates the cost of this bill over 75 years at nearly $2 trillion, and Medicare premiums are estimated to increase by some $50 billion.

It seems there is no level of spending and debt that Washington Democrats aren't willing to pile on struggling families and future generations. We're here today considering this latest deficit-spending bill because Democrat leaders refuse to address health care reform in a fiscally responsible way. It is worth noting that this so-called doctors fix was a part of earlier versions of health care reform, but to perpetrate the fiction that their government takeover of health care was passed in a fiscally responsible way, we are doing this addendum to the Pelosi health care bill.

The truth is, the spending policies of this Congress and this administration are a fiscal timebomb being placed on the doorstep of our children's future. We have a responsibility to put our fiscal house in order. But sadly, there are those who would rather pursue an ambitious liberal agenda, no matter what the cost, at the possible expense of our children's posterity and prosperity.

There is a Republican plan which we support. It will fix the problem that we are trying to address over the next 4 years. It will pay for the bill. It will lay the groundwork for meaningful health care reform by ending an era of defensive medicine. I just hasten to repeat, this is just one more deficit-spending bill in an era when the American people are bone weary of runaway Federal spending.

Frankly, when Republicans were in control, we did our share of deficit spending, and the American people showed us the door. What we have here in Washington, D.C., as evidence today, is runaway Federal spending on steroids. You know, there is a rule back in Indiana, where I grew up. When you are in a hole, stop digging. Today we're going to dig the hole of the deficit even deeper, and the American people deserve better.

I urge my colleagues to oppose this measure and support the Republican plan.

Mr. WAXMAN. Mr. Speaker, I yield myself 1 minute.

I do want the American people to understand the Republican position, because this is what they would do to Medicare. If we didn't have health reform, we still have to deal with the problem we are having with Medicare, where millions of seniors are relying on that program. And if they produce a 20 percent cut in physician fees, the people in Medicare will not be able to get access to doctors. That means that if we don't deal with the whole health care system and hold down the costs, and we don't do health reform, Medicare will face deeper and deeper cuts, and the Republicans are giving a clear indication of that's exactly what they would do.

Mr. Speaker, I yield 2 minutes to our champion on health reform, the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I rise as a proud supporter of H.R. 3961, and I urge my colleagues to join me in supporting it. H.R. 3961 fulfills a promise to our doctors that they're going to be appropriately paid for their services, and it assures that Medicare will continue to be available to provide services for our seniors.

In my home State of Michigan, this bill will prevent a loss of $610 million next year for the care of elderly and disabled patients. On average, H.R. 3961 will prevent cuts of $23,000 to each Michigan physician next year. Our Republican colleagues would have us think that this is a gimmick. What this legislation does is do away with a gimmick. I would remind my colleagues that H.R. 3961 solves a problem that's plagued the Congress since 2002 and actually ends a budget gimmick that artificially reduces the deficit by assuming that physician payments will be cut by 40 percent over the next several years, even though the Congress consistently intervenes to prevent those cuts from occurring.

Due to our failure to fix this problem permanently, the price tag has grown each year and will continue to do so. In 2005, the cost of fixing the problem was $48 billion. Today, just 4 years later, the cost has skyrocketed to $210 billion. We can no longer kick the can down the road. That is fiscally responsible. So today the choice is clear: Either we're going to be serious about protecting our seniors and protecting Medicare by providing a fiscally responsible, permanent fix to our perennial problems or we're going to play political games.

I urge my colleagues to choose the former. Vote in favor of H.R. 3961. Vote for fair treatment for our doctors. Vote to make Medicare payments available for doctors and for seniors. And make sure by so voting that you will have a situation where our doctors will be available to provide service for our senior citizens.

Mr. BARTON of Texas. I yield 1 minute to the gentleman from Kentucky (Mr. WHITFIELD), a member of the Health Subcommittee.

Mr. WHITFIELD. There is certainly enough blame to go around for both parties in the U.S. Congress as far as the debt is concerned. I have heard a lot of discussion today about being concerned about senior citizens having access to Medicare, and yet the health care bill that passed this House takes $500 billion out of Medicare. We've heard a lot about the PAYGO rules. In the 110th Congress, the PAYGO rules were waived 12 times for almost $500 billion.

As I have said, both parties have a lot of blame for the debt that we're in, and the American people want us to be responsible. We have a $12 trillion debt today. Within 10 years, it's supposed to be $23 trillion. At some point, we have to meet our obligation, meet our responsibility and try to pay for some of these programs. All of us support the purpose of this legislation, but there must be a way that we can do it and have it paid for. So for that reason, I would have great difficulty voting for this legislation without it being clearly paid for.

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Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE), the chairman of the Health Subcommittee of the Energy and Commerce Committee.

Mr. PALLONE. Mr. Speaker, I respect my Republican colleagues, but I think they are suffering from a severe case of amnesia when I listen to what they are saying on the other side. It was they who contributed to this problem in the first place. It was they who stuck their heads in the sand year after year and refused to enact any kind of meaningful reform. They talk about pay-for. They never paid for anything. They just kicked the can down the road and said, Okay, we won't have a cut this year but we will have a larger cut next year. If this continues, we will have a 40 percent cut in the reimbursement rate in the next 2 years. So there is no pay-for on their side. There never has been. It is just a budget gimmick.

Now this year, we have a permanent solution to the problem, and we are saying enough is enough with the threat of severe payment cuts that will drive physicians from Medicare and put beneficiaries' access to doctors in jeopardy.

Mr. Speaker, this legislation is an important element of our overall effort to improve Medicare for seniors. We have done a lot in health care reform. Two weeks ago we passed comprehensive health reform that made critical investments in Medicare. Amongst those, we closed the doughnut hole, thereby making prescription drugs more affordable. We improve access to preventative, primary, and coordinated care, and we increased financial assistance so that low-income seniors can better afford their monthly premiums.

We are helping seniors with this bill today by making them have a choice of physicians and quality physicians. We are helping them with the doughnut hole. We are helping them with everything with this larger health care reform.

I would just ask my Republican colleagues, don't kick the can down the road again. Don't give us all these budget gimmicks again. This is a real solution to the problem. Join us. Make this a bipartisan effort today, and let's pass this comprehensive reform.

Mr. BARTON of Texas. I yield myself 1 minute.

I would ask the distinguished chairman of the Health Subcommittee: Where is the fix? There is no fix in this bill.

They split one formula into two, but there is no reform in it. It is not based on medical expenses. It is not based on anything. There is no automatic reduction. It simply erases the current deficit in the account, has two formulas instead of one, and then 4 or 5 years from now, we will kick the can down the road again.

If there really is a fix, let's have somebody on the majority side explain it. You can't explain it because it is not there.

I yield 1 minute to a member of the Health Subcommittee, the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY of Georgia. Mr. Speaker, I rise today as a medical practitioner, one of 13 on the Republican side, in strong opposition to H.R. 3961. H.R. 3961 does not fix our physician reimbursement problem. It simply replaces one system of cuts with another. The bill, however, would add more than $200 billion to the Federal deficit at a time when our patients are struggling to find or keep the jobs they have today.

Mr. Speaker, if the details of this bill are not bad enough, the political reality is even worse. The Senate tried a similar sham of a bill last month, and 13 Senate Democrats sided with every Republican to reject it; however, House Democrats don't seem to be listening.

The time for empty promises has long since passed. We as a Nation can no longer afford to walk blindly down this path of fiscal irresponsibility. As mentioned, with $12 trillion in debt, I, for one, refuse to add another quarter trillion dollars to that debt.

I urge my colleagues to vote against this empty promise.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 2 minutes to the chairman of the House Budget Committee, the gentleman from South Carolina (Mr. SPRATT).

Mr. SPRATT. Mr. Speaker, I was here at the creation of the sustainable growth rate formula. It was part of the balanced budget agreement of 1997. I am here today to say that the SGR has not worked.

Here is the problem MedPAC presented to us in 1997:

In year 2, when we sought to curb or cut Medicare rates, volume increases in year 2 tended to make up the difference due to reduced rates.

In year 3, therefore, an automatic adjustment factor or formula was needed to target and recoup excess payments. Sound complicated? Well, that is a simple version. Suffice it to say, the SGR has proven to be so complex, so blunt an instrument, and so draconian that it has barely been used.

For example, in 2008, we reversed a 10.6 percent decrease in physicians'

rates and replaced it with a 1.1 percent increase. In 2010, the SGR dictates a 21 percent cut in physicians' payment rates. You and I know that is not going to happen.

By assuming that the SGR will be applied, when we know it has not been applied, and is unlikely to be followed in the future, Medicare spending is substantially understated. CBO says that the rewrite of SGR now before us will result in a net spending increase of $210 billion over 10 years. The CBO has to assume that the SGR will be strictly applied in each of those 10 years. CBO is bound by its rule of projecting the budget; we are not. We know that the SGR is unlikely to be applied, and so the right step, straightforward step, is to pass this bill and change the SGR, not by wiping it out, but by replacing it with an updated formula that is realistic and likely to be used.

The bill before us reflects two agreements that are in the budget resolution for this year. One is to strengthen fiscal responsibility by enacting a statutory pay-as-you-go rule. The other is to institute realistic budgeting by changing this flawed formula called the sustainable growth rate factor.

The budget resolution allows the budget effects of changing the SGR to be calculated against a realistic baseline, one that reflects current policy. This means the baseline assuming the payment rates in effect for physicians in 2009 will stay in effect through 2019.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. WAXMAN. I yield the gentleman an additional 1 minute.

Mr. SPRATT. This baseline assumption represents a realistic benchmark against which to measure the fiscal effects of legislation reforming Medicare's physician payment system. Without a realistic baseline, we will revisit this issue every year, as we have in the past, by passing short-term fixes that do nothing to address the long-term problems. Without the reforms in this legislation, the budget will continue to understate the real cost to the Treasury of Medicare payments.

So now is the time to adjust the SGR. The bill before us is a constructive solution. After 6 years of short-term fixes that did little to address the underlying causes of excess cost growth, we now have the opportunity to vote for a substantive bill. This bill does not allow for uncontrolled spending growth. It provides realistic spending targets that are fair, frugal, and holds physicians accountable.

This bill does address two of the most important challenges in health care: better support for primary care and better coordination of care. It does so by, among other things, providing an extra growth allowance for primary care services. The bill also provides incentives for the creation of accountable care organizations which encourage providers to improve quality and control costs by coordination among all providers serving a patient. This is the type of structural reform we need.

This is a good bill. I urge its support.

Mr. BARTON of Texas. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. GOHMERT).

Mr. GOHMERT. Mr. Speaker, you know, we are still hearing blame for Bush and blame for the Republican-controlled House from the Democrats. The Speaker of the House has been a Democrat for right at 3 years now. It is time to take responsibility. We keep hearing that word "responsibility." This is a good time to take it.

Now, we heard about the PAYGO rules that were passed, and now it is going to be PAYGO. And I tell you what, it didn't apply. It wasn't used like it should have been. And then in July, some of my Democratic colleagues convinced me that, you know what, we are really, really, really serious this time about PAYGO. Just vote with us. We'll show you how serious we are. I was one of 24 Republicans that voted for the PAYGO bill. But then we find out, no, no, no, this time we are really, really, really, really serious about PAYGO if you'll just pass it again this time. Come on now.

The docs do need a fix, but we don't need lectures on this side about the seniors not needing cuts when the bill that is before the House, that passed the House, is going to cut Medicare $400 billion or so.

Let's fix the problem for the doctors permanently. They deserve that. Let's not stockpile more debt on our grandchildren irresponsibly. We can do it, but this is not a permanent fix as some have said; otherwise, it wouldn't have a year limitation on it. Let's do the right thing by seniors, by doctors and our grandchildren and vote this one down and really, really, really get serious about PAYGO.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 1 minute to the gentleman from New York (Mr. ENGEL), an important member of our committee.

Mr. ENGEL. I thank my friend for yielding to me.

You know, it is always amazing to me when my Republican friends lecture us about debt or fiscal responsibility when they were in the majority here for 12 years, and for six of those years they did nothing to stop the debt. They did nothing to balance the budget. And now we get lectured.

But I rise in strong support of the Medicare Physician Payment Reform Act, a key component of comprehensive health insurance reform. It is providing our seniors with stable access to their trusted health care providers.

Each year, due to a flawed Medicare payment policy, our physicians face mounting cuts which threaten their ability to care for the patients that depend on them, and at the 11th hour, we have done a short-term patch each and ever year. It is not a good way to run Medicare. This year we are doing it differently. We are ending that. Not only will we eliminate the scheduled 21 percent reduction, but we will replace the flawed sustainable growth rate formula which is responsible for these annual cuts with a more rational payment system.

By doing so, we will preserve access to care and provide physicians with the financial stability they need. The 11th hour is not a way to do it. Our physicians face these mounting cuts, threatening their ability. This is the best way to go about it.

I urge my colleagues to support the bill.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 1 minute.

Since my friends on the Democrat side won't explain their procedure, their bill, I am going to try and do it, and if I am wrong, I am sure that they will correct me.

Current law, we have one SGR formula. It is based on GDP and inflation. It is not based on any kind of medical index. Whatever that is perceived to be each year, that is the amount of increase we can pay our physicians. All physicians get the same increase.

Under this bill, they say if you are a primary care doctor, you get the formula plus 2 percent. If you are a specialist, you get the formula plus 1 percent, but they don't change the formula. The formula is the same as it is under the current law, and they don't change the enforcement mechanism. The enforcement mechanism is the same as it is under current law; i.e., Congress has to vote to either accept the cuts or to not accept the cuts and provide a temporary fix. As I understand it, that is their fix. Now, if I am wrong in that, I want my friend Mr. WAXMAN or Mr. PALLONE or Mr. RANGEL or Mr. STARK to tell me how I am wrong.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 1 minute to the gentleman from Maryland (Mr. SARBANES), a member of the Energy and Commerce Committee and the Health Subcommittee.

Mr. SARBANES. Mr. Speaker, I thank the chairman for yielding me this time.

I just want to say to all of the seniors in my district and seniors across the country who have expressed anxiety over the last few months, and really for longer than that, that this physician payment cut would go into effect, that we heard what you were saying and we will take action today. Many of you are concerned because your doctors have been telling you that this payment cut is coming. Frankly, these physicians don't feel they are treated as professionals when we jerk them around at the end of a string every

year. That is why we want to permanently fix this problem.

We make sure that physicians are reimbursed properly and fairly so they will have an incentive to remain in the Medicare program, and that way there will be a good, robust supply of physicians to serve the Medicare population. That is why we are doing this today.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Nebraska (Mr. TERRY), a member of the Energy and Commerce Committee.

Mr. TERRY. Mr. Speaker, I don't think there is really any debate whether on one side or the other. This side supports a permanent fix to SGR. The argument here today, and the dispute here today is that we have, what, $270 billion that is not being paid for or offset properly.

If we are going to be about fiscal responsibility and protecting the future of our kids by not piling on deficit and then debt onto them, this is where the buck stops, literally, here today is that we need to pay for this, not just put it to the deficit and the debt.

But I keep hearing the talk about seniors here. We want to make sure that they have complete access to their health care, but I have to point out the irony that at 11, 11:30 a week ago last Saturday, they took a vote to cut half a trillion dollars out of Medicare and move it to a new plan away from seniors. I think we need to talk about the irony here and who is really standing up for the seniors.

□ 1430

Mr. WAXMAN. Mr. Speaker, I yield myself 1 minute.

I want to point out to my colleagues while we're blaming each other on a partisan basis that the reason we got into this situation is in 1997 with a Republican Congress and a Democratic President, there was a so-called balanced budget proposal adopted, and the way it was funded for tax cuts was to make future cuts in Medicare, especially in the physician payment side. We are paying the price of that poorly thought-through approach, which was the reason I voted against that bill in 1997.

The gentleman from Texas made some points about the situation we're in. What he did not point out is that this bill is part of a comprehensive improvement in our health care system. It would reward primary care. It would provide for accountability care organizations, which would be a better delivery mechanism. This ought to be looked at in a more comprehensive way.

That's why I'm pleased to support this bill today and the health care reform bill that the House passed a week or so ago, and we hope to complete our actions with the Senate later this year.

Mr. Speaker, I yield the balance of my time to the Ways and Means Committee chairman, the gentleman from New York (Mr. RANGEL), and I ask unanimous consent that he be allowed to control that time.

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

There was no objection.

GENERAL LEAVE

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 3961.

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

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished minority leader from the great State of Ohio (Mr. BOEHNER).

Mr. BOEHNER. I thank my colleague for yielding.

I tell my colleagues that during this debate over health care that's gone on for most of this year, Republicans have been listening to the American people; and what the American people want is they want to lower the cost of health care so that it's more affordable for more Americans.

When it comes to this issue of fixing the doctors' payment reimbursement system in Medicare, there's no dispute on either side of the aisle about the need to address it. Republicans addressed it when we were in the majority; and when we did, we made sure that there were offsets in spending elsewhere or some other types of revenue to make sure that it was paid for and not added to the budget deficit.

The issue here is twofold. One is that the proposal will not fix the problems that docs have in terms of their reimbursements down the road. It's a flawed formula that is not eliminated in this proposal. Secondly, it's going to add some $250 billion worth of debt put onto the backs of our kids and grandkids.

Now, I have listened to Democrats. The President, the President's Chief of Staff, Democrat leaders over the last couple of weeks talk about the fact that we need to do something about the budget deficit. Well, give me a break. Why don't we start right now. Right now and say that we're not going to do this, that we're not going to pass this bill that has no chance of becoming law. The Senate has already rejected it.

Why don't we just work together to come up with something that we can afford to cover the next 2, 3, 4 years so the doctors will have some idea of what their payments will be from us and get serious about working together for a long-term fix that doesn't put this responsibility on the backs of our kids and our grandkids.

That's the real issue here, the fact that there is no pay-for here. There is no offsetting other types of spending. There are no increases in revenue somewhere to cover this. It's just going to be dumped onto the backs of our kids and grandkids.

The American people want us to relearn fiscal responsibility. My colleagues on my side of the aisle over the course of this year have stood up, I believe, for fiscal responsibility. And if we're going to get our economy going again, we'd better get our fiscal house in order as well.

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

Mr. Speaker, I rise in support of H.R. 3961, and I feel so proud that the Ways and Means Committee was able to make a contribution with the other two committees, Education and Labor as well as Energy and Commerce, to bring the John Dingell medical reform bill before this House and before this country.

What it does, really, is a new way to provide health care that is perfected in such a way that the patients are able to get medical care before they become patients, have preventative care, to provide for new doctors to be able to be made, and to get rid of a flawed physician payment system that, indeed, will strengthen the Medicare program.

At the end of the day when you hear the opposition, most all of their comments are going to be negative and saying ''no.'' Even when we make our case as to why we should fulfill our obligation to the doctors, they will make some decisions here, procedure decisions, which my friend Mr. BARTON gets fed up with, but I assume he will be leading the race and saying that there should be a way to resubmit this bill to the committees to do something all over again.

If that is the case, I am certain that the American Medical Association as well as the older people and those people who need these doctors will not have to fear anything because their answer to this will be rejected, and once again we will be able to fulfill the promise that we made with the health bill by making certain they have doctors in order to support it.

At this time, Mr. Speaker, I yield the balance of my time to Chairman PETE STARK, who has made such an important contribution over the years to reform our health system, and I ask unanimous consent that he be allowed to control that time.

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

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, could I inquire as to how much time I still control, please.

The SPEAKER pro tempore. The gentleman has 3 minutes remaining.

Mr. BARTON of Texas. I want to yield 1 of those 3 minutes to the gentlewoman from Nashville, Tennessee, a

member of the Energy and Commerce Committee, Congresswoman MARSHA BLACKBURN.

Mrs. BLACKBURN. I thank the gentleman from Texas for yielding.

Mr. Speaker, I would remind my colleagues here in the House that we know something is wrong with the piece of legislation when you have major media outlets talking about how off-track this is, and you also know something's wrong with it when you have our colleagues in the Senate who take up a bill, this bill, and they can't get to 50 votes in the Senate for the companion legislation. So it is with a real sense of regret that I think many of us look at this.

Does the standard growth rate, SGR, need to be fixed? Absolutely. And there is agreement on that. It is an issue out of fairness to our Nation's physicians, the providers of health care. It is an issue of fairness to our Nation's seniors.

Mr. Speaker, I think it has been really something that has been of concern to us as we have watched some of our colleagues in this House treat Medicare as a slush fund rather than recognizing that it is a trust fund and it's there for those seniors. We can do better. Our seniors and our physicians deserve better.

Mr. STARK. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, I would like to place in the RECORD a letter from the American Medical Association and a list of over 150 supporters of H.R. 3961, among which are the American College of Obstetricians and Gynecologists, the Iowa Medical Society, the Texas Medical Society, all of whom I think place Hippocrates ahead of Sarah Palin in terms of their assessment of what should be done.

I would further begin in addressing my dear friend from Texas in some of his inquiry earlier by quoting from the ranking member of the Health Subcommittee on the Ways and Means Committee back last July when he said he believed Members on both sides of the aisle agree that there is a need for a long-term fix for the Medicare physician payment. All 15 members, Republican members, of the Ways and Means Committee voted basically for the fix we're talking about today.

Let me make no mistake about blame and where we are. It may come as a surprise to our side of the aisle we make mistakes. In 1997 we made a mistake in setting the formula by which we would automatically limit the increase that doctors get paid. Well, we're here today trying to correct that mistake.

You've said so, correctly, that it's the same formula plus 2 percent for primary care, 1 percent for other physicians, some other plans to help encourage primary care doctors to come into practice. Hopefully, we've done it right, and recognizing if we don't correct it, we're talking about hundreds of billions of dollars by postponing. So we have postponed, whether on either side of the aisle, we have postponed correcting a mistake that we should have done earlier.

That's where we are today. No place else. And I hope that we can get the continued support to do that. I hope we don't have to come back and keep addressing it. I see not correcting it increases the amount we will have to pay in the future.

So there is plenty of blame, as the gentleman suggested, to go around. We could have fought harder to correct it earlier. We didn't and that's where we are today.

Literally every major medical society in the country has suggested that we do it this way, and I urge my colleagues to join with me, hopefully with my 15 colleagues on the Ways and Means Committee who haven't changed their mind, and support H.R. 3961 today so we can put this behind us. Then we can go on and have some really spirited debate about whether they do a better job in Texas or California of reforming medical care. That will be more fun.

But today let's fix this. Pass H.R. 3961, go home and have a wonderful Thanksgiving holiday, and come back to work on health care reform.

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, November 19, 2009.

Hon. DAVE CAMP,
Ranking Member, House of Representatives, Washington, DC.

DEAR REPRESENTATIVE CAMP: Thank you for your letter of November 18, 2009, regarding the pending Congressional consideration of H.R. 3961, the Medicare Physician Payment Reform Act of 2009. We appreciate your agreement that having physicians face annual cuts due to the flawed SGR is unacceptable and your support for the intent of the legislation. As you know, it is the same policy supported by every Republican on the Ways and Means Committee during the mark-up of H.R. 3200.

We are disappointed, however, that you and your colleagues do not support the bill. As you know, the SGR was put into place by the Balanced Budget Act of 1997, which originated in your committee. At that time, the AMA wrote numerous letters to Speaker Gingrich and your committee leadership warning that limiting growth in physician services to GDP would inevitably lead to sharp cuts in physician reimbursement and a crisis in access to care for our nation's seniors. Previously we had supported legislation that would have allowed growth at a rate above GDP.

As predicted, the SGR did result in a 4.8% cut to physicians for the year 2002. Congress declined to intervene and that cut went into effect. In subsequent years, Congress did step in to prevent additional cuts from occurring. The Consolidated Appropriations Resolution of 2003, the Medicare Modernization Act of 2003, the Deficit Reduction Act of 2005, the Tax Relief and Health Care Act of 2006, the Medicare, Medicaid, and SCHIP Extension Act of 2007, and the Medicare Improvement for Patients and Providers Act of 2008 each provided temporary relief for seniors and their physicians from pending cuts.

What these bills did not do, however, was make any progress toward fixing the problem. Instead, Congress fell into a comfortable rhythm of kicking the can down the road and putting off real reform to some unspecified point in the future. In 2005, physicians faced a cut of 3.3% which was averted by the MMA. At that time, the Congressional Budget Office reported that the cost of just a ten-year freeze in physician rates was $48.6 billion. Just four years later, the pending cut stood at 21.5% and the cost of a ten year freeze stood at $285 billion. The AMA believes that this cycle must come to an end. Anything short of permanent reform will not be supported by the AMA. Every year that Congress ''pays-for'' a temporary solution, the cost of permanent reform climbs higher still. These are obligations to our seniors which the Medicare program has already made. To pretend that they will not be incurred is unrealistic. To continue to grow the size of the problem is irresponsible.

As for the implication that the recent action by the Administration to remove drugs from the SGR are ''budget gimmicks to hide the true deficit impact,'' we are reminded of a letter you signed on May 21, 2004, to the Bush administration calling the policy of including drugs in the formula ''our greatest concern'' regarding the magnitude of the SGR problem. That letter was also signed by other members of your committee. On June 16, 2004, Representative Cantor sent a similar letter with Representative Pryce urging that CMS ''remove prescription drug expenditures from the Sustainable Growth Rate (SGR) determination.''

The Congressional Record is replete with statements by members from both sides of the aisle calling for permanent reform. What is missing, however, is the result. The record shows temporary patches and a ballooning problem.

The AMA does not support any motion to recommit that would have a temporary fix. How steep will cuts be after those four years? How many hundreds of billions of dollars will it then cost to fix this problem? Medical liability reform remains among the highest priorities of the AMA and all physicians. However, when Republicans controlled both chambers of Congress and the White House, capping damages could not be accomplished. We fail to see why you believe it is possible today. With less than seven weeks before Medicare rates are cut more than 21%, we need solutions that can be achieved quickly.

This should not be a partisan issue. Both sides of the aisle have professed a desire to permanently address this issue. The opportunity to advance permanent reform through passage of H.R. 3961 cannot be missed. We urge all members to vote for H.R. 3961.

Sincerely,

J. JAMES ROHACK.

H.R. 3961 is supported by a wide range of organizations representing patients, doctors and other providers, including: AARP; Air Force Association; Air Force Sergeants Association; Air Force Women Officers Associated; Alliance for Retired Americans; AMDA—Dedicated to Long Term Care Medicine; American Academy of Allergy, Asthma and Immunology; American Academy of Child and Adolescent Psychiatry; American Academy of Cosmetic Surgery; American Academy of Dermatology Association; American Academy of Facial Plastic and Reconstructive Surgery; American Academy of Family Physicians; American Academy of Hospice and Palliative Medicine; American Academy of Neurology Professional Association.

American Academy of Ophthalmology; American Academy of Pain Medicine; American Academy of Pediatrics; American Academy of Sleep Medicine; American Association of Clinical Urologists; American Association of Hip and Knee Surgeons; American Association of Neurological Surgeons; American Association of Neuromuscular and Electrodiagnostic Medicine; American Association of Orthopaedic Surgeons; American College of Allergy, Asthma and Immunology; American College of Cardiology; American College of Chest Physicians; American College of Emergency Physicians; American College of Gastroenterology.

American College of Obstetricians and Gynecologists; American College of Osteopathic Internists; American College of Osteopathic Surgeons; American College of Physicians; American College of Radiation Oncology; American College of Radiology; American College of Rheumatology; American College of Surgeons; American Gastroenterological Association; American Geriatrics Society; American Logistics Association; American Medical Association; American Medical Group Association; American Osteopathic Academy of Orthopedics; American Osteopathic Association.

American Psychiatric Association; American Society for Clinical Pathology; American Society for Gastrointestinal Endoscopy; American Society for Metabolic and Bariatric Surgery; American Society for Radiation Oncology; American Society for Reproductive Medicine; American Society for Surgery of the Hand; American Society of Addiction Medicine; American Society of Anesthesiologists; American Society of Cataract and Refractive Surgery; American Society of Clinical Oncology; American Society of Hematology; American Society of Nephrology; American Society of Ophthalmic Plastic and Reconstructive Surgery; American Society of Plastic Surgeons.

American Society of Transplant Surgeons; American Thoracic Society; American Urological Association; AMVETS; Arizona Medical Association; Arkansas Medical Society; Army Aviation Association of America; Association of American Medical Colleges; Association of Military Surgeons of the United States; Association of the United States Army; Association of the United States Navy; California Medical Association; Chief Warrant Officer and Warrant Officer Association of the U.S. Coast Guard; College of American Pathologists; Colorado Medical Society.

Commissioned Officers Association of the U.S. Public Health Service, Inc.; Congress of Neurological Surgeons; Connecticut State Medical Society; Contact Lens Association of Ophthalmologists; Emergency Department Practice Management Association; Enlisted Association of the National Guard of the United States; Fleet Reserve Association; Florida Medical Association Inc.; Gold Star Wives of America; Hawaii Medical Association; Heart Rhythm Society; Idaho Medical Association; Illinois State Medical Society; Indiana State Medical Association; Infectious Diseases Society of America.

International Society for Clinical Densitometry; International Spine Intervention Society; Iowa Medical Society; Iraq and Afghanistan Veterans of America; Jewish War Veterans of the United States of America; Joint Council of Allergy, Asthma and Immunology; Kansas Medical Society; Kentucky Medical Association; Louisiana State Medical Society; Maine Medical Association; Marine Corps League; Marine Corps Reserve Association; Massachusetts Medical Society; MedChi, The Maryland State Medical Society; Medical Association of Georgia.

Medical Association of the State of Alabama; Medical Group Management Association; Medical Society of Delaware; Medical Society of the District of Columbia; Medical Society of the State of New York; Medical Society of Virginia; Michigan State Medical Society; Military Chaplains Association of the United States of America; Military Officers Association of America; Military Order of the Purple Heart; Minnesota Medical Association; Mississippi State Medical Association; Missouri State Medical Association; Montana Medical Association; National Association for Uniformed Services.

National Committee to Preserve Social Security and Medicare; National Guard Association of the United States; National Medical Association; National Military Family Association; National Order of Battlefield Commissions; Naval Enlisted Reserve Association; Nebraska Medical Association; Nevada State Medical Association; New Hampshire Medical Society; New Mexico Medical Society; Non Commissioned Officers Association; North Carolina Medical Society; North Dakota Medical Association; Ohio State Medical Association; Oklahoma State Medical Association.

Oregon Medical Association; Pennsylvania Medical Society; Renal Physicians Association; Reserve Enlisted Association; Reserve Officers Association; Rhode Island Medical Society; Society for Cardiovascular Angiography and Interventions; Society for Maternal-Fetal Medicine; Society for Vascular Surgery; Society of Critical Care Medicine; Society of Gastrointestinal and Endoscopic Surgeons; Society of Gynecologic Oncologists; Society of Hospital Medicine; Society of Interventional Radiology; Society of Medical Consultants to the Armed Forces.

South Carolina Medical Association; South Dakota State Medical Association; Tennessee Medical Association; Texas Medical Association; The Endocrine Society; The Retired Enlisted Association; The Society of Thoracic Surgeons; United States Army Warrant Officers Association; USCG Chief Petty Officers Association; Utah Medical Association; Vermont Medical Society; Veterans of Foreign Wars; Washington State Medical Association; West Virginia State Medical Association; Wisconsin Medical Society; Wyoming Medical Society.

Mr. Speaker, I reserve the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair reminds Members on both sides of the aisle to direct their remarks to the Chair.

Mr. BARTON of Texas. Mr. Speaker, I'm not used to dealing with a warm and fuzzy PETE STARK. I have to admit that was a very good speech.

Mr. Speaker, I yield 1 minute to my good friend from Michigan from the Energy and Commerce Committee, Mr. ROGERS.

Mr. ROGERS of Michigan. Mr. Speaker, the SGR fix is incredibly important, but this approach is disingenuous at best. Let's go back quickly.

In 2008 the Medicare Improvement for Patient and Providers Act, sponsored by my friends on the other side of the aisle, had a 21 percent cut to go into effect for doctors this year. Your bill, your issue, your 21 percent. And you come here today knowing full well this bill will go nowhere.

Why this is disingenuous is because 2 weeks ago, you added about 16 million people to Medicaid that shorts doctors hundreds of millions of dollars in reimbursement every single year. And, oh, by the way, you tax doctors, and everything in their operation; their costs go up. And here's the thing: you cut a half trillion dollars out of Medicare, hospitals, home health services, nursing homes, hospice care. You cut Medicare a half trillion dollars. You know this bill will go nowhere.

This is an easy fix. Let's work together. Let's find some offsets. Let's fix it for doctors. And, by the way, let's go back and take back that money that you have cut, a half trillion dollars, out of Medicare for the lives and betterment of seniors.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair reminds Members on both sides of the aisle to address their remarks to the Chair.

Mr. STARK. Mr. Speaker, at this time I'm delighted to yield 1 minute to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. This bill is about more than the reasonable desire of physicians for reimbursement rates that cover their actual cost and fairly compensate their work. It is about access to quality health care and your ability to choose the doctor best for you.

When accepting new Medicare patients means losing money, fewer physicians can accept new patients. In 1997, a Republican Congress enacted a payment formula that never worked, and then they kept everyone guessing year after year as to what kind of gimmick they would come up with in lieu of the next year's payment cut.

Now we have revised their flawed formula and prevented what could be up to a 40 percent cut for physicians. Our bill will not only help seniors and the disabled, but it will help many members of the active duty military and our veterans who rely on TRICARE. Our troops should never have to worry whether their family can get the care and the doctor that they need.

Instead of another Republican Band-Aid, we offer a cure for what ails the Medicare-TRICARE formula. Today is one time that the ''just say no'' party ought to say ''yes'' to good public policy, which is supported by the Texas Medical Association and medical societies across the country.

□ 1445

The SPEAKER pro tempore. The gentleman from Texas (Mr. BARTON) has 1 minute remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield myself the balance of the time.

I'd like to put into the RECORD a statement from the vice chairman of the American Medical Association on

March 20, 1997, where they went on record before the Ways and Means Committee subcommittee supporting the current system. And now, I understand and I accept what Subcommittee Chairman STARK said, that mistakes have been made, and I think, in hindsight, both sides can agree that a mistake has been made.

It is my opinion, and I think most of the Republicans would share this opinion, that this is not the solution. When all you do is change which formula gets reimbursed, either primary care or specialist, but you use the same underlying formula, the same lack of enforcement, that's not, in my opinion, a fix. So respectfully, I believe that we should defeat this bill and then work together.

I do sense some bipartisanship on this floor. Let's work together to come up with a real fix. It will not be easy. It's not easy to come up with $350 billion. It's not easy to allocate that. It's not easy to change the formula to something that more accurately reflects the costs of practicing medicine in the modern era. But, we can do it. This is not the solution. I hope we'll vote this down.

As has been pointed out, this bill isn't going anywhere in the Senate. This is an act, in my opinion, of paying off a political debt to the American Medical Association for endorsing the larger health care bill several weeks ago. Please vote ''no.''

STATEMENT OF THOMAS R. REARDON, M.D., VICE CHAIR, AMERICAN MEDICAL ASSOCIATION

Mr. Chairman, my name is Thomas R. Reardon, M.D. I am a general practitioner from Boring, Oregon, and a member of the Board of Trustees for the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I thank you for this opportunity to testify before the Subcommittee today regarding Medicare physician payment issues.

A wide range of experts have independently concluded that, despite Medicare's clear success in improving the health status of our elderly and disabled citizens, the program cannot be sustained without fundamental restructuring. The Hospital Insurance Trust Fund faces bankruptcy in five years or less, and Medicare's current overall expenditure growth cannot be sustained. Medicare faces a much more serious long-term problem as the ''baby boom'' generation ages and the number of workers paying taxes for every Medicare beneficiaries will decline from 3.9 currently to only 2.2 in the year 2030.

The high growth rates for many of the services are due to a combination of factors, including increased beneficiary demand for new services, flaws in payment rules which encourage high volume growth in some categories of service, insulation of most beneficiaries from cost considerations, and ineffective approaches to cost control. However, as the chart below indicates, physician spending growth is well below the rate for any other major sector of Medicare, and well below overall Medicare growth. The AMA is pleased that the President's 1998 budget proposal explicitly recognizes this fact.

We are also pleased that the Administration's budget supports the development of innovative provider sponsored organizations in order to offer greater choice to Medicare beneficiaries. We believe these types of options hold the promise of enhancing beneficiary choice while controlling Medicare's costs. The AMA also supports the President's investment in preventive health care to improve seniors' health status by covering colorectal screening, diabetes management, and annual mammograms without copayments, and by increasing reimbursement rates for immunizations to ensure that Medicare beneficiaries are protected from pneumonia, influenza and hepatitis.

Unfortunately, the Administration's budget primarily adopts the strategy of cutting physician and other provider payments in hopes of getting more services for less money. We believe this approach will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care, while postponing the major restructuring needed for Medicare's long-term survival. In the meantime, the long-term problems will only grow larger, requiring more draconian and expensive solutions.

AMA'S PROPOSAL FOR MEDICARE TRANSFORMATION

The AMA has a plan which addresses both the short and long-term problems with Medicare, while preserving the bond of trust between a patient and physician that makes medicine unique. The AMA's Transforming Medicare proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens and the disabled. We must give the patient both the opportunity and the responsibility to make wise prospective choices of physician and health plan, with the reasonable opportunity to change either if they prove unsatisfactory.

Our plan would modernize traditional Medicare, eliminating the need for Medigap, while preserving the security and quality of care beneficiaries now receive. It would create a new MediChoice option, which would provide a broad menu of health plan choices for Medicare beneficiaries to choose from, including medical savings accounts and provider sponsored organizations. And finally, it would ensure that a healthy Medicare is available for future generations. The AMA would welcome the opportunity to discuss our Transforming Medicare proposal with the Subcommittee in greater detail at an appropriate forum.

IMPROVING THE PHYSICIAN PAYMENT SYSTEM

The Administration's 1998 budget proposal targets $5 billion in savings over five years from refinements to the Medicare physician payment schedule. In particular, the Administration proposes moving to a single conversion factor (CF) for the payment schedule, and replacing the current Medicare Volume Performance Standard (MVPS) update formula with a Sustainable Growth Rate (SGR) formula.

Under the Administration's budget proposal, the overall payment update for 1998 would be set at 1.9%, yielding an overall CF of $36.63 in 1998. With the move to a single CF of $36.63, surgical service payments would fall by 10.6% compared to 1997 levels, while primary care payments would increase by 2.4% and other service payments would increase by 8.2%. The payment reductions for surgical services are further exacerbated by the implementation of resource-based practice expense relative value units scheduled for 1998, as discussed below.

The AMA has consistently sought a return to a single growth standard and conversion factor for physician services. We adopted this position well before any indication of which services would benefit from multiple standards. At our Annual House of Delegates meeting in 1996, AMA policy was modified to adopt a compromise that responds to two realties. First, because moving to a single conversion factor could lead to large single year cuts for some services and specialties, we support a transition of as close to three years as possible. Second, because we also recognize that one of the purposes of a transition is to allow those who face cuts time to adjust, and that there has been ''fair notice'' of a shift to a single conversion factor, our House of Delegates voted that the ''clock should start running'' on such a transition on January 1, 1997.

In addition to moving to a single conversion factor, the AMA supports replacing the MVPS system of updating physician payments. There is widespread agreement that the current method of updating physician payments, the MVPS system, is fundamentally flawed. The Congress, the Administration, and the Physician Payment Review Commission (PPRC) have all proposed replacing the current MVPS update formula with a sustainable growth rate (SGR) formula, which uses real per capita gross domestic product (GDP) to adjust for volume and intensity.

The Administration's fiscal year 1998 budget proposes implementing an SGR formula, with the volume target in the SGR formula initially set at growth in real per-capita GDP plus one percentage point. However, the Congressional Budget Office (CBO) scoring of the proposal apparently failed to yield the targeted savings of $5 billion in savings from the Medicare fee schedule, and the volume allowance in the SGR was reportedly reduced to GDP+0.

In general, the AMA supports implementing the SGR approach as a needed correction for the MVPS. Fundamentally, the question for policymakers is determining the level of annual spending growth for physician services that best balances patient care needs and the federal budget. Under the current MVPS physician update formula, the projected Medicare payment level for physicians is a steep actual decline, while hospital and other provider payment rates go up, as the chart below indicates. Although these non-physician services are unlikely to see their full projected increases, their budget savings will be charged against this rising baseline, while further savings from physicians require even steeper cuts.

Budget reconciliation for Medicare should reflect the fact that physician spending is under better control than any other major Medicare segment, and that the budget baseline already assumes steep annual payment cuts. Physician practice costs, as measured by the Medicare Economic Index (MEI), continue to rise while physician reimbursement under Medicare is projected to fall. Physicians are only asking for the opportunity to have Medicare payments keep up with the costs of providing care to Medicare beneficiaries, and are willing to accept the challenge of maintaining volume growth at current low levels.

While we believe that MEI is the appropriate goal for physician updates, we understand that budgetary constraints may not presently allow for a full MEI update for physicians. Physicians are willing to do their part to put Medicare's fiscal house in order, as we have repeatedly done in the past. Physicians, who accounted for 32% of combined

physician and hospital Medicare spending from 1987 to 1993, absorbed 43% of Medicare provider cuts over the same time. We would be willing to accept GDP+2 under an SGR system as a temporary measure, if there were assurances that this could be increased to cover MEI once the necessary Medicare savings were obtained. In contrast, under GDP+O as the Administration proposes, physician payments would continue to fall well below MEI, as they are projected to do under the current MVPS system.

Given a new SGR, with a realistic growth allowance, we could also support a new ceiling on positive MVPS adjustments, which would provide direct financial benefits to the federal budget if actual volume is below target. Moreover, the federal government receives a very real additional benefit—the ability to pay for the payment rates needed to maintain the viability of Medicare fee-for-service out of reduced service volume. At the same time, like the PPRC, we believe it essential to maintain the current 5% maximum payment reduction from the MEI (increased from 3% by OBRA 93) and to reject Administration proposals to lower the floor to MEI minus 8.25%.

RESOURCE-BASED PRACTICE EXPENSE

As mentioned above, many physicians face additional extreme payment reductions due to the implementation of the resource-based practice expense in 1998. The Social Security Act Amendments of 1994 requires the Health Care Financing Administration (HCFA) to implement a ''resource-based'' practice expense component of the Medicare fee schedule by January 1, 1998. That is, the payment for this component—which represents over 40 percent of the payment for physician services—is to be based on the actual expenses incurred in delivering each service. Currently, the practice expense allowance is derived from a formula based on the prior reasonable charge payment system.

The AMA supports resource-based practice expenses so long as they reflect actual practice expenses, but is seeking a one-year extension of the implementation date. The 1994 legislation said that HCFA should ''recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.'' HCFA contracted with Abt Associates to conduct a two-part study of 3,000 physician practices expenses. When the survey was pulled back due to poor response rates, HCFA was left without adequate data to meet the intent of the law.

HCFA is relying primarily on data derived from clinical practice expert panels, or CPEPs. Early review of the recently-released CPEP findings suggest that they contain a number of errors. HCFA has even rejected certain direct costs that its expert panels found were part of the cost of surgery when doctors supply their own staff and supplies in hospital operating rooms. The AMA and medical specialties are working to identify and correct those flaws but more time is needed.

Those who want to adhere to the current January 1, 1998, deadline argue that any problems can be corrected later through a refinement process similar to the one used when new work values were implemented in 1992. The AMA believes this is an inappropriate comparison. HCFA invested nearly three times as much time and money on the design of new work values as it has spent to revise practice expense values. Whereas thousands of doctors were surveyed to come up with the work values, in the end, there was no broad survey of practice expenses. Simply put, with work values, the product being tested was much further along in the development process than is now the case with practice expense values.

Opponents of an extension also maintain that there is no point in waiting another year because the demise of the indirect cost survey shows that it will never be possible to collect this information independently. We believe that with another year, HCFA could develop alternative relative values that bear some relationship to actual practice expenses. There would be adequate time to validate and correct the CPEP data. Better indirect cost allocation methodologies could be developed and tested. Missing data could be collected, perhaps through an expansion of existing surveys.

The cuts HCFA projected in January are so extreme that they would nearly eliminate practice cost reimbursement for some procedures and specialties. Many inpatient surgical procedures and two specialties could suffer cuts of more than 80% in their practice expense values, and at least 40% in their total payments. Under HCFA's projections, payments for many surgical procedures would fall below Medicaid levels. Thus, there is good reason to fear that if Medicare makes deep cuts in its payments for complex procedures, doctors performing these services may find that they can no longer afford to accept Medicare patients.

In addition, even some of the specialties which seem relatively unscathed in HCFA's projections could actually experience significant cuts if other payers pick up the new Medicare values because the projections do not show the impact of cuts in procedures usually done on patients under age 65. To impose such deep payment cuts based on such spotty research seems certain to undermine physician support for the RBRVS.

The AMA urges Congress to: (1) extend the resource-based practice expense implementation date by one year to January 1, 1999, in order for HCFA to incorporate data on physicians' actual practice expenses into the new relative values; (2) direct HCFA to give physicians the opportunity to review the practice expense data and assumptions six months prior to issuing the proposed rule; and (3) instruct HCFA to take whatever steps may be necessary to ensure that implementation of the new values will not have a negative effect on physicians' ability to provide high quality medical services to Medicare beneficiaries.

OTHER PHYSICIAN PAYMENT ISSUES

Assistants at Surgery

The Administration is proposing to save $400 million over the next five years by making a single payment for surgery. This means that the additional payment Medicare now makes for a physician assisting the principal surgeon in performing an operation would no longer be made. Instead, the payment amount for the operation would have to be split between the principal surgeon and the assistant at surgery. We believe this provision dangerously imposes financial disincentives for the use of an assistant at surgery. The AMA supports efforts to develop guidelines for the appropriate use of assistants at surgery, but believes that patient care should not be compromised in search of Medicare savings. The professional judgment of surgeons regarding the need for an assistant at surgery for a specific patient must be recognized, even for operations in which an assistant ordinarily may not be required. Congress has considered and rejected this proposal in the past, and we urge the Subcommittee to reject it again.

High Cost Medical Staff

The Administration proposes to reduce Medicare payments for so-called high cost hospital medical staffs. This proposal is not new. In its 1994 Annual Report to Congress, the PPRC concluded that such a ''provision's disadvantages . . . outweigh its advantages.'' The Commission went on to note that such a provision: ''may have unintended effects on physician behavior, including a shifting of admissions away from hospitals with the high-cost designation. The provision would also increase the cost and complexity [of] administering the Medicare program.''

In some cases, the physicians responsible for a hospital's medical staff being designated ''high cost'' for a given year might simply take their patients elsewhere, leaving the remaining physicians on staff to bear the financial consequences, with potentially serious repercussions for the affected hospital. Finally, the proposal could have the effect of inappropriately reducing payments to physicians who treat a sicker patient population. In the absence of a sound methodology to measure differences in the severity of illness of the patient population being treated by the medical staff, it is too risky to put in place a formula-driven process that could inappropriately lower payments for treating patients who are more expensive to treat because they are sicker.

Centers of Excellence

The Administration proposes to expand what it calls the ''Centers of Excellence'' demonstration project, under which Medicare makes a bundled payment to participating entities covering both physician and facility services for selected conditions, such as coronary artery bypass operations. We are concerned that these demonstration projects do not offer a potential increase in quality and cost-effectiveness, and that these ''centers of excellence'' in fact emphasize cost-cutting rather than excellence. We also find the name ''centers of excellence'' inappropriate in that it implies that institutions participating in this payment arrangement provide higher quality services than non-participating institutions.

FRAUD AND ABUSE

The AMA strongly opposes the Administration's efforts to repeal the fraud and abuse safeguards included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which would eliminate the obligation of the Departments of Justice and Health and Human Services to issue advisory opinions on the anti-kickback statute, reduce the government's burden of proof for civil monetary penalties, and repeal the risk sharing exception to the anti-kickback statute.

Fraud and abuse has no place in medical practice and the AMA is committed to setting the highest ethical standards for the profession. For those who wish to comply with the law, the incidence of misconduct can be greatly reduced by setting standards of appropriate behavior, disseminating this information widely, and designing and implementing programs to facilitate compliance. HIPAA provides new and much needed guidance by requiring HHS to establish mechanisms to modify existing safe harbors, create new safe harbors, issue advisory opinions, and issue special fraud alerts. This guidance will allow physicians, hospitals and insurers to develop efficient and effective integrated delivery systems that will benefit Medicare, Medicaid and the private health care marketplace.

In the area of civil monetary penalties (CMPs), HIPAA requires that the Inspector

General establish that the physician either acted ''in deliberate ignorance of the truth or falsity of the information,'' or acted ''in reckless disregard of the truth or falsity of the information.'' The AMA fought long and hard to preserve this clarified standard in the face of huge opposition. This standard makes the burden of proof for imposing CMPs under HIPAA identical to the standard used in the Federal False Claims Act, and there is no reason that two enforcement tools designed to address the same fraudulent behavior should have different standards of proof. Moreover, this section provides important protection for physicians who may unwittingly engage in behavior that is impermissible.

Finally, the AMA strongly opposes the Administration's proposal to eliminate the new risk sharing exception to the anti-kickback law provided in HIPAA. The expansion of managed care in today's health care market requires additional exceptions to the anti-kickback laws so that more flexibility in marketing practices and contractual arrangements is afforded. The future of the Medicare and Medicaid programs depends upon the ability of competing plans to offer quality alternatives to the existing program. HIPAA provides a much needed exception to the anti-kickback law for certain risk-sharing arrangements which will facilitate the development of innovative and cost-effective integrated delivery systems.

CONCLUSION

Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely on this program in the future, as well as those working Americans who are called upon to help finance it. Simplistic budget-cutting has not resulted in cost-control over recent years; on the contrary, price controls have had the perverse effect of exacerbating Medicare's fiscal crisis and severely threatening the promised access of beneficiaries to medical care.

However Medicare is reformed, it will be our overriding goal to ensure that the change not damage the essential elements of the patient-physician relationship. Above all, reform should not break the bond of trust between a patient and physician that makes medicine unique. By that we mean:

All patients must remain free to choose the physician they feel is best qualified to treat them or individually elect any restrictions on choice;

All patients, including those with chronic conditions and special health or financial needs, must have access to any needed service covered by Medicare;

No restrictions on information about treatment options and no financial incentive program can be allowed to interfere with the physician's role as patient advocate;

Both patients and physicians must have complete, easily understood information about the Medicare program, and a right to raise questions, voice grievances, and to have them responded to in a fair, effective process; and

Patients must be protected from unscrupulous or inept health plans, physicians, and other providers.

Americans who depend on the Medicare program for their medical and health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. The AMA looks forward to working with the Subcommittee and the 105th Congress in protecting Medicare for our seniors and saving it for our children.

Mr. STARK. Mr. Speaker, I am pleased at this time to recognize a distinguished member of the Ways and Means Committee, Mr. NEAL of Massachusetts, for 1 minute.

Mr. NEAL of Massachusetts. Mr. Speaker, I rise in support of this Medicare Physician Payment Reform Act, and remind our friends on the other side that this is similar to the 2-minute drill. We do this every year. It's like the 2-minute warning in professional football. H.R. 3961 is about preserving patient choice, which is a fundamental element of our health care system, and very important to the reform measure that we passed about a week ago.

This legislation will ensure that seniors on Medicare and TRICARE across America continue to have access to care and to the physician of their choice. But conversely, this bill also provides physicians with the certainty they need and have been missing to operate their offices in a predictable way and to continue to serve Medicare patients.

It eliminates the steep payment cut scheduled for next year, a cut that, if it were allowed to happen, could reduce physician access across the country. H.R. 3961 is a good piece of legislative work. It increases payments to primary care providers for office visits, and it encourages the formation of accountable health care organizations. It goes a long way in preserving the vital patient-doctor trust contract and to strengthening that relationship.

I urge support of this legislation.

Mr. CAMP. Mr. Speaker, I yield myself 2½ minutes.

The Medicare system paying for doctors is broken. It's broken badly, and on that, I don't think there's any disagreement. The question before us today is not whether to fix the so-called ''sustainable growth rate formula,'' but how.

Time and time again, Republicans have supported America's doctors, while always paying for a so-called doctor fix. And the fact remains true today. It's irresponsible for the Speaker to force this House to choose between protecting doctors and seniors today and protecting our children's future. The bill before us directly adds at least $210 billion to the deficit, plus another 50 billion in added debt payment, and as The Washington Post noted, the budget gimmicks mask the true costs, which are closer to $300 billion. So much for health care reform not adding one dime to the deficit.

Adding insult to injury, the bill before us doesn't even solve the underlying problem with the SGR. The Democrats' new ''targeted growth rate'' would allow doctors to face cuts again as soon as 2011. We can and should do better by our doctors, our seniors and our children.

Republicans are offering a better alternative, a 2 percent increase in doctor and Medicare payments in each of the next 4 years that is fully paid for, primarily by implementing real medical liability reform, a proven way to cut wasteful health care spending.

It's telling that our colleagues on the other side prefer to pile up hundreds of billions of dollars in new debt on our children, instead of standing up to their friends in the trial lawyer lobby. For all of the talk about PAYGO, this bill makes a mockery of the majority's so-called commitment to fiscal responsibility. This is new spending and lots of it. It should be paid for, it must be paid for, and Republicans are offering a way to pay for it.

I reserve the balance of my time.

Mr. STARK. I'd like to recognize Mr. BLUMENAUER from Oregon for 1 minute, but pending that, I yield myself 30 seconds to respond to my distinguished colleague and ranking member of the Ways and Means Committee that we debated this back in July, and that all of us agreed and voted for the fix that we're talking about today. And I hope that we could continue that. It was done on a bipartisan basis at that time. It was probably the only part of the bill that was bipartisan, but we did all vote for it and voted for exactly what we're talking about today, and I hope we could get those votes again.

I yield to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. I appreciate the gentleman's courtesy. This is a necessary budget adjustment, the consequence of the Republican gimmick that I voted against in 1993 because it was an artificial attempt that nobody had an expectation we were actually going to do. Indeed, every single year, except one, the Republicans blinked and kicked the can down the road.

We are facing up to the problem today in a comprehensive way, not holding doctors and their patients hostage. Health care reform actually moves us in the direction to be able to reduce costs in the long term, and I'm optimistic that what the House has already done will move us in that direction.

But whether or not reform is enacted, failure to pass this inflicts unacceptable damage on our constituents. This legislation gets us off the merry-go-round. I would strongly urge my colleagues to vote with us, my Republican friends not to vote ''no,'' but work with us with a strong, resounding vote of support, and then work with the Senate to adopt this reasonable long-term adjustment.

Mr. CAMP. I yield 2 minutes to the ranking member of the Health Subcommittee, the distinguished gentleman from California (Mr. HERGER).

Mr. HERGER. Mr. Speaker, while I rise today in support of reversing the

devastating Medicare cuts for physicians, I also rise in opposition to passing the buck to our children and grandchildren.

Mr. Speaker, our government is facing a severe and unprecedented debt crisis. Yet, despite the President's pledge that health care legislation won't add one dime to the deficit, we're voting today on a health care bill that adds 2 trillion dimes to the debt, while piling trillions of dollars more onto Medicare's unfunded liabilities.

Mr. Speaker, the American people are tired of these budget games. Two weeks ago, 219 Members of the Democratic majority voted to cut Medicare by $500 billion. We could have taken a fraction of those savings and kept them within Medicare to pay for this much-needed relief for physicians. It would have passed with a huge bipartisan vote. But, instead, the majority decided to raid Medicare and spend the money on a new government-run health program.

Republicans will be offering an alternative to ensure that doctors in Medicare are paid appropriately, and protect them from frivolous medical lawsuits, all without adding to the debt.

I urge the Speaker to stop the political games and allow the House to vote on our responsible solution. It's the right thing to do for our doctors, it's the right thing to do for our seniors, and it's the right thing to do for the future of our country.

Mr. STARK. Mr. Speaker, could I inquire as to the remaining time on either side?

The SPEAKER pro tempore. The gentleman from California has 7 minutes and the gentleman from Michigan has 11½ minutes.

Mr. STARK. At this time, Mr. Speaker, I'm delighted to yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. First thing we have to get straight here is that the past administration masked the costs of our one-sided tax cuts in 2001 and 2003, unpaid for; masked the costs of two wars, never in the base budget; masked the costs of taking care of our returning brave soldiers. You have been the masters of masks. And now you're advising Democrats? Case closed.

Mr. Speaker, today we have the opportunity to vote on legislation for which many of us here have hoped for years, a permanent solution to the flawed Medicare physician payment formula. I implore my colleagues to set aside partisan bickering. Each year for the past 7 years, both Republican Congresses and Democratic Congresses have stepped in to preserve seniors' access to care by preventing steep cuts to physician payments. Each year.

The sustainable solution before us today deserves bipartisan support. If we're truly serious about enacting comprehensive health reform then we will pass this vital legislation. Providing a realistic, long-term solution that embraces a legitimate effort to rein in spending while recognizing—

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. STARK. I yield the gentleman an additional 15 seconds.

Mr. PASCRELL. To rein in spending while recognizing the value of primary care is a necessary foundation to true reform. Without it, it's like building our house on a foundation of sand that not only jeopardizes access to care for 45 million seniors and individuals with disabilities but also has important consequences for our entire physician workforce.

Mr. CAMP. I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Texas (Mr. BRADY).

Mr. BRADY of Texas. Mr. Speaker, unfortunately, this conversation is not about doctors. It's about a budget gimmick to try to hide the true cost of NANCY PELOSI's health care takeover. There is a right way and there is a wrong way to help our doctors get paid fairly under Medicare. But because not one dime of this bill is paid for, it forces Americans to borrow another $279 billion from China and pass the bill of debt down to our grandchildren to pay, all to hide the cost of this health care reform in Washington.

This is irresponsible, and it's the wrong way. I support the Republican alternative. We give our doctors cost-of-living increases, but we pay for them by chasing frivolous lawsuits that drive up the costs of medicine out of our system. So we help our doctors and we help the patients at the same time.

And I want to finish with this: This Medicare, the way we pay our doctors, it's a great taste, sort of a look into the future of what happens when the government is going to run your health care decisions. Not paying doctors fairly is how Medicare rations care today, and it's the main reason seniors have difficulty finding a doctor. This is a peek into the future when Medicare makes budget decisions about your life and death medical decisions. This is the future, and it's frightening.

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Mr. STARK. I reserve the balance of my time.

Mr. CAMP. At this time, Mr. Speaker, I yield 2 minutes to the ranking member of the Budget Committee and a distinguished member of the Ways and Means Committee, the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Speaker, there is so much irony surrounding this bill here.

First of all, everybody knows this bill is not going anywhere because the Senate already defeated a cheaper version because it created a huge deficit.

I have a score from the Congressional Budget Office which I will insert into the RECORD that says this thing raises the deficit by $210 billion. What's more ironic is that the majority, which put in this huge PAYGO system, has just swept it aside and decided to say, No, the CBO is wrong, this doesn't increase the deficit. It costs nothing.

Why did they do that? They did that because they're trying to pass this health care bill and suggest that it doesn't cost anything.

I have a letter from the CBO today that simply says when you merge these bills together—because they are together; in fact, this doc fix bill was in the original bill in the first place—that it raises the deficit, now and into the future. It adds more than many dimes to the deficit now and into the future. It breaks the President's pledge and promise on how health care reform will be conducted.

What is even more ironic are the doctors who are telling us to fix this—and we all want to fix this—is that we can't even bring a bill to the floor to fix it without raising the deficit. That's irony.

What I also find especially ironic are that some physicians say fix this but then create this new system, which is basically to have Medicare for everybody else. So if they think the SGR is a problem now, just wait until you see this system writ large throughout all of American health care. That is a mistake.

We should do this in a bipartisan way, fix it without cranking a huge hole in the deficit, and if the majority would have allowed us to bring a bill to do that, we could have done just that. It's cynical. We know this bill is not going anywhere. So let's get back to work and fix this problem without cranking up a huge hole in the deficit.

Mr. STARK. I yield myself 30 seconds, Mr. Speaker, just to remind the distinguished gentleman from Wisconsin that he and 14 of his colleagues voted for this bill in the Ways and Means Committee last July.

I don't mind mixing it up with the health care reform, but it's not. It's the doctor fix.

Mr. RYAN of Wisconsin. Will the gentleman yield?

Mr. STARK. In just a moment, yes.

The important thing is that if we move this aside, we're correcting the mistake that was made. Let's forget about who made it. It was there.

Now this may not be the end-all correction, but there is no reason that we couldn't come back next year if we find that the formula doesn't work.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. STARK. I will yield myself an additional 30 seconds.

If we don't do it and we do the 4-year fix that you, MIKE, suggested, or the 3-year, and then it doesn't work, we will have $400 billion to correct.

My point is this. If we could remove it for a moment from the discussion on the overall health reform bill—which we can have a spirited discussion on—this is a technical fix which all of your members supported on a bipartisan basis.

Mr. RYAN of Wisconsin. Will the gentleman yield?

Mr. STARK. I yield to the gentleman from Wisconsin.

Mr. RYAN of Wisconsin. If you recall during the debate, at the time we said we should be paying for this and let's come together to find a solution to fix this without raising the deficit. This was inside of your health care bill to begin with. So it's difficult to say that these two things aren't connected.

Mr. STARK. Well, as I say, the gentleman supported it a few months ago.

At this point, Mr. Speaker, I'd like to yield 1 minute to the gentlelady from Nevada (Ms. BERKLEY).

Ms. BERKLEY. I thank the gentleman from California for yielding me the time.

I have had the fastest growing senior population in the United States for many decades in a row. My seniors need health care and they need to be able to see a doctor. But every year when we get to the end of the year, we play this ridiculous game of whether or not we're going to provide a doctors fix and be able to reimburse the doctors for seeing our senior patients under the Medicare program. And every year I receive telephone calls from doctors in the Las Vegas area telling me that if in fact they don't get reimbursed as they should, that they will not be able to continue seeing Medicare patients.

Now, short of me going to medical school so I could go home and take care of the seniors in my district when I go home on the weekends, we better figure out a way of adequately reimbursing the doctors—not doing it on a year-to-year basis which gives them an accounting nightmare—and being able to provide stability for the Medicare system so that the millions of seniors in this country that depend on the Medicare program for their health care needs to be met, that we are able to meet them. I urge that we support this bill.

Mr. CAMP. Mr. Speaker, I yield 1 minute to a distinguished member of the Ways and Means Committee, the gentlewoman from Florida (Ms. BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I rise today in opposition to the Medicare Physician Payment Reform Act.

Let me be clear. We all want to fix the flawed physician reimbursement rate. Without a fix, physicians around this country may be closing their practices and turning seniors away. This is an extremely serious matter. However, Democrats are using physicians and seniors as political pawns and playing games with people's livelihoods. It's unconscionable that the AMA traded their support for $210 billion.

The Congressional Budget Office has said that this bill will increase Medicare part B premiums to our Nation's seniors by $50 billion. This bill will add nearly a quarter of a trillion dollars to our Nation's exploding deficit. My constituents want to know how in God's name are we ever going to pay this debt down. I am one of the few Republicans who voted for PAYGO, and I'd like to see it being used instead of regularly waived as it is here.

This bill is fatally flawed, and I urge my colleagues to follow the lead of the Senate and reject this bill so we can work together on a solution.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. CAMP. I yield 1½ minutes to the gentleman from Illinois (Mr. ROSKAM), a distinguished member of the Ways and Means Committee.

Mr. ROSKAM. I thank the gentleman for yielding.

Can you imagine what it would be like if this House at this time took President Obama's admonition seriously? A couple days ago he said this on his trip to China:

It's important, though, to recognize that if we keep on adding to the debt, even in the midst of this recovery, that at some point people could lose confidence in the U.S. economy in a way that could actually lead to a double dip recession.

Can you imagine what would happen if this House came together and said, No, no, no, no, no. We're actually going to take this seriously. We're going to deal with this debt question, and we're going to lean into it in such a way that gives, what, a buoyancy to the American economy as opposed to continuing to drag down.

With all due respect to the majority leader when he was on the House floor a bit ago, he argued, in essence, don't worry about it because it's in the President's budget. Well, think about where that takes you. The President's budget is the problem. The President's budget doubled our national debt in 5 years and will triple that debt in 10 years, which is one of the reasons why Americans are so increasingly concerned.

Look, we all come together and we know the physicians need to be compensated fairly. We know that seniors ought not bear this burden. But why not work together to take the President's admonition seriously to take the debt question seriously and come up with a real fix?

Mr. STARK. I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from California has 3¾ minutes, and the gentleman from Michigan has 5½ minutes.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Louisiana, Dr. BOUSTANY.

Mr. BOUSTANY. Mr. Speaker, as a physician I know directly about access problems that our seniors are having. Clearly we must protect seniors' access to physicians of their choice. I also know directly about the flawed formula for physician reimbursement. We all want to deal with it.

What we need to do is repeal the flawed SGR formula and replace it with a more equitable reimbursement for physicians that is paid for. This bill ignores over $200 billion in added deficit spending. It continues the same price-controlled formula for physicians. And it does not eliminate—let me repeat—it does not eliminate the tendency for physician cuts. Instead of providing a realistic, long-term solution, this bill spends borrowed money and basically increases the Medicare shortfall by $1.9 trillion.

I urge my colleagues, let's get real about this. I urge my colleagues to vote ''no'' on this bill. Let's support a real solution that protects patient access to a physician of their choice. Let's support a real solution that's honest with physicians and treats them fairly, and a solution that avoids massive debt passed on to our children and grandchildren.

Vote ''no'' on this bill.

Mr. STARK. I yield myself such time as I may consume, Mr. Speaker, to remind my distinguished friend from Louisiana that the American College of Cardiology, the Louisiana Medical Association, and most every medical association in the United States has endorsed the legislation.

I reserve the balance of my time.

PARLIAMENTARY INQUIRIES

Mr. RYAN of Wisconsin. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. RYAN of Wisconsin. Mr. Speaker, clause 10 of rule XXI, what is known as the pay-as-you-go or PAYGO rule, provides a point of order against direct spending or revenue legislation that would increase the deficit, and the bill before us today increases the deficit by $209.6 billion according to the Congressional Budget Office. While there is no authority to reduce the estimated cost of legislation in the rules adopted by the House at the beginning of the 111th Congress, am I correct that the House has effectively modified the application of this rule on two separate occasions with respect to its application to Medicare legislation?

The SPEAKER pro tempore. In addition to its adoption of standing rules on January 6, 2009, the House has further exercised its rulemaking authority in section 421 of the current budget resolution, Senate Concurrent Resolution 13, and in section 2 of House Resolution 665.

Mr. RYAN of Wisconsin. Further parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his inquiry.

Mr. RYAN of Wisconsin. The first modification was made by the conference report on the FY 2010 budget resolution adopted on April 29, 2009. Am I correct that the budget resolution provided authority to reduce CBO's deficit estimate of this legislation by up to $38 billion?

The SPEAKER pro tempore. The gentleman alludes to section 421(a)(2)(A) of the budget resolution, which the Chair will not characterize. The text speaks for itself and may be addressed by Members in debate.

Mr. RYAN of Wisconsin. Further parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. RYAN of Wisconsin. My understanding is that on July 22, in passage of that PAYGO bill, that the budget resolution was modified to allow the CBO estimate of the cost of the legislation to go up to $284 billion which could not be counted. Am I correct that even though the Congressional Budget Office says that this bill raises the deficit by $209.6 billion, the rule in place right now gives the chairman of the Budget Committee the ability to simply say that this costs nothing, that the score is zero.

Am I correct in saying that?

The SPEAKER pro tempore. This is not a parliamentary inquiry. Such commentary may be presented by the gentleman in his own voice by remarks in debate.

Mr. RYAN of Wisconsin. I thank the Chair.

Mr. STARK. Mr. Speaker, at this time I am pleased to yield 1½ minutes to the distinguished gentleman from North Carolina (Mr. ETHERIDGE).

Mr. ETHERIDGE. Mr. Speaker, I thank the gentleman for yielding time and for this bill.

You know, folks, Medicare is a vital lifeline for our seniors, but it's worthless if doctors can't afford to see Medicare patients. Seniors should be able to see the doctors they prefer, and fixing the doctor payment system will make sure that they have access to high quality care from people that they trust.

Countless doctors in my district have told me that they're happy to treat seniors, but they risk going out of business with current Medicare payments. We must make sure that they continue to be able to treat patients.

By fixing the doctor payment issue and including PAYGO, Congress is ending budget gimmicks and the reckless borrow-and-spend policies of the last decade.

I strongly support this bill, and I urge my colleagues to join me in strong support of our seniors and the physicians who keep them healthy.

Mr. Speaker, this bill deserves every Member's support.

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

□ 1515

When we reviewed this debate on this physician payment formula fix, clearly, this is something that we, both sides, agree needs to be addressed. But as you look at how this has evolved, initially this provision was part of the Pelosi-Obama health care bill. But when that 2,000-page bill came in at $1 trillion, this was pulled out, and then it was made a separate bill that be will magically merged into ObamaCare as that moves over to the Senate. And we have experts who have said this provision alone, without being paid for, could add to Medicare's unfunded liability as much as $1.9 trillion over a 75-year period. And obviously, with Medicare, we are looking at the long term. Given that there is already a $39 trillion hole in Medicare, this ends up making a commitment that will be borne by our children and grandchildren.

We believe that we should have the opportunity to offer an alternative that would be paid for, as every alternative over the years has been. And I know the other side has cited this vote in committee. That vote was simply, in the context of full health care reform, saying that health care reform needed to be paid for and we needed to be fiscally responsible.

We think this is a very important issue. Certainly, the public has weighed in on this incredible explosion in the debt over these last few months. And we believe that it is irresponsible to bring this bill to the floor, to make us choose between doctors and seniors and our children, and we believe that an alternative that is fully paid for is the right way to go.

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

Mr. STARK. Mr. Speaker, I yield to the gentlewoman from Texas (Ms. JACKSON-LEE) for a unanimous consent request.

Ms. JACKSON-LEE of Texas. Thank you very much, Mr. STARK.

I rise to support H.R. 3961 because it provides a payment for our doctors, allows seniors to keep their doctors, and is paid for.

Mr. Speaker, I am pleased to stand before you today in support of the Medicare Physician Payment Reform Act. This bill, which will finally put an end to the cycle of threats of larger and larger fee-cuts followed by short-term fixes, is long overdue. This bill will repeal a 21 percent fee reduction that currently scheduled right around the corner, January 2010.

Given the fact that Healthcare reform has been, and still is, a very lively and relevant topic over the recent months, the timing of this bill is apropos in that is intended to make our nations healthcare system more efficient. The importance of this bill is evidenced by its widespread support from a range of organizations representing both patients and doctors, including the American Medical Association, AARP, and the American Academy of Family Physicians just to name a few. Their support shows that there has been a need for better management of the Medicare system, and this bill presents the sustainable solution that physicians and patients alike have been looking for.

Proper management of Medicare funding ensures that the Medicare system will be able to properly support the medical needs of its intended beneficiaries. This bill will help promote the use of primary care and give access to the use of primary care practitioners in Medicare and throughout the healthcare system. By providing incentives to physicians, this bill will also encourage integrated care and increased communications amongst doctors on the care of their specific patients. These improvements to the Medicare system will result in a higher quality of care and ultimately, a healthier population of patients.

With so many Americans currently uninsured or receiving inadequate healthcare, it is paramount that the funds set aside to support Medicare are used wisely to provide the best possible care for patients.

In my home state of Texas, the need for a more efficient healthcare is more prevalent now than ever. One in four Texans, about 5.7 million people, or 24.5 percent of the state's population, has no health insurance coverage. An estimated 1,339,550 Texas children—20.2 percent of Texas children—are uninsured. According to the U.S. Census Bureau, Texas has the nation's highest percentage of uninsured residents. This poses consequences for every person, business and local government in the state who bear extra costs to pay for uncompensated care. If Medicare funding is allowed to be cut or capped, the number of uninsured will grow dramatically.

I realize that we must consider budgetary concerns while we champion the push for better quality healthcare, and the Medicare Physician Payment Reform Act does just that. It was drafted with fiscal responsibility in mind. We want to protect both the medical and fiscal health of our people and this bill takes steps to do just that. The cost of the bill is already included in the House-passed and President's budgets. This money represents the ongoing care and maintenance of the Medicare program. The legislation fully complies with the House-passed PAYGO requirements because the PAYGO legislation explicitly accommodates physician reform legislation that is designed to maintain current spending. As such, the bill, while it contains new reforms, represents continuation of an existing policy rather than new spending. H.R. 3961 will be coupled with Statutory PAYGO legislation when it is sent to the Senate.

The cost of addressing this problem will only grow in the future. In 2005 a permanent freeze for physician payments was scored as costing $48.6 billion; today, a policy with a similar score costs $210 billion. Delays today mean larger and larger price tags in the future and continuing damage to the Medicare program. Therefore prompt action on this issue is necessary and must be taken.

As we talk about fixing the issue of Medicare payments to physicians, this raises similar fixes that I proposed in H.R. 3962—The America's Affordable Health Choices Act of 2009. Specifically, I proposed two changes to Section 1156 of H.R. 3962, to prevent existing physician-owned hospitals from being forced out of business, amendments that enjoyed bipartisan support. First, to avoid harming existing physician-owned hospital projects, I proposed extending the date of the grandfathering provision of Section 1156 to January 1, 2011 and by strengthening the requirements for Hospitals to qualify for an extension. Next, I suggested that we extend the cut-off date for determining the baseline number of beds and procedure rooms for purposes of the expansion prohibition (currently, date of enactment) to the same date proposed or the grandfathering provision.

Along with this, I share the concerns of health advocates that, as is, the public option in H.R. 3962 is not equipped to provide real competition to large mega insurance plans. As such, I proposed that H.R. 3962 incorporate Congressman KUCINICH's proposal to allow states to choose public insurance options more robust than the Federal plan.

I look forward to working with the leadership going forward to fix these items along with a system that each year cuts Medicare reimbursements to Physicians.

Mr. STARK. Mr. Speaker, I yield myself the balance of the time.

I again encourage my friends on the other side of the aisle to support this fix for the physician reimbursement. It was correct originally in our major health reform bill. The reason it was separated, I would have to admit, was purely political. We had to abide by the President's request that we did not exceed certain costs, and we separated it for that.

For those of you who suggest that the Senate may do nothing with this, I'm afraid we have to leave that to the American Medical Association and America's physicians. They will have to pressure the Senate to add this at some point in their deliberations. I think it's beyond us to do that, and my suspicion is that with the more than 150 medical societies around the country, they will be able to importune our friends on the other side of the Capitol.

Mr. Speaker, I believe that we will see a format of this bill facing us from the other side. I hope we do. We are talking about postponing any length of time increases, whether it's 4 years and we get $400 billion, whether it's a couple of years and we get $200 billion, there was a mistake made. The distinguished gentleman whom the current ranking member and I know so well is no longer with us. He is probably chuckling up his sleeve at the angst he has caused us.

But we recognize the mistake. We did try to fix it. We did try to fix it on a bipartisan basis. I know there are other issues that are tangential to this. I hope we can put these aside today. Take care of the physician fix. Hopefully we've got the formula right. As I said earlier to the distinguished gentleman from Wisconsin, we might not have it perfect, but we have some time in the next year or 2 to make those adjustments. I commit to you that we certainly will, and I hope that you would work with us to help correct it if that comes in the future so we can set this aside. It's a separate debate.

We are going to have a long and strenuous debate on health care reform as we go down toward the end of the year and into next year. And I look forward to that. But I would like to see this set aside so that we can see that the physician payment fix, which we all know has been facing us for years, is ended today and that we pass this bill.

I thank my friends on the minority side for their kindness in this debate and, Mr. Speaker, I urge passage of the bill.

Mr. REYES. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009. Over this past summer, physicians in my district consistently stressed the need to reform our flawed Medicare reimbursement formula to ensure continued access to care for our Medicare beneficiaries. I could not agree more. For the last several years, Congress has had to act to reverse reimbursement reductions that would have prompted many doctors to close their doors or refuse to see more Medicare beneficiaries. If we do not act today, physicians serving Medicare patients will see a 21 percent reduction in their reimbursements next year. A cut of this magnitude will reduce access to physicians for Medicare beneficiaries throughout the country. Today, we in the House of Representatives are demonstrating our commitment to permanently fixing this problem.

I am pleased that H.R. 3961 will eliminate this steep payment cut scheduled for 2010 and protect access to care for seniors and people with disabilities into the future. It will also help protect access for our men and women in uniform and their families, since physician payment rates in TRICARE are tied to those used by Medicare. By providing a boost to primary care providers through increased payments for evaluation and management services, such as routine office visits, we help our physicians and patients focus on preventive measures and general wellness. Above all, this important legislation will ensure fair and adequate payment for physicians who participate in Medicare.

The American Medical Association, AARP, the Military Officers Association of America, the American Academy of Family Physicians, the American College of Physicians, the American College of Surgeons, the Center for Medicare Advocacy, the Medicare Rights Center, and the National Committee to Preserve Social Security and Medicare support this legislation. Like them and many of my colleagues, I too support comprehensive reforms to Medicare physician payments that enhance efficient and high-quality care for beneficiaries that protect their choice of physicians. For these reasons, I urge my colleagues to vote in favor of H.R. 3961.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise today in support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009.

This important piece of legislation will repeal the 21 percent physician payment cut, which is scheduled to go into effect on January 1 and replace it with a 1.2 percent increase for next year.

It has been over a decade since the physician fee schedule was put in place to help control increases in Medicare payments to physicians. The Medicare program reimburses physicians who treat seniors using a complex formula that is based on a number of factors.

Unfortunately, payments for physician services matched the SGR and expenditure targets for only the first 5 years. Since then, the actual expenditures have exceeded the target by so much that the system is no longer realistic.

As we have learned in recent years the formula reduces payments to physicians when the economy goes down—a time when doctors are least able to absorb the extra costs. These payment reductions have caused many physicians to hold off on accepting new Medicare patients, withdraw from the program, or retire altogether.

In areas like mine that rely heavily on Medicare and Medicaid, we probably will not be in a situation where doctors stop taking Medicare. Rather, we will see access problems created by gap from physician retirements that is not filled by new crops of doctors willing to take Medicare patients. If we reach that point, Medicare will have failed in its mission to provide equality in access to health care for our senior citizens.

We passed H.R. 3962, the Affordable Health Care for America Act a couple of weeks ago, but we cannot successfully implement health care reform if we do not reimburse our physicians correctly. It is time for Congress to intervene and revamp the SGR formula and pass H.R. 3961.

Mr. KLEIN of Florida. Mr. Speaker, I rise in strong support of H.R. 3961, the Medicare Physician Payment Reform Act. This vital component to health care reform will finally eliminate the widely criticized Sustainable Growth Rate, or SGR, and implement a new, fairer system to pay our doctors and protect and strengthen Medicare for all our seniors.

Originally enacted in 1997, the SGR has been, in my opinion, an attempt to balance the budget on the backs of doctors and other providers, and this is not acceptable. Not only has the SGR failed to curtail spending, but in some cases it incentivizes volume of services instead of quality of care, and it may be expediting the shift from primary care services to specialty and sub-specialty services. As you well know, Mr. Speaker, the alarming shortage of primary care physicians remains one of the most pressing challenges to our health care system.

Make no mistake: Passing this bill today is of the utmost importance for our seniors and our physicians. Since 2001, doctors have faced cut after cut in their Medicare reimbursements due to the flawed SGR. Each time, Congress stepped in at the 11th hour to block the cuts and provide increases to their pay to ensure that seniors can continue to see the doctors of their choice under Medicare.

We are facing the same alarming situation now due to the SGR. Doctors are facing a crippling cut of 21 percent in January 2010. Let me repeat that number so all my colleagues who intend to vote against this bill can hear this loud and clear. Doctors who care for our seniors are facing a 21 percent cut in their pay. It doesn't take an economist to know that if doctors face a 21 percent cut in their salary, they will stop taking Medicare patients.

I can't speak for my colleagues, but I will say this. When I came to Congress 3 years ago, I vowed to strengthen and protect Medicare for my seniors, and that means fixing once and for all the way we pay our doctors under Medicare. By passing this bill, seniors will not have to lose another night of sleep over whether they can be treated by the doctor of their choice. This bill will bring peace of mind to thousands of seniors and health care professionals in South Florida.

This important legislation builds on the critical reforms that we passed in H.R. 3962, the Affordable Health Care for America Act, which will finally close the donut hole for seniors enrolled in Part D, allow for drug price negotiation in Medicare, and eliminate copayments for vital preventive services to our seniors. Combined with this permanent fix to the way we pay doctors, this Congress is following through on our promises to our seniors and strengthening Medicare for years to come.

This bill will also include an important component to reducing the federal deficit. The "pay as you go" principle of budget discipline requires Congress to offset any new spending with either cuts to existing programs or increases in revenue. It was in place during the 1990s when Congress balanced the budget and actually ran a budget surplus. Pay-Go was allowed to expire and now we have the situation we are in now.

As a deficit hawk, I am absolutely committed to balanced budgets and reducing our deficit. I am a very strong supporter of writing pay-as-you-go requirements into law. This is a common-sense principle that families follow around their kitchen tables every day, and the government should be no different. We can only buy what we can afford, and nothing more.

I urge my colleagues to support H.R. 3961.

Mr. VAN HOLLEN. Mr. Speaker, I rise in support of this legislation. The bill before us today would accomplish two very important things—provide a long-term fix to the Medicare physician reimbursement problem and implement statutory pay-as-you-go, PAYGO, rules will promote long-term fiscal responsibility for our nation.

Permanent reform of the flawed Medicare physician payment formulas is necessary to ensure that beneficiaries can see their doctor of choice and protect access to care. Consistent with the House Budget Resolution and President Obama's recommendation, this bill uses realistic and responsible assumptions about future Medicare spending on physician services. The choice is clear: We need to fix this problem honestly today and not continue to kick the can down the down the road.

As we put Medicare physician payments on a sustainable path, so must we tend to the fiscal health of our Nation. The day President Obama was sworn into office, he inherited huge deficits and exploding debt in this country. The previous administration wanted to put everything on our national credit card and ask future generations to pay for it. It is the legacy of this irresponsible spending that has left us with today's historic Federal debt.

Fortunately, there is a time-tested solution for bringing our budget back into balance: PAYGO budget rules. We have had the benefit of PAYGO in the past. For example, when the PAGYO rule was in place in the 1990s, our Federal budget went from record deficits to record surplus. In fact, when President Clinton left office, CBO projected that America would have an $800 billion surplus this year. However, when Congress abandoned PAYGO in 2002, the Federal debt exploded. Today, we are saddled with a $1.4 trillion deficit.

Digging out of this economic ditch will take time, but it is important that we put our economy on a long-term, sustainable path. PAYGO will do that by requiring policies that result in revenue reduction or increased mandatory spending be offset over the next 5 and 10 years. It will force Congress to evaluate the tradeoffs inherent in its financial decisions and make hard choices, just like any family in America.

Mr. Speaker, with this legislation, we will be putting our country on a path of fiscal responsibility. Let's tell our children and grandchildren that we're going to take some responsibility. I urge my colleagues to support this important legislation.

Mr. LANGEVIN. Mr. Speaker, I rise today in support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009. This legislation will prevent a scheduled 21 percent Medicare payment cut to physicians, while providing a long-term fix to the flawed Medicare reimbursement formula that has threatened access to care for over a decade.

Congress has made unprecedented strides this year in the fight to reform our nation's health insurance system. On November 7, I was proud to support the first comprehensive health reform bill to pass the House in several decades. This was an historic achievement, but we have more work to do. Low Medicare reimbursement rates have made it difficult to retain qualified doctors in Rhode Island, particularly those who practice primary care. This is not just a problem for Rhode Island's seniors; it is an issue that affects every patient in Rhode Island and throughout the country.

The Medicare Sustainable Growth Rate formula, or SGR, was a cost control measure instituted in 1997 that has required repeated cuts in physician reimbursements that don't reflect the true costs of care. Since 2002, Congress has recognized this fact and passed yearly fixes to prevent these cuts from taking effect. If left unresolved, this problem will result in a total reimbursement cut of 40 percent to doctors by 2016, the same time period during which we will see even more baby boomers entering the Medicare program.

H.R. 3961 replaces the pending 21 percent fee cut with an update for 2010 based on the Medicare economic index, estimated at 1.2 percent. Beginning in 2011, the update adjustment factor would be based on spending for each category of service since 2009, wiping the slate clean from the onerous accrual of cuts that have loomed over doctors for years. In addition, it provides an extra growth allowance for primary care services to promote access to primary care practitioners in Medicare and throughout the health care system.

Successful health reform must include a Medicare payment structure that ensures fair reimbursement for doctors and continued access for seniors. H.R. 3961 is a necessary step toward achieving that goal, and I urge my colleagues to support its passage.

Mr. BACA. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act.

Congress is only a few steps away from passing a healthcare reform bill and sending it to the President's desk for a signature.

However the 21% cut to physician payments under Medicare scheduled to go into effect on January 1st is just around the corner.

We must act now to protect Medicare patient's access to their doctors. We must act now to protect military and their families under TRICARE the access to their doctors. The status quo is not an option; we must not let these cuts go through. Let's stop the cuts and short-term patches once and for all; this is real reform with a real solution.

Today I will vote for the 194,510 Medicare patients in my District. Access to healthcare is not a privilege, it is a human right. I urge my colleagues vote for H.R. 3961 and preserve the access of Americans to see their doctor.

Ms. RICHARDSON. Mr. Speaker, I rise today in strong support of H.R. 3961, the "Medicare Physician Payment Reform Act of 2009." Our seniors and veterans have worked for affordable, quality, and accessible health care. The bill before us, H.R. 3961, ensures that Medicare payments fairly compensate physicians for their services. This legislation will ensure that doctors will be available to treat their Medicare patients.

Over the last five years, Medicare payment rates to doctors were set artificially low just to keep the system from becoming insolvent. That was the wrong approach. Instead of saving money, the system had the unintended consequence of discouraging doctors from accepting Medicare patients. Under the "Sustainable Growth Rate" formula, or "SGR," employed by the previous Administration and Congresses, the rate of physicians' reimbursement steadily decreased in order to restrain the growth of overall Medicare spending. So while aggregate spending was balanced, payments to individual doctors provided minimal incentive for them to continue treating Medicare patients.

Indeed, if this flawed SGR formula were implemented in its current form, Medicare physicians would suffer a 21 percent fee reduction in January 2010. This would be disastrous for Medicare patients because many of their doctors would no longer be able to afford to provide them with the quality care they need.

H.R. 3961 will allow doctors to keep their doors open to their Medicare and TRICARE patients. Rather than being reimbursed based on some externally constructed, faulty measure such as the SGR, doctors will be reimbursed based on a new measure, one that reflects the actual cost of the services they provide to their patients. H.R. 3961 also sets 2009 as the baseline for years to come. This

means that, rather than a steadily declining reimbursement, doctors will experience a reimbursement rate that either matches or slightly exceeds what they received the year before. This bill ends the cycle of fee reductions based on an artificially constructed formula and replaces it with a stable system that reflects the valuable relationship between seniors and their doctors.

In my district alone, there are more than 60,000 seniors on Medicare. For them, this bill means access to the quality care provided by their doctor. Since doctors know they will be reimbursed fairly for their services, they will not feel compelled to close their doors to the Medicare and TRICARE patients in my district.

This bill also establishes more moderate target growth rates for Medicare spending. These target growth rates are much more realistic than the SGR and they will not result in the types of fee reductions like the 21 percent reduction that is currently threatening physicians. Finally, this bill encourages integrated care so that providers can communicate and develop a comprehensive wellness plan that meets the needs of each patient.

Mr. Speaker, it is not surprising that President Obama strongly supports H.R. 3961. He understands the relationship between reasonable reimbursement rates and availability of quality care for Medicare beneficiaries. Likewise, the American Medical Association supports this bill because it provides physicians with the financial stability they need to invest in the infrastructure needed to build a health care system that works. The AARP supports this bill because it represents meaningful, sustainable reform for the 40 million seniors it represents.

I support this bill because it continues the work we began this month when we passed the historic Affordable Health Care for America Act. This necessary and timely reform benefits our seniors and our veterans. As we approach the Thanksgiving holiday, the security and peace of mind that this legislation will bring to our seniors and veterans is something for which we can all be thankful. I urge my colleagues to support H.R. 3961.

Mr. POSEY. Mr. Speaker, I rise in strong support of legislation to fix the physician fee cut. This system has been broken for more than six years and rather than fix the problem, previous Congresses have simply kicked the can down the road and now physicians are facing more than a 20 percent reduction in payments come January 1, 2010. This is unacceptable.

Stopping the cut and putting physician payments on a realistic payment formula should have been a higher priority for this Congress. Here we are, less than one month away from the January 1 deadline, and the Speaker finally decides to bring legislation to the floor for a vote. Unfortunately, the bill she has brought to the floor has many of the same shortcomings in it that S. 1776 did when the Senate rejected that bill on October 21, 2009. That bill fell 13 votes short of the number needed for passage, principally, because it was not paid for and simply added hundreds of billions of dollars to the record level national debt.

On November 7, 2009, the House passed comprehensive health care reform legislation (H.R. 3962) on a 220–215 vote. That bill creates a new unsustainable health care program that the federal government has no way to pay for long-term. Rather than making H.R. 3962 a priority, the Congress should have first considered legislation to fix the physician payment problem by replacing the inherently flawed sustainable growth rate (SGR) formula. Sadly, the majority chose the opposite path. Congress should, in my view, fix the problems with the current programs—Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)—before creating new programs that we cannot afford.

In states such as Florida, which have large numbers of seniors, the erosion of payments under Medicare has had an adverse impact on the ability of some seniors to have access to good medical providers, and it makes it difficult for Florida to attract new providers.

The only reason that this bill (H.R. 3961) has been separated out from H.R. 3962, which passed the House two weeks ago, is because Congressional leaders want to make the cost of overall comprehensive health care reform (H.R. 3962) appear less expensive.

The American people deserve better. The most appropriate approach is to end the budget games, acknowledge the realistic costs of legislation, and find the appropriate ways to pay the costs of the bill without adding further to our Nation's record debt.

Fixing the payment formula should be the top priority for the Congress at this time, not an afterthought. The good news is that there are appropriate and sufficient ways to fund the cost of averting the 21 percent payment cut. The question before Congress is whether the Leaders in Congress will switch gears and put the SGR fix at the top of the legislative agenda and use these offsets to fix what is broken with Medicare, rather than playing politics and budget games.

I will be voting for the alternative to the Speaker's bill. This alternative will increase physician payments by 2 percent in each of the next four years, enact liability reforms, and implement insurance administrative simplification reforms to cut physicians' administrative costs. Overall, this is a much better and more certain approach for physicians.

Our physicians and seniors deserve a quick fix to this problem. Let's pass a bill that has a chance in the Senate, rather than passing a bill that has the same fatal flaws as a bill they have already voted down.

Mr. THOMPSON of California. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act.

We've all heard from our constituents how important their relationship is with their doctor. We have a system that works—over 45 million people across the country depend on Medicare for that doctor-patient relationship.

Yet every year this doctor-patient relationship is threatened by excessive cuts to Medicare reimbursement rates. Every year we wait until the last minute to address it in Congress. Meanwhile, patients worry that they will lose access to their doctors. And doctors worry about how they will be able to continue to serve their patients.

This bill will permanently fix this problem—so that we don't have to put patients and their doctors through this yearly ritual, and Medicare recipients will have continuous access to their doctors. I urge my colleagues to vote yes on this legislation.

Mr. FRELINGHUYSEN. Mr. Speaker, I rise in opposition to H.R. 3961.

It goes without saying that I recognize that doctors are the backbone of Medicare and our health care system in general. As such, they must be compensated by the federal government in a manner that allows them to recover their expenses at the very least. I have been very supportive of providing doctors with a fair and equitable reimbursement for their services.

I recognize that an increasing number of physicians are finding it financially impossible to treat Medicare patients and another reduction in reimbursement levels would encourage more doctors to drop Medicare patients, endangering the health of the most vulnerable of our society—the frail elderly.

I have also been informed that nearly one-third of physicians in America are near or have actually achieved retirement age.

It would not take much in terms of lower reimbursements or additional bureaucratic red tape to encourage them to close their practices, further limiting access to quality health care for many older Americans.

I have supported Medicare fee "fix" legislation over the years. However, this bill is different. It is not "paid for" and presents another unnecessary blow to our embattled taxpayers and future generations of Americans.

Enough is enough! We have to stop spending borrowed federal dollars like there is no tomorrow!

As I stated earlier, I understand that we must prevent the Medicare physician reimbursement level from being slashed by a catastrophic 21 percent. But the $285 billion cost of this legislation can and must be offset.

I suggest that the unspent balance of the failed economic stimulus bill is a great place to start.

Mr. Speaker, I urge defeat of the bill.

Mrs. MALONEY. Mr. Speaker, I rise in strong support of H.R. 3961, the Medicare Physician Payment Reform Act, also known as the Doc Fix. I am proud to represent thousands of doctors who both live and work in New York's 14th Congressional District. Each year, I am visited by hundreds of them and hear from hundreds more, who are concerned about their patient's access to care due to a scheduled annual cut to their Medicare payments. Under the current system, when Medicare utilization of physicians' services exceeds the Sustainable Growth Rate, SGR, target, physicians are unfairly penalized with steep cuts in their payment update. With this bill, we are averting a 21-percent cut in Medicare rates while saving patient access to care by working toward a permanent fix of the SGR. After all, a stable and predictable payment system for physician service delivery is critical to preserving patient-centered care and investing in health care for the 21st century.

H.R. 3961 finally addresses the problem with the SGR formula that plagues Congress each year when we are forced to do a quick fix to prevent drastic cuts to doctor payments. This important legislation makes a critical first step toward physician payment reform by establishing distinct growth rates and spending

targets. It establishes fairer growth targets to keep doctors' pay steady and erases the debt that was produced by the short-term patches that stopped cuts from going into effect over the past 7 years. At the same time, it holds physicians accountable for spending growth. H.R. 3961 promotes primary care that can keep Americans healthier longer by providing an extra growth allowance for primary care services to promote access to primary care practitioners in Medicare and throughout the health care system.

H.R. 3961 encourages integrated care to ensure our doctors are communicating with one another. When doctors speak about our care, mistakes are avoided and quality improves.

Finally, H.R. 3961 is fiscally responsible and is paid for. This bill will not increase total payments to physicians above what they are today and is paygo neutral.

The old system is broken, and this bill fixes it. With the lack of predictability in Medicare payments, older doctors with older patients retire early and younger doctors are discouraged from entering specialties that treat predominately Medicare patients. Fixing the SGR is critical to preserving Medicare patients' access to care and passage of this bill is a crucial part of health care reform. I urge my colleagues to vote in favor of this important legislation.

Mr. KUCINICH. Mr. Speaker, I rise in support of H.R. 3961, the Medicare Physician Payment Reform Act. Unfortunately, the bill includes statutory-pay-as-you-go requirements. Our country's economy continues to flounder in the worst downturn since the Great Depression, yet Congress insists on passing legislation that will constrain our ability to respond appropriately to our economic circumstances.

The Nation's unemployment rate is over 10 percent, and is likely to remain high well into the next year. The private sector is slashing payrolls and squeezing productivity out of the employees who remain, stubbornly refusing to contribute to an economic recovery. The government must be the spender of last resort to get Americans working again. While the Recovery Act has certainly helped to stave off a more severe economic downturn, it is obviously insufficient. We have more work to do, but pay-as-you-go requirements will only inhibit our ability to help our constituents.

However, Medicare is one of the most popular government programs in part because, in contrast to private insurance plans, seniors and people with certain disabilities can have access to their doctor of choice. Doctors will be less willing to participate, however, if they are not sufficiently paid, as is the case now. I have met with doctors and doctor representatives in the Cleveland area to discuss the issue and the urgency is clear. We must maintain incentives that lead to a high standard of care. I am especially supportive of the extra growth allowance for primary care services as a small down payment toward addressing a severe shortage of primary care physicians. For those reasons, I support the Medicare Physician Payment Reform Act.

Mr. ETHERIDGE. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009.

H.R. 3961 repeals the irresponsible budget gimmicks of the last decade, replacing a scheduled 21 percent fee reduction for doctors who accept Medicare with a more rational and stable system. The new payment formula will support primary care and encourage coordination among providers, while holding physicians accountable for spending growth. H.R. 3961 builds on the historic health insurance reform bill the House passed two weeks ago, which will lower premiums, extend the solvency of Medicare by 5 years, and close the ''donut hole'' drug coverage gap.

Medicare is a vital lifeline for seniors, but it is worthless if doctors cannot afford to see Medicare patients. Seniors should be able to see the doctors they prefer, and fixing the doctor payment system will make sure they have access to high-quality care from people they trust. Countless doctors in my district have told me that they are happy to treat seniors, but that they risk going out of business with current Medicare payments. We must make sure that they continue to be able to provide high-quality health care to Medicare beneficiaries.

H.R. 3961 will replace the flawed physician payment system that continually threatens access to care for our Nation's elderly and disabled patients. Since TRICARE rates are tied to Medicare, the current system also threatens the health of our military families covered by TRICARE. Fixing the system will provide physician practices with financial stability and predictability and enable them to invest in the infrastructure needed to build a health care system for the 21st century.

Without Medicare physician payment reform, the goals of health system reform will remain out of reach. Another short-term ''patch'' would only increase the severity of future cuts and raise the costs of permanently repealing the sustainable growth rate. Medicine can no longer support the sort of short-term patches that have been used in the past to postpone true payment reform. By fixing the doctor payment issue and including PAYGO, Congress is replacing the reckless borrow-and-spend policies of the last decade with responsible and reliable budget planning.

Mr. Speaker, H.R. 3961 is fiscally responsible and will improve the health and health care of people across my district, North Carolina, and the country. I urge my colleagues to join me in strong support of our seniors and the physicians who keep them healthy.

Mr. GOODLATTE. Mr. Speaker, I rise in opposition to H.R. 3961.

Under current law, Medicare physician reimbursement rates are expected to be cut by 21 percent next year and by roughly 5 percent for each of the next several years thereafter, according to the 2009 Medicare Trustees Report.

While we can all agree that our current physician reimbursement rate is flawed, Republicans and Democrats have many different ideas about how to fix it.

Since 2003, Congress has offset the cost of averting physician payment cuts. Unfortunately, today's legislation's further exacerbates the Democratic majority's infatuation with deficit spending.

According to CBO, the full cost of H.R. 3961 is $260 billion, $210 billion of which is deficit spending by the federal government. Furthermore $50 billion will be paid for by Medicare beneficiaries in the form of higher Part B premiums.

The Democrats' health care takeover already costs over $1 trillion. In order to hide the additional costs of that bill, the Democrats separated this physician reimbursement rate legislation from the larger health care bill.

It is clear that this procedural move is simply a budget gimmick by Democrats to avoid including the full cost of this Medicare physician fix in their health care reform bill. This trickery is insulting to Americans who are tired of politics as usual and who are demanding straight answers about our nation's deteriorating fiscal situation.

This legislation also breaks President Obama's promise that health care reform would not cost more than $900 billion. Taking CBO's 10-year score of the health care overhaul, $1.055 trillion, and adding the cost of this physician reimbursement fix, the total cost of the Democrats' health care reform would be at least $1.3 trillion.

Mr. Speaker, I cannot support the deficit spending in this legislation. As I stated previously, according to the Congressional Budget Office, CBO, this bill would increase the Federal deficit by more than $210 billion with this one bill alone.

The American people know that we can't borrow and spend our way back to prosperity. The path to our economic recovery starts with fiscal responsibility in Washington. The Federal Government must follow the example set by our Nation's families.

Unfortunately, Democrats continue to ignore this reality. We have accumulated a 2009 deficit of $1.42 trillion and a national debt of over $12 trillion and Democrats seem determined to dig us deeper into this debt hole.

While my colleagues on the other side of the aisle may have concocted a scheme to enable this bill to pass today, I hope they realize that the Senate has already rejected a bill substantially similar to this one, almost identical in cost, because of its crippling deficit impact. In fact, 13 Democrat Senators opposed it.

Mr. Speaker, the Rules Committee is a very powerful committee—one that determines under what rules every bill will be brought to the House floor. In yet another strong-armed tactic, the majority has used yet another rule to limit discussion and amendments offered by Republicans. Instead of having an honest debate, the Democratic majority has decided they didn't like the discussion, so they have effectively decided to stifle alternative ideas and debate. This doesn't seem very democratic to me.

House Republicans have a better alternative. Our proposal, which was not given the light of day, much less a vote, would provide: $54 billion in savings from medical liability reform that would enact caps on noneconomic damages and lawyers' fees, encouraging speedy resolutions of claims, and limit punitive damages. This will reduce defensive medicine, protect doctors from frivolous lawsuits, and bring down the cost of health care; $5.7 billion in savings from the creation of a pathway for approval at the Food and Drug Administration for bio-similar products, with appropriate protections that continue to promote innovation while providing access to affordable drugs; and $19 billion in savings through enacting health insurance administrative simplification

policies such as the creation of standardized forms and transactions.

Mr. Speaker, there is a fiscally responsible way to solve this physician reimbursement problem. I urge my colleagues to oppose H.R. 3961.

Mr. TIAHRT. Mr. Speaker, I rise today in reluctant opposition to H.R. 3961. I say reluctant because we desperately need a real physician reimbursement rate fix. The future of medicine and the health of Americans, especially seniors, depends on a cost-based formula to reimburse providers for medical expenses. This bill, however, is not a real fix but yet another political and budget gimmick.

The issue known as the "doctor fix" is familiar to us all, but I don't think that the majority fully understands who suffers under inadequate physician pay—the American people. CMS reimbursement rates to providers is anywhere from 30–70 percent of actual cost, based on the specific procedure. Even the highest CMS reimbursement is still loss to providers. It isn't just the doctors who suffer but also the patients. Many doctors have to close their door to new Medicare and Medicaid patients or face bankruptcy. This is especially troubling in rural areas where there are limited providers and seniors face a serious medical accessibility problem. In Kansas, between 20–30 percent of physicians say they will no longer accept new Medicare patients. These doctors, especially in rural areas, go into their profession to help people and having to turn away patients is a measure of absolute last resort.

The current formula for physician reimbursement is known as the sustainable growth rate, SGR, and has little if anything to do with actual costs. That is why year after year Congress passes adjustments to prevent cuts in reimbursement rate. These adjustments are the bare minimum that we can do, even staving off cuts for one year does not allow for certainty in the system.

For that reason, for years several of us have been trying to get CMS to get rid of the SGR and instead base reimbursement rates on actual medical costs. I brought data to then-Chairman Bill Thomas showing that more and more Kansas doctors were refusing new Medicare patients. Due to the overwhelming evidence that this is a real problem, the House version of the Medicare Modernization Act, the prescription drug bill, included language directing CMS to scrap the SGR and come up with a real reimbursement rate formula. Unfortunately, the Senate stripped that provision and subsequent efforts to enact real SGR reform have failed.

H.R. 3961 is not real SGR reform, but rather putting lipstick on a pig. As the Association of American Physicians and Surgeons asserts, "It just trades one complicated federal formula for another, and still leaves physician pay subject to Congressional whim in the future." The Democrat proposal uses GDP and other factors instead of actual cost to calculate reimbursement rates and does nothing to prevent the need for further congressional 1-year adjustments to the rate.

The Democrat health care proposals, including H.R. 3961, do nothing to address the rising cost of health care, and indeed will cause costs to rise faster than they do today. There are several things we need to do to improve access to and quality of health care, including addressing physician reimbursement rates. Real health reform requires addressing the cost centers that are driving insurance costs up, reducing provider services, and discouraging professionals from entering medicine. For this reason, a recent IB/TIPP Poll revealed that two-thirds of physicians oppose the Democrat bills, and furthermore warn of dire consequences should they be enacted. In addition, 45 percent of physicians said that they would consider leaving their practice or take early retirement.

I am hopeful that the Democrat leadership will abandon this political gimmick and work with us to address physician reimbursement rates. This is no "Chicken Little" story. Without congressional action, the sky will fall in, doctors will be unable to participate in Medicare and our seniors will be left without care—regardless of Obamacare reforms.

Ms. ESHOO. Mr. Speaker, I rise today in support of H.R. 3961, the Medicare Physician Payment Reform Act.

H.R. 3961 would repeal the current Medicare Sustainable Growth Rate, SGR, formula and save our physicians from a looming 21 percent reimbursement cut. Instead of temporarily overriding the cut as Congress has done before, H.R. 3961 will replace the broken SGR formula with a sustainable solution.

This bill is essential, not only for the doctors who deserve adequate reimbursement for services, but for the millions of Medicare beneficiaries and members of the military and their families, since physician payment rates in TRICARE are tied to those used by Medicare. With comprehensive healthcare reform on the horizon, it's our responsibility to ensure physicians are reimbursed appropriately.

H.R. 3961 is supported by a wide range of organizations representing patients, doctors and other providers, including the American Medical Association, AARP, the Military Officers Association of America, the American Academy of Family Physicians, the American College of Physicians, the American College of Surgeons, the Center for Medicare Advocacy, the Medicare Rights Center, and the National Committee to Preserve Social Security and Medicare.

This is critically needed and sound legislation and I look forward to voting in favor of H.R. 3961 and ask my colleagues to do the same.

Mr. HOLT. Mr. Speaker, I rise in strong support of the Medicare Physician Payment Reform Act, H.R. 3961, legislation that would ensure that physicians are reimbursed fairly for treating Medicare patients. Improving this payment system is vital to improving our Nation's health insurance system.

There is broad consensus that the current Medicare formula for reimbursing physicians, the Sustainable Growth Rate, SGR, is fundamentally flawed. This formula would be eliminated by this bill and replaced with a better structure for Medicare physician payments. Without this necessary action, doctors' payments would be cut 21 percent in 2010, forcing many doctors to stop accepting Medicare patients and undermining the ability of millions of Medicare beneficiaries to get the care they need to stay healthy. I am pleased that this new formula would compensate physicians fairly for their services to seniors.

As a U.S. Representative and the spouse of a physician, I have heard from many physicians, nurses, and other health care providers frustrated with the annual ritual of preventing major Medicare physician payment cuts. I am pleased that this legislation, a crucial part of health care reform, would stop this cycle and reset the Medicare physician payment baseline to ensure seniors continue to have access to their doctors. In addition, this bill recognizes the importance of primary care, a key component of health reform, and would provide seniors with greater access to primary care practitioners. This would help seniors with greater coordination of their medical care and promote medical care that keeps seniors healthy.

Additionally, the legislation we are considering today would require all new spending to be paid for and not increase the debt by instituting pay-as-you-go budgeting as law. I support pay-as-you-go rules because fiscal discipline must always be a hallmark of our government. In the 1990s with pay-as-you-go as the law, we turned the massive deficits of the 1980s into a record surplus under President Clinton. Pay-as-you-go is only one tool, but it is a strong one to return our Nation back to fiscal stability.

I voted in favor of this bill to help physicians and health care providers continue to provide excellent service to our Nation's seniors.

Ms. SCHAKOWSKY. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician "Payment Reform Act. We recently made history when we passed H.R. 3962, the Affordable Health Care for America Act and now we must pass H.R. 3961 to guarantee access to physician-provided benefits in Medicare.

As we work to overhaul our flawed system to improve health security for all Americans, we must fix policies that consistently threaten to reduce access to care for seniors and people with disabilities. H.R. 3962 makes substantive improvements to the Medicare program. We lower Medicare drug costs, eliminate cost sharing for preventive services, and strengthen federal oversight on deceptive marketing practices in the Medicare Advantage program. Unfortunately, unless we act, Medicare physicians will face a 21 percent rate cut in less than 2 months. So, too, will physicians serving military members, retiree and families in TRICARE, where rates are linked to Medicare payments.

We need to fix that problem and create a new payment system that will fairly and adequately reimburse doctors. Time and again we have shied away from permanently fixing the Medicare payment system. This is a time for big ideas and bold health care changes. The time to act is now. I urge my colleagues to support H.R. 3961.

Mr. HOLT. Mr. Speaker, I rise in strong support of the Medicare Physician Payment Reform Act, H.R. 3961, legislation that would ensure that physicians are reimbursed fairly for treating Medicare patients. Improving this payment system is vital to improving our nation's health insurance system.

There is broad consensus that the current Medicare formula for reimbursing physicians, the Sustainable Growth Rate (SGR), is fundamentally flawed. This formula would be

eliminated by this bill and replaced with a better structure for Medicare physician payments. Without this necessary action, doctors' payments would be cut 21 percent in 2010, forcing many doctors to stop accepting Medicare patients and undermining the ability of millions of Medicare beneficiaries to get the care they need to stay healthy. I am pleased that this new formula would compensate physicians fairly for their services to seniors.

As a U.S. Representative and the spouse of a physician, I have heard from many physicians, nurses, and other health care providers frustrated with the annual ritual of preventing major Medicare physician payment cuts. I am pleased that this legislation, a crucial part of health care reform, would stop this cycle and reset the Medicare physician payment baseline to ensure seniors continue to have access to their doctors. In addition, this bill recognizes the importance of primary care, a key component of health reform, and would provide seniors with greater access to primary care practitioners. This would help seniors with greater coordination of their medical care and promote medical care that keeps seniors healthy.

In addition to stopping the Medicare physician payment cuts, the legislation also would implement the Statutory Pay-As-You-Go Act. This Act would require all new spending to be paid for and not increase the debt by instituting pay-as-you-go budgeting as law. I support pay-as-you-go rules because fiscal discipline must always be a hallmark of our government. In the 1990s with pay-as-you-go as the law, we turned the massive deficits of the 1980s into a record surplus under President Clinton. Pay-as-you-go is only one tool, but it is a strong one to return our nation back to fiscal stability.

I voted in favor of this bill to help physicians and health care providers continue to provide excellent service to our Nation's seniors.

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

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 903, the previous question is ordered on the bill.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. GINGREY of Georgia. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. GINGREY of Georgia. In its present form, I am.

Mr. WAXMAN. Mr. Speaker, I reserve a point of order.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Gingrey of Georgia moves to recommit the bill, H.R. 3961, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare SGR Improvement and Reform Act of 2009''.

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

Sec. 1. Short title; table of contents.

TITLE I—ENSURING CONTINUED ACCESS TO PHYSICIANS IN MEDICARE

Sec. 101. Improving Medicare physician payments.
Sec. 102. Statement of policy.

TITLE II—DEFICIT PROTECTION AND FISCAL RESPONSIBILITY

Subtitle A—Enacting Real Medical Liability Reform

Sec. 201. Encouraging speedy resolution of claims.
Sec. 202. Compensating patient injury.
Sec. 203. Maximizing patient recovery.
Sec. 204. Additional health benefits.
Sec. 205. Punitive damages.
Sec. 206. Authorization of payment of future damages to claimants in health care lawsuits.
Sec. 207. Definitions.
Sec. 208. Effect on other laws.
Sec. 209. State flexibility and protection of states' rights.
Sec. 210. Applicability; effective date.

Subtitle B—Application of Medicare Improvement Fund

Sec. 211. Application of Medicare Improvement Fund.

Subtitle C—Pathway for Biosimilar Biological Products

Sec. 221. Licensure pathway for biosimilar biological products.
Sec. 222. Fees relating to biosimilar biological products.
Sec. 223. Amendments to certain patent provisions.

Subtitle D—Administrative Simplification

Sec. 231. Administrative simplification.

TITLE I—ENSURING CONTINUED ACCESS TO PHYSICIANS IN MEDICARE

SEC. 101. IMPROVING MEDICARE PHYSICIAN PAYMENTS.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraphs:

''(10) 2 PERCENT ANNUAL UPDATE FOR YEARS 2010 THROUGH 2013.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B) and subparagraph (B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for each of 2010, 2011, 2012, and 2013, the update to the single conversion factor shall be 2 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2014 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied, subject to paragraph (11).

''(11) UPDATE FOR 2014 AND POSSIBLE SUBSEQUENT YEARS THROUGH 2019.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B) and subparagraph (B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014 and, at the Secretary's discretion, for subsequent years ending not later than 2019, the update to the single conversion factor shall be such percentage for each such year as the Secretary determines will result in additional expenditures under this title in the aggregate for all such years of $26,400,000,000. Not later than October 1, 2013, the Secretary shall establish by regulation the method the Secretary will use in allocating the $26,400,000,000 under the previous sentence between 2014 and subsequent years. Such allocation shall be designed in a manner so that the single conversion factor for a year is not less than 79 percent of the conversion factor for the previous year.

''(B) LIMITED EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for subsequent years as if subparagraph (A) had never applied, but taking into account the aggregate additional increase in expenditures permitted under such subparagraph.''.

SEC. 102. STATEMENT OF POLICY.

It is the policy of the Federal Government that the sustainable growth rate formula, upon which physician payments are based for the Medicare program, should be permanently repealed and replaced with a reimbursement policy that pays doctors an amount reflecting the true cost of services provided in a high-quality and efficient manner and uses a fiscally responsibly funding mechanism.

TITLE II—DEFICIT PROTECTION AND FISCAL RESPONSIBILITY

Subtitle A—Enacting Real Medical Liability Reform

SEC. 201. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 202. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not

be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 203. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 204. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 205. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

SEC. 206. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 207. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term ''compensatory damages'' includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products,

such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 208. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 209. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this subtitle (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This subtitle shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this subtitle or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this subtitle shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 202(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 210. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Application of Medicare Improvement Fund

SEC. 211. APPLICATION OF MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''for services furnished'' and all that follows and inserting ''for services furnished on or after January 1, 2010, $0.''.

Subtitle C—Pathway for Biosimilar Biological Products

SEC. 221. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

''(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

''(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations);

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(5).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) PEDIATRIC STUDIES.—

''(A) EXCLUSIVITY.—If, before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant or holder of the approved application agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act the period referred to in paragraph (7)(A) of this subsection is deemed to be 12 years and 6 months rather than 12 years.

''(B) EXCEPTION.—The Secretary shall not extend the period referred to in subparagraph (A) of this paragraph if the determination under section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act is made later than 9 months prior to the expiration of such period.

''(C) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (h), (j), (k), and (l) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(9) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(10) NAMING.—The Secretary shall ensure that the labeling and packaging of each biological product licensed under this subsection bears a name that uniquely identifies the biological product and distinguishes it from the reference product and any other biological products licensed under this subsection following evaluation against such reference product.

''(l) PATENT NOTICES; RELATIONSHIP TO FINAL APPROVAL.—

''(1) DEFINITIONS.—For the purposes of this subsection, the term—

''(A) 'biosimilar product' means the biological product that is the subject of the application under subsection (k);

''(B) 'relevant patent' means a patent that—

''(i) expires after the date specified in subsection (k)(7)(A) that applies to the reference product; and

''(ii) could reasonably be asserted against the applicant due to the unauthorized making, use, sale, or offer for sale within the United States, or the importation into the United States of the biosimilar product, or materials used in the manufacture of the biosimilar product, or due to a use of the biosimilar product in a method of treatment that is indicated in the application;

''(C) 'reference product sponsor' means the holder of an approved application or license for the reference product; and

''(D) 'interested third party' means a person other than the reference product sponsor that owns a relevant patent, or has the right to commence or participate in an action for infringement of a relevant patent.

''(2) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until the individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

''(3) PUBLIC NOTICE BY SECRETARY.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

''(A) the reference product identified in the application; and

''(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

''(4) EXCHANGES CONCERNING PATENTS.—

''(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

''(i) Within 30 days of the date of acceptance of the application by the Secretary, the applicant shall provide the reference product sponsor with a copy of the application and information concerning the biosimilar product and its production. This information shall include a detailed description of the biosimilar product, its method of manufacture, and the materials used in the manufacture of the product.

''(ii) Within 60 days of the date of receipt of the information required to be provided under clause (i), the reference product sponsor shall provide to the applicant a list of relevant patents owned by the reference product sponsor, or in respect of which the reference product sponsor has the right to commence an action of infringement or otherwise has an interest in the patent as such patent concerns the biosimilar product.

''(iii) If the reference product sponsor is issued or acquires an interest in a relevant patent after the date on which the reference product sponsor provides the list required by clause (ii) to the applicant, the reference product sponsor shall identify that patent to the applicant within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

''(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information from the applicant.

''(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A)(i), unless the applicant and interested third party otherwise agree.

''(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

''(iv) If the interested third party is issued or acquires an interest in a relevant patent after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

''(i) shall explain in writing why the sponsor or the interested third party believes the relevant patent would be infringed by the making, use, sale, or offer for sale within the United States, or importation into the United States, of the biosimilar product or by a use of the biosimilar product in treatment that is indicated in the application;

''(ii) may specify whether the relevant patent is available for licensing; and

''(iii) shall specify the number and date of expiration of the relevant patent.

''(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 45 days after the date on which a patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each identified patent to the party that identified the patent. Such statement shall either—

''(i) state that the applicant will not commence marketing of the biosimilar product and has requested the Secretary to not grant final approval of the application before the date of expiration of the noticed patent; or

''(ii) provide a detailed written explanation setting forth the reasons why the applicant believes—

''(I) the making, use, sale, or offer for sale within the United States, or the importation into the United States, of the biosimilar product, or the use of the biosimilar product in a treatment indicated in the application, would not infringe the patent; or

''(II) the patent is invalid or unenforceable.

''(5) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent identified by the reference product sponsor under clause (ii) or (iii) of paragraph (4)(A), or by an interested third party under clause (iii) or (iv) of paragraph (4)(B), is brought within 60 days of the date of receipt of a statement under paragraph (4)(D)(ii), and the court in which such action has been commenced determines the patent is infringed prior to the date applicable under subsection (k)(7)(A) or (k)(8), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

''(6) NOTIFICATION OF AGREEMENTS.—

''(A) REQUIREMENTS.—

''(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B), the applicant and sponsor shall each file the agreement in accordance with subparagraph (C).

''(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products with the same reference product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

''(B) SUBJECT MATTER OF AGREEMENT.—An agreement described in this subparagraph—

''(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of—

''(I) the biosimilar product (or biosimilar products) for which an application was submitted; or

''(II) the reference product;

''(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) that is contingent upon, provides a contingent condition for, or otherwise relates to an agreement described in clause (i); and

''(iii) excludes any agreement that solely concerns—

''(I) purchase orders for raw material supplies;

''(II) equipment and facility contracts;

''(III) employment or consulting contracts; or

''(IV) packaging and labeling contracts.

''(C) FILING.—

''(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than—

''(I) 10 business days after the date on which the agreement is executed; and

''(II) prior to the date of the first commercial marketing of, for agreements described in subparagraph (A)(i), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of an application described in such subparagraph.

''(ii) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms and conditions of the agreement.

''(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed by subparagraph (A) shall include in any filing under this paragraph a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 351(l)(6) of the Public Health Service Act, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to such section and have not been reduced to writing.'.

''(D) DISCLOSURE EXEMPTION.—Any information or documentary material filed with the Assistant Attorney General or the Federal Trade Commission pursuant to this paragraph shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this subparagraph prevents disclosure of information or documentary material to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

''(E) ENFORCEMENT.—

''(i) CIVIL PENALTY.—Any person that violates a provision of this paragraph shall be liable for a civil penalty of not more than $11,000 for each day on which the violation occurs. Such penalty may be recovered in a civil action—

''(I) brought by the United States; or

''(II) brought by the Federal Trade Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act.

''(ii) COMPLIANCE AND EQUITABLE RELIEF.—If any person violates any provision of this paragraph, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Federal Trade Commission.

''(F) RULEMAKING.—The Federal Trade Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this paragraph—

''(i) may define the terms used in this paragraph;

''(ii) may exempt classes of persons or agreements from the requirements of this paragraph; and

''(iii) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this paragraph.

''(G) SAVINGS CLAUSE.—Any action taken by the Assistant Attorney General or the Federal Trade Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this paragraph shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product applicant under subsection (k) and the reference product sponsor, or any agreement between biosimilar product applicants under subsection (k), under any other provision of law, nor shall any filing under this paragraph constitute or create a presumption of any violation of any competition laws.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act

that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

SEC. 222. FEES RELATING TO BIOSIMILAR BIOLOGICAL PRODUCTS.

Subparagraph (B) of section 735(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is amended by inserting '', including licensure of a biological product under section 351(k) of such Act'' before the period at the end.

SEC. 223. AMENDMENTS TO CERTAIN PATENT PROVISIONS.

(a) Section 271(e)(2) of title 35, United States Code is amended—

(1) in subparagraph (A), by striking ''or'' after ''patent,'';

(2) in subparagraph (B), by adding ''or'' after the comma at the end;

(3) by inserting the following after subparagraph (B):

''(C) a statement under section 351(l)(4)(D)(ii) of the Public Health Service Act,''; and

(4) in the matter following subparagraph (C) (as added by paragraph (3)), by inserting before the period the following: '', or if the statement described in subparagraph (C) is provided in connection with an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of which is claimed in a patent before the expiration of such patent''.

(b) Section 271(e)(4) of title 35, United States Code, is amended by striking ''in paragraph (2)'' in both places it appears and inserting ''in paragraph (2)(A) or (2)(B)''.

Subtitle D—Administrative Simplification

SEC. 231. ADMINISTRATIVE SIMPLIFICATION.

(a) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

''(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.''.

(2) OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

''(J) Electronic funds transfers.''; and

(B) by adding at the end the following new subsections:

''(g) OPERATING RULES.—

''(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction described in subsection (a)(2) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

''(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall rely on recommendations for operating rules developed by a qualified nonprofit entity, as selected by the Secretary, that meets the following requirements:

''(A) The entity focuses its mission on administrative simplification.

''(B) The entity demonstrates an established multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

''(C) The entity has established a public set of guiding principles that ensure the operating rules and process are open and transparent.

''(D) The entity coordinates its activities with the HIT Policy Committee and the HIT Standards Committee (as established under title XXX of the Public Health Service Act) and complements the efforts of the Office of the National Healthcare Coordinator and its related health information exchange goals.

''(E) The entity incorporates national standards, including the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

''(F) The entity supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

''(G) The entity allows for public review and updates of the operating rules.

''(3) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—

''(A) review the operating rules developed by a nonprofit entity described under paragraph (2);

''(B) determine whether such rules represent a consensus view of the health care industry and are consistent with and do not alter current standards;

''(C) evaluate whether such rules are consistent with electronic standards adopted for health information technology; and

''(D) submit to the Secretary a recommendation as to whether the Secretary should adopt such rules.

''(4) IMPLEMENTATION.—

''(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(D) and having ensured consultation with providers.

''(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—

''(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for transactions for eligibility for a health plan and health claim status shall be adopted not later than July 1, 2011, in a manner ensuring that such rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

''(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice shall be adopted not later than July 1, 2012, in a manner ensuring that such rules are effective not later than January 1, 2014.

''(iii) OTHER COMPLETED TRANSACTIONS.—The set of operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, shall be adopted not later than July 1, 2014, in a manner ensuring that such rules are effective not later than January 1, 2016.

''(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

''(h) COMPLIANCE.—

''(1) HEALTH PLAN CERTIFICATION.—

''(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

''(B) OTHER COMPLETED TRANSACTIONS.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

''(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

''(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

''(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

''(3) SERVICE CONTRACTS.—A health plan shall be required to comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance)

under this subsection for any entities that provide services pursuant to a contract with such health plan.

''(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may contract with an independent, outside entity to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or rules issued by the Secretary.

''(5) COMPLIANCE WITH REVISED STANDARDS AND RULES.—A health plan (including entities described under paragraph (3)) shall comply with the certification and documentation requirements under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that amends any standard or operating rule described under paragraph (1) of this subsection. A health plan shall comply with such requirements not later than the effective date of the applicable interim final rule.

''(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1).

''(i) REVIEW AND AMENDMENT OF STANDARDS AND RULES.—

''(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

''(2) EVALUATIONS AND REPORTS.—

''(A) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the existing standards and operating rules established under this section.

''(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

''(3) INTERIM FINAL RULEMAKING.—

''(A) IN GENERAL.—Any recommendations to amend existing standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

''(B) PUBLIC COMMENT.—

''(i) PUBLIC COMMENT PERIOD.—The Secretary shall accept public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

''(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

''(4) REVIEW COMMITTEE.—

''(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

''(i) the National Committee on Vital and Health Statistics; or

''(ii) any appropriate committee as determined by the Secretary.

''(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall consider the standards approved by the Office of the National Coordinator for Health Information Technology.

''(j) PENALTIES.—

''(1) PENALTY FEE.—

''(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with the standards (and their operating rules) as described under paragraph (1) of such subsection.

''(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

''(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

''(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

''(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

''(i) an amount equal to $20 per covered life under such plan; or

''(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

''(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

''(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

''(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

''(4) COLLECTION OF PENALTY FEE.—

''(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

''(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

''(C) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

''(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

''(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6601 of the Internal Revenue Code of 1986; and

''(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

''(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.''.

(b) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee of Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (a)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(c) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking the ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.''.

(d) MEDICARE AND MEDICAID COMPLIANCE REPORTS.—Not later than July 1, 2013, the Secretary of Health and Human Services shall submit a report to the Chairs and Ranking Members of the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Chairs and Ranking Members of the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate on the extent to which the Medicare program and providers that serve beneficiaries under that program, and State Medicaid programs and providers that serve beneficiaries under those programs,

transact electronically in accordance with transaction standards issued under the Health Insurance Portability and Accountability Act of 1996, part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

Mr. GINGREY of Georgia (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

Mr. WAXMAN. I object.

The SPEAKER pro tempore. Objection is heard.

The Clerk will read.

The Clerk continued to read the motion to recommit.

Mr. WAXMAN (during the reading). Mr. Speaker, I ask unanimous consent that we dispense with the reading.

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

There was no objection.

POINT OF ORDER

Mr. WAXMAN. Mr. Speaker, pursuant to clause 7 of House rule XVI, matters within the motion to recommit are not germane to the underlying bill, and I insist on my point of order.

The SPEAKER pro tempore. Does any other Member wish to be heard on the point of order?

PARLIAMENTARY INQUIRY

Mr. GINGREY of Georgia. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. GINGREY of Georgia. Mr. Speaker, the gentleman from California reserved a point of order. Does that not allow me the opportunity to speak to the point of order?

The SPEAKER pro tempore. The Chair will hear the gentleman on the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, I rise today as an OB/GYN physician who knows very well the challenges that our doctors face with the current SGR system. I can say with 100 percent confidence as a physician Member of Congress that this bill, H.R. 3961, is a bad deal. It's a bad deal for doctors, it's a bad deal for patients, and it's a bad deal for the American people upon whom this majority seems content to simply pile another $210 billion worth of debt.

Mr. WAXMAN. Mr. Speaker, I don't believe the gentleman's argument is pertinent to the point of order. I insist on my point of order.

The SPEAKER pro tempore. The gentleman from Georgia must confine his remarks to the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, during his meeting earlier this week with Chinese President Hu Jintao, I hope that President Obama asked for that $210 billion, because that's how the majority plans to pay for this bill, by borrowing more money from the Chinese.

The SPEAKER pro tempore. The gentleman must confine his remarks to the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, I will proceed.

To make matters worse, and contrary to the assertions of this majority, this bill does not fix our physician reimbursement problem, but it simply replaces one flawed system for another.

So, Mr. Speaker, my motion to recommit ensures that physicians are reimbursed fairly and that this reimbursement is fully paid for and would add not one cent to the deficit.

The SPEAKER pro tempore. The Chair will remind the Member to confine his remarks to the point of order.

Mr. GINGREY of Georgia. Allow me to explain, Mr. Speaker.

This motion to recommit will provide physicians with a 2 percent Medicare payment rate increase in each of the next 4 years. The motion to recommit would erase the scheduled 21 percent cut in 2010——

Mr. WAXMAN. Mr. Speaker, I insist on my point of order.

The SPEAKER pro tempore. The Chair will remind the Member to confine his remarks to the point of order.

The Chair is prepared to rule.

Mr. GINGREY of Georgia. Mr. Speaker, am I allowed to continue?

The SPEAKER pro tempore. The gentleman may continue on the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, the motion to recommit would erase the scheduled 21 percent cut in 2010 and the estimated 5 percent cuts in 2011, 2012, and 2013. The Democratic bill would only provide eight-tenths of 1 percent payment rate increase.

The SPEAKER pro tempore. The gentleman must confine his remarks to the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, in this underlying bill, we actually pay for our plan by enacting legislation that will not only achieve savings, but will also——

The SPEAKER pro tempore. The Chair reminds the gentleman that he must confine his remarks to the point of order.

The Chair is prepared to rule.

The gentleman from Georgia may proceed on the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, on the point of order, I would like to say that unlike the underlying bill, we actually pay for our plan by enacting legislation that will not only achieve savings, but it will also improve——

The SPEAKER pro tempore. The gentleman must confine his remarks to the point of order.

The Chair is ready to rule.

Mr. GINGREY of Georgia. Mr. Speaker, I'm trying to confine my remarks to the point of order.

The SPEAKER pro tempore. The gentleman must address why the amendment is germane.

Mr. GINGREY of Georgia. In doing so, I say we simply prefer to pay for what we do without raising taxes.

The SPEAKER pro tempore. The Chair will rule.

The gentleman from California makes a point of order that the amendment proposed in the instructions included in the motion to recommit offered by the gentleman from Georgia is not germane.

The bill, H.R. 3961, addresses the narrow topic of payments under the Medicare sustainable growth rate system. The bill adjusts the formulas for the SGR system to alter payments to physicians under that system.

Among other topics, the motion to recommit addresses the subject of medical liability reform. It includes provisions on compensation, court procedure, and liability for damages.

As recorded in section 934 of the House Rules and Manual, a general principle of germaneness is that an amendment must confine itself to the committee of jurisdiction over the subject matters contained in the bill. The bill, H.R. 3961, merited referral only to the Committee on Energy and Commerce and the Committee on Ways and Means. The motion to recommit, addressing the subject of medical liability reform, introduces subject matter properly within the jurisdiction of the Committee on the Judiciary.

The motion is therefore not germane and the point of order is sustained.

Mr. GINGREY of Georgia. Mr. Speaker, I appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is, Shall the decision of the Chair stand as the judgment of the House?

Mr. WAXMAN. Mr. Speaker, I move to table the appeal of the ruling of the Chair.

The SPEAKER pro tempore. The question is on the motion to table.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GINGREY of Georgia. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to table will be followed by 5-minute votes on passage of the bill, if arising without further proceedings in recommittal, and the motion to suspend the rules on H.R. 1834.

The vote was taken by electronic device, and there were—yeas 251, nays 177, not voting 6, as follows:

[Roll No. 907]

YEAS—251

Abercrombie	Becerra	Boyd
Ackerman	Berkley	Brady (PA)
Adler (NJ)	Berman	Braley (IA)
Altmire	Berry	Brown, Corrine
Andrews	Bishop (GA)	Butterfield
Arcuri	Bishop (NY)	Capps
Baca	Blumenauer	Capuano
Baird	Boccieri	Cardoza
Baldwin	Boren	Carnahan
Barrow	Boswell	Carson (IN)
Bean	Boucher	Castor (FL)

Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Taylor
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wilson (OH)
Woolsey
Wu
Yarmuth

NAYS—177

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Bright
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Carney
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McClintock
McCotter
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOT VOTING—6

Brown (SC)
Carter
McCaul
Melancon
Miller, George
Wexler

□ 1553

Messrs. SESSIONS, LUETKEMEYER, WALDEN, CARNEY and GERLACH changed their vote from ''yea'' to ''nay.''

Mr. WILSON of Ohio, Ms. KILPATRICK of Michigan, Messrs. ELLISON, RODRIGUEZ, JOHNSON of Georgia and Ms. McCOLLUM changed their vote from ''nay'' to ''yea.''

So the motion to table was agreed to.

The result of the vote was announced as above recorded.

MOTION TO RECOMMIT

Mr. CANTOR. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CANTOR. In its current form, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Cantor moves to recommit the bill, H.R. 3961, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Add at the end of the bill the following:

SEC. 3. FINDINGS.

Congress finds that the Secretary of Health and Human Services has the authority to increase payments for services under section 1848 of the Social Security Act (related to payments for physician services) in an amount not to exceed $22,300,000,000.

SEC. 4. LIMITATIONS.

(a) IN GENERAL.—In executing the amendments made by section 2(b) of this Act the Secretary of Health and Human Services shall implement an adjustment in payments under section 1848 of the Social Security Act under such amendments for 2011 or any subsequent year only to the extent that the Secretary determines that the cost of such adjustment when added to the cost of the amendment made by section 2(a) does not exceed $22,300,000,000. Such cost determinations shall be calculated based on the difference between net expenditures resulting from the provisions of this Act and anticipated net expenditures for each year under the law as in effect before the date of the enactment of this Act.

(b) CONTINGENCY.—If the Secretary is prevented from implementing an adjustment described in subsection (a) as a result of such subsection, the Secretary shall implement section 1848 of the Social Security Act as such section was in effect before the date of the enactment of this Act.

Mr. WAXMAN (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

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

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Virginia for 5 minutes in support of his motion.

Mr. CANTOR. Thank you. Mr. Speaker, we have tried to do everything possible to pay for this doctor fix, and it seems that the majority just refuses to do the fiscally responsible thing. We just offered a proposal that was a fully paid doctor fix that provided our doctors with 2 percent updates for 4 years. The majority blocked this House from even voting on that proposal because they object to paying for the costs of the doctor fix.

It seems that the rules that the majority is using prevent us from paying for this bill simply because, Mr. Speaker, the majority doesn't pay for this bill. Seeing that that is the case, one has to ask how perverse is that? Because the majority is okay with adding $250 billion to our debt, the Republicans are prevented under the rules from trying to be responsible and pay for those costs. Is this what passes for fiscal responsibility in the majority party, I ask?

So now we are offering a second motion to recommit that attempts to address the deficit costs while living under the rules imposed on us by the majority. What does this motion do? Very simply, it recognizes that there is a fund already in existing law that has $22.3 billion in it that can be used to pay for the doctor fix. It further limits spending under this bill to that same amount, $22.3 billion. That is enough to provide the doctor payment updates for all of 2010 and most, if not all, of 2011 envisioned under the Democratic bill.

So we've identified, Mr. Speaker, an amount of money that is available to pay for 2 years' worth of a doctor fix and limited this bill to 2 years. A vote for this motion to recommit is a vote

to recognize that we ought to help our doctors, but we ought to do it in a fiscally responsible manner, and this motion shows us how to do it. I wish we could do more, but the rules imposed on us by the majority simply won't permit it.

So now is the time to choose: Do we want to plan for a fiscally responsible doctor fix or $250 billion in new debt? Mr. Speaker, I ask this House to vote for fiscal responsibility.

I yield to the gentleman from Georgia, Dr. PRICE.

Mr. PRICE of Georgia. Thank you. As a physician, I know that the SGR, the sustainable growth rate, is neither sustainable nor growing. It is, however, truly destroying the ability of doctors to provide the needed care for patients across our land. And though the underlying bill is an acknowledgement that there is a huge problem and may be a step in the right direction, it exacerbates the phenomenal fiscal recklessness of this administration and the majority party.

As a physician, I know with every fiber of my being that the doctors of this land are sick and tired of being played for fools, duped into support of another nonsolution because there is not a commitment to a responsible revenue stream with a recognition of the care that they provide.

□ 1600

With this trick, the majority demeans our Nation's caring and compassionate physicians. So let's commit to solve this challenge together, positively, with a plan that respects those who have dedicated their lives to our health.

Mr. Speaker, our Nation is at a fiscal tipping point. We can continue to march further and further to the liberal left and bankrupt our Nation's future, or we can restore fiscal sanity to an overgrown and unrestrained Federal budget. Our motion to recommit is a step in the right direction, not another plan that further adds to our Nation's debt and contributes to the financial ruin of future generations.

Mr. Speaker, the American people are demanding a stop to runaway debt. They reject this spending and they reject this trick. Let's stand up for fiscal responsibility and vote for the responsible Republican solution.

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

Mr. WAXMAN. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from California is recognized for 5 minutes.

Mr. WAXMAN. Mr. Speaker and my colleagues, this motion to recommit proposes to spend $22.3 billion for a $210 billion problem. It simply postpones the problem. It is the same old kicking the can down the road. There are no guarantees of cuts when this money runs out. The gentleman from Virginia says his proposal would mean no cuts for 2 years. I am not convinced of that 2-year period. But whatever period of time it would allow for, there would be another cliff, and that is why the American Medical Association wrote to the Honorable DAVE CAMP, ranking member of the Ways and Means Committee, that they oppose anything short of permanent reform. They want us to deal with this problem now and not just kick it down the road. The AMA does not support any motion to recommit that would have a temporary fix.

I want to yield at this time to the gentleman from California (Mr. STARK).

Mr. STARK. I thank the gentleman for yielding only to suggest that being nice doesn't seem to get you much around here.

This motion makes a mockery of the debate. My friends on the other side simply propose the same old same old. They can't even tell us or the American people how this will affect doctors or military families or others. It is legislating in the dark.

The distinguished minority whip voted in committee enthusiastically for the bill that is before us, now seems to have forgotten and changed his mind. It is a continuation of the Republican history of mismanagement of Medicare and dishonest budget gimmicks, and I urge its opposition.

Mr. WAXMAN. Mr. Speaker, I yield to the gentleman from Florida (Mr. BOYD).

Mr. BOYD. Mr. Speaker, I appreciate the gentleman from California yielding.

As we have seen so many times in the past, ladies and gentlemen, the minority party has again offered a very insincere proposal that does not fix the issue at hand. This proposal is a gimmick that would eventually lead to deep cuts in Medicare.

In contrast, this underlying bill recognizes that the current baseline of physician spending is no longer useful in projecting obligations for providing physician services to Medicare beneficiaries.

The underlying bill fundamentally addresses this issue that Congress has acted on six times in the last 6 years for a temporary patch that has only made the problem worse. That is what they want to do again.

As my colleague, Ranking Member PAUL RYAN, mentioned earlier, this issue should be resolved in a bipartisan way, but that is not forthcoming here today. In the meantime, we must ensure that our seniors have access to their doctors.

In addition, this bill also addresses the pay-as-you-go rule. Under Republican rules, record surpluses were turned into record deficits as the pay-as-you-go rules expired. We cannot police ourselves with regard to fiscal discipline. That is why we have to have these rules in place. My Blue Dog colleagues and I have urged implementation of this policy for years.

I urge a ''no'' vote on the MTR and a ''yes'' vote on the underlying bill.

Mr. WAXMAN. Mr. Speaker, I urge a ''no'' vote on the motion to recommit and an ''aye'' vote on the underlying bill, and I yield back the balance of my time.

PARLIAMENTARY INQUIRIES

Mr. CANTOR. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. CANTOR. Mr. Speaker, is it true that the Democrats' bill will add $210 billion to the deficit?

The SPEAKER pro tempore. The Chair does not respond to commentary posed as a parliamentary inquiry.

Mr. CANTOR. Further parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. CANTOR. Mr. Speaker, my prior inquiry asked: Would the Democrats' bill add $210 billion to the deficit, and I would say even the Blue Dogs know that the Democrat bill adds $210 billion to the deficit.

The SPEAKER pro tempore. The gentleman from Virginia has not stated a parliamentary inquiry.

Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

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

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on passage of the bill, if ordered, and the motion to suspend the rules on H.R. 1834.

The vote was taken by electronic device, and there were—ayes 177, noes 252, not voting 5, as follows:

[Roll No. 908]

AYES—177

Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Austria
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Boehner
Bonner
Bono Mack
Boozman
Boustany
Bright
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Cassidy
Castle
Chaffetz
Childers
Coble
Coffman (CO)

Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kosmas
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
Lipinski
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McClintock
McCotter
McHenry
McKeon
McMahon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Peterson
Petri
Pitts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Sanchez, Loretta
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stupak
Sullivan
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOES—252

Abercrombie
Ackerman
Andrews
Arcuri
Baca
Bachmann
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Blunt
Boccieri
Boren
Boswell
Boucher
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Broun (GA)
Brown, Corrine
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Cole
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Pingree (ME)
Platts
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Sutton
Tanner
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOT VOTING—5

Brown (SC)
Carter
McCaul
Melancon
Miller, George

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1622

Mr. CLEAVER changed his vote from ''aye'' to ''no.''

Mr. LAMBORN changed his vote from ''no'' to ''aye.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

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

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 243, noes 183, not voting 8, as follows:

[Roll No. 909]

AYES—243

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Burgess
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOES—183

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Baird
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boren
Boustany
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Cooper
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Edwards (TX)
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Granger

Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Herseth Sandlin
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Kosmas
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
Lipinski
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McClintock
McCotter
McHenry
McKeon
McMahon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Peterson
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Souder
Stearns
Sullivan
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOT VOTING—8

Brady (TX)
Brown (SC)
Carter
Kennedy
McCaul
Melancon
Miller, George
Towns

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1629

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. KENNEDY. Mr. Speaker, I regret that my vote on H.R. 3961, the Medicare Physician Payment Reform Act of 2009 was not recorded in the House of Representatives today.

Had my vote been recorded on rollcall No. 909, final passage of H.R. 3961, the Medicare Physician Payment Reform Act of 2009, I would have voted "aye" on the question.

Mr. BRADY of Texas. Mr. Speaker, on rollcall No. 909, I was unavoidably detained. Had I been present, I would have voted "no."

NATIVE AMERICAN BUSINESS DEVELOPMENT ENHANCEMENT ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill, H.R. 1834, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Ms. VELÁZQUEZ) that the House suspend the rules and pass the bill, H.R. 1834, as amended.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 343, nays 55, not voting 36, as follows:

[Roll No. 910]

YEAS—343

Abercrombie
Ackerman
Aderholt
Adler (NJ)
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachus
Baird
Baldwin
Barrett (SC)
Barrow
Bean
Becerra
Berkley
Berman
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blumenauer
Blunt
Boccieri
Bonner
Bono Mack
Boozman
Boren
Boucher
Boustany
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Brown, Corrine
Buchanan
Burgess
Butterfield
Buyer
Calvert
Camp
Cantor
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coffman (CO)
Cohen
Cole
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Dreier
Driehaus
Edwards (MD)
Edwards (TX)
Ehlers
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Fleming
Forbes
Fortenberry
Foster
Frank (MA)
Frelinghuysen
Fudge
Garamendi
Gerlach
Giffords
Gohmert
Gonzalez
Gordon (TN)
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Heller
Herseth Sandlin
Higgins
Hill
Himes
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inslee
Israel
Issa
Jackson (IL)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, Sam
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Michaud
Miller (MI)
Miller (NC)
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pastor (AZ)
Paulsen
Perlmutter
Peters
Peterson
Petri
Pingree (ME)
Platts
Polis (CO)
Pomeroy
Price (NC)
Quigley
Radanovich
Rahall
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rooney
Roskam
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shea-Porter
Sherman
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Space
Speier
Spratt
Stark
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Wexler
Wilson (OH)
Wilson (SC)
Wittman
Woolsey
Wu
Yarmuth
Young (AK)

NAYS—55

Akin
Bachmann
Bartlett
Barton (TX)
Boehner
Broun (GA)
Brown-Waite, Ginny
Burton (IN)
Campbell
Coble
Conaway
Culberson
Duncan
Foxx
Garrett (NJ)
Gingrey (GA)
Goodlatte
Granger
Harper
Hensarling
Herger
Inglis
Jordan (OH)
King (IA)
Kingston
Lamborn
Latta
Linder
Lummis
Manzullo
Marchant
McClintock
Mica
Miller (FL)
Moran (KS)
Neugebauer
Paul
Pence
Pitts
Poe (TX)
Posey
Price (GA)
Putnam
Rohrabacher
Royce
Scalise
Shadegg
Shimkus
Souder
Stearns
Thornberry
Tiahrt
Westmoreland
Whitfield
Wolf

NOT VOTING—36

Berry
Blackburn
Boswell
Boyd
Brown (SC)
Carson (IN)
Carter
Delahunt
Doyle
Ellison
Fallin
Flake
Franks (AZ)
Gallegly
Gutierrez
Hastings (WA)
Hinchey
Jackson-Lee (TX)
Johnson, E. B.
McCaul
Meeks (NY)
Melancon
Miller, Gary
Miller, George
Nadler (NY)
Nunes
Pascrell
Payne
Perriello
Rangel
Ros-Lehtinen
Ross
Snyder
Wamp
Welch
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SCHRADER) (during the vote). There are 2 minutes remaining in this vote.

□ 1637

Messrs. BOOZMAN and COFFMAN of Colorado changed their vote from "nay" to "yea."

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. GEORGE MILLER of California. Mr. Speaker, I was unavoidably absent for medial reasons today, and missed recorded votes on the House floor.

Had I been present, I would have voted in the following manner: "Yes" on rollcall No.

902 on ordering the previous question; "yes" on rollcall No. 903 on agreeing to the resolution; "yes" on rollcall No. 904 on Passage of the Reserve Officers Association Modernization Act of 2009; "yes" on rollcall No. 905 on Passage of H.R. 2781; "yes" on rollcall No. 906 on Passage of H. Con. Res. 212; "yes" on rollcall No. 907 on the Motion to Table the Appeal of the Ruling of the Chair; "no" on rollcall No. 908 on the Motion to Recommit H.R. 3961; "yes" on rollcall No. 909 on Passage of H.R. 3961 the Medicare Physician Payment Reform Act of 2009; and "yes" on rollcall No. 910 on Passage of H.R. 1834, the Native American Business Development Enhancement Act of 2009

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 3904

Mr. LOEBSACK. Mr. Speaker, I ask unanimous consent to remove my name as a cosponsor of H.R. 3904.

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

There was no objection.

PERSONAL EXPLANATION

Ms. JACKSON-LEE of Texas. Mr. Speaker, I was absent on November 17 and November 18 because of official business in my district dealing with the honoring of a former President and as well the launch. Had I been present for S. 1314, I would have voted ''aye''; for H.R. 3539 I would have voted ''aye''; for H.R. 3767 I would have voted ''aye''; for H.R. 3360 I would have voted ''aye''; for H. Res. 841 I would have voted ''aye''; and for H. Res. 891 I would have voted ''aye.''

SUPPORTING THE OBSERVANCE OF NATIONAL DIABETES MONTH

Mrs. CAPPS. Mr. Speaker, I ask unanimous consent that the Committee on Energy and Commerce be discharged from further consideration of House Resolution 914 and ask for its immediate consideration in the House.

The Clerk read the title of the resolution.

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

There was no objection.

The text of the resolution is as follows:

H. RES. 914

Whereas there are nearly 24,000,000 people in the United States with diabetes and 57,000,000 with pre-diabetes;

Whereas diabetes contributed to the deaths of over 300,000 people in the United States in 2007, making diabetes the seventh leading cause of death;

Whereas every minute, 3 people are diagnosed with diabetes;

Whereas each day approximately 4,384 people are diagnosed with diabetes and approximately 1,600,000 new cases of diabetes were diagnosed in people 20 years or older in 2007;

Whereas between 1990 and 2001, diabetes prevalence in the United States increased by more than 60 percent;

Whereas over 24 percent of diabetes is undiagnosed, down from 30 percent in 2005 and 50 percent 10 years ago;

Whereas over 10 percent of adults and nearly a quarter (23.1 percent) of people in the United States age 60 and older have diabetes;

Whereas diabetes is a serious chronic condition that affects people of every age, race, income level, and ethnicity;

Whereas Hispanic, African, Asian, Pacific Islanders, and Native Americans are disproportionately affected by diabetes and suffer at rates much higher than the general population;

Whereas 15,000 youth in the United States are diagnosed with type 1 diabetes annually and about 3,700 youth are diagnosed with type 2 diabetes annually;

Whereas 1 in 3 people in the United States born in the year 2000 will develop diabetes in their lifetime, this statistic grows to nearly 1 in 2 for minority populations;

Whereas diabetes costs the United States an estimated $174,000,000,000 in 2007 and $1 in every $10 spent on health care is attributed to diabetes and its complications;

Whereas approximately $1 out of every $4 Medicare dollars is spent on the care of people with diabetes;

Whereas every day 230 people with diabetes undergo an amputation, 120 people enter end-stage kidney disease programs, and 55 people go blind from diabetes;

Whereas there is not yet a cure for diabetes;

Whereas there are proven means to reduce the incidence of and delay the onset of type 2 diabetes;

Whereas people with diabetes live healthy, productive lives with the proper management and treatment; and

Whereas National Diabetes Month is celebrated in November: Now, therefore, be it

Resolved, That the House of Representatives—

(1) supports the goals and ideals of National Diabetes Month, including encouraging people in the United States to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease;

(2) recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for type II diabetes, which include being over the age of 45, coming from certain ethnic backgrounds, being overweight, having a low physical activity level, high blood pressure, and a family history of diabetes or a history of diabetes during pregnancy; and

(3) supports decreasing the prevalence of diabetes, developing better treatments, and working toward an eventual cure for type I and type II diabetes through increased research, treatment and prevention.

Ms. SHEA-PORTER. Mr. Speaker, I rise today in strong support of H. Res. 914, recognizing November as National Diabetes Awareness Month. I would also like to thank Congresswoman DEGETTE for sponsoring this resolution.

Because someone in my family has diabetes, I know how awful it is. Diabetes affects nearly 24 million adults and children nationwide. Even more frightening is the fact that an additional 57 million more are at risk for Type II diabetes. According to the New Hampshire Department of Health and Human Services, diabetes is currently the 7th leading cause of death in New Hampshire. Approximately 7.2 percent of the population between 18–64 years of age have been diagnosed with diabetes.

We need to increase awareness about this epidemic. Not only is it a health issue, but it is a financial issue. Diabetes treatment costs total $174 billion a year in this country. If we place emphasis on prevention, we can drastically reduce these costs.

We must be more aggressive in preventing, diagnosing, and treating this disease. We also must continue striving for a cure.

Raising awareness and increasing funding to tackle the root of the problem is essential. As a proud cosponsor of this resolution, I urge my colleagues to join me in supporting the fight against diabetes.

The resolution was agreed to.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mrs. CAPPS. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks on House Resolution 914.

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

There was no objection.

TERMS OF SERVICE IN THE OFFICE OF COMPLIANCE

Mrs. DAVIS of California. Mr. Speaker, I ask unanimous consent to discharge the Committee on House Administration from further consideration of the bill (S. 1860) to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

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

There was no objection.

The text of the bill is as follows:

S. 1860

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

SECTION 1. ADDITIONAL TERM FOR MEMBERS OF BOARD OF DIRECTORS OF OFFICE OF COMPLIANCE.

Notwithstanding the second sentence of section 301(e)(1) of the Congressional Accountability Act of 1995 (2 U.S.C. 1381(e)(1)), any individual serving as a member of the Board of Directors of the Office of Compliance as of September 30, 2009, may serve for 3 terms.

Mrs. DAVIS of California. Mr. Speaker, the statute we are amending limits the terms of the current Board of Directors of the Office of Compliance to two consecutive five year terms. The Board consists of five legal practitioners from around the country, each of whom is an expert in labor and employment matters. They were originally appointed in 1999 and 2000, and reappointed to second terms in 2004 and 2005. The terms of three Board members expired last month, and the terms of the remaining two Board members will expire this coming May. The Congressional Accountability Act does not allow for

holdovers, so the current Board has already lost its quorum.

The Government Accountability Office (GAO) found in 2004 that term limits for Board members caused a loss of leadership, and negatively impacted the Office's continuity of operations. To avoid that negative impact, the Committee proposes to amend the law to allow the current Board to serve for an additional term.

This particular Board has demonstrated extraordinary productivity and balance in its handling of multiple cases, and its issuance of a number of substantive regulations. The current Board operates collegially, and appreciates the operating environment in which they perform their responsibilities. Over the last decade, the Board has met its statutory mandate without cause for concern from the Congress. The Board has been a neutral body, committed to advancing safety, health, and workplace rights, while working with the Congress to promulgate regulations that reflect the unique nature of the Legislative Branch.

The Congress amended the Congressional Accountability Act five years ago to allow for a second term. The GAO's 2004 report on the operations of the Board noted that, in comparable administrative regulatory agencies, such as the Equal Employment Opportunity Commission, the Federal Labor Relations Board, and the National Labor Relations Board, there were no limitations on board members serving consecutive terms.

The Board members have provided an excellent balance, and unnecessary change to the composition of this Board creates a risk of loss of such balance. The Committee therefore recommends that the term limits for the current Board members be extended by an additional five year term. By enacting S. 1860, we will accomplish this purpose.

The bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

GENERAL LEAVE

Mrs. DAVIS of California. I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks in the RECORD on S. 1860.

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

There was no objection.

CONDITIONAL ADJOURNMENT TO MONDAY, NOVEMBER 23, 2009

Mrs. DAVIS of California. Mr. Speaker, I ask unanimous consent that when the House adjourns today on a motion offered pursuant to this order, it adjourn to meet at 3 p.m. on Monday, November 23, 2009, unless it sooner has received a message from the Senate transmitting its concurrence in House Concurrent Resolution 214, in which case the House shall stand adjourned pursuant to that concurrent resolution.

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

There was no objection.

CONGRATULATING SCHENECTADY COUNTY COMMUNITY COLLEGE ON ITS 40TH ANNIVERSARY

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

Mr. TONKO. Mr. Speaker, I would like to take this opportunity to congratulate Schenectady County Community College on its 40th anniversary of founding. Over the last 40 years, Schenectady County Community College has met the educational needs of tens of thousands and offered a pathway to career success and prosperity.

SCCC has recently expanded its educational offerings to meet the needs of the 21st-century workforce. The college offers a cutting-edge Nanoscale Materials Technology program that trains students for top careers in the high-tech industry. The Culinary Arts program at SCCC attracts students from around the country and is a model for other community colleges as well. In addition, the college offers one of the only aviation programs currently available at a community college.

As testament to the college's importance to the community, full-time enrollment at the campus has increased by 15 percent over the past year.

On behalf of the residents of the 21st Congressional District, I would like to take this opportunity to thank President Quintin Bullock and Schenectady County Community College for 40 years of educating students and preparing tens of thousands for successful futures. We look forward to your continued achievement, and express our heartfelt congratulations.

MIAMI-DADE COUNTY PUBLIC SCHOOLS SUPERINTENDENT'S BENEFIT CONCERT SERIES

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

Ms. ROS-LEHTINEN. Mr. Speaker, I applaud Miami-Dade County Public Schools for its Superintendent's Benefit Concert Series. This groundbreaking event will bring together singers, dancers and performers from throughout our public school system. Entitled ''Listen to the Music,'' their first event will be tomorrow, Friday, November 20, at Miami Beach Senior High School, located in my congressional district. This uplifting event supports the ''cultural passport program,'' which provides kindergarten through 12th-grade students with a different cultural experience each school year.

This unique program will ensure that our students get to visit local museums and art galleries, as well as experience live musical theatrical and dance performances before they graduate.

As a former educator and Florida certified teacher, I am proud to see our teachers, our students, and our community working together to make this great series a success. I encourage all in south Florida to attend this historic event tomorrow and enjoy a great performance for a great cause. I congratulate Superintendent Alberto Carvalho for doing such professional work in a challenging economic environment.

NATIONAL EPILEPSY AWARENESS MONTH

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

Mr. SKELTON. Mr. Speaker, November is National Epilepsy Awareness Month, and I rise today to help bring awareness to the month and to this year's theme, which is ''Talk About It.'' Epilepsy is a neurological condition that affects more than 3 million Americans and more than 50 million people worldwide. It affects people of all ages, nations, and races. A burst of electrical energy in the brain can cause an individual with epilepsy to experience a seizure. Seizures can be mild, but sadly, in some cases, they are fatal.

In 2008, Congress passed legislation to establish epilepsy centers of excellence within the Veterans Administration. A traumatic brain injury can put a servicemember at greater risk for developing epilepsy in later years. And these centers of excellence will help ensure our veterans receive top-of-the-line care.

Fortunately, research into epilepsy has resulted in the development of medications and other treatments that have proven successful in controlling epileptic seizures. However, these treatments are not effective for everyone with epilepsy, which means more work remains.

Mr. Speaker, I urge my colleagues to join me in recognizing National Epilepsy Awareness Month and to pay tribute to all those working to promote a greater understanding.

MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 1963. An act to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

The message also announced that pursuant to Public Law 105–83, the Chair, on behalf of the Majority Leader, announces the appointment of the following individual to serve as a member of the National Council of the Arts:

The Senator from Missouri (Mrs. MCCASKILL).

□ 1645

RELIGIOUS FREEDOM IN IRAQ

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

Mr. DUNCAN. Mr. Speaker, the fall of Saddam Hussein in Iraq has unleashed tremendous religious violence against the Christian community there.

According to the London Times, ''In the chaos after the U.S.-led war invasion of Iraq in 2003, Christians found themselves targeted by Islamic terrorists.''

Archbishop Paul Faraj Rahho said Christians in Iraq faced three bad choices: either they fled, converted to Islam, or risked being killed. Then in 2008, Archbishop Rahho himself was kidnapped and murdered.

These horrendous human rights violations and crimes against Christians in Iraq were brought to my attention by one of my constituents, Susan Dakak, a civil engineer who is a native of Iraq. Iraq's Christian Ambassador, the Iraqi Ambassador to the Vatican, my constituents tell me, is doing almost nothing to call attention to the plight of these people.

The U.S. should do more to aid the Christian minority in Iraq. At least one-third, maybe closer to one-half of these Christians, have fled the country. They should be allowed to return. The killings, kidnappings, and religious persecutions must stop.

The U.S. Government should substantially reduce our aid if Christians are not allowed to freely express their religion in Iraq.

IN RECOGNITION OF MYRA FARR

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

Ms. WASSERMAN SCHULTZ. Mr. Speaker, I rise today to pay tribute to Myra Farr for a lifetime of service and volunteerism.

In 1938, when Myra Farr married, the National Council of Jewish Women Miami Chapter gave her a gift of membership. She then served NCJW as its president and honorary national vice president. Throughout the 70 years since, Myra has given of her time and energy to improve our community.

She became one of the original volunteers of the Greater Miami Jewish Federation, where she continues to serve on the board of directors as a lifetime appointee. Myra has also served on the National Conference of Christian and Jews and in various capacities with Jewish Family Services, American Jewish Committee, and the University of Miami Women's Guild. She was a delegate to the White House Conference on Families and has been awarded the Call to Service Award from the U.S. President's Council on Volunteerism.

Myra Farr has dedicated her life to advocating for the well-being of others. At age 94, Myra continues to mentor generations of women—including me—and has improved the lives of countless individuals. She sets a remarkable example for all Americans.

IN MEMORY OF STAFF SERGEANT JUSTIN M. DECROW

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

Mr. BROUN of Georgia. Mr. Speaker, I rise today to pay respect to the memory of Staff Sergeant Justin M. DeCrow, one of the 13 victims that died in the tragic and senseless attack at Ford Hood, Texas, on November 5, 2009.

Staff Sergeant DeCrow is survived by his wife Marikay and their 13-year-old daughter Kylah who currently live in Evans, Georgia. Justin was described as a loving father and husband with an ''infectious charm and wit that always put others at ease.'' This is what many of us aspire to be, but it seems Justin was an exemplary person to display such character.

We owe Staff Sergeant DeCrow's family an answer as to why this has happened and to ensure that it never happens again. I pledge to all the victims and their families that I will do everything that I can to find the answers as to why this act of terror took place.

MEDICARE PHYSICIAN PAYMENT REFORM ACT

(Ms. JACKSON-LEE of Texas asked and was given permission to address the House for 1 minute.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise to reaffirm my support for physicians, for the work that they do, and, of course, the fix that we just passed, the Medicare Physician Payment Reform Act, that finally responds to the medical care that doctors give all over America.

This bill will repeal a 21-percent fee reduction that currently was scheduled right around the corner for January 2010. It also reinforces the rights of seniors to keep their doctors and, as well, to lower costs. It has a pay-for as well. It is a procedure that has already been handled.

Proper management of Medicare funding ensures that the Medicare system will be able to properly support the medical needs of its intended beneficiaries. This bill will help promote the use of primary care and give access to the use of primary care practitioners in Medicare and throughout the health care system.

I have been working to support and protect physician-owned hospitals which give quality care, physicians who are able to go in and protect the quality of medical care in rural and urban areas. This bill also supports our physicians, and I am proud of it.

RELEASE FATHER NGUYEN VAN LY

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

Mr. CAO. Mr. Speaker, I rise today to call upon the administration and Congress to ask the Vietnamese Government to unconditionally release Father Nguyen Van Ly to his family.

Father Ly is one of many Vietnamese citizens who have been harassed for religious and democracy advocacy. He has been placed on trial without defense and imprisoned more than once for a total of almost 17 years.

As a Roman Catholic priest and prominent Vietnamese dissident, Father Ly has become a powerful icon in the ongoing fight for human rights. For his continuous imprisonment and nonviolent protests, Amnesty International adopted him as the Prisoner of Conscience in 1983. His support for the Bloc 8406 Manifesto, which called for a democratic Vietnam, has led to his most recent sentence on March 30, 2007, for an additional 8 years in prison. Sadly, Father Ly suffered his second stroke just 5 days ago, leaving the right side of his body paralyzed.

In a letter to His Excellency Nguyen Tan Dung, the Prime Minister of the Socialist Republic of Vietnam, Members of Congress asked the government of Vietnam to unconditionally release Father Ly on humanitarian grounds; provide access for his immediate and long-term medical care; and grant his family unencumbered admittance to lend moral, physical, and spiritual support during this difficult time.

We believe Father Nguyen Van Ly to be a prisoner of conscience held solely for the peaceful expression of his dissenting political and religious beliefs. Asking for his release is an opportunity for Congress to take a bold stand for human rights.

DON'T BRING TERRORISTS TO THE UNITED STATES

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

Mr. GOHMERT. Mr. Speaker, we've had people saying yes, we want to bring terrorists to New York. We want to bring them to Illinois. We had Senator DURBIN say, This is a lifeline. This is an opportunity for these people to finally have a chance to save their communities, and this project will give them that chance. Talking about bringing jobs to Illinois, Governor Pat Quinn said the prison that will be proposed in Thompson, Illinois, would provide economic opportunity.

We're talking about terrorists. And the moment these terrorists put their feet in New York after we've spent millions and millions of dollars, they will then file a motion to transfer venue. My friends across the aisle who have said, we want to look them in the eye and sentence them to death will have their statements as exhibits in the motion to transfer venue as to why they could not get a fair trial in New York.

This is a huge mistake. A terrorist whose own pleading earlier this year says that ''your end is very near and your fall will be just as the fall of the towers on the blessed 9/11 day'' does not need to be brought to the most densely populated area in the country.

Don't do it, Mr. President.

HONORING MARY ANNE SHARP

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

Mr. JOHNSON of Georgia. Mr. Speaker, I rise today to recognize and honor one of my constituents, Mary Anne Sharp. She is celebrating her 45th year as director of the Decatur Civic Chorus in Decatur, Georgia.

Under Ms. Sharp's leadership, the chorus has grown from a small group to a well-known and widely respected ensemble of 60 voices which has performed at hundreds of civic functions and organizations, including hospitals, nursing, and retirement homes.

Under Mary Anne Sharp's direction, the chorus has represented Georgia and the United States on tours and at festivals throughout the world. She is one of the points of light in my district, and I just recognize her from the well of the House for the great job she has done. Culture brings us all together; and I just applaud her efforts in this regard.

Mr. Speaker, as we continue to grapple with the great issues of war and peace, health care policy and other matters of state, let us not forget to recognize the heroes in our communities who give their time and spirit to share the arts with their neighbors.

Let us thank Mary Anne Sharp for her work, her heart, and her contributions to the community I am privileged to represent.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

WHERE ARE THE JOBS?

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Louisiana (Mr. SCALISE) is recognized for 5 minutes.

Mr. SCALISE. Mr. Speaker, I rise today to address the House to ask the question that many Americans are asking, and that is, Where are the jobs?

Over the last few months, the American people have been saying very vocally that they want this Congress to address the big problems that are affecting them today—and there are a number of problems. But the top problem I hear from my constituents—and I am hearing from so many of my other colleagues that their constituents are saying the same thing—is that they want this Congress to be focused on creating jobs. Unfortunately, we're seeing just the opposite happen in terms of the policies that are being brought forth by the liberal leadership of this Democratically controlled Congress.

It started back with the first bill that came out, the so-called stimulus bill. This was a bill that added $787 billion of debt that our children and grandchildren have to pay—money we didn't have—but the White House said, Don't worry. We've got to roll this thing through quickly, ram it through. Don't let anybody have the opportunity to read it, and it's got to go quickly because we need to stop unemployment from breaking 8 percent, and this bill's going to do it.

And then they said, When this bill passes, there's going to be so much transparency, you'll be able to track every dime, there won't be any waste, fraud, and abuse; and you can even go to a Web site and track where that money is going.

So, of course, after that bill passed, a bill that many of us opposed because we knew it wouldn't create jobs—in fact, it would actually make our economy worse because it was all borrowed money, money that our children and grandchildren have to pay. But what was worse is now that we're starting to try to find out where that money is, where is that money? We know when we're asking where are the jobs, we can't find the jobs because millions more Americans have lost their job since that bill passed. So it actually had the opposite effect that the American people were promised when the President stood right here on this podium.

But now as people across the country are trying to track down and say, Where is that transparency? Where are those billions and billions of dollars that have been spent going to?, we just find out the other day when you go to the White House's own Web site, Recovery.gov, you can't actually track those jobs. You can't track where that money's gone because there's an incredible amount of fraudulent information on that Web site.

Now, those of us in Louisiana were waking up on Tuesday going to that Web site, and maybe some people would think it would be good news that we found out that we had 15 congressional districts, according to the White House's own Web site. They actually tracked districts that don't exist.

□ 1700

Of course, in Louisiana, we only have seven congressional districts. So a reporter from our local newspaper called the White House. And first of all, they said, How can you possibly have all this accurate data on your Web site? You're telling the American people that jobs were created in congressional districts that don't even exist. And the first response from the White House was, ''We are not certifying the accuracy of the information.'' Now, these are the people who said this would be the most transparent administration in history. Now they are not certifying the accuracy of the information now that they have got their hands on the money.

So then they followed it up, and they said, Well, how can you actually have mistakes made that are this big where you have a State that only has seven congressional districts, and when we go to your Web site, there is a District 45, and it actually says how many jobs were created in that district that doesn't exist? How can you actually have a system that is set up that allows that kind of inaccurate information to be reported? And the White House's spokesperson actually said, ''Who knows, man? Who really knows?''

Mr. Speaker, this is unbelievable and an insult to the American people who are still asking, Where are the jobs? Now, maybe it's fitting that the White House is showing jobs created in districts that don't exist because their stimulus bill was passed using money that doesn't exist. It is all money that is borrowed from our children and grandchildren, not a dime that was paid for.

And, of course, the latest that the President was talking about just 2 days ago, he said, if we keep on adding to this debt, even in the midst of this recovery, at some point, people could lose confidence in the United States' economy in a way that could actually lead to a double-dip recession.

So here you have the President of the United States admitting that all of this debt spending, this deficit spending that they are on this road to continue going down, is a bad thing and actually could lead to a double-dip recession, and yet their answer from day one has been a stimulus bill that adds another $787 billion of debt. Then he came back right behind there with another bill, his budget, his budget that doubles the national debt. And then they went on with the bill called ''cap-and-trade,'' a national energy tax, a bill that adds hundreds of billions of dollars.

You wonder why people are still asking, Where are the jobs? We need to get back to fiscal sanity. We need to actually have real transparency.

KARZAI INAUGURATION NO CURE FOR WHAT AILS AFGHANISTAN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Massachusetts (Mr. MCGOVERN) is recognized for 5 minutes.

Mr. MCGOVERN. Mr. Speaker, today Hamid Karzai was inaugurated to serve another 5-year term as President of Afghanistan. International leaders, including President Obama and Secretary of State Clinton, are calling upon Karzai to reform his government, clean up corruption, and make us all proud of being his allies.

Well, Mr. Speaker, there is an old saying that fits this occasion, ''Fool me once, shame on you; fool me twice, shame on me.'' The Karzai government is ineffective, incompetent, and corrupt. He stole the elections. He has placed drug lords and warlords in key positions of power and influence. He has tolerated and promoted cronyism, graft, and a flourishing drug trade in his government and throughout his country, all of which have destroyed the confidence of the Afghan people in their own government and contributed to the resurgence of the Taliban.

What in the world makes anyone believe that he will be a catalyst for change? If someone won an election by committing rampant fraud, wouldn't he be more likely to commit fraud again and again? Why would he change a winning strategy? If someone personally picked and appointed warlords to take up key positions in his government, what makes you think he will now kick them out? Because the U.S. and Gordon Brown of Great Britain have asked him to?

If corruption and cronyism keep his friends healthy, wealthy, and happy, what makes you think he will turn off the spigot? Because he creates a special commission to look into the problem? Because his corrupt police are now going to have a special anticorruption unit and a unit to fight major crime?

What have they been doing up until now? Is he going to morph into being a new man, a different kind of leader, because he put a few words into his inaugural address about the need to create a clean government, the kind of government that people can trust?

Corruption is like a sickness, easier to spread than to cure.

Mr. Speaker, we do not have a partner we can trust in Afghanistan, yet we are asking tens of thousands of our servicemen and -women to go to Afghanistan and fight and die for Mr. Karzai's government. That's too high a price to pay, Mr. Speaker.

Soon the President will announce and outline the new U.S. strategy in Afghanistan, including a likely increase in the number of troops to be deployed there. I believe in the President's desire to do what's good for Afghanistan and the United States. I believe he wants to get it right and to be able to hand off to his successor at some point in the future a stable country, an Afghanistan that has turned the corner on violence and division and is beginning to flourish and develop once again.

I want that, too. But I do not think that sending more troops to a corrupt government is going to achieve that, no matter how many commissions and special police units are created or how many pretty words are put into an inaugural address. We should not send a single additional soldier to Afghanistan. It's that simple. We cannot afford to be fooled again.

CONGRATULATING PROFESSOR ELLEN MORELAND

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. CONAWAY) is recognized for 5 minutes.

Mr. CONAWAY. Mr. Speaker, today I rise to congratulate Ms. Ellen Moreland, a senior instructor in mathematics at Angelo State University on her recognition as the 2009 Texas Professor of the Year. While some folks may be surprised that a professor from ASU is being honored, it is no surprise to her students who see her devotion to her craft every single day.

The Professor of the Year Awards are awarded annually to those professors who have ''extraordinary dedication to undergraduate teaching, which is demonstrated by excellence in the following areas: an impact on and involvement with undergraduate students; a scholarly approach to teaching and learning; a contribution to undergraduate education in the institution, community and the profession; and support from colleagues and current and former undergraduate students.

They could not have found a more fitting honoree than Ellen Moreland. Professor Moreland has carved out an invaluable role as an educator of educators. Among her classes, she teaches the capstone course at ASU, which is a broad survey of everything that graduating math majors have learned in their 4 years. It is designed for future mathematics teachers to take before they take the State certification exam. The test is difficult, but Professor Moreland's students all seem to do well on it. In fact, over the last decade, every single student who has taken her capstone course has passed the certification exam on the first try. This 100 percent success rate is unmatched anywhere in Texas. And it is not a stretch to say that her impact will be felt by generations of students all over Texas.

Unfortunately, Professor Moreland could not be in Washington this week to receive her award. It is getting to be about time for finals, and she thought it was too important of a time for her to be away from her students. Instead, the 2009 Texas Professor of the Year is exactly where we would expect her to be, instructing her students and preparing another generation of American educators.

Mr. Speaker, it is my deep honor to represent all of the people of District 11 of Texas, but it is always a great pleasure to be able to single out some of them for their extraordinary accomplishments. On behalf of the people of my congressional district, especially the math students, I want to thank Professor Moreland for her dedication to teaching and her generosity with her time. They could not have selected a better educator to be the 2009 Texas Professor of the Year, Ms. Ellen Moreland.

THE GLOBAL WATER AND HUNGER CRISIS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. COSTA) is recognized for 5 minutes.

Mr. COSTA. Mr. Speaker, I rise this evening to talk about the challenges we face both in this country, my district, and around the world on critical issues affecting our country and the world, and that is food, water, and hunger. Because without water, you can't grow food, and without the sufficient sustainability of our ability to produce food in this country and around the world, hunger continues to be a pressing issue both at home and abroad.

Next week, Thanksgiving will be celebrated in this country, and we will all hopefully be with our families and friends. But in some parts of America, people will go hungry. In some parts of my district that has been ground zero on a drought that has been caused by a combination of regulatory and dry conditions for 3 consecutive years in California, we will have people in food lines. Sadly, these food lines have existed for months, and sadly, these food lines will continue throughout the winter because we have a problem in California. But that problem is exemplified throughout the world, and that is without sufficient water supplies, sustainable water supply, you cannot grow food, and without that ability, hunger persists.

On October 15, Bill Gates spoke at the 2009 Food Prize Symposium about the importance of productivity and sustainability of agriculture to feed our Nation and the world. He said, ''This global effort to help small farmers is endangered by an ideological wedge that threatens to split the movement in two. On one side is a technological approach that increases productivity. On the other side is an environmental approach that promotes sustainability. Productivity or sustainability—they say you have to choose.''

Bill Gates said, ''It's a false choice, and it's dangerous for the field. It blocks important advances. It breeds

hostility among people who need to work together. And it makes it hard to launch a comprehensive program to help poor farmers. The fact is, we need both productivity and sustainability—and there is no reason we can't have both.''

The San Joaquin Valley in my district in central California is a good example that we must have both, yet we find ourselves in a regulatory drought because we are faced with posing the question: Should we have sustainability or productivity? Farmers who produce some of the most varied amount of production anywhere in the world have proven that you can have both productivity and sustainability, provided, provided you have water. That's why Bill Gates went on to say, ''That's why our foundation works closely with local farmers' groups. And that's why we are one of the largest funders of sustainable approaches such as no-till farming, rainwater harvesting, drip irrigation, and biological nitrous fixation.

''The environment also benefits from higher productivity. When productivity is too low, people start farming on grazing land, cutting down forests, using any new acreage they can to grow food. When productivity is high, people can farm on less land.''

In our valley, we have proven that time and time again. I ask my colleagues to ensure that we hold this administration accountable.

Last week, Secretary of the Interior Salazar made a positive statement. He said, on November 9, that the Department of the Interior will make a public announcement taking actions on California's water crisis next year to make sure that the intertie to Gates, the diversification of refuge water in level 2 and in level 4 supplies are made available to farmers and that the Patterson fish screen and pipeline will, in fact, take place next year. These are important.

The last administration left these on the backlog for years. This administration pretends they are going to take place next year. I will hold them accountable. These projects are very important. Again, without water, you can't have food and you can't have jobs.

I urge this administration to continue to move forward on these important efforts along with the National Academy of Science's attempt to look at the biological opinions that are providing the constraints to allow for the flexible operations of the Federal and State projects that provide the water to allow us to grow the food to have the jobs.

As I close, my colleagues, let me tell you, we are talking about trying to get the economy going. We are going to be talking about a jobs package this year when we come back from Thanksgiving. If we provide water to the people of the San Joaquin Valley, we will have 30,000 jobs that were eliminated this summer because we had no water. It's very simple. All we have to do is focus on flexibility with these biological opinions.

We hope that before the National Academy of Science completes their work, the administration will understand that regardless of what kind of a rainfall year we have this winter and snow in the Sierra, it's important that we are sensitive to operational flexibility of the State and Federal projects.

I urge all of my colleagues to understand that, as Bill Gates said, sustainability and productivity are key. You can have both. It should be a false choice. Water provides food, and that equals jobs.

□ 1715

THE TRUE MEANING OF THANKSGIVING

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Arizona (Mr. FRANKS) is recognized for 5 minutes.

Mr. FRANKS of Arizona. Mr. Speaker, the Thanksgiving thoughts that I offer this evening were written by someone who sacrificed a great deal for someone that they loved. It has really nothing to do with roast turkey or pumpkin or all of the homey images that we have come to equate with this holiday. Tonight, I want to speak of a day whose noble purpose and origins are often lost on those who think of it as only ''Turkey Day.''

The truth is, this national holiday has much more to do with Presidents than it does pilgrims; more to do with our precious freedoms than sumptuous feasts. Yes, it's wonderful to have Thanksgiving dinner with precious loved ones, it's wonderful to have that time with those that we care about, but this was also meant to be a time of giving thanks to God for all of his blessings, including the gift of freedom, something that often gets lost in this season, forgetting it was bought by the blood of past generations of Americans, a sacrifice still borne by so many men and women in the armed services in the battlefield these very moments.

A national day of thanksgiving to God was actually called after America became a Nation by two of our greatest Presidents and Commanders in Chief, George Washington and Abraham Lincoln. The first one was in 1789, right after this new Nation was still healing from the wounds of the American Revolution. General Washington, who had led those who favored revolution against the will of those who did not, was now seeking to unite a people with a new Constitution as one Nation under God.

There wasn't another national celebration of the day for 74 years and, ironically, it was during the Civil War in 1863, in the midst of one of our greatest national tragedies, that President Abraham Lincoln called for all his ''fellow citizens in every part of the United States to set apart and observe the last Thursday of November as a day of Thanksgiving and praise to our beneficent Father who dwelleth in the heavens'' so ''that God could and should be solemnly, reverently, and gratefully acknowledged, as with one heart and one voice, by the whole American people.''

He went on to say ''We have forgotten God'' and ''It is the duty of nations as well as men to own their dependence upon the overruling power of God; to confess their sins and transgressions in humble sorrow and to recognize the sublime truth, announced in the Holy Scriptures and proven by all history, that those nations are blessed whose God is the Lord.''

Those words spoken nearly 1½ centuries ago came from a President who had found his own faith just a few months before. As he walked among the graves of thousands of soldiers who had fallen at the Battle of Gettysburg, his heart had broken over their tragic sacrifice. Abraham Lincoln was a President who deeply valued the lives of all Americans—civilian, slaves, and all soldiers, including everyone who actually fought against him.

The just freedom of hundreds of thousands of slaves had cost hundreds of thousands of American lives. It was an unspeakable sacrifice that weighed so heavily on him, and he believed only God could give him strength to unite the Nation again. He wrote a letter to a friend and said that he had not been a truer believer when he left Illinois to assume the Presidency.

''I asked the people to pray for me,'' he wrote. I was not a Christian. When I buried my son, the severest trial of my life, I was not a Christian. But when I went to Gettysburg and saw the graves of thousands of soldiers, I then and there consecrated myself to Christ.''

Abraham Lincoln understood the high cost of freedom, but counting the cost and trusting God to hold and ultimately heal the Nation, President Abraham Lincoln ended slavery in America forever. Mr. Lincoln and George Washington both understood the high cost of freedom and helped to forge a new Nation with unheard of liberties, Mr. Speaker, including the right to disagree. And both of them called the Nation to thank God.

So, Mr. Speaker, as we prepare to go home to our families and loved ones, let us remember what every man and woman in the Armed Forces can tell you personally: freedom is never free. And as we sit down to Thanksgiving dinner, let us be thankful to all of those who have died that we might live in freedom—from the American Revolution to this current war we fight

against jihadist terrorism. And let us thank the God, from Whom all blessings come, for this marvelous gift we call liberty and justice for all.

IN MEMORY OF SERGEANT EDUVIGES WOLF

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WATERS) is recognized for 5 minutes.

Ms. WATERS. Mr. Speaker and Members, I have come to the floor to speak about two extraordinary individuals today. I rise first to honor the memory of Sergeant Eduviges Preciado Wolf of Hawthorne, California. Sergeant Eduviges was an Army sergeant assigned to the 704th Brigade Support Battalion, 4th Brigade Combat Team, 4th Infantry Division, out of Fort Carson, Colorado. Sergeant Wolf was a hero who gave her life in service to her country.

Sergeant Wolf, also know as ''Duvi,'' dreamed of serving in the U.S. military as a child who emigrated to the United States from Mexico with her family. As soon as Duvi was able, she joined the United States military so that she could fulfill her lifelong dream to serve and protect her country. She met her husband Josh at Fort Bragg. Together, they had two daughters: 3-year-old Isabel and 1-year-old Valerie. Both Duvi and Josh were deployed to Afghanistan, where they served in separate units. Tragically, Duvi recently died in an insurgent attack while in Afghanistan. She was only 24 years old.

Earlier this month, on Veterans Day, I had the honor and privilege of participating in events with veterans and their families in my congressional district in Hawthorne and Inglewood, California. I was deeply moved by the families of our servicemembers. Not only do servicemembers make major sacrifices, but so do their families. They live with the harsh realities of war and its implications on them. Spouses must sacrifice long-term career planning, and children are oftentimes forced to transfer to different schools throughout the country. Tragically, as is the reality of combat theatre, some of our troops do not make it home.

Today, I salute and thank Sergeant Wolf, along with all of our Nation's past and present heroes who sacrifice a great deal in service to this country. I expressed my condolences to Duvi's sister Cecilia in Hawthorne on Veterans Day, and I know that her friends and family are still mourning. It is my hope that they will find comfort and peace in the loving memories and the distinguished legacy of service that Duvi leaves behind.

IN MEMORY OF TOMMY JACQUETTE

Ms. WATERS. I rise in memory of Tommy Jacquette, my dear friend of over 40 years, who passed away this week. I know that the community of Watts and the greater Los Angeles area are grieving with me, because we have all lost a truly unique, larger-than-life friend and activist who had his finger on the pulse of the community.

Born in South Central Los Angeles in 1943, Tommy Jacquette as a young man became part of the Black Power Movement of the 1960s and sharpened his leadership skills during his studies at Cal-Poly Pomona. He was acutely aware of the problems and issues facing the African American community, and he wanted to make a difference.

Tommy especially loved Watts, and he dedicated his life's work to enriching the community. He was the founder of the Watts Summer Festival at Ted Watkins Memorial Park, formerly Will Rogers Park, which became an annual tradition in the community following the 1965 insurrection, which were riots that shook the Watts community and surrounding areas.

Tommy created the festival to honor and celebrate our roots, our talents, and our culture; and it subsequently helped to spark African American festivals across the country. Today, it's known as the ''grandfather'' of all African American cultural events.

Even in years when he struggled to get funding for the festival, when traditional donors such as the business community and others wouldn't contribute, he always came through and was able to put on a festival, using the resources he had and his amazing life skills, largely stemming from being a self-made man. Just this year I joked with him that if he had two dimes to rub together, there would be a Watts Summer Festival.

I have no doubt, however, that in making the festival possible each and every year for almost half a century, Tommy knocked a few heads together. This tall, handsome, and fatigue-wearing man made his presence known, often using his penchant for colorful language to drive home the point. His confrontations with City Hall, L.A. County, and other elected officials and community leaders are legendary. He spoke his mind and he was bold and uncompromising in his support of the African American community. So when he was mad, you knew it. However, when he was pleased and happy, you knew it too, because he had a smile that would light up a room and a hearty laugh that would resonate throughout an entire building.

The Watts Summer Festival is uniquely Tommy, bringing people together and focusing both on local and national talent, always with an Afrocentric theme.

Tommy was an inspiration to me and to so many other people. He was daring, fearless and bold, helping us to gain the courage to openly discuss and deal with race, discrimination and inequality in a way that few had been able to before.

I will truly miss his presence and the long conversations we would often have, which would usually start when he'd say "Hey Mac, what do you think about that?" He was an incredibly deep thinker. He was especially an inspiration to young people in the community, often speaking at high schools, colleges and universities to encourage them to succeed, to give back, and to hold their heads up high.

There will never be another Tommy Jacquette, and I know that the legacy he has left behind is enshrined not only in the Watts Summer Festival, but in the larger community. I look forward to working with his family and the Board of Directors to make sure that the festival continues, though there will be a big hole that can never be filled.

I thank him for all that he was and all that he was not, for all the lives he reached, and for his friendship. I will miss him dearly, but am comforted because I know Tommy Jacquette's life was one of impact, purpose, and fulfillment.

TRIBUTE TO FORMER GOVERNOR BRUCE KING OF NEW MEXICO

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Mexico (Mr. HEINRICH) is recognized for 5 minutes.

Mr. HEINRICH. Mr. Speaker, it's difficult to put into words the tremendous loss that New Mexicans are suffering due to the passage of an unforgettable New Mexico public servant. Last Friday, we lost former Governor Bruce King at the age of 85. He was our revered ''Cowboy in the Roundhouse,'' who served three terms as Governor of New Mexico.

Across our State, we were all touched by this one-of-a-kind New Mexican who personified a rare brand of leadership, perseverance, and integrity. That brand of leadership epitomizes what I love about New Mexico, and I believe it was a result of his humble upbringing on a ranch near the small town of Stanley, New Mexico. There, his parents raised him to always provide water to travelers passing through their homestead, no matter their background, and certainly never asking whether they were a Republican or Democrat.

From the very beginning, Governor King's philosophy remained that New Mexicans needed to ''work together and be one large family,'' to be successful, whether from rural New Mexico towns like Stanley or an urban center like Albuquerque. Wherever he went in our State, New Mexicans felt like Governor King spoke their language, and they felt like his agenda was to address their family's struggles.

It was clear that he loved New Mexico and New Mexicans. He loved spending time with them. He loved bridging people's differences to get things done. His leadership united New Mexicans, and I think as we near our 100th anniversary of statehood, I have no doubt that his impact will be a central chapter in our history.

Governor King passed away Friday on the ranch where he was raised in Stanley, New Mexico, almost 1 year after the passing of his wife of 61 years, Alice King. Alice was equally revered for her contributions to our great State. Together, their humanitarian legacy includes equalizing funding between wealthy and not-so-wealthy schools, as well as establishing the Children, Youth and Families Department to tackle struggles faced by youth across our State. We're heartbroken at the loss of Governor and Mrs. King, but we're comforted that they are together again.

Mr. Speaker, I extend my heartfelt condolences to the entire King family, and I thank them for sharing such an incredible public servant with our State. It is an honor to be able to serve in the kind of State that loved two public servants like Alice and Bruce King and that was so deeply loved by both of them.

IN MEMORY OF FORMER GOVERNOR BRUCE KING OF NEW MEXICO

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Mexico (Mr. LUJÁN) is recognized for 5 minutes.

Mr. LUJÁN. Mr. Speaker, today I join my friends MARTIN HEINRICH and HARRY TEAGUE to celebrate the life of Bruce King. For so long, Governor King has been a constant and warming presence in New Mexico, dedicating himself to our State and touching the lives of New Mexicans from border to border with his kind words, hardy laugh, and friendly drawl. It's tough to go far in New Mexico without talking to someone who has a story about Governor King, and I'm no different.

When I turned 1 year of age, Governor King sent my parents a silver cup from himself and Mrs. King, from Alice, that still holds a prominent place in my mom and dad's house. It's a practice he followed to let people know he cared and that they were in his thoughts, even as he presided over a growing and emerging State. I'm sure that there are silver cups and similar stories across New Mexico, memories sitting on mantels, stories retold around family dinner tables. His thoughtfulness and down-home way of reaching out to people across our State made him a legend.

Raised in the fields of New Mexico and instilled with a sense of value in public service, the worth of a hard day's work and a kindness toward all, Governor King went to work early in life for our country and State.

□ 1730

He served in the Army in World War II, and when he came home, he settled his family in a beautiful place called Stanley, New Mexico. He was always a rancher, a genuine cowboy, and the values he learned on the ranch guided his service in our State. Governor King used to say that when cowboys came to the ranch to water their stock, his parents didn't ask if they were Democrats or Republicans. And he took that lesson to heart.

While working across the aisle in his time as a county commissioner, State legislator, as speaker of the House and finally as our Governor, when he got a question about a tough piece of legislation or a tough issue, his approach to bipartisanship was often highlighted by his wit. ''Well, some of my friends are for it,'' and he'd continue to say, ''and some of my friends are against it, and I will support my friends.''

This steady and collaborative approach to governance led to many accomplishments that were only overshadowed by the strength of Governor King's character and the size of his heart. With the helpful guidance of his wife, Alice, he made the Children, Youth, and Families Department a new State agency to look out for New Mexico's children, and he made sure the students statewide had access to kindergarten, and their schools had steady funding, no matter if they lived in a growing city or in a quiet little farm.

He valued the land, and he made sure it was protected through an environmental improvement agency. And his commonsense approach to finances led to the creation of the State's Rainy Day Fund and the Mineral Trust.

Governor King's accomplishments were many, but his legacy will be shaped by his deep affection for our State and his ability to connect with New Mexicans. He remembered names and family members all over the State, whether you were a mom or a dad or a brother or a sister. When he walked into a general store, a local restaurant or a farmhouse, he made sure to extend his hand to everyone and ask them with a drawl, ''How are y'all doing?'' When they returned the question, he answered, ''Mighty fine, mighty fine'' before starting a conversation.

Our State and our country are better for Governor King's service, and his words and deeds will long echo in our State. For generations, people will remember Governor King's legacy and benefit from his work, and I hope all New Mexicans will heed his most important lessons and take some time to talk to their neighbors and get to know them, help their communities, and give a little back to our State. If we do this, if we all work a little bit harder, with a little more compassion and a little more common sense, when someone asks you how you're doing, we might be able to look them in the eye and say, ''Mighty fine, mighty fine.''

We're going to miss you, Bruce.

HONORING GOVERNOR BRUCE KING OF NEW MEXICO

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Mexico (Mr. TEAGUE) is recognized for 5 minutes.

Mr. TEAGUE. Mr. Speaker, I thank my colleague BEN RAY LUJÁN from the great State of New Mexico. I also want to thank the gentleman from New Mexico's First Congressional District, MARTIN HEINRICH, for helping to arrange this tribute to one of New Mexico's greatest citizens. Bruce King is, without a doubt, a New Mexico legend. If you never got a chance to meet him, then all I can tell you is that you missed an opportunity to meet someone who really was a dedicated public servant and a good man.

Many of us that are public servants in New Mexico today have learned from his example. One thing I learned from Bruce King was how important it is to stay in touch with the people that you represent. In fact, I first met Governor King in the steer barn at the Lea County Fair. And over the years, it seemed that you would run across the Governor shaking hands at nearly every fair in New Mexico. Bruce King was New Mexico. A lot of people describe him as ''the cowboy Governor,'' and that could mean a lot of different things to a lot of different people. But for Bruce King, it meant that his heart was as big as our skies. It meant that his handshake was as good as his word. It meant the only way he knew how to work was hard. It meant his family and the people he represented always came first, and that he was willing to look out for their needs. It meant that when he had to make tough choices, he stuck by them, even when that meant that he had to make sacrifices.

It also meant that he led by example. During one of his terms as Governor, Bruce King had to contend with an energy crisis like the rest of the country. He didn't just tell New Mexicans that they had to save energy. He showed them by trading in his motorcade for a horse. For a while, Bruce would actually ride his horse from the Governor's mansion in Santa Fe to the State capitol as a way of showing folks that he was willing to do his part.

When I ran for Congress, I kept telling voters that I was running to put New Mexico's families first in everything that I did. Governor King did that when he created the Children, Youth and Families Department in New Mexico that looks after the well-being of our children and our loved ones. He put New Mexico families first because, in a lot of ways, the people of New Mexico were his family. He put the education of our kids first when he changed the way we fund our schools back home.

In too many States, wealthy neighborhoods have the best schools while poor rural areas or inner city schools

have to scramble for funds every year because their families are poor. Governor King changed that. He made sure that every single child in New Mexico got a shot at an education when he made sure that all money for education was doled out equally for every school district. He knew that one child's education was not more important than another's, and countless New Mexicans have benefited from that change.

In a recent interview, Bruce told a story about how he started making a few people angry on the Santa Fe County Commission when he, as a first-term commissioner, kept pushing the county employees to get roads paved faster. He remembered that one person took him aside and said, ''Bruce, you're new here, and you don't know how things are done.'' He just smiled and told him, ''I understand the way things are done. The people pay their taxes on time, and they expect us to do our work on time. That's how it's done.''

Governor King's service to our Nation and our State should never be forgotten. As a county commissioner, speaker of the House and as Governor, he was one of those unique public officials who never had forgotten where he came from. He listened sincerely to the needs and concerns of his constituents, and then he got to work addressing those issues because he cared deeply about the State of New Mexico. He showed the rest of the country what it meant to be a New Mexican. He brought out the best in all of us.

That's probably why so many of his political rivals became friends of his afterwards. For so many years, Bruce King was ours. Now the cowboy Governor's ridden off into the sunset one last time, and he will be missed.

REVISIONS TO THE 302(a) ALLOCATIONS AND BUDGETARY AGGREGATES ESTABLISHED BY THE CONCURRENT RESOLUTIONS ON THE BUDGET FOR FISCAL YEARS 2010 AND 2014

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from South Carolina (Mr. SPRATT) is recognized for 5 minutes.

Mr. SPRATT. Madam Speaker, under section 421(a)(4) of S. Con. Res. 13, the concurrent resolution on the budget for fiscal year 2010, I hereby submit a revision to the budget allocations and aggregates for certain House committees for fiscal year 2010 and the period of fiscal years 2010 through 2014. This adjustment responds to House consideration of the bill H.R. 3961, the Medicare Physician Payment Reform Act of 2009. Corresponding tables are attached.

For the purposes of the Congressional Budget Act of 1974, as amended, this revised allocation is to be considered as an allocation included in the budget resolution, pursuant to section 427(b) of S. Con. Res. 13.

BUDGET AGGREGATES

[On-budget amounts, in millions of dollars]

	Fiscal year 2009	Fiscal year 2010	Fiscal years 2010–2014
Current Aggregates: [1]			
Budget Authority	3,668,601	2,882,149	n.a.
Outlays	3,357,164	3,002,606	n.a.
Revenues	1,532,579	1,653,728	10,500,149
Change for Medicare Physician Payment Reform Act (H.R. 3961):			
Budget Authority	0	1,177	n.a.
Outlays	0	1,177	n.a.
Revenues	0	0	0
Revised Aggregates:			
Budget Authority	3,668,601	2,883,326	n.a.
Outlays	3,357,164	3,003,783	n.a.
Revenues	1,532,579	1,653,728	10,500,149

n.a. = Not applicable because annual appropriations Acts for fiscal years 2011 through 2014 will not be considered until future sessions of Congress.

[1] Current aggregates do not include the disaster allowance assumed in the budget resolution, which if needed will be excluded from current level with an emergency designation (section 423(b)).

DIRECT SPENDING LEGISLATION—AUTHORIZING COMMITTEE 302(A) ALLOCATIONS FOR RESOLUTION CHANGES

[Fiscal years, in millions of dollars]

House Committee	2009		2010		2010–2014 total	
	BA	Outlays	BA	Outlays	BA	Outlays
Current allocation:						
Ways and Means	0	0	6,840	6,840	37,000	37,000
Change for Medicare Physician Payment Reform Act (H.R. 3961):						
Ways and Means	0	0	1,177	1,177	37,546	37,546
Revised allocation:						
Ways and Means	0	0	8,017	8,017	74,546	74,546

HEALTH CARE REFORM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Georgia (Mr. GINGREY) is recognized for 60 minutes as the designee of the minority leader.

Mr. GINGREY of Georgia. Mr. Speaker, I thank you for the recognition, and I thank on the minority side, my side, the Republican side for allowing me to take this hour this evening to talk about health care reform and talk about what happened on the floor of the House today in regard to what's known as the doc fix bill. I think it's very important, Mr. Speaker, that we take this time so that all of our colleagues will have a full understanding of what's been going on. Certainly we've all been here, but we each have not had equal access to the deliberations and the writing of bills and the writing of amendments and of course motions to recommit and this sort of thing. So this, hopefully, Mr. Speaker, will be an information hour for all of our colleagues as we move forward.

When the bill was first marked up—the bill, the Pelosi health care reform act of 2009, Mr. Speaker, when it was first marked up back in July of this year in the three committees of this House, the Energy and Commerce Committee, the Ways and Means Committee, and the Education and Labor Committee, there were certain issues that gave me great pause. I do happen to sit on one of those three committees, Energy and Commerce.

When we began to mark up that bill at the time, Mr. Speaker, as you recall, it was H.R. 3200. Now the bill that we voted on and passed last Saturday night is H.R. 3962. But in their original bill, and in the bill that has passed the House, I had great concern, as did many of my colleagues, especially on this side of the aisle, Mr. Speaker, with a section in there called Comparative Effectiveness Research Council. We had trouble with another section in there that created something known as the health services coordinator. But let me get back to that Comparative Effectiveness Research Council, Mr. Speaker, for just a second because basically, as you read through that portion of the bill, it was obvious that these bureaucrats would decide based on hopefully accurate research, scientific research, what was the best treatment for each and every disease known unto man, but that hopefully it would be a recommendation that this research council could give to our practicing physicians.

We know, Mr. Speaker, that medicine is not an exact science like physics and chemistry. It's a science, yes, but not an exact science. There is a lot of art to the practice of medicine. Doctors have a sixth sense, if you will, many times where a diagnosis is made based on just an observation or a feeling or, indeed, a sixth sense and not necessarily a scientific test or a specific lab result. So that was why, Mr. Speaker, I felt very concerned with this Comparative Effectiveness Research Council, if this bill is enacted in its current form.

Of course it looks like the Senate is going to be taking up the bill sometime soon. And if this is in there, indeed, these people, these bureaucrats, these nonmedical government folks will have the opportunity to say, Doctor, you can or cannot do that procedure. You can or cannot order that test. You can or cannot prescribe that medication based on, hopefully, what is best based on research. But could they do it, Mr. Speaker, simply based on cost? And the answer, regrettably, is, yes, they could. Yes, they could. That's why I proffered,

submitted an amendment when we were marking up the bill that said that no bureaucratic decision or recommendation from this Comparative Effectiveness Research Council could force a physician, especially based on cost, that could lead to denial and eventually to rationing.

Now that seemed like such a good amendment, Mr. Speaker, that I was very optimistic, indeed, that my colleagues on both sides of the aisle—there are about 56 of us on the Energy and Commerce Committee. I think there are 35 Democrats and 21 Republicans. But I was optimistic. And yes, indeed, that amendment passed on a voice vote, and people on the committee I think realized that that was a concern, and they didn't want this to happen either. Now unfortunately, Mr. Speaker, when the Speaker—you are sitting in for her—but when the Speaker of the House of Representatives, NANCY PELOSI, got the three bills from the three committees and sort of combined and came up with H.R. 3962 that, indeed, we voted on last Saturday night, that amendment disappeared miraculously, as did 15 other Republican amendments that were passed in committee. And in the dark of night, poof, they're gone.

You know, this is a pretty serious retraction, subtraction from the bill, and my fear, my concerns, Mr. Speaker, just this week have really come home to roost. Now I don't know how many of my colleagues have had the opportunity to read about, see about on television the United States Preventive Services Task Force, an entity embedded within the Department of Health and Human Services. Oh, by the way, Medicare and Medicaid is also embedded within the Department of Health and Human Services. Well, this little-known-to-some but well-known-to-many United States Preventive Services Task Force has come out, Mr. Speaker, with a recommendation that says that women should no longer practice breast self-examination in trying to detect early, at the earliest opportunity, if they have a suspicious lump.

They went even further and said that women should not routinely have a mammogram done every 2 years starting at age 40; they should put that off until age 50.

Now when an entity like this makes a recommendation, Mr. Speaker, it eventually becomes not a suggestion, but it essentially becomes, for all intents and purposes, a mandate.

□ 1745

Now, Ms. Sebelius, the Secretary of Health and Human Services, immediately said, no, no, doctors can still do whatever they want to. We are not telling the doctor what to do.

But, Mr. Speaker, as most of my colleagues know, I am a physician, and I just happen to be an OB/GYN specialist and practiced for 26 years before I had the privilege to be elected to Congress back in 2002. I am also a very proud member of the American College—a fellow we call it—of the American College of Obstetrics and Gynecology, and I am a board certified fellow. The recommendation from our college, our subspecialty, has been to commence routine screening mammograms for women at age 40 and to do that every 2 years, and of course not only allow, but to encourage and even to teach them how to do breast self-examination, probably commencing that in their early thirties if not their late twenties. It is something that I am just shocked that any so-called credible organization other than my own subspecialty of OB/GYN or, indeed, the American Cancer Society would make that kind of recommendation, and they haven't. I think they are appalled at this recommendation.

And like I say, when the Secretary of Health and Human Services says not to worry, doctor, patient, you can continue to do whatever you want to, but the patients are already very confused and frightened. And even if the doctor recommends to, let's say, a woman in her early forties, Hey, it is time to get that mammogram done. I don't feel anything on the exam, and I am glad you are checking yourself on a regular basis. Everything looks good, but it is time to go ahead and get that screening mammogram because we would certainly hope, if you are unfortunate enough to develop breast cancer, that we can detect it with the mammography, which is an x-ray, before a lump has developed, certainly before the patient can feel it, and certainly before the doctor can detect.

You write out that prescription and that order and you send the patient to the hospital and she gets over there and she is told, Well, we can do it, but you are going to have to write us a check or you are going to have to pay cash for it because your insurance company doesn't pay for this anymore, and they don't pay for it anymore because the U.S. Preventive Services Task Force of the U.S. Department of Health and Human Services says it is not necessary. We will be glad to do it. You have to write us a check, cash on the barrelhead, and we will do it; otherwise, we will see you in 10 years, at age 50. And at that point, that patient might happen to have, since she has been discouraged from doing breast self-examination, cancer the size of a golf ball, and that being cancer that has already spread to the point where her chances of survival over a 5-year period of time is down around 10 percent instead of 95 percent.

Mr. Speaker, this is serious stuff. This is life and death that we are talking about. That is why so many of us are so concerned about this massive takeover of our health care system by the Federal Government, by bureaucrats. We have got 13 practicing physicians on our side of the aisle that probably, in the aggregate, have 400 years of clinical experience. All kinds of specialists. In fact, I have a family practitioner with me tonight.

Mr. Speaker, maybe you wish that we had been consulted, and there are four or five doctors on the Democratic majority side. I don't think that they were consulted. It is a waste of talent and the waste of an opportunity for bipartisanship. This is the result of it, though. This is what happens when things are done behind closed doors. Folks overlook, forget. I am not saying that it is deliberate, but the unintended consequences have life and death consequences.

And with that, I yield to my good friend, the gentleman from Athens, Georgia (Mr. BROUN).

Mr. BROUN of Georgia. Dr. GINGREY, thank you so much for yielding tonight, and I appreciate the opportunity to come here to try to help our colleagues and hopefully the American public to understand what we are dealing with with this PelosiCare bill. And what is apparent thus far, since it has just been out, I can't say for certain, but it is apparent within the Senate bill, the ReidCare bill, of where we are going as a Nation.

The American people need to understand something very clearly, and that is there is going to be rationing of care, as Dr. GINGREY was just talking about, and we are already seeing the beginning of this.

Mr. Speaker, over the August break, I went up to Canada and I talked to Canadian patients. I actually lived in Canada many, many years ago for a short period of time. I didn't talk to doctors, but I talked to Canadian patients, since we hear our Democratic colleagues holding that up as the kind of model we need to go to.

Mr. Speaker, the American people need to understand very clearly that the Canadians have marked rationing of care. I talked to women in their forties and fifties who never, ever have been told that they needed a pap smear and never have had one. What Dr. GINGREY was just saying, Mr. Speaker, about this recommendation that women not have mammograms until they are after 50 years of age, I have seen patients in my own medical practice in their thirties who have been diagnosed and treated for breast cancer. In fact, I had one lady 29 years of age in my own practice who found a lump in her breast. She came to me, she got a mammogram and went to surgery and was found to have breast cancer at 29 years of age.

Mr. Speaker, this is the beginning of the process of rationing of care that we already see the Federal Government doing just in anticipation, in my belief,

of what the PelosiCare, the ReidCare, the ObamaCare bill is going to do. You see, the Democratic Party's health care reform plans which have been introduced in the House and the Senate will allow you to have anything that you want as long as the boss would allow you to do it. Boss Hogg is going to determine whether a patient can have a mammogram, as we already see in the Federal Government saying we need to stop these mammograms for patients that desperately need them from a medical perspective.

Mr. GINGREY of Georgia. If I understand the gentleman correctly, Mr. Speaker, the gentleman is holding a poster. That poster is a representation of this health choices administrator in this new bill, this H.R. 3962 which has already passed this House, and it also could be representative of the U.S. Services Task Force. And I want to yield back to the gentleman from Athens, Georgia, and I want us all to focus in just for a minute on Boss Hogg, because I think it is a great characterization of what we are trying to point out here.

Mr. BROUN of Georgia. This comparative effectiveness panel that is going to be set up in Washington, D.C., they are going to look at how to spend dollars. They are going to use age and dollars on how to make health care decisions, which means that senior citizens are going to be denied care because they are going to determine that it is not effective to spend dollars on seniors' care as opposed to spending it for young people's care. So this mammogram recommendation is just the harbinger of where we are going.

One other thing, Mr. Speaker, that the American people need to understand is that not only Boss Hogg is going to tell them whether they can have surgery, whether they can have a mammogram, whether they can have a pap smear, whether they can have lab tests, MRIs, CAT scans, but Boss Hogg and another group is going to tell the American people what their health insurance looks like.

So we have heard the President over and over say that if you like your current health insurance policy, you can keep it. That is a bald-faced lie. It is not true, because the health care czar panel is going to dictate every single health care policy in this country. Not only in the public exchange, but also everybody's private insurance in this country is going to be dictated by Boss Hogg, the health care czar panel in Washington, D.C.

They are going to say whether that insurance will pay for insurance coverage for those mammograms, and they are going to use this recommendation that just came out this week to deny women under the age of 50 of being able to get those mammograms that their doctor thinks that they need and that they think that they need. There are medical indications for those mammograms, but Boss Hogg is going to say ''no'' because it does not fit within the parameters of the insurance that the Boss Hogg health care czar panel is going to put into place.

Mr. GINGREY of Georgia. I thank Dr. BROUN for that point.

As we continue this colloquy, Mr. Speaker, Boss Hogg could also restrict other screening procedures. It is probably never going to be proven that screening, mass screening for many different diseases is going to be cost effective, but it is going to save lives. You ask yourself, if we are going to get to the point where Boss Hogg or the health choices administrator or the U.S. Preventive Services Task Force or the Comparative Effectiveness Research Council decides that something is not going to be cost effective, as Dr. BROUN points out occurs in Canada. And he has some experience. He lived there. We know it occurs in the U.K. They have a group, an oversight entity that goes by the nice acronym of NICE, N-I-C-E, the National Institute for Clinical Excellence, but it is a rationing body that decides what can and cannot be done.

Indeed, talking about breast cancer, Dr. BROUN, the survival rate, the 5-year survival rate for breast cancer in the U.K. is something like 15 points lower than it is in the United States, and it is simply because they are denied these routine screening procedures.

The point I also wanted to make in regard to other things, how many children, how many young children have to be screened with a blood test for sickle cell anemia before you find one? How many young children in preschool have to have a hearing examination before you find one that is hearing impaired, or vision screening before you find one that is visually impaired? How do you put a dollar value on these kinds of things, Mr. Speaker? You cannot do it. And if you start trying to do it, then you ration everything and it becomes a matter of what is a person's life worth, whether it is at the beginning or the end.

I yield to my colleague.

Mr. BROUN of Georgia. I thank you, Dr. GINGREY, for yielding.

Carrying down that same road that you were talking about, I have practiced almost four decades as a family doctor. I have done colonoscopies and sigmoidoscopies. We do routine digital rectal examinations on patients for prostate cancer. We do PSAs routinely in screening. We do cholesterol screening and blood sugars and hemoglobins and all of these different tests that the American people wouldn't understand unless they have those diseases or have studied those things.

□ 1800

But you're exactly right, Dr. GINGREY. The screening for, for instance, colon cancer, we do a lot of checking stools for blood, doing flexible sigmoidoscopies even colonoscopies for colon cancers. Frequently even at colonoscopies we take out polyps that could turn out to be cancer if they're not removed.

This cost-effectiveness panel, Boss Hogg, very probably is going to cut off all that screening. And you're going to have more people get prostrate cancer, more people get colon cancer, more people get breast cancer, more ladies get cervical cancer because those screening tests that Dr. GINGREY is talking about, Mr. Speaker, very probably are going to be cut off and denied to patients because they have to stop paying for all these tests because of the comparative effectiveness. Particularly when you look at it, young people from old people compared to how you spend your dollars, we're going to have tremendous rationing of care.

So everybody in this country is going to have their insurance dictated by Boss Hogg, the Federal Government. Everybody is going to have their care dictated by Boss Hogg, the Federal Government. Everybody in this country is going to have a Federal bureaucrat standing between them and their doctor. It's not right and the American people need to stand up and say ''no'' to the ReidCare bill. They need to say ''no'' to the PelosiCare bill, no to ObamaCare. And let's lower the prices for everybody.

Republicans have many, many bills that we've introduced. I have introduced one myself, H.R. 3389, which is a comprehensive bill. It does not add one nickel of increased spending to the Federal Government, and it puts the patient and doctor in charge of those health care decisions.

Dr. GINGREY, I appreciate your doing this Special Order, and I appreciate your bringing these very pertinent things to the attention of the American public by doing this Special Order. And I just applaud what you're doing here because in Hosea 4:6 God says, ''My people are destroyed for lack of knowledge.'' And the American people are going to be destroyed for a lack of knowledge about what this PelosiCare bill is going to do or the ReidCare bill is going to do that Barack Obama is pushing down the road. We've got a steamroller of socialism that's going to cost jobs and destroy the quality of health care, and the American people need to stand up and say ''no.''

Thank you, Dr. GINGREY. I appreciate it.

Mr. GINGREY of Georgia. Representative BROUN, Dr. BROUN, I thank you very much.

Before we move on, Mr. Speaker, to another subject that's hugely important, indeed, what we took up here today on the floor of our great House of Representatives, I just want to make one closing comment in regard to this

issue of rationing of care and in particular in regard to this new recommendation to dumb down the care, indeed, the screening, for breast cancer. I don't know how to put it any other way than to say that it dumbs down that care and that opportunity for early detection and lives saved.

Mr. Speaker, there are female Members of this body, great, great Members on both sides of the aisle, women that represent their districts all across this country that serve in this 435–Member House of Representatives. And, unfortunately, a number of them, a number of them have been stricken with breast cancer. In fact, Mr. Speaker, it may have even been before you were here that a Member on our side, a wonderful, wonderful Member from Virginia, struggled with her breast cancer for several years with great, great courage and fortitude and hopefulness and faithfulness, and God called her home. She died from the spread of that breast cancer. And it was such a sad day.

And then I think of Members, Mr. Speaker, on your side of the aisle that at a young age, in their early 40s, have been stricken with breast cancer, women with beautiful young toddler children. I've seen them walking down the Hall of the Cannon Building, you know, a great Member, a great friend, but I'm very thankful for her that early detection occurred because of, I don't know, probably a combination of breast self-exam but maybe it was mammography, and we hope and pray and really feel very confident that our colleague has a complete cure.

So when we bring up a subject like this, it's not to be morbid and not to scare people, Mr. Speaker, but just to inform in the reality and the unintended consequences sometimes of the things that we do. Particularly when we draft 2,000-page bills that you don't bring everybody together on both sides of the aisle in a bipartisan way and utilize the doctors, the doctors, not just the leadership and people that have been on these committees of jurisdiction for 30 years who write these bills in the dark of night and then just throw them out there in front of us and say you've got 24 hours to read it and vote up or down and, oh, by the way, you can't amend, it's a closed rule. It's wrong. It's wrong but it also is dangerous.

Mr. Speaker, in the time that I have remaining, I want to shift gears a little bit because today on the floor of the House the main thing that we dealt with was a bill called H.R. 3961. Now, the number is insignificant really except to look it up on the Internet, but let's call it what most people would recognize it as, certainly most physicians, all physicians across the country would understand, the ''doc fix'' bill. The ''doc fix'' bill.

Our physicians for the last 15-or-so years, maybe more, maybe closer to 20 years, but there is a flawed formula for calculating how much they are reimbursed for the procedures that are done under the Medicare program. And for the last at least 6 or 7 years when you calculate that formula—we'll call it for abbreviation purposes the SGR formula, sustainable growth rate—and every year for the last 6 or 7, the calculation says you doctors who are just barely breaking even, maybe not even breaking even, maybe losing money, seeing Medicare patients out of the goodness and compassion of your heart, for which we commend you, are going to have to take next year a 5 percent cut, and then we calculate it and then the next year a 4½ percent cut, and on and on and on.

Well, each year over the last several years, we have come in and passed a law that would say we're going to mitigate that cut for this year, and we're going to let you get reimbursed on the basis of what you got last year and we're going to bump it up 1 percent or .5 percent or whatever, and we're going to do that for a couple of years.

We literally are going to kick the can, kick the can down the road, Mr. Speaker. You know that expression. Because that's what we're doing. Maybe we kick it soccer style. But the problem doesn't really go away. So the next time in the aggregate, instead of a 5 percent cut, you've got a 10 percent cut or a 15 percent cut. Indeed, January 1, 2010, in the aggregate that cut will be 21 percent if we don't do something about it.

Well, Mr. Speaker, what the Democratic majority and what President Obama said to the American Medical Association way back in June is in this bill, this health reform act that we're going to pass that we're going to totally reform one-fifth of our economy, we're going to have in there a permanent fix for the doctors. We're going to solve the problem.

And, doctors, also we know you have another concern. Mr. Speaker, you're aware of this. My colleagues, I know are aware of it. You doctors have this concern over medical malpractice and this need to defend yourself against these frivolous lawsuits by ordering all these tests on patients that are not only unnecessary but indeed could be downright dangerous to the patient, but yet you keep doing them because you don't want to be dragged into a court of law and have some slick attorney or some expert witness hired by some very capable, smart attorney saying, Oh, yes, this doctor practiced below the standard of care because he didn't order a fizzle phosphate level, whatever the heck that is.

So I was so thrilled when Mr. President said to the AMA, Mr. Speaker, that there would be medical liability reform. We would solve the low payment based on that flawed formula, SGR, and we would at last have medical liability reform.

This bill, 3962, that we passed last Saturday night had none of that in there, and the Democratic majority just took out the ''doc fix'' because, guess what. To do it costs about $290 billion, Mr. Speaker, and would push the cost of this massive monstrosity of a bill over the $900 billion, which the President had put a cap on, a ceiling, and said he wouldn't sign anything that cost more than $900 billion. I say even if you pay for something that costs $900 billion, if the final result is an Edsel, you have not accomplished very much.

But, indeed, the bill was pulled out and the President and Ms. PELOSI said, basically, not to worry, not to worry. We're going to come and we're going to introduce this bill as a stand-alone, and indeed that's what we did today, 3961, and we're going to pass it. But you know what? It ain't paid for. And whether it costs $210 billion, $230 billion, $275 billion, I'm not sure of the exact figure, but it's north of $200 billion, and my Georgia Tech math tells me that that's about a quarter of a trillion dollars. It's going to cost that much money and we're not going to pay for it.

The debt now is something like $12 trillion. So we're going to add another quarter-trillion dollars to the debt. In fact, we're going to even have to add to the debt ceiling because we're going beyond what the law allows us to do.

So, Mr. Speaker, my side of the aisle looked at this very carefully, particularly the physician Members, the 13 of us that form the GOP Doctors House Caucus. And we said, you know, we want to do right by our doctors and we want to do right by our patients and we want to do right by the country, and we can fix this and we can pay for it. So we had one opportunity today to offer a motion to recommit with our design of how we pay the doctors a 2 percent increase every year for the next 4 years under Medicare and we pay for it.

And the way we pay for it, Mr. Speaker, in that motion to recommit, is to have that medical liability reform in the bill among a couple of other things to generate revenue, and it's revenue that the CBO says is at least $54 billion. So our motion to recommit, our bill, on ''doc fix'' is paid for. It's a real ''doc fix.''

But you know what, Mr. Speaker? You were here. All my colleagues were here. We got ruled out of order. The Chair said our motion to recommit was nongermane because H.R. 3961, the Democrats' ''doc fix'' bill, the $290 billion not-paid-for bill, well, we weren't consistent with that because we paid for our bill; therefore, it was nongermane. Now, what can kind of idiocy, what kind of idiocy is that, Mr. Speaker and my colleagues?

This is something the American people need to understand, and certainly I

think the doctors understand. We had an opportunity to do this and do it right, and we were denied even to vote on that motion to recommit. It was tremendously disappointing to me because, Mr. Speaker, I had the opportunity, the privilege, the distinction of offering that motion to recommit, and I wanted to explain to my colleagues exactly what our bill does. And the chairman of the Energy and Commerce Committee denied me the opportunity even to speak, getting the Chair to rule that our motion to recommit was nongermane.

□ 1815

So every time I tried to speak, I was gaveled down. Mr. Speaker, that's not what the American people want. If we were in the leadership, they would be appalled. I think they're appalled tonight with your party in the leadership. The American people don't want that. They want Members to have an opportunity to represent their districts, to represent their principles, and to represent and fight for this country and not be silenced.

And that's what happened on this floor today. And it's got to stop, Mr. Speaker. It's got to stop. And we will continue to fight. This bill that was passed here today, there was not—I think there may have been one Republican that voted for it, and there were 9 Democrats that voted against it. So there was bipartisan opposition. But your party, Mr. Speaker, had the votes, and you passed it.

But it's a sham of a bill, and you know it, because the Senate, 3 weeks ago, totally rejected the bill with 14 Democratic Senators voting no. They couldn't even get a cloture vote. That bill is dead on arrival when it gets to the Senate. Our bill had an opportunity to pass and get to the President's desk and give the doctors relief for the next 4 years, at least. But, no. We had to do it the same old same old way of forcing things on the American people. It's not right, Mr. Speaker, and it's not going to stand.

I appreciate the opportunity, as I said at the outset, to come and to talk about this with my colleagues, because I only had 5 minutes to speak about our motion to recommit this afternoon. Five minutes to explain, not hyperbole, not harsh rhetoric, just to explain what our bill did in contrast to 3961, the majority bill, which, as I say, is not going anywhere and the Democratic leadership knows it's not going anywhere. So it is a sham. It's not a ''Doc Fix,'' it's a ''Doc Trick.''

And I want to be, as I move to wrap up, I want my colleagues to just look at this one chart, one poster that I have to show. And this is my depiction of a Trojan horse. And you might not can read this writing, but on the Trojan horse is a saddle, and it says, the Democratic ''Doc Fix'' Bill, H.R. 3961. But on the back of the horse you see the overall health care reform act, the Pelosi Health reform act of 2009, yes, with the $500 billion cuts to our precious seniors under the Medicare program, kind of slipping right on in there. That Trojan horse is this democratic ''Doc Fix.''

But when they, and if they, and I hope and pray to God, Mr. Speaker, that it doesn't pass, but if it does, this is what's going to happen to the American people, not only to our doctors, but to our patients and especially to our seniors.

With that, Mr. Speaker, I want to yield a little time to my great friend from Texas, Judge LOUIE GOHMERT.

Mr. GOHMERT. And I appreciate my friend for yielding, and the great points that he's been making as a physician, someone who is used to healing people and taking care of people, and it's great to have your insights as a physician. But the points you've made are so right on target. As our friend knows, they added on what they call the PAYGO provision to the end of this bill, saying, all right, from now on we're going to start paying for things and having offsets so we don't add to the American deficit.

Mr. GINGREY of Georgia. After we don't pay.

Mr. GOHMERT. After we don't pay. And that's the thing. They put the PAYGO provision in the rules when they took the majority and have repeatedly ignored it over and over. Well, this past summer there was a bill that they called the PAYGO bill, and it was, they said, now, we realize we put this in the rules, that we would have to provide, if we're going to add money to the deficit, well, we're going to have to come up with some way to pay for it so that doesn't add to the deficit.

And so this past summer, there were 24 Republicans who were persuaded—you know, even though they haven't meant it for the last 2½ years, they've repeatedly violated their PAYGO provision, this time they really, really, really mean they're serious about PAYGO. And I knew they hadn't, when they were really serious, and when they were really, really serious they were going to abide by the PAYGO rules. But this time I thought, you know, they're going to put this in a stand-alone bill, so certainly they would not want the flak of coming back. And I voted with my friends across the aisle, the Democrats, that they couldn't just bring up a bill unless there was money provided in the bill that would make it deficit-neutral. And so I voted for that.

Well, they fooled me. Here they come right back with a bill costing hundreds of billions of dollars, and they said, you know, what, that PAYGO stuff we passed in July? We still mean it, and we really, really, really, really mean it this time, but we're going to add it on and start applying it after this bill.

Well, that is just so incredible. I mean, the American people, as we're seeing, are not stupid. They realize what's being done.

Mr. GINGREY of Georgia. Reclaiming just for a second on this point. The gentleman from Texas, Mr. Speaker, is so right. And to do this, of course, now they're going to have—they're going to go over the current debt ceiling by law. They're within, I think, $70 billion of the current debt ceiling, so they're going to have to, in the next couple of weeks, before Christmas, they're going to have to increase the debt ceiling once again.

And you know what? That's not going to be a stand-alone bill, because they don't want that, the light of day to shine on that. That's going to be embedded in something else, is it not, my friend?

Mr. GOHMERT. It certainly will be. You figure that's what they'll do so that maybe people may not notice that they've yet again increased the deficit. And that was one of the things they ran on and took the majority for in 2006. There was too much spending. And now, they have just come in and taken that, as somebody said earlier today, I mean, it's deficit spending on steroids.

But even more than that, coming back to health care, I don't want the government between me and my doctor. I don't want insurance companies between me and my doctor. And for a long time now, we have had not health insurance, but health insurance companies managing health care. And I appreciate insurance. I think it is extremely important to help us ensure against unforeseeable events. But some of us have talked about and have pushed, on our side of the aisle, the health savings account. Everything that—all of the bills that have been proposed from the other side make detrimental cuts and damage to the health savings account. That is the one area where people in their twenties and thirties now are given incentives, and their employers, and they start paying into health savings accounts now.

Most of them, the statisticians tell us, by the time they're ready to retire, they will have so much money in their health savings account they could continue to pay out of that to buy a catastrophic care policy. But they won't need the government between them and their doctor. They won't need an insurance company telling them, well, that medicine is not covered, that treatment's not covered. They've got their own money. And in the meantime, we could even have health savings accounts. It would be cheaper than what we're doing just to let seniors have health savings accounts and buy them catastrophic care, provide the health savings accounts and the insurance, and then, for the first time in the

history since we've had Medicare, seniors would have nobody in the government standing between them and their doctor, them and their treatment.

That's the kind of thing I know, talking to friends on this side of the aisle, we want. We don't want an intermediary between patients and their doctors, not the government, not the insurance companies. And we've got plans, we've got bills, we've got suggestions, and everybody on our side of the aisle has been shut out. And this bill today, a ''Doc Fix,'' was a ''Doc Tricks.'' And I'm hoping and praying my doctor friends understand that this was not going to address their needs. It looked like a fix. This wasn't going to pass the Senate. This was an effort to drive a wedge between physicians and the people that believe politically in the Constitution the way they do.

Mr. GINGREY of Georgia. Mr. Speaker, reclaiming my time, the gentleman from Texas is dead on. He's absolutely right. This 3961, the so-called ''Doc Fix,'' and Representative GOHMERT and I agree, it's a ''Doc Trick.'' It mitigates the 21 percent cut that's coming due January 1st. And it gives a positive update, I think, of 1 percent for 1 year. But then after that, Mr. Speaker, here comes the trick that Judge GOHMERT was talking about. There's going to be a formula, a new formula, not the SGR, but this new formula, based on GDP. So if you're a primary doc and you're doing examinations, histories and physicals in your office, so-called ''evaluation and management,'' you get GDP plus 2 percent.

But if you're a specialist, like I was, an OB–GYN or, say, a urologist or general surgeon, it's going to be GDP plus 1 percent. Well, if the GDP is a negative number, then here again the doctors have no confidence that they're going to get paid a decent reimbursement for their services. So indeed, it is a trick. It is not a fix.

Mr. Speaker, I want to take an opportunity—we've been joined by our good friend from Missouri, who has been with us on a number of occasions on health care and other issues, and I want to yield to him some time. And I'll yield to the gentleman, Representative TODD AKIN from Missouri.

Mr. AKIN. Well, it's just a treat I have a chance to join on the floor a couple of my very good friends. We've got a guy who's a medical doctor and a Congressman. We have a friend of mine whose a lawyer, an attorney, of course, and also a judge, and here I am the engineer. I guess it's almost setting up the beginning of a joke or something. You're talking about the cost of this bill that was unfunded today. We're talking about, and the numbers have been different. I've heard different people quote things. The lowest number was $210 billion. The higher number was $279 billion, as I recall, somewhere in that neighborhood of a quarter of $1 trillion.

Now, just the amount of money that I have to pay bills, that amount of money is a little beyond my imagination, so I'd like to try and think of how much really are we talking about here. And I think maybe it helps to put it into perspective. Democrats and some Republicans were critical of George Bush for spending too much money. His worst year, in terms of creating a deficit, or creating a debt within a year, was 2008. That's when the Democrats ran the House here, and that was his biggest spending year, and he ran up a deficit of 250 something, no, excuse me, 450-some billion dollars, which was too much money, and various people thought we shouldn't have spent so much money—450.

Now, if you take a look at 2008, then you move to 2009 and you have President Obama spending, with a Democrat Congress, and that's $1.4 trillion. So we're talking about three times more money was spent beyond our budget in 2009 than in 2008. So putting those numbers, you've got 450 for Bush, 2008; $1.4 trillion, 2009. And now, on top of that, you're talking about here 250, perhaps, billion dollars in addition, which is not small change when you're already way beyond with the budget.

And I recall my good friend from Texas, he has a down-home way of putting things that Missourians like me can understand. He says, this time I really, really, really am going to do it. It reminds me of trying to get through high school. You guys were really smart in school. But, you know, I always had trouble trying to study. And there would always be a test coming up. I'd say, God help me in this test because next time I really, really, really will study for this test.

Mr. GINGREY of Georgia. If the gentleman would yield. Is that similar to a triple-dog dare?

Mr. AKIN. That may be almost a triple-dog dare. I've also heard it, now that I'm starting to get older and have to push my hands away from the cookie platter, you know, that I'm going to start my diet to lose a little bit of weight, but it's going to start tomorrow, you know.

□ 1830

Maybe just the day after tomorrow, but that is when I am going to start up. I really am going to do it, it's just not going to happen right now.

Mr. GINGREY of Georgia. I thank my colleagues. And they're well on target, of course. We're just, Mr. Speaker, trying to make sure that all of our colleagues, all of our colleagues and their constituents understand that we on this side of the aisle, the Republican Party, we feel that we have the best health care system in the world. We think doing routine screening mammograms starting at age 40 and emphasizing and recommending breast self-examination, screening young African American children for sickle cell anemia, doing routine screening of hearing and vision in preschool for all of our children, we think all of these things are good.

We have a great health care system, and it's not perfect. We know that there are things that can and should be done. But in an incremental way, Mr. Speaker. Not spending $1.5 trillion, not spending $900 billion. I guess the Senate got a score of $785 billion, and they're just elated.

Mr. Speaker, when you spend $250 billion—when you spend $100,000, for that matter, on something that is bad for the American people, you have done them a grave disservice—and especially all of the spending at a time when our unemployment rate is 10.2 percent. Some of us have members of our own family who have children who have lost their jobs—16 million across this country.

And we have this situation in Afghanistan where a four-star general, Mr. Speaker, a commander who was put there by President Obama, says to his Commander in Chief, ''Mr. President, I need help. We can win. I need help.''

Well, how can that not be a higher priority than totally reforming our health care system, throwing the baby out with the bath water, spending a trillion dollars, or $2 trillion, or $2½ trillion? How can that be more important than putting people back to work?

The President, Mr. Speaker, was just over there on a 9-day trip. I wish he had been right here inside the Beltway in the Oval Office working on this issue and this economy. But I hope while he was over there that he got some advantage out of it, Mr. Speaker, and maybe asked Hu Jintao, the Chinese President, to write him a check for $210 billion so he can bring it back and pay for this Trojan horse that we just passed here on the floor of the House today in the name of H.R. 3961.

I want to yield to my good friend from Texas, Judge GOHMERT.

Mr. GOHMERT. Thank you.

I just had a quick question back to my physician friend, Dr. GINGREY from Georgia.

If my friend were in his doctor's office in Georgia and somebody from Washington came and said, ''Look. I want to get this message out to all of your doctor friends. Here's what we're going to do. We're going to cut $500 billion in reimbursements to you and your friends, but you need to be ecstatic because we've got a bill that's not going to pass, it won't ever get through the Senate, but it will get you back $250 billion of that $500 billion we're going to cut. Aren't you happy?''

Would you really trust that person from Washington that came with that kind of news?

Mr. GINGREY of Georgia. I have heard it said, ''I'm here from the government. Trust me. I'm here to help you.''

Mr. GOHMERT. That is the kind of trust that is being asked.

Mr. GINGREY of Georgia. I think Mr. Reagan said it right. ''Trust but verify.'' The verification is yet to come.

Mr. GOHMERT. And when you do verify, you see this is not a fix for the doctors, and it's going to have to be addressed next year. It's called a 10-year fix, but it's not really a fix that is going to fix anything for very long. It's just a game being played here in Washington, and we want something better.

When I think about our seniors, the relatives of mine that are seniors, and think about somebody cutting the care to their doctors; and then I hear from doctors who say, ''Look, I'm younger than I anticipated retiring, but with the games you guys are playing, I'm about ready to hang it up.'' I know if they do, because of the areas of service they provide to our seniors, to those who need care, there's not going to be anybody there to fill those needs, and they're going to be in lines if we keep doing this stuff to our doctors.

We can't be playing games like this with our doctors. It's unfair to the seniors. It's unfair to those who need health care. It's time to do a real fix of the health care system—not the games played with this ridiculous 2,000-page bill—but a real bill that will get people in the government and from insurance out from between patients and their doctors; give patients coverage, give them control, and let health care finally be healed of this government disease that has afflicted it for too long.

Mr. GINGREY of Georgia. I thank the gentleman from east Texas so much for being with me tonight.

Mr. Speaker, as I bring this to a conclusion, let me just say that we hear the term all the time in the military about collateral damage, and we worry about it. Every time we fire a rocket or use a predator drone to get the really bad guys, we worry about collateral damage.

Well, we should be just as worried about collateral damage in the social programs that we are enacting up here as the representatives of the people, especially when it's dealing with health care, because in both instances, both in the military and socially, the collateral damage can result in lost lives. We're talking serious business here. We will continue to fight for the right thing.

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

THE HISTORY OF THANKSGIVING

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Missouri (Mr. AKIN) is recognized for 60 minutes.

Mr. AKIN. Good evening.

I have a chance to get out here on the floor at various times, and some of our subjects that we cover are pretty serious in the sense that we are talking about overspending and some of the various government policies.

However, at this time I would really like to turn to a somewhat different topic, as we have already adjourned and are thinking about heading on our way home to celebrate Thanksgiving. As many, many people know, when you think of Thanksgiving in America, a uniquely American national holiday, your mind goes immediately to the story of the Pilgrims.

In fact, they were maybe not the first to declare a day of Thanksgiving. Supposedly, according to history, in 1619 there was a celebration of some Thanksgiving in Virginia. But the main one that we think of is the story of the Pilgrims, and the Pilgrims' story is probably the greatest adventure story that history has ever dealt to mankind. It's bigger than life. It's bigger than the biggest screen kind of thing you could imagine on television.

It's big because the fact that the Pilgrims had such a bold vision for where they were going and what they were trying to accomplish. It's big because of the tremendous amount of daring and their enterprise and the tremendously high price that they paid; the suffering, and the perseverance in terms of character. It is a huge story because of the incredible intricacies of the providence of God that wove all of these amazing different kind of situations together in such a fascinating pattern.

It is the story of American Thanksgiving, but it is a story of much more besides, because the Pilgrims gave us much more than just Thanksgiving—they gave us our entire American system of government and some views on economics and a couple of other very, very important starting points for America.

The Pilgrims had a tremendous influence on the way that America as a nation was going to start partly because of their early arrival date, but also partly because of the vision and the source of where they got their knowledge from.

Today, we are going to look at this incredible, bigger-than-life adventure story about the Pilgrims. I believe it is probably being recorded and may be available in segments on our Web site at some time in the future.

First of all to understand the Pilgrims, we have to know who they were. The Pilgrims were comprised of several different groups. The most noteworthy were a group of people that were frequently called either Brownists or Separatists. They were in England in the 1610-, 1620-ish type of time frame, and they were, if you will, in a sense a sect of the Puritans. They were what we would today call evangelical Christians, except for they had this weird idea. Not weird to us today, but weird in those days.

And that was, as you recall, in England after Henry the VIII, the church in England had been taken over by the King. So the King ran everything. He ran the church, he ran the state, and everybody's lives, and everything else. So that was the way he did it in jolly Old England.

But there was a group of these Christians who had been reading some of the writings that were written about 1580 or so in Scotland talking about a pattern that they saw in the Old Testament; and that pattern was that there appeared to be several types of governments. They noticed Moses seemed to be a little bit like the governor or the President or whatever, but Aaron ran the worship service. They saw this separation of civil government from church government. As they studied it, they found other patterns.

They found the first King of Israel, Saul, and Saul had an army, and the army was very frightened. Samuel was supposed to give a sacrifice, and he was hoping the sacrifice would buck up people's courage. But Samuel wasn't around when he was hoping he'd be there so Saul took the initiative, offered the sacrifice, Samuel read him the riot act and said, ''Now you really got God mad at you.'' And again you see a mixing of civil and church governments which apparently in the Old Testament seemed to be separated.

Anyway, this theologian was making notes, and this little group of people called Separatists took the idea that they were going to separate civil government from church government. Now, they never had the idea of taking God out of anything. That's more of an invention of the Supreme Court in the mid-1900s.

But this little group of people here, this picture that I have—which has been touched up a bit; computers do wonderful things—is actually in the public domain, and it is on the wall of the Rotunda of the Capitol not more than a few hundred feet from where we're standing right now. It's a bit darker. This has been lightened up some. You have a picture here of these Separatists, and these Separatists are at prayer, and this is being depicted. It has got a beautiful rainbow. It says ''God with us.'' This has been touched up so you can read it a little bit better. You have got the building of Delfthshaven over here. You have the Pilgrims at prayer before they're going to be starting on this fantastic adventure.

But we need to back up just a little bit to say, where did these guys come from?

They were these Separatists in England. They met in Scrooby, England, and there were different leaders. One was John Robinson, who was their pastor; another one was Bradford, who was actually an orphan. He had been growing up as a child with some relatives

and then attached himself to these Separatists—or as some people thought of it, in a way, as a cult.

And what these people decided to do was to create their own New Testament church. So they met at a manor house in Scrooby, England, and together they covenanted to start this little church.

□ 1845

It was not under the king, particularly King James. They didn't like King James. King James was a little bit weird. He had some very weird habits. They didn't want him running their church, and they decided they were going to be Separatists, get their own pastor and have their own worship service.

Well, King James didn't like that. He said, I'm going to harry them out of my country. And so, they were harassed at every side, all kinds of different taxes, their women put in stocks, humiliated, put in jail, and property confiscated. In fact, the life of these Separatists was made so miserable, even though they tried to meet secretly and arrive at worship services at different times so people wouldn't get wise to them, eventually they were harried out of England as the king said he would do, and they moved over to Holland in the Leiden area.

Now, they worked there for a number of years. It was very, very hard living. Of course, they had a different language, it was not easy to make that cultural jump, but they did have religious freedom in Holland. And after, though, about a 10-year-or-so period, what they started to notice was there were a number of things that they didn't like.

First of all, their bodies were being worn out. They had to work so many hours 6 or 7 days a week that they were prematurely aging. But worst of all, their children were picking up bad habits from the Dutch children, and they had made such a big effort to try to walk closely with God that they didn't like the idea of their children being sort of absorbed into the Dutch culture. So they started casting about for what they might do, and they had a vision for trying to do something that was significant and different in their day. And so it was that they struck on the idea of moving from Holland over to America.

At that time in England, there were these various loan sharks and merchant adventurers and different companies that were being set up that thought they could make a whole lot of money if they could just get some trading posts set up over in North America. So they were going to the king and getting what we would think of today as a corporate charter to start a company, which was really planting a plantation or a little colony, which would be a trading post or a base to do trade for different things that might be of value in North America. There were also some that were going down further into South America from other countries as well.

So anyway, this little group of Separatists under John Robinson with Bradford, who was the young, now strapping farmer who was growing up, are here pictured on a ship that is called the Speedwell. Many people have not heard of the Speedwell, but Speedwell was rented by them to take across the ocean to North America. In fact, their charter that they were getting was for a colony in Virginia. And so here they are, and what has happened is they have gone from Leiden earlier this day in three barges and run down some canals from Leiden to Delft Haven. This picture is in Delft Haven and depicts one of their prayer meetings before they were going to leave, just as they were departing.

Now, we have from history a record of some of John Robinson's, their pastor's, words at this time of departure. Robinson was very much loved by the Separatists because he was, first of all, a very kind and gentle guy. He wasn't judgmental, and he tended to bring groups of Christians together that had their different doctrinal disputes. They used to settle things with fisticuffs and worse in these days if you didn't agree with something theologically. Robinson was a much more tolerant kind of guy but a man who knew what he believed, and he believed that God meant civil and church governments to be separated. And so he preached, and you can imagine, because he had many, many people who could not go on this expedition, so he stayed behind with his congregation. But his heart was in this great, great adventure that was soon to take place. So he set, in a sense, the tone by his last words. This was the last time that Robinson would ever see his beloved Pilgrim people again. And so, in a sense, he is preaching to them here.

I think we need to take a close examination of these words because it sets up the entire great story of the Pilgrims. He says, I'm fully persuaded that the Lord has more truth yet to break forth out of His holy word. Remember, that it is an article of your church covenant that you shall be ready to receive whatever truths shall be made known to you from the written word of God.

Now, what he is saying here is the concept that while lots of people can read the Bible, what he is saying is the Bible, in a sense, is a blueprint for civilization, a blueprint to do something new that the world has never seen before. So he says now you need to keep your hearts and minds open to what is in God's word. Remember every other article of your sacred covenant, but I must here withal exhort you to take heed what you receive as truth. Examine it, consider it, and compare it with other scriptures of truth before you receive it, because it is not possible that the Christian word should come so lately out of such thick anti-Christian darkness and that perfection of knowledge should break forth at once. Now, here, what you have is a vision for what Robinson was giving to the Pilgrims coming to this land.

It's commonly told, people, that the Pilgrims came here for religious freedom. Of course, that's not true. In fact, much of what you hear, the stereotypes of history, in fact, are not true. They had religious freedom in Holland, so they didn't come to America for religious freedom. They had that in Holland. Instead, this shows a much greater vision, a vision that they were trying to build a civilization different from what they had seen in England and in Holland, a new entire concept using the Bible as the blueprint to do things in a different way.

Now that is not exactly a small thing to want to do because we tend, as we grow up, to do things the way our parents taught us to do them. We tend to do things the way the people around us do them. We copy the habits and the way that our culture works. And so these people are saying, wait a minute, before we just assume the way we used to do it was right, we are going to keep checking it with the Bible and see is this really a biblical way to do things? And so, this was the vision of Robinson and it was depicted here by the artist as the Pilgrims here are leaving Delft Haven and on their way over to England. They are going to be shuttled to England over to Plymouth, and there they are going to rendezvous with a larger ship, the Mayflower, and the Mayflower also has some Separatists and other just jolly old blokes that came off the streets of England.

Now, what is going to happen in this expedition is new to America in this regard. It is true that Jamestown, there had been numerous attempts to try to establish a colony there, but it was always groups of men mostly interested in finding their fortune and finding gold. This was a very different kind of expedition, because this, as you can see, is men, women, and children, and they are coming particularly for this great purpose of this great adventure.

The first thing that happened was a little bit like a family vacation. The idea was to start across the North Atlantic in the summertime. And as you think about family vacations, sometimes they start with somebody forgetting their wallet, forgetting to lock the door of the house, forgetting to bring a suitcase, and so they had a couple of fitful starts. The fitful starts particularly were because this ship, the Speedwell, when it put to sea, started leaking.

Now, leaking is not a good thing in the North Atlantic, and so they had to

go back and they had the ship recaulked. The Speedwell started out again and, under heavy sail, she started leaking again. So they brought her back, finally made the decision to leave the Speedwell, to sell it, and to put as many of these different people we call Pilgrims into the Mayflower; it turns out, 102 of them. So they were all packed as tight as could be into the Mayflower. Speedwell was left behind, and that, of course, delayed their getting off, and so they got off later in the year at a more dangerous time in the North Atlantic.

As they were on that trip, to begin with, as you can imagine, the first thing that happened was they started to get seasick. And if anybody has been seasick badly and been on a little, small ship being tossed about by the waves, it can be pretty miserable. There was a boatswain's mate that made fun of them. He called them ''puke stockings'' or ''puke socks,'' and he said they were kind of green colored. And he said, We are going to be feeding you to the fish pretty soon. We are going to sew you up in a sail and put a brick at your feet and push you overboard, and you are going to be dying.

Well, what happened is the storms got worse and worse, and even the sailors got concerned. It turns out the one guy, the boatswain's mate that was teasing them and making fun of them, he just sort of amazingly within 1 day got very sick and died, and he was the first one that went overboard.

In the meantime, the storms got more and more severe, and the Mayflower, and you can imagine 102 of these Pilgrims basically underneath the decks, not safe to go on deck, underneath the decks, seasick, lots of kids down there, men and women packed into these tight quarters and being just tossed about continuously by the storms, and they were a noteworthy group. These people did very little complaining, and it would have been an absolutely miserable time.

How long were they down underneath that deck with the storms banging them around? Well, on the main part of their expedition coming across from Plymouth, England, over to the North America continent, that was a 66-day trip; in other words, 2 months of being under.

Now there was one young man that made the decision that he wasn't going to stay down there. It smelled so bad, it was so crowded and so noisy and intolerable, he decided he was going to go up on deck. He went up on deck, and all of a sudden, the deck dropped out from underneath him, and he found himself in the middle of the North Atlantic in November. That water will wake you up in November. And it is estimated that he wouldn't have lasted more than a few minutes at that temperature. But at that time, the Mayflower was knocked over by such a severe blow that some of the rigging dragged in the water, and as he was drowning, he put his hand out, grasped the piece of rope—he is turning blue he is so cold—holds on to it and is hauled back on deck. He went down like a halfway drowned rat down below and did not return back again on deck until there was a safe time to come up after they had sighted land.

This was a very, very difficult passage for the Pilgrims, yet they showed an incredible endurance and willingness to suffer hardship. So we have this little group of people propelled by prayer, propelled by a vision, not coming to America for religious freedom, but for a much bigger vision, the idea of a new nation founded on a different set of principles, unlike anything found in England and Europe before.

Well, let's see, how well did they do? Well, first of all, one of the things that happened was, as a result of all of those storms, they were driven off course in their ship. And as they were driven off course, they landed or they first sighted land out on Cape Cod. We summer vacation out in Cape Cod. I go sailing there and know something about the nature of the way Cape Cod sticks out into the ocean. It's thought it was pushed there by great glaciers. They saw the shore of Cape Cod. They knew enough about the shoreline of North America to know it was Cape Cod. They knew where they were. They knew where Virginia was. They were too far north, and they immediately tried to head south down toward Virginia because the contract that had been signed, or the charter as it was called, was for Virginia. But the hard winds and the weather did not allow them, even though they tried several times to go south along the outside of Cape Cod.

If you think of Cape Cod as a great sandy hook, they were out on the tip. They were trying to get south. But these old square-rigged ships like the Mayflower were not very good at pointing into the wind, and it was very dangerous to be caught with the wind blowing you on the lee shore, and so they had to be careful. After a number of tries, they decided instead to bring the Mayflower to anchor around the tip of Cape Cod where there's a natural kind of swirl of sand which we call Provincetown. There was a nice harbor there. So they pulled the Mayflower into the harbor, dropped anchor, and kind of caught their breath, if you will, from this trip.

They weren't beaten by the waves, of course, there, and the first thing that came to their mind was some of the people realized, hey, this is like Australia. No rules, mate, down under, and so when we go to shore, there is no contract. The contract was for Virginia. There are no rules, and therefore we can do whatever we want.

Well, the Separatists saw that that was very much close to anarchy, and they knew that they had to do something to establish some type of order. And so they struck on the idea of pulling a piece of paper out and writing what we call the Mayflower Compact. The Mayflower Compact was actually the first U.S. Constitution and the first constitution in the world of this type. And it was, as we will talk about in just a minute here, you will realize that this was an absolutely incredible foundational stone for the building of a new nation.

But let's take a look at what the Mayflower Compact actually said. I just have some excerpts from it. It's about 2½ times longer. This is pretty short, just one page. It starts out: In ye name of God, Amen. We whose names are underwritten, having undertaken for ye glory of God and advancement of ye Christian faith and mutually in ye presence of God and one another, covenant and combine ourselves together into a civil body politick for our better ordering and preservation to enact, constitute, and frame such just and equal laws as shall be thought most meet and convenient for ye general good of ye colony under which we promise all due submission and obedience.

Notice the basic ideas here in this document. The first thing is that this is a contract under God by a group of free people to create a civil government to frame just and equal laws and essentially to be their servant. Let's say that again. This is a government under God of a group of free people creating a civil government to be their servant and to frame just and equal laws to protect their rights and liberties.

□ 1900

That basic idea of this Mayflower Compact is the same idea as in our Declaration of Independence: We hold these truths to be self-evident that all men are endowed by their creator with certain inalienable rights. Among these is life, liberty, and the pursuit of happiness, and governments are constituted among men deriving their just powers from the consent of the governed.

Sound a little familiar? 170 years later, this is the first Constitution in America, a group of free men and women, under God, creating a civil government to be their servant.

Now you say, Well, that does seem like a nice thing, but what's so unique or special about that? Well, you recall these people had a vision of planning a civilization different than the way they did things in Europe. If you take a look at the way they did these in Europe, this becomes much sharper in how distinctive it is, because in Europe the basic idea was the divine right of kings. For people who were politicians,

this was a good deal. The king says, God made me the king. When I say jump, you're supposed to say: How high? And that was the way it was done all through Europe, and yet these people rejected the concept of the divine right of kings and said, No, the government is to be the servant of the people, protecting their God-given rights. They turned everything upside down.

Now this particular tremendous development in civil government not only is at the beginning of our Declaration and U.S. Constitution; it is also something that, to them, was fairly logical, because they had done the exact same thing when they started their little New Testament Church in Scrooby, England. A group of free people, under God, covenanted together to create a church government. They merely took their church government concept and moved it over into the area of civil government, and in this regard displaced the whole concept of divine right of kings and, in a sense, in 1620, in November, when this was signed by the Pilgrims on the *Mayflower*, they were putting the powder keg under the throne of King George that, 170 years later, would reject the divine right of kings in the American War of Independence.

So we have already, before they've hardly had a chance to get dried off from their trip, they have already established a completely new idea for the foundation of the land, but this great adventure story just has barely begun.

Here we have an old lithograph, a picture that was done of the Pilgrims in the great room of the *Mayflower*, signing this Mayflower Compact. We do not have a copy of the original Mayflower Compact. It's been lost. It was probably lost back about 180 years later during the War of Independence. But Governor Bradford—he was not yet Governor, he was just Bradford, who was part of this great expedition—in his chronicles wrote a lot in the history of Plymouth Plantation, a lot about the story of these Pilgrims, and he has a copy so we have these words that come down to us from Bradford. Here is a picture, again, of them sitting with this Mayflower Compact.

Now they had a plan, and part of that plan included a prefabricated, small-size boat that would hold maybe about 30 people—30 at the most. It was called a shallop, a shallow-drafted vessel, and it had been taken apart and left in pieces in the hold. It was to be refabricated when they got to this country.

Well, the storms had beaten on the *Mayflower* so much that a lot of these pieces were damaged, and they had to do some work so it took them some time to assemble this shallop and get it so it was seaworthy. When they had done that, they left the *Mayflower* in Provincetown Harbor; and a group of them went in the shallop around the inside of Cape Cod. Again, Cape Cod is like a hook. The *Mayflower* is anchored out here in Provincetown. And they head around the inside of Cape Cod.

Again, now we're starting to get into December, when the weather is really cold, late November and December, and the spray off the waves that are hitting the shallop is freezing to their clothes and they're really cold. For a while there, they got on around the inside of the cape. They made their first landing at Eastham, which is over about here on Cape Cod, and spent the night. They pulled some different trees and things together to make a little bit of a shelter for themselves, and all night long they heard the howling and yelling of the Indians. Those were the Nauset Indians. They had an attitude problem—and for good reason. There had been some dishonest sea captains that had shanghaied warriors and sold them into slavery.

So the Nausets had a bad attitude about white men and ships. So early, just before sunrise, they attacked and sent arrows all through the different coats that were hanging up, and yelling and screaming. In the meantime, these Pilgrims had managed to get a couple of their gunpowder firing—they were basically blunderbuss kinds of weapons—and fired those, and nobody got hit. The Indians were bad shots with the arrows because, fortunately, no one was hit of the Pilgrims.

Eventually, after sort of a confrontation, the Nausets were scared off. And the Pilgrims, at that point, being well woken up, got back in their shallop and headed back around the inside of Cape Cod. But as they were coming around, the weather turned to the worse. It started to snow heavily, and they were trying to find the entrance to what we would call Barnstable Harbor. That, of course, is not the way it's said up on Cape Cod. It's Barnstable Harbor. They were looking for Barnstable.

They were out in the surf, with the snow going hard, very cold, water freezing all over them, trying to find the entrance to the harbor. Their pilot thought they saw it. They pulled in toward the shore, only to see that it was just waves breaking on the shallow sands of Cape Cod. That, of course, would have been big problems for the shallop.

There was a seaman among them by the name of Clark, and he grabbed a couple of steering oars and swung the shallop between a couple of waves around, pointing the bow out to the ocean, and he said, If ye be men, pull for your lives. So everybody dug in with the oars. They pulled off of the shore, got out where it was deep, where the waves weren't breaking so badly, and there they were at night, with the snow coming down, wind howling, ice freezing all over them, in Cape Cod Bay.

Well, as it turned out, before too long they found that they had managed to get around into the shelter in the lee of some land, which turned out to be an island. They called it Clarks Island. The next morning, they woke up. They were cold and wet and everything, and observed Sunday on Clarks Island, and then immediately started doing some exploration and they found one wonderful thing after the next. They found that they were in a natural harbor that was deep enough for the *Mayflower* to be able to come around from Provincetown, come around over here to Plymouth. And so it had deep water in the harbor.

There was land, fantastic land that had been cleared, that didn't have a lot of trees on it, which of course is a big problem if you're trying to farm, to get all the trees off the land. This land had been cleared and there was beautiful fresh water coming down from several streams from springs on the hill, with a hill behind, which was defendable. You could put a fort on it and try to protect yourself some.

So you had a place for the *Mayflower* to anchor, a fort on the hill, beautiful fresh water, cleared land, and no sign of anybody there except for a bunch of human bones and skeletons that remained and some tattered pieces of fabric and all and some poles, various things like that. A very curious kind of situation, but they didn't see anyone, and there were no Indians to give them a hard time. And so they came as it was, in December, to Plymouth Harbor.

Now when they got to Plymouth, they started in about Christmastime and started to build some houses and things which, of course, was slow work. And they had to wade through the water to get off and on, back and forth from the *Mayflower*. They started to get sick, partly because they didn't have very good food. Probably some of it was scurvy and maybe their bodies were just weakened by the tremendous difficulties of the crossing from the ocean. It was not uncommon when people first came across the ocean for a number of people to die—not so much dying on the trip, but when they got over, partly because of food, nutrition, and various types of sicknesses.

So as December rolled along, they had, of their 102, we had six people die. And then in January, another eight people died. Of course, it's cold and they're trying to build the buildings. At one time, they had one of the buildings built, they had people with blankets that were going to sleep in the building, and all of a sudden somebody yells, Fire, and the whole grass roof of the building was on fire. Inside the building they had open barrels of gunpowder and the sparks are starting to come down from the ceiling that's on fire. And they grabbed the gunpowder, ran out into the night, and didn't escape with too much of their blankets or clothing; but, fortunately, no one was blown up or killed. So it was a very difficult time.

By the time in January, there were eight that died. February, 17 people died, sometimes as much as three or four people in a day. And in March another 13 died. So now you're starting with about 102 Pilgrims and you've gotten, in total, about 47 had died. When you take a look at that, you must be thinking a little bit in your own mind, Look, John Robinson, our pastor, had a beautiful vision for what we're going to accomplish here, and we thought God wanted us to come to this new land, but now look, almost half of us have died. This is kind of discouraging. We didn't complain when we were cast about inside the great room of the *Mayflower* as we were tossed in the oceans. Yet, now half of us have died.

If you take a look down the list, you find that of the daughters—and there were seven daughters—none of them died. Of the little boys, there were 13 little boys. Three of them died. Well, the reason the children didn't die so much is the mothers had been sacrificing. Of the 18 mothers, 13 of them died. And in the middle of the night, so that the Indians wouldn't think that the Pilgrims were weak, in the middle of the night sometimes they would take their dead and drag them out across the frozen ground and try to scrape out with their hands a shallow grave of rocks and leaves and things to cover up their dead and the dead bodies. And so it was a very, very grim time.

When you think about the story of the Pilgrims, it's a great story in terms of adventure, in terms of vision, but also in terms of the terrible suffering that these people underwent here, not only in coming across the ocean, but having almost half of them die in these first 4 months. It just seemed like death had them in its grip until about mid-March, when they made their first sort of face-to-face, if you will, encounter with an Indian.

It was, again, just like everything to the Pilgrims, it's bigger than life. You picture here it is, mid-March, and somebody yells from the wall, Indian coming. Well, you must have got that wrong. You mean Indians? No, Indian coming. You look out and here, coming right up to the blockhouse is this tall, stately dignified Indian, nothing on but his loin cloth. He walks right into the blockhouse and right up to the leader and says, Welcome. And they're thinking, How did this guy learn to speak English?

They're kind of taken aback. Welcome, they said. His next words were, Do you have any beer? That was kind of surprising to them, too, as well. They said, Where did this guy find about how to speak English and whether they had beer or not?

Well, it turned out they were out of beer, but they did have some brandy. So he sat down and helped himself to the brandy and to the roast duck and had a very nice large meal. They kept asking him questions about the local Indians and he didn't say a word until he'd had a nice, big square meal. Then, later on they find out who the Indian was. His name was Samoset. Samoset was a sachem, or a chief, of the Algonquins up in Maine. It seems that he had the concept of going from Maine down south in the wintertime, and he had bummed a ride from an English sea captain down the coast. He had learned to speak English and had stopped to spend the winter with Massasoit down in Massachusetts. So he would have gone from Maine to Massachusetts. And when he heard about the Pilgrims, he decided to go pay them a visit.

So their first contact was actually an Indian from Maine, Samoset, a great man; and he told them that the Indian chieftain in the area was named Massasoit. He was a great chieftain and he ruled over quite a number of the Indians, but the main tribe was 50 miles to the southeast, some considerable distance away.

They asked him about whose land they were on, and he said, Well, this land used to belong to the Patuxets, a very warlike tribe that had been completely destroyed in a plague. And that was several years before. So the land that they found didn't belong to anybody and the other Indians thought it was cursed so they would have nothing to do with that particular place.

So they found, by God's providence, perhaps the one or only area on the eastern seaboard where they had cleared land, beautiful water, a good place for defense, and nobody claimed the land.

□ 1915

So that's what they had found, almost by God's providence, of course. Well, before too long, it was about a week later, other Indians arrived—not just Samoset, but Massasoit came with the other warriors. Massasoit was of the Wampanoag Tribe. But there was somebody who had attached himself, aside from Samoset, to Massasoit, and that was an Indian by the name of Tisquantum.

Tisquantum had an incredibly interesting story. Tisquantum was the last remaining Indian of the Patuxets. He had taken a trip with the English some years before over to England, spent 10 years, learned to speak English flawlessly, developed a taste for English food and English customs and all, and then got a ride back across the ocean to come back to the Patuxets.

Later, however, he was shanghaied, sold into slavery over in the Spain area, was bought free by some monks there, traveled back to England and made a trip again back to his Patuxet Village in Plymouth. But when he arrived, he discovered that his village was gone. There was no one there. The places that he had learned to swim and play, the trees he had climbed in, the forests he had walked in were there, but his tribe was all gone, everyone dead.

And heartbroken, he went and hiked for miles over to Massasoit and attached himself for a while to the Wampanoags. But later in his sorrow, he just kind of moved off and lived by himself. When he got word that there was a little band of English settlers that were hard-pressed, he figured out a new reason for living, and he decided to come and visit with the Pilgrims.

Tisquantum became a great friend to the Indians, teaching them all kinds of practical things. One of the things I am certain the young ladies would like to know about was, they didn't have much food, and he taught them how to take their moccasins off and to walk in the mud of the creeks and to find eels with their toes and to trap the eels and bring them up, fry them up and eat them. The eels were apparently good eating.

He also taught the English settlers about beaver pelts, which were very sought after. They became a mainstay of trade. The trade worked between corn that was traded to the Indians for beaver pelts, and beaver pelts were sent back to England and Europe and used for making hats. You just weren't cool if you didn't have a beaver pelt hat when you were back in England. So they got a very good price for the beavers, and there were a lot of beavers still in the New England area at that time.

By April 21, you have perhaps one of the great tests of the indomitable will of the Pilgrim people. Captain Jones of the *Mayflower* has lost almost half his crew to the same sicknesses and diseases, and he had agreed to stay just to try to give them a little bit of a headstart on their new home. But he went to the remaining 52 Pilgrims, and he said, You know, things aren't going so well. I recommend that you come back to England on the *Mayflower* with me. So it was that they had to make a decision. Were they going to stay on with the vision that Robinson had given them to plan new things, that they had felt God was calling them to this great adventure? Or were they going to give up after half of them died, almost, and go back to England?

So it was that Jones and the sailors with him departed in the long boat for the *Mayflower*. They heard the sound of the old anchor cable being wound in and the boatswain giving the commands, the yardarms swinging into place, the bowsprit pointing out to sea, the sails filling and being trimmed. The *Mayflower*, first large and then small, disappears over the horizon as a speck. Nothing but the gray sky and the wind blowing through the pine trees behind them. And there are 52 brave Pilgrims with still this dream that God's put in their heart to build

something unlike anything they'd ever seen before, something based on ideas that they took from the Bible.

Well, as this summer started and the spring went on, things got a little more cheery. In May, because of the deaths in some of the families, they had their first wedding between Mr. Winslow and Mrs. White. She had lost her husband. He had lost his wife, so they had a nice occasion for a wedding. In October 1621, they decided to celebrate a day of Thanksgiving. This is a beautiful picture of this day of Thanksgiving. It didn't work quite the way they planned. The plan was to invite Massasoit and a few of his chiefs to join them in the celebration of Thanksgiving. What actually happened was Massasoit came with 90 braves, and when the poor little 52 Pilgrims—those were just women and kids, some of them, too—when they saw 90 braves, they go, Oh, my goodness, how are we going to feed this Army?

But fortunately, Massasoit had had some of his hunters hunt for deer and turkey, and they brought a lot of food with them. So they celebrated a day of Thanksgiving. In the process of doing Thanksgiving, the young braves and the young men of the colony took part in shooting contests with rifles and with bows and arrows. They did wrestling and foot races and leg wrestling, all kinds of activities. In the meantime, the Pilgrims were taught about some new delicacies. They took the ground corn and mixed it with the maple syrup—which perhaps even today people put a little maple syrup on their cornbread—and found that that made a pretty good meal.

They also took some of their precious flour and worked it with the berries and wild fruit of the area and made pies and other kinds of things as well as the turkey and venison and all that they had.

It seems that Massasoit liked a good party, and he had his 90 braves. They were having a good time. So they decided to stay for 3 extra days. So Thanksgiving was quite a celebration and treat. It wasn't too long after the first Thanksgiving that another ship arrived, and that ship dropped off quite a number of passengers. I think 30 or 40 as I recall. The problem was, they didn't have any food or supplies. So that second winter was also a very, very difficult one for them. They didn't have a lot of deaths, but people didn't have a whole lot to eat either.

After that, the colony started growing. Of course Tisquantum, or Squanto, had taught them about planting corn. That was the main thing that they needed was corn. He taught them how to plant corn, how to clear land for it, and how to put a couple of fish by each ear of corn to help it grow. They had a problem, and that was because the loan sharks or the merchant adventurers or whatever you want to call them from England, the people who financed the expedition, had insisted that the charter included that they would live socialistically. That was that there would just be one cornfield, and everybody had to work in the cornfield. Everything that was grown belonged to everybody. The women were supposed to wash the clothes of everybody else.

And this was something that Governor Bradford—by this time, he was Governor. I should have mentioned before that Governor Carver had been Governor, but he had not been there for more than a few months when he had some type of either a stroke or something wrong with his brain. He just passed out, never regained consciousness and died several days later. He was replaced and voted in by Governor Bradford, who was the one who has given us in his wonderful diary a lot of the stories of the Pilgrims.

Governor Bradford knew that socialism was un-Biblical. He knew it was a bad idea. It wasn't going to work. Eventually they were forced to throw it out because they're going to starve to death if they kept working, trying to make socialism work. So these are words from Governor Bradford's diary. After much debate of things, the Governor, with the advice of the chiefest among them, gave way that they should set corn to every man to his own particular, and in that regard, trust to themselves.

In other words, instead of having a communal cornfield, everybody had a piece of land they could grow their own corn on. This had very good success, for it made all hands very industrious. Governor Bradford then continues. He said, ''The experience that was had in this common course and condition, tried sundry years and that amongst godly and sober men, may well evince the vanity of that conceit of Plato's and other ancients''—these are the people, Plato and the other ancients, the ones advocating socialism—''that the taking away of property and bringing in community (or communism) into a commonwealth would make them happy and flourishing; as if they were wiser than God.''

Governor Bradford had studied his Bible, as he had been instructed by their Pastor Robinson, and realized that socialism was un-Biblical. It was a form of theft, and it was not a good system for this community. It was found to breed much confusion and discontent and retard much employment that would have been to their benefit and comfort. It went on to say that people who, before, they had to almost whip them to get them into going to the cornfield, now went willingly and happily forward to grow the corn. The corn, again, was traded for the beaver skins and all.

So you have the beginning of the colony. It wasn't until about 8 years later that Governor Bradford wrote that they had a chance to almost catch their breath and taste the sweetness of the land. It was scratching. Every day it wasn't clear what the meals were going to be. It was a very, very difficult time. But through this very difficult and trying time, this group of people came together on a vision to build a new civilization. So what was it now if we start to add all these things up? What was it that the Pilgrims gave us?

Well, first it was the first of the northern colonies up in Massachusetts. Second of all, they gave us the Mayflower Compact which was America's first constitution and based on the same principles that would later become the Declaration of Independence, the U.S. Constitution, and other State constitutions as well. They did separate their church and civil governments. They never thought that there was any idea of separating God from any government. If you take a look at Bradford's writing—he was the Governor. He is declaring a Christian day of Thanksgiving to give thanks to God and encouraged people in trying to run a Christian civil government.

But he also had Brewster, who ran the church, a different person, and the church had a different function than the civil government. So they separated church and civil governments, never thinking to take God out of any government. They also had a vision for a Christian civilization. And when you take a look at the things they gave us, first of all, the idea of the written constitution, a group of free people under God, covenanting together—that was quite a development. That was the equivalent of Einstein to the science of civil government.

But they also separated church and State. We take that for granted today as well, but when you think about the Muslim countries, they don't tend to separate their civil from their church governments. This was a very important technology for America, to bring a lot of peace and harmony to America by this idea of separating civil and church governments.

Then there was the rejection of socialism. Governor Bradford knew his Bible well enough to know that socialism was in violation of God's law. God's law says, ''Thou shalt not steal.'' It allows for the ownership of private property, and it never gives the government the right to take something that belongs rightfully to one person and redistribute it to someone else. Governor Bradford understood that far better than the pastors of our churches in America do today. They rejected socialism.

And of course they gave us this wonderful tradition of Thanksgiving. You perhaps may be wondering. You're saying, My goodness, Congressman AKIN. You are making a long story of getting around to Thanksgiving. Well, that was

a wonderful Thanksgiving, tremendous food, 3 days of celebration and giving thanks to God. Thanksgiving became a very popular holiday among different colonies up and down the seaboard. But the first national day of Thanksgiving was declared in 1789 by George Washington to thank God for the fact that the new U.S. Constitution had just been ratified.

So the ratification of the Constitution was the event for the first national day of Thanksgiving. And later on, under Abraham Lincoln, he declared in the middle of the Civil War—in 1863, he declared that there should be a yearly national day of Thanksgiving. There was some moving around of when the date would be, and finally was settled in November on the fourth Thursday. So we see that the Pilgrims gave us this beautiful celebration of Thanksgiving. But so, so, so much more, particularly the idea of our Constitution, the separation of civil and church governments, the rejection of socialism, and particularly the vision for civilization, so much different than where they had come from.

Quite a work of accomplishment. Were the Pilgrims proud of what they did? Actually they had a very hard time. The contracts that they were part of—for the next 25 years, they were paying way, way more than what was fair. The merchant loan sharks in London charged them a tremendous amount of money. In fact, they paid 20,000 pounds after having borrowed 1,800. So it was more than a 10 times ratio. Sometimes interest rates at 30 and 40 percent. So they were really taken advantage of.

□ 1930

As they were older and the puritan culture had come in and settled Boston, the seaboard was getting more and more ships coming across, they might have wondered did we really accomplish so much.

But yet, Governor Bradford, looking back, must have seen into the future when he wrote, "Thus out of small beginnings greater things have grown by his hand, who made all things of nothing, and gives being to all things that are, and as one small candle may light a thousand, so the light kindled here has shone to many. Yea, in a sense to our whole nation. Let the glorious name of Jehovah have all the praise."

And so it was that though they didn't feel very important, this little, small band of water-tossed saints of God, men, women and children, daring to come across this vast ocean, landing on the stern and rocky shoreline of Massachusetts in wintertime, carving out an existence, barely snatched from starvation by Tisquantum, always looking to God, were able to carve out a civilization which laid the foundations for a Nation yet to come.

And so we have the great adventure story, a great adventure story in terms of the sacrifice and the vision that is involved, and particularly the trajectory of the great ideas that they established, were to be the foundation and the pinning for our Nation.

So as we celebrate Thanksgiving, my American friends, we have a lot to be thankful for, not just for some good food and turkey, not just to remember the terrible sacrifices of those who have come before, but also to remember how it was that as they used their Bibles, they built a civilization unlike anything the world had ever seen before.

God bless you all. Enjoy a fantastic Thanksgiving.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. CARTER (at the request of Mr. BOEHNER) for today on account of attending a funeral.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. MCGOVERN) to revise and extend their remarks and include extraneous material:)

Mr. ELLSWORTH, for 5 minutes, today.
Ms. WATERS, for 5 minutes, today.
Mr. MCGOVERN, for 5 minutes, today.
Mr. COSTA, for 5 minutes, today.
Mr. LUJÁN, for 5 minutes, today.
Mr. HEINRICH, for 5 minutes, today.
Mr. TEAGUE, for 5 minutes, today.
Ms. WOOLSEY, for 5 minutes, today.
Mr. JOHNSON of Georgia, for 5 minutes, today.
Mr. DEFAZIO, for 5 minutes, today.
Ms. KAPTUR, for 5 minutes, today.
Mr. SPRATT, for 5 minutes, today

(The following Members (at the request of Mr. BROUN of Georgia) to revise and extend their remarks and include extraneous material:)

Mr. FRANKS of Arizona, for 5 minutes, today.
Ms. ROS-LEHTINEN, for 5 minutes, today.
Mr. SCALISE, for 5 minutes, today.
Mr. CONAWAY, for 5 minutes, today.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 1963. An act to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes, the Committee on Veterans' Affairs.

ADJOURNMENT

Mr. AKIN. Mr. Speaker, pursuant to the order of the House of today, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 7 o'clock and 33 minutes p.m.), pursuant to the previous order of the House of today, the House stands adjourned until 3 p.m. on Monday, November 23, 2009, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 214, in which case the House shall stand adjourned pursuant to that concurrent resolution.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized for Speaker-Authorized Official Travel during the first quarter, second quarter, and third quarter of 2009 pursuant to Public Law 95–384 are as follows:

(AMENDED) REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JAN. 1 AND MAR. 31, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Jean Schmidt	2/16	2/18	Mexico		989.50		(3)				989.50
	2/18	2/19	Nicaragua		357.73		(3)				357.73
	2/19	2/20	Jamaica		775.68		(3)				775.68
Committee total					2,122.91						2,122.91

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

[3] Military air transportation.

HON. JAMES L. OBERSTAR, Oct. 30, 2009.

(AMENDED) REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN APR. 1 AND JUNE 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Sander Levin	4/12	4/17	Colombia		1,534.00		4,292.79		7,027.00		12,853.79
	4/17	4/19	Trinidad and Tobago		1,338.58				4,132.59		5,471.17
	4/19	4/21	Panama		192.00				2,058.21		2,250.21
Hon. Kevin Brady	4/17	4/20	Trinidad and Tobago		2,089.17		1,233.01				3,322.18
Alexander Perkins	4/12	4/17	Colombia		1,534.00		3,399.89				4,933.89
	4/17	4/20	Trinidad and Tobago		2,506.07						2,506.07
Jason Kearns	4/17	4/20	Trinidad and Tobago		2,641.89		1,816.51				4,458.40
Angela Ellard	4/16	4/20	Trinidad and Tobago		2,552.00		1,831.51				4,383.51
Jennifer McCadney	4/19	4/22	Panama		288.00		2,163.70				2,451.70
Committee total					14,675.71		14,737.41		13,271.80		42,630.92

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

HON. CHARLES B. RANGEL, Chairman, Nov. 2, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON AGRICULTURE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Collin C. Peterson	9/19	9/21	Denmark		[4] 430.00		7,061.00				7,491.00
Hon. David Scott	9/19	9/21	Denmark		[4] 430.00		7,061.00				7,491.00
Hon. Steven King	9/19	9/21	Denmark		[4] 430.00		7,061.00				7,491.00
Hon. Leonard Boswell	9/19	9/21	Denmark		[4] 430.00		7,061.00				7,491.00
Maj. Committee Staff—Cheryl E. Slayton	9/19	9/21	Denmark		[4] 430.00		7,061.00				7,491.00
Maj. Committee Staff—E. Chandler Goule	9/19	9/21	Denmark		[4] 430.00		7,061.00				7,491.00
Min. Committee Staff—John J. Goldberg	9/19	9/21	Denmark		[4] 430.00		7,061.00				7,491.00
Hon. Earl Pomeroy	8/27	8/28	Mali		150.00		(3)				150.00
	8/28	8/30	Djibouti		350.00		(3)				350.00
	8/30	8/31	Kabal		76.00		(3)				76.00
	8/31	9/2	Kenya		336.00		(3)				336.00
	9/2	9/3	Morocco		371.88		(3)				371.88
Committee total					4,293.88		79,427.00				53,720.88

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transportation.
[4] Does not include hotel costs—N/A from State Dept.

HON. COLLIN C. PETERSON, Chairman, Nov. 3, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Adam Schiff	6/27	6/30	Jordan		1,021.18		(3)		(3)		1,021.18
	6/30	7/1	Algiers		531.00		(3)		(3)		531.00
	7/1	7/3	Tunisia		501.74		(3)		(3)		501.74
Misc. embassy costs							(3)		1,570.44		1,570.44
Local ground transportation							573.18		(3)		573.18
Hon. Steve Israel	6/27	6/30	Jordan		1,021.18		(3)		(3)		1,021.18
	6/30	7/1	Algiers		531.00		(3)		(3)		531.00
	7/1	7/3	Tunisia		501.74		(3)		(3)		501.74
Misc. embassy costs							(3)		1,570.44		1,570.44
Local ground transportation							573.18		(3)		573.18
Hon. John Blazey	6/27	6/30	Jordan		1,021.18		(3)		(3)		1,021.18
	6/30	7/1	Algiers		531.00		(3)		(3)		531.00
	7/1	7/3	Tunisia		501.74		(3)		(3)		501.74
Misc. embassy costs							(3)		1,570.44		1,570.44
Local ground transportation							573.18		(3)		573.18
Shalanda Young	6/27	6/30	Jordan		1,021.18		(3)		(3)		1,021.18
	6/30	7/1	Algiers		531.00		(3)		(3)		531.00
	7/1	7/3	Tunisia		501.74		(3)		(3)		501.74
Misc. embassy costs							(3)		1,570.44		1,570.44
Local ground transportation							573.18				573.18
Clelia Alvarado	6/27	6/30	Jordan		1,021.18		(3)		(3)		1,021.18
	6/30	7/1	Algiers		531.00		(3)		(3)		531.00
	7/1	7/3	Tunisia		501.74		(3)		(3)		501.74
Misc. embassy costs							(3)		1,570.44		1,570.44
Local ground transportation							573.18				573.18
Elizabeth C. Dawson	6/28	6/30	France		1,418.00						1,418.00
	6/30	7/3	Belgium		1,224.00						1,224.00
Commercial airfare							7,367.48				7,367.48
Hon. David E. Price [4]	8/1	8/3	Canada		704.29		(3)				704.29
Hon. Harold Rogers [4]	8/1	8/3	Canada		704.29		(3)				704.29
Hon. Ciro Rodriguez [4]	8/1	8/3	Canada		704.29		(3)				704.29
Hon. John Carter [4]	8/1	8/3	Canada		704.29		(3)				704.29
Stephanie Gupta [4]	8/1	8/3	Canada		704.29		(3)				704.29
Ben Nicholson [4]	8/1	8/3	Canada		704.29		(3)				704.29
Kristi Mallard	8/16	8/17	Norway		539.23						539.23
	8/17	8/20	Germany		1,080.00						1,080.00
	8/20	8/24	Hungary		1,062.17						1,062.17
	8/24	8/26	Italy		1,270.00						1,270.00
Commercial airfare							9,338.44				9,338.44

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009—Continued

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Misc. transportation							62.00				62.00
BG Wright	8/16	8/17	Norway		539.23						539.23
	8/17	8/20	Germany		1,080.00						1,080.00
	8/20	8/24	Hungary		1,062.17						1,062.17
								(3)			
	8/24	8/26	Italy		1,270.00						1,270.00
Commercial airfare							9,338.44				9,338.44
Misc. transportation							120.00				120.00
BG Wright	8/4	8/5	Kuwait		494.08		(3)				494.08
	8/5	8/7	United Arab Emirates		827.42		(3)				827.42
	8/7	8/9	Germany		722.56		(3)				722.56
Hon. Sanford Bishop	8/4	8/5	Kuwait		494.08		(3)				494.08
	8/5	8/7	United Arab Emirates		827.42		(3)				827.42
	8/7	8/9	Germany		722.56		(3)				722.56
Hon. Carolyn Kilpatrick	8/4	8/5	Kuwait		494.08		(3)				494.08
	8/5	8/7	United Arab Emirates		827.42		(3)				827.42
	8/7	8/9	Germany		722.56		(3)				722.56
							(3)				
Beverly Aimaro Pheto	8/4	8/5	Kuwait		494.08		(3)				494.08
	8/5	8/7	United Arab Emirates		827.42		(3)				827.42
Commerical airfare							4,045.02				4,045.02
Adam Harris	8/4	8/5	Kuwait		494.08		(3)				494.08
	8/5	8/7	United Arab Emirates		827.42		(3)				827.42
	8/7	8/9	Germany		722.56		(3)				722.56
John Blazey	8/1	8/4	Poland		435.00						435.00
	8/4	8/7	Germany		837.00						837.00
Commercial airfare							7,998.00				7,998.00
Misc. transportation costs							83.30				83.30
Mike Ringler	8/1	8/4	Poland		564.00						564.00
	8/4	8/7	Germany		837.00						837.00
Commercial airfare							8,027.50				8,027.50
Beverly Aimaro Pheto	8/11	8/12	Madrid, Spain		443.27						443.27
	8/12	8/13	Milan, Italy		451.80						451.80
	8/13	8/14	Florence, Italy		617.02						617.02
	8/14	8/15	Rome, Italy		600.15						600.15
Commercial airfare						8,577.80					8,577.80
Kate Hallahan	8/9	8/10	Barcelona, Spain		445.75						445.75
	8/10	8/12	Madrid, Spain		886.54						886.54
	8/12	8/13	Milan, Italy		451.80						451.80
	8/13	8/14	Florence, Italy		617.02						617.02
	8/14	8/15	Rome, Italy		600.15						600.15
Commercial airfare							8,264.80				8,264.80
Hon. Nita Lowey	8/4	8/6	Kenya		1,359.00						1,359.00
	8/6	8/9	South Africa		5,586.37						5,586.37
Misc. Embassy Costs									1,442.50		1,442.50
Commercial airfare					6,226.00						6,226.00
Misc. travel expenses							235.50				235.50
Michele Sumilas	8/3	8/6	Kenya		494.08						494.08
	8/6	8/9	South Africa		827.42						827.42
Misc. embassy costs									1,442.50		1,442.50
Commercial airfare							9,882.01				9,882.01
Misc. travel expenses							235.50				235.50
Hon. Kay Granger	8/30	9/2	Argentina		1,023.00						1,023.00
	9/2	9/5	Paraguay		780.00						780.00
Commercial airfare							8,101.20				8,101.20
John Blazey	8/30	9/2	Argentina		1,023.00						1,023.00
	9/2	9/5	Paraguay		780.00						780.00
Commercial airfare							9,763.20				9,763.20
Misc. transportation costs							132.00				132.00
Diana Simpson	8/30	9/2	Argentina		1,023.00						1,023.00
	9/2	9/5	Paraguay		780.00						780.00
Commercial airfare							5,263.20				5,263.20
Mike Ringler	8/17	8/19	El Salvador		542.00						542.00
	8/19	8/21	Guatamala		554.00						554.00
Commercial airfare							2,283.41				2,283.41
Misc. embassy costs									616.65		616.65
Anne Marie Chotvacs	8/17	8/19	El Salvador		542.00						542.00
	8/19	8/21	Guatamala		554.00						554.00
Commercial airfare							2,207.70				2,207.70
Misc. embassy costs									616.65		616.65
Anne Marie Chotvacs	8/29	8/31	Pakistan		180.00						180.00
	8/31	9/4	Ukraine		1,710.64						1,710.64
Misc. embassy costs									335.17		335.17
Commercial airfare							11,490.90				11,490.90
Craig Higgins	8/29	8/31	Pakistan		180.00						180.00
	8/31	9/4	Ukraine		1,710.64						1,710.64
	9/4	9/6	London		965.31				2,484.31		3,449.62
Commercial airfare							11,629.80				11,629.80
Misc. embassy costs									335.17		335.17
Steve Marchese	8/29	8/31	Pakistan		180.00						180.00
	8/31	9/4	Ukraine		1,710.64						1,710.64
Misc. embassy costs									335.17		335.17
Commercial airfare							11,490.90				11,490.90
Paul Juola	8/12	8/13	United Arab Emirates		463.00						463.00
	8/13	8/15	Afghanistan		162.00						162.00
	8/15	8/16	United Arab Emirates		463.00		(3)				463.00
	8/16	8/17	Italy		329.00		(3)				329.00
Commercial airfare							10,391.00				10,391.00
Misc. transportation costs							70.00				70.00
Linda Pagelsen	8/12	8/13	United Arab Emirates		463.00		(3)				463.00
	8/13	8/15	Afghanistan		162.00		(3)				162.00
	8/15	8/16	United Arab Emirates		463.00		(3)				463.00
	8/16	8/17	Italy		329.00		(3)				329.00
Commercial airfare							10,391.00				10,391.00
Misc. transportation costs							128.50				128.50
Christopher White	8/12	8/13	United Arab Emirates		463.00		(3)				463.00
	8/13	8/15	Afghanistan		162.00		(3)				162.00
	8/15	8/16	United Arab Emirates		463.00		(3)				463.00
	8/16	8/17	Italy		329.00		(3)				329.00
Commercial airfare							10,391.00				10,391.00
Misc. transportation costs							70.00				70.00

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009—Continued

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Jack Kingston	8/27	8/30	Tunisia		725.75		(3)				725.75
	8/30	9/1	Rwanda		750.95		(3)				750.95
	9/2	9/2	Zimbabwe		142.00		(3)				142.00
	9/3	9/4	Senegal		561.96		(3)				561.96
Hon. Jack Kingston	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
Hon. Betty McCollum	9/18	9/21	Guatemala		686.28	(3)					686.28
Commercial airfare							1,657.70				1,657.70
Local transp.							1,340.88				1,340.88
Misc. embassy costs									2,080.16		2,080.16
John Blazey	9/26	9/28	Chile		1,095.00						1,095.00
Commercial airfare							7,860.70				7,860.70
Misc. transportation costs									36.00		36.00
Committee total					75,848.97		187,330.78		17,576.48		280,756.23

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transportation.
[4] Part foreign, part domestic travel.

HON. DAVID R. OBEY, Chairman.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON ARMED SERVICES, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Visit to Jordan, Tunisia, Algeria With CODEL Schiff, June 26–July 3, 2009:											
Hon. Solomon Ortiz	6/27	6/30	Jordan		502.00						502.00
	6/30	7/1	Algeria		98.00						98.00
	7/1	7/3	Tunisia		288.00						288.00
Visit to Ireland, Bahrain, Afghanistan, Germany, June 27–July 3, 2009:											
Hon. Brad Ellsworth	6/28	6/29	Ireland		628.69						628.69
	6/30	7/1	Bahrain								
	7/1	7/2	Afghanistan		28.00						28.00
	7/2	7/3	Germany		298.00						298.00
Hon. Dave Loebsack	6/28	6/29	Ireland		628.96						628.96
	6/30	7/1	Bahrain								
	7/1	7/2	Afghanistan		28.00						28.00
	7/2	7/3	Germany		298.00						298.00
Joseph Hicken	6/28	6/29	Ireland		628.96						628.96
	6/30	7/1	Bahrain								
	7/1	7/2	Afghanistan		28.00						28.00
	7/2	7/3	Germany		298.00						298.00
Lara Battles	6/28	6/29	Ireland		628.96						628.96
	6/30	7/1	Bahrain								
	7/1	7/2	Afghanistan		28.00						28.00
	7/2	7/3	Germany		298.00						298.00
John Wason	6/28	6/29	Ireland		628.96						628.96
	6/30	7/1	Bahrain								
	7/1	7/2	Afghanistan		28.00						28.00
	7/2	7/3	Germany		298.00						298.00
Visit to Qatar, Bahrain, June 28–July 3, 2009:											
Erin C. Conaton	6/29	7/1	Bahrain		699.12						699.12
	7/1	7/3	Qatar		681.32						681.32
Commercial airfare							9,085.32				9,085.32
John Phillip MacNaughton	6/29	7/1	Bahrain		699.12						699.12
	7/1	7/3	Qatar		681.32						681.32
Commercial airfare							9,085.32				9,085.32
Visit to Bosnia, Herzegovina With CODEL Carnahan, July 10–13, 2009:											
Hon. Michael Turner	7/11	7/13	Bosnia-Herzegovina		230.57						230.57
Visit to Afghanistan, Pakistan, United Arab Emirates, July 12–17, 2009:											
Michael Casey	7/13	7/14	United Arab Emirates								
	7/14	7/15	Afghanistan								
	7/15	7/17	Pakistan		80.00						80.00
Commercial airfare							10,729.04				10,729.04
Paul Arcangeli	7/13	7/14	United Arab Emirates								
	7/14	7/15	Afghanistan								
	7/15	7/17	Pakistan		80.00						
Commercial airfare							10,729.04				10,729.04
Jenness Simler	7/13	7/14	United Arab Emirates								
	7/14	7/15	Afghanistan								
	7/15	7/17	Pakistan		80.00						80.00
Commercial airfare							10,729.04				10,729.04
Visit to Cuba, July 20, 2009:											
Hon. Howard P. "Buck" McKeon	7/20	7/20	Cuba								
Hon. Rick Larsen	7/20	7/20	Cuba								
Hon. Bobby Bright	7/20	7/20	Cuba								
Hon. Randy Forbes	7/20	7/20	Cuba								
Andrew Hunter	7/20	7/20	Cuba								
Robert L. Simmons	7/20	7/20	Cuba								
William Spencer Johnson	7/20	7/20	Cuba								
Visit to Kuwait, Iraq, Israel With CODEL Lynch, July 24–28, 2009:											
Hon. Joe Courtney	7/25	7/25	Kuwait								
	7/25	7/26	Iraq								
	7/26	7/26	Kuwait								
	7/27	7/27	Israel		714.00						714.00

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON ARMED SERVICES, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009—Continued

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Todd Platts	7/25	7/25	Kuwait								
	7/25	7/26	Iraq								
	7/26	7/26	Kuwait								
	7/27	7/27	Israel		579.00						579.00
Visit to Kuwait, Iraq, Afghanistan, Pakistan, Qatar, Turkey, Germany, August 3–12, 2009:											
Hon. Patrick Murphy	8/4	8/5	Turkey		122.00						122.00
	8/5	8/7	Afghanistan		26.00						26.00
	8/7	8/8	Kuwait		109.00						109.00
	8/8	8/9	Iraq		11.00						11.00
	8/9	8/10	Qatar		114.00						114.00
	8/10	8/11	Germany		143.00						143.00
Hon. Howard P. "Buck" McKeon	8/4	8/5	Turkey		122.00						122.00
	8/5	8/7	Afghanistan		26.00						26.00
	8/7	8/9	Kuwait		109.00						109.00
	8/8	8/9	Iraq		11.00						11.00
	8/9	8/10	Qatar		114.00						114.00
	8/10	8/11	Germany		143.00						143.00
Hon. Joe Wilson	8/4	8/5	Turkey		122.00						122.00
	8/5	8/7	Afghanistan		26.00						26.00
	8/7	8/8	Kuwait		109.00						109.00
	8/8	8/9	Iraq		11.00						11.00
	8/9	8/10	Qatar		114.00						114.00
	8/10	8/11	Germany		143.00						143.00
Hon. Bill Shuster	8/4	8/5	Turkey		122.00						122.00
	8/5	8/7	Afghanistan		26.00						26.00
	8/7	8/8	Kuwait		109.00						109.00
	8/8	8/9	Iraq		11.00						11.00
	8/9	8/10	Qatar		114.00						114.00
	8/10	8/11	Germany		143.00						143.00
Jack Shuler	8/4	8/5	Turkey		122.00						122.00
	8/5	8/7	Afghanistan		26.00						26.00
	8/7	8/8	Kuwait		109.00						109.00
	8/8	8/9	Iraq		11.00						11.00
	8/9	8/10	Qatar		114.00						114.00
	8/10	8/11	Germany		143.00						143.00
Thomas Hawley	8/4	8/5	Turkey		122.00						122.00
	8/5	8/7	Afghanistan		26.00						26.00
	8/7	8/8	Kuwait		109.00						109.00
	8/8	8/9	Iraq		11.00						11.00
	8/9	8/10	Qatar		114.00						114.00
	8/10	8/11	Germany		143.00						143.00
Delegation expenses	8/9	9/10	Qatar						5,276.60		5,276.60
Visit to South Korea, August 8–14, 2009:											
Hon. Gene Taylor	8/9	8/12	South Korea		378.00						378.00
Commercial airfare			South Korea				8,320.00				8,320.00
William Ebbs	8/9	8/12	South Korea		378.00						378.00
Commercial airfare			South Korea				8,320.00				8,320.00
Jenness Simler	8/9	8/12	South Korea		378.00						378.00
Commercial airfare			South Korea				8,320.00				8,320.00
Visit to France, Luxembourg, Belgium, United Kingdom With CODEL Smith, August 8–12, 2009.											
Timothy McClees	8/9	8/12	Paris		658.00						658.00
	8/12	8/13	Luxembourg		142.00						142.00
	8/13	8/14	Belgium		173.00						173.00
	8/14	8/15	Normandy		97.00						97.00
	8/15	8/19	London		594.00						594.00
Commercial airfare							8,298.13				8,298.13
Visit to Kuwait, Iraq, Afghanistan, Bahrain, Qatar, August 23–30, 2009:											
Hon. Madeleine Z. Bordallo	8/24	8/25	Kuwait		415.93						415.93
	8/25	8/25	Iraq								
	8/25	8/27	Bahrain		792.50						792.50
	8/27	8/28	Afghanistan		26.00						26.00
Commercial airfare							9,043.69				9,043.69
Mr. John Phillip MacNaughton	8/24	8/25	Kuwait		415.93						415.93
	8/25	8/25	Iraq								
	8/25	8/27	Bahrain		792.50						792.50
	8/27	8/28	Afghanistan		26.00						26.00
Commercial Transportation							9,043.69				9,043.69
Mr. Thomas Hawley	8/24	8/25	Kuwait		415.93						415.93
	8/25	8/25	Iraq								
	8/25	8/27	Bahrain		792.50						792.50
	8/27	8/28	Afghanistan		26.00						26.00
Commercial Transportation							9,043.69				9,043.69
Delegation Expenses							290.00				290.00
Visit to Mali, Afghanistan, Kenya, Djibouti, Morocco, August 27–September 3, 2009:											
Hon. Jim Marshall	8/27	8/28	Mali		150.00						150.00
	8/28	8/30	Djibouti		350.00						350.00
	8/30	8/31	Afghanistan		76.00						76.00
	8/31	9/2	Kenya		336.00						336.00
	9/2	9/3	Morocco		371.88						371.88
Hon. Frank LoBiondo	8/27	8/28	Mali		150.00						150.00
	8/28	8/30	Djibouti		350.00						350.00
	8/30	8/31	Afghanistan		76.00						76.00
	8/31	9/2	Kenya		336.00						336.00
	9/2	9/3	Morocco		371.88						371.88
Hon. Bill Shuster	8/27	8/28	Mali		150.00						150.00
	8/28	8/30	Djibouti		350.00						350.00
	8/30	8/31	Afghanistan		76.00						76.00
	8/31	9/2	Kenya		336.00						336.00
	9/2	9/3	Morocco		371.88						371.88
Mark Lewis	8/27	8/28	Mali		150.00						150.00
	8/28	8/30	Djibouti		350.00						350.00
	8/30	8/31	Afghanistan		76.00						76.00
	8/31	9/2	Kenya		336.00						336.00
	9/2	9/3	Morocco		371.88						371.88
Lynn Williams	8/27	8/28	Mali		150.00						150.00
	8/28	8/30	Djibouti		350.00						350.00

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON ARMED SERVICES, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009—Continued

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
	8/30	8/31	Afghanistan		76.00						76.00
	8/31	9/2	Kenya		336.00						336.00
	9/2	9/3	Morocco		371.88						371.88
Delegation Expenses	8/27	8/28	Mali						974.46		974.46
	8/28	8/30	Djibouti						3,425.00		3,425.00
	9/2	9/3	Morocco						649.00		649.00
Visit to Afghanistan, Pakistan, September 3–8, 2009:											
Hon. Adam Smith	9/5	9/8	Pakistan		120.00						120.00
	9/6	9/6	Afghanistan								
Commercial Transportation							10,132.00				10,132.00
Hon. Gabrielle Giffords	9/5	9/8	Pakistan		120.00						120.00
	9/6	9/6	Afghanistan								
Commercial Transportation							10,132.00				10,132.00
Hon. Bobby Bright	9/5	9/8	Pakistan		120.00						120.00
	9/6	9/6	Afghanistan								
Commercial Transportation							10,132.00				10,132.00
Timothy McClees	9/5	9/8	Pakistan		120.00						120.00
	9/6	9/6	Afghanistan								
Commercial Transportation							10,132.00				10,132.00
Alexander Kugajevsky	9/5	9/8	Pakistan		120.00						120.00
	9/6	9/6	Afghanistan								
Commercial Transportation							10,132.00				10,132.00
Committee Total					26,857.67		161,696.96		10,325.06		198,879.69

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

HON. IKE SKELTON, Chairman, Oct. 30, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON ENERGY AND COMMERCE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Cliff Stearns	6/27	6/30	Jordan		509.00		([3])				509.00
	6/30	7/01	Algeria		148.00						148.00
	7/1	7/3	Tunisia		288.00						288.00
Mary Neumayr	8/2	8/4	China		525.98		11,931.87				12,457.85
	8/4	8/6	China		324.00						324.00
	8/6	8/8	China		422.00						422.00
	8/8	8/9	China		95.00						95.00
Lisa Miller	8/2	8/4	China		525.98		11,931.87				12,457.85
	8/4	8/6	China		324.00						324.00
	8/6	8/8	China		422.00						422.00
	8/8	8/9	China		262.99						262.99
Kevin Kohl	8/2	8/4	China		525.98		11,931.87				12,457.85
	8/4	8/6	China		324.00						324.00
	8/6	8/8	China		422.00						422.00
	8/8	8/9	China		262.99						262.99
Gregory Dotson	8/2	8/4	China		525.98		11,931.87				12,457.85
	8/4	8/6	China		324.00						324.00
	8/6	8/8	China		192.00						192.00
	8/8	8/9	China		262.99						262.99
Lorie Schmidt	8/2	8/4	China		525.98		11,931.87				12,457.85
	8/4	8/6	China		324.00						324.00
	8/6	8/8	China		422.00						422.00
	8/8	8/9	China		262.99						262.99
Angele B. Kwemo	8/16	8/17	Liberia		536.40						536.40
	8/17	8/19	Ghana		294.00		([3])				294.00
	8/19	8/23	South Africa		1,806.07						1,806.07
	8/23	8/24	Morocco		341.00						341.00
Timothy Robinson	8/16	8/17	Liberia		536.40						536.40
	8/17	8/19	Ghana		294.00		([3])				294.00
	8/19	8/23	South Africa		1,806.07						1,806.07
	8/23	8/24	Morocco		341.00						341.00
Ingrid Gavin-Parks	8/16	8/17	Liberia		536.40						536.40
	8/17	8/19	Ghana		294.00		([3])				294.00
	8/19	8/23	South Africa		1,806.07						1,806.07
	8/23	8/24	Morocco		341.00						341.00
Shannon Weinberg	8/16	8/17	Liberia		536.40						536.40
	8/17	8/19	Ghana		294.00		([3])				294.00
	8/19	8/23	South Africa		1,806.07						1,806.07
	8/23	8/24	Morocco		341.00						341.00
Nishith Pandya	8/16	8/17	Liberia		536.40						536.40
	8/17	8/19	Ghana		294.00		([3])				294.00
	8/19	8/23	South Africa		1,806.07						1,806.07
	8/23	8/24	Morocco		341.00						341.00
Hon. G. K. Butterfield	8/16	8/17	Liberia		536.40				3,741.31		4,277.71
	8/17	8/19	Ghana		294.00		([3])		9,904.24		10,198.24
	8/19	8/23	South Africa		1,806.07				20,378.67		22,184.74
	8/23	8/24	Morocco		341.00				2,634.00		2,975.00
Committee total					26,086.68		59,659.35		36,658.22		122,404.25

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transportation.

HON. HENRY A. WAXMAN, Chairman, Nov. 21, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON FOREIGN AFFAIRS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
June Beittel	8/15	8/19	Peru		1,270.70		(3)				1,270.70
	8/19	8/20	Paraguay		235.24		(3)				235.24
	8/20	8/23	Colombia		1,266.00		(3)				1,266.00
Hon. Howard L. Berman	8/17	8/19	South Korea		798.88		(3)		[4] 5,857.30		6,656.18
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)		[4] 6,061.17		6,722.43
	8/22	8/24	Hong Kong		1,055.10		(3)		[4] 9,012.06		10,067.16
Paul Berkowitz	8/12	8/17	Austria		3,070.20						3,070.20
	8/17	8/18	Iraq		0.00						0.00
	8/18	8/19	Jordan		360.97						360.97
	8/19	8/22	Israel		1,988.40						1,988.40
							[5] 9,384.14				9,384.14
Daniel Bob	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
Genell Brown	8/28	8/30	Egypt		504.00						504.00
	8/30	9/1	Tunisia		508.00						508.00
	9/1	9/3	Algeria		631.00						631.00
	9/3	9/5	Morocco		544.00						544.00
							[5] 9,739.29				9,739.29
Hon. Russ Carnahan	7/10	7/13	Bosnia		429.51		(3)		[4] 4,968.38		5,397.89
Joan Condon	8/24	8/28	Sudan		1,090.27						1,090.27
	8/28	8/29	Rwanda		220.54						220.54
	8/29	8/30	DRC		206.00						206.00
							[5] 11,500.56				11,500.56
Theodros Dagne	8/2	8/6	Kenya		2,266.04						2,266.04
	8/6	8/9	South Africa		1,180.74						1,180.74
	8/9	8/11	Angola		1,086.00						1,086.00
							[5] 13,258.55				13,258.55
Marissa Doran	8/24	8/28	Sudan		1,090.27				[4] 3,717.04		4,807.31
	8/28	8/29	Rwanda		220.54				[4] 407.65		628.19
	8/29	9/3	DRC		1,011.00						1,011.00
							[5] 12,291.22				12,291.22
Hon. Keith Ellison	8/5	8/8	Sudan		534.43						534.43
							[5] 6,275.40				6,275.40
Hon. Eni F.H. Faleomavaega	7/17	7/19	Somoa		416.00						416.00
	7/19	7/21	Fiji		530.00				[4] 217.06		747.06
							[5] 2,514.53				2,514.53
	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
	8/30	9/7	South Korea		3,458.20				[4] 539.22		3,997.42
					9,916.93						9,916.93
Ricardo Farraj-Ruiz	8/15	8/22	Peru		2,332.47						2,332.47
							[6] 1,647.41				1,647.41
David Fite	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
Julissa Gomez-Granger	8/15	8/22	Peru		2,352.67		(3)				2,352.67
							[6] 1,647.41				1,647.41
Dennis Halpin	8/21	8/23	Malaysia		326.00						326.00
	8/23	8/27	Thailand		760.00						760.00
	8/27	8/30	Burma		350.00						350.00
							[5] 12,167.83				12,167.83
Daniel Harsha	8/28	8/29	Rwanda		220.54						220.54
	8/29	9/3	DRC		1,011.00						1,011.00
							[5] 9,380.66				9,380.66
Hans Hogrefe	8/28	8/30	Egypt		534.00				[4] 211.00		745.00
	8/30	9/1	Tunisia		508.00						508.00
	9/1	9/3	Algeria		656.00						656.00
	9/3	9/5	Morocco		544.00						544.00
							[5] 9,739.29				9,739.29
Elizabeth Hoffman	8/28	8/30	Egypt		484.00						484.00
	8/30	9/1	Tunisia		488.00						488.00
	9/1	9/3	Algeria		621.00						621.00
	9/3	9/5	Morocco		524.00						524.00
							[5] 9,739.29				9,739.29
Eric Jacobstein	9/1	9/4	Guatemala		670.07				[4] 592.00		1,262.07
							[5] 760.70				760.70
Jonathan Katz	8/26	8/28	Turkey		698.83						698.83
							[5] 8,197.75				8,197.75
Jessica Lee	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
	8/24	8/27	Thailand		542.00						542.00
	8/27	8/30	Burma		402.00				[4] 462.44		864.44
							[6] 5,037.70				5,037.70
Vili Lei	8/30	9/7	South Korea		3,458.20						3,458.20
							[5] 9,916.93				9,916.93
John Lis	8/15	8/19	Peru		0.00		(3)		[4] 1,120.56		1,120.56
	8/19	8/20	Paraguay		0.00		(3)		[4] 692.93		692.93
	8/20	8/23	Colombia		0.00		(3)		[4] 562.00		562.00
Noelle Lusne	8/2	8/6	Kenya		2,266.04						2,266.04
	8/6	8/9	South Africa		1,180.74						1,180.74
	8/9	8/11	Angola		1,068.00						1,068.00
							[5] 13,248.60				13,248.60
Hon. Connie Mack	7/25	7/26	Honduras		303.00						303.00
							[5] 1,843.70				1,843.70
Alan Makovsky	8/24	8/28	Sudan		1,135.27						1,135.27
							[5] 10,943.65				10,943.65
Pearl Alice Marsh	8/3	8/12	Kenya		4,478.37						4,478.37
	8/13	8/14	Switzerland		382.42						382.42
							[5] 10,227.68				10,227.68
Mary McVeigh	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON FOREIGN AFFAIRS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009—Continued

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Gregory W. Meeks	9/12	9/13	Canada		321.00						321.00
							[5] 927.62				927.62
Margaret Mott	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
Hon. Donald M. Payne	8/4	8/6	Kenya		1,133.62		(3)				1,133.62
	8/6	8/9	South Africa		4,267.03		(3)		[4] 1,576.42		5,843.45
	8/9	8/11	Angola		1,656.00		(3)				1,656.00
							[6] 11,656.10				11,656.10
Lauren Ploch	8/24	8/28	Sudan		1,090.27						1,090.27
	8/28	8/29	Rwanda		220.54						220.54
	8/29	9/3	DRC		1,011.00						1,011.00
							[5] 16,230.82				16,230.82
Frederick Ratliff	7/25	7/26	Honduras		303.00						303.00
							[5] 1,081.70				1,081.70
	9/1	9/4	Guatemala		670.07						670.07
							[5] 1,150.70				1,150.70
Sheri Rickert	8/5	8/12	Kenya		3,588.00						3,588.00
	8/13	8/14	Switzerland		423.00						423.00
							[5] 9,766.80				9,766.80
Hon. Dana Rohrabacher	8/12	8/17	Austria		2,409.66						2,409.66
	8/17	8/18	Iraq								0.00
	8/18	8/19	Jordan		360.97				[4] 491.23		852.20
	8/19	8/22	Israel		1,988.40				[4] 5,679.04		7,677.44
							[5] 13,483.73				13,483.73
Amanda Sloat	7/10	7/13	Bosnia		429.51		(3)				429.51
	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
Hon. Diane E. Watson	8/17	8/19	South Korea		798.88		(3)				798.88
	8/19	8/20	China		291.31		(3)				291.31
	8/20	8/22	Taiwan		661.26		(3)				661.26
	8/22	8/24	Hong Kong		1,055.10		(3)				1,055.10
Robyn Wapner	7/25	7/26	Honduras		303.00						303.00
							[5] 1,601.70				1,601.70
	9/1	9/4	Guatemala		670.07						670.07
							[5] 760.70				760.70
Lynne Weil	8/18	8/20	China		399.61						399.61
	8/20	8/22	Taiwan		350.26						350.26
	8/22	8/24	Hong Kong		774.10						774.10
							[7] 4,118.17				4,118.17
	8/24	8/27	Thailand		510.00				[4] 792.22		1,302.22
	8/27	8/30	Burma		275.00						275.00
							[6] 7,192.00				7,1902.00
Clay Wellborn	8/15	8/22	Peru		2,352.67		(3)				2,352.67
							[6] 1,647.41				1,647.41
Kristin Wells	8/3	8/12	Kenya		4,478.37						4,478.37
	8/13	8/14	Switerland		382.42				[4] 1,135.00		1,517.42
							[5] 10,984.68				10,984.86
Hon. Robert Wexler	8/26	8/28	Turkey		698.83				[4] 109.68		808.51
							[5] 8,197.75				8,197.75
Lisa Williams	8/30	9/7	South Korea		3,458.20						3,458.20
							[5] 9,916.93				9,916.93
Shanna Winters	8/4	8/5	Bahamas		307.65						307.65
							[5] 774.20				774.20
Hon. Lynn C. Woolsey	7/10	7/13	Bosnia		429.51		(3)				429.51
Brent Woolfork	8/3	8/9	Kenya		3,101.02						3,101.02
	8/9	8/15	Germany		1,915.18						1,915.18
							[5] 10,392.89				10,392.89
Committee total					127,868.51		279,346.19		44,204.40		451,419.10

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transportation.
[4] Indicates delegation costs.
[5] Round-trip airfare.
[6] Return airfare.
[7] One-way airfare.

HON. HOWARD L. BERMAN, Chairman, Nov. 2, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Mike Quigley	7/25	7/25	Kuwait				(3)				
	7/25	7/26	Iraq								
	7/27	7/28	Israel		714.00						714.00
Scott Lindsay	7/25	7/25	Kuwait				(3)				
	7/25	7/26	Iraq								
	7/27	7/28	Israel		714.00						714.00
Bruce Fernandez	7/25	7/25	Kuwait				(3)				
	7/25	7/26	Iraq								
	7/27	7/28	Israel		714.00						714.00
Adam Fromm	7/25	7/25	Kuwait				(3)				
	7/25	7/26	Iraq								
	7/26	7/27	Israel		714.00						714.00
Hon. Stephen F. Lynch	7/25	7/25	Kuwait				(3)				
	7/25	7/26	Iraq								
	7/27	7/28	Israel		714.00				7,847.30		8,561.30
Hon. Brian P. Bilbray	7/25	7/26	Honduras		301.00		1,947.70				2,248.70

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009—Continued

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Kristina Moore	8/2	8/4	China		525.98		11,931.87				12,457.85
	8/4	8/6	China		324.00						324.00
	8/6	8/8	China		422.00						422.00
	8/8	8/9	China		262.99						262.99
Michael McCarthy	8/2	8/4	China		525.98		11,931.87				12,457.85
	8/4	8/6	China		324.00						324.00
	8/6	8/8	China		422.00						422.00
	8/8	8/9	China		262.99						
Ryan Dwyer	7/11	7/13	Bosnia		429.51		(3)				429.51
Hon. Wm. Lacy Clay	8/16	8/17	Liberia		536.40		(3)				536.40
	8/17	8/19	Ghana		294.00						294.00
	8/19	8/23	Angola		1,806.07						1,806.07
	8/23	8/24	South Africa		341.00						341.00
Committee total					10,347.92		25,811.44		7,847.30		44,006.66

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transportation.

HON. EDOLPHUS TOWNS, Chairman, Oct. 30, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON SCIENCE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Shimere Williams	7/1	7/4	United Kingdom		1,242.88		[4] 8,370.22				9,613.10
Holly Logue Prutz	7/1	7/5	United Kingdom		1,242.88		[4] 8,370.22				9,613.10
Dahlia Sokolov	8/2	8/5	Costa Rica		(5) 702.00		41.30		56.88		800.18
	8/5	8/8	Panama		756.60						756.60
							[4] 2,046.02				2,046.02
Marcy Gallo	8/2	8/5	Costa Rica		702.00		41.30		56.88		800.18
	8/5	8/8	Panama		756.60						756.60
							[4] 2,046.02				2,046.02
Bess Caughran	8/2	8/5	Costa Rica		702.00		41.30		56.88		800.18
	8/5	8/8	Panama		756.60						756.60
							[4] 2,046.02				2,046.02
Mele Williams	8/2	8/5	Costa Rica		702.00		41.30		56.88		800.18
	8/5	8/8	Panama		756.60						756.60
							[4] 2,046.02				2,046.02
Hon. David Wu	8/27	8/28	Mali		150.00		(3)		195.65		345.65
	8/28	8/29	Djibouti		350.00		(3)		380.55		730.55
	8/28	8/31	Afghanistan		76.00		(3)				76.00
	8/31	9/2	Kenya		814.10		(3)		851.30		1,665.40
	9/2	9/3	Morocco		371.88		(3)		81.11		452.99
Committee total					10,082.14		25,089.72		1,736.13		36,907.99

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transport.
[4] Commercial airfare.
[5] One night at personal expense.

HON. BART GORDON, Chairman, Oct. 30, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Jean Schmidt	6/28	2/29	Ireland		628.69		(3)				628.69
	6/30	7/1	Bahrain				(3)				
	7/1	7/2	Afghanistan		20.00		(3)				20.00
	7/2	7/3	Germany		298.00		(3)				298.00
Hon. Eddie Bernice Johnson	8/4	8/5	Kuwait		494.08		(3)				494.08
	8/5	8/7	Dubai		827.42		(3)				827.42
	8/7	8/8	Germany		362.56		(3)				362.56
	8/8	8/9	Germany		360.00		(3)				360.00
Ward McCarragher	8/9	8/10	Spain		445.75		8,190.39				8,636.14
	8/10	8/12	Spain		886.54						886.54
	8/12	8/13	Italy		451.80						451.80
	8/13	8/14	Italy		618.02						618.02
	8/14	8/15	Italy		585.55						585.55
Joyce Rose	8/9	8/10	Spain		445.75		8,105.80				8,551.55
	8/10	8/12	Spain		886.54						886.54
	8/12	8/13	Italy		451.80						451.80
	8/13	8/14	Italy		618.02						618.02
	8/14	8/15	Italy		585.55						585.55
Committee total					8,966.07		16,296.19				25,262.26

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.
[3] Military air transportation.

HON. JAMES L. OBERSTAR, Chairman, Oct. 30, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON VETERANS' AFFAIRS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Zachary Space	8/23	8/25	Kabul		152.00						152.00
	8/27	8/28	Mali		150.00						150.00
	8/28	8/29	Djibouti		350.00						350.00
	8/30	8/31	Kabul		76.00						76.00
	8/27	9/3	Kenya		336.00						336.00
	9/2	9/3	Morocco		154.00				217.88		217.88
Committee total					1,218.00				217.88		1,281.88

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

HON. BOB FILNER, Chairman, Oct. 29, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Alexander Perkins	7/12	7/18	Peru		468.00		2,743.00				3,211.70
William Thomas	7/13	7/18	Peru		390.00		2,743.00				3,133.70
Hon. Brian Higgins	7/25	7/25	Kuwait								
	7/25	7/26	Iraq								
	7/27	7/28	Israel		714.00						714.00
Hon. Jim McDermott	8/2	8/7	Kenya		590.00		12,023.64				12,613.64
Alexander Perkins	8/3	8/6	Kenya		354.00		10,565.85				10,919.85
	8/6	8/9	Ethiopia		516.00						516.00
Angela Ellard	8/3	8/6	Kenya		354.00		10,565.85				10,919.85
	8/6	8/9	Ethiopia		516.00						516.00
Hon. Devin Nunes	8/4	8/5	Kuwait		553.08						553.08
	8/5	8/7	United Arab Emirates		827.42						827.42
	8/7	8/9	Germany		722.56						722.56
Committee total					6,005.06		38,642.74				44,647.80

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

HON. CHARLES B. RANGEL, Chairman, Nov. 2, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, PERMANENT SELECT COMMITTEE ON INTELLIGENCE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Adam Smith	8/7	8/9	Europe		708.00						
	8/9	8/10	Europe		192.00						
	8/10	8/11	Europe		223.00						
	8/11	8/13	Europe		147.00						
	8/13	8/17	Europe		792.00						
Commercial airfare							1,187.37				3,249.37
Mark Young	8/7	8/9	Europe		708.00						
	8/9	8/10	Europe		192.00						
	8/10	8/11	Europe		223.00						
	8/11	8/13	Europe		147.00						
	8/13	8/17	Europe		792.00						
Commercial airfare							4,835.13				6,897.13
Robert Minehart	8/7	8/9	Europe		708.00						
	8/9	8/10	Europe		192.00						
	8/10	8/11	Europe		223.00						
	8/11	8/13	Europe		147.00						
	8/13	8/17	Europe		792.00						
Commercial airfare							4,835.13				6,897.13
Laurence Hanauer	8/8	8/10	Europe		884.00						
	8/10	8/11	Europe		521.00						
	8/12	8/13	Europe		372.00						
	8/14	8/15	Europe		392.00						
Commercial airfare							8,220.80				10,389.80
Mary Stone-Ross	8/8	8/10	Europe		884.00						
	8/10	8/11	Europe		521.00						
	8/12	8/14	Europe		372.00						
	8/14	8/15	Europe		392.00						
Commercial airfare							8,220.80				10,389.80
Kathleen Reilly	8/7	8/9	Europe		884.00						
	8/10	8/11	Europe		521.00						
	8/12	8/13	Europe		372.00						
	8/14	8/16	Europe		392.00						
Commercial airfare							8,220.80				10,389.80
Stacey Dixon	8/7	8/12	Australia		744.00						
	8/13	8/15	New Zealand		626.00						
Commercial airfare							13,243.74				14,613.74
Donald Campbell	8/7	8/12	Australia		744.00						
	8/13	8/15	Asia		626.00						
	8/16	8/19	Asia		850.00						
Commercial airfare							15,123.65				17,343.65
Frank Garcia	8/7	8/12	Australia		744.00						
	8/13	8/15	Asia		378.00						
	8/16	8/19	Asia		850.00						
Commercial airfare							15,123.65				17,095.65
George Pappas	8/7	8/12	Australia		744.00						
	8/13	8/15	New Zealand		378.00						

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, PERMANENT SELECT COMMITTEE ON INTELLIGENCE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009—Continued

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
	8/16	8/19	Asia		850.00						
Commercial airfare							13,901.77				15,873.77
Brian Morrison	8/9	8/11	S. Asia		486.00						
	8/12	8/14	S. Asia		207.00						
	8/14	8/15	S. Asia		220.00						
Commercial airfare							11,940.63				12,853.63
Harry Hulings	8/9	8/11	S. Asia		486.00						
	8/12	8/14	S. Asia		207.00						
	8/14	8/15	S. Asia		220.00						
Commercial airfare							12,628.49				13,541.49
Iram Ali	8/9	8/11	S. Asia		486.00						
	8/12	8/14	S. Asia		207.00						
	8/14	8/15	S. Asia		220.00						
Commercial airfare							14,504.69				15,417.69
Jamal Ware	8/9	8/11	S. Asia		486.00						
	8/12	8/14	S. Asia		207.00						
	8/14	8/15	S. Asia		220.00						
Commercial airfare							12,641.71				13,554.71
Hon. Peter King	8/12	8/16	Middle East		638.82						
Commercial airfare							9,605.48				10,244.30
Christopher Donesa	8/12	8/16	Middle East		638.82						
Commercial airfare							11,006.48				11,645.30
Joshua Kirshner	8/12	8/16	Middle East		638.82						
Commercial airfare							6,656.60				7,295.42
Hon. Silvestre Reyes	8/24	8/26	S.E. Asia		436.00						
	8/26	8/28	S.E. Asia		566.00						
	8/28	8/29	S.E. Asia		163.00						
Commercial airfare							10,167.64				11,932.64
Michael Delaney	8/24	8/26	S.E. Asia		436.00						
	8/26	8/28	S.E. Asia		566.00						
	8/28	8/29	S.E. Asia		163.00						
Commercial airfare							16,286.54				17,451.54
Hon. Mike Rogers	9/6	9/8	Middle East		922.00						
Commercial airfare							7,295.90				8,217.90
Christopher Donesa	9/6	9/8	Middle East		922.00		[3]				
Commercial airfare							7,295.90				8,217.90
Hon. Michael Conaway	9/20	9/22	Latin America		720.00						
Commercial airfare							2,697.70				3,417.70
Chelsey Campbell	9/20	9/22	Latin America		720.00						
Commercial airfare							1,971.70				27691.70
Harry Hulings	9/20	9/22	Latin America		720.00						
Commercial airfare							1,971.70				2,691.70
In accordance with title 22, United States Code, Section 1754 (b)(2), information as would identify the foreign countries in which the Committee Members and staff have traveled is omitted.											
Committee total											

[1] Per diem constitutes lodging and meals.
[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

HON. SILVESTRE REYES, Chairman, Oct. 30, 2009.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of Rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

4715. A letter from the Management and Program Analyst, Department of Agriculture, transmitting the Department's final rule — Sale and Disposal of National Forest System Timber; Downpayment and Periodic Payments (RIN: 0596-AC80) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4716. A letter from the Chief, PRAB/Office of Research and Analysis, Department of Agriculture, transmitting the Department's final rule — Senior Farmers' Market Nutrition Program Regulations, Nondiscretionary Provisions of Public Law 110-246, the Food, Conservation, and Energy Act of 2008 (RIN: 0584-AD92) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4717. A letter from the Chair, Congressional Oversight Panel, transmitting the Panel's monthly report pursuant to Section 125(b)(1) of the Emergency Economic Stabilization Act of 2008, Pub. L. 110-343; to the Committee on Financial Services.

4718. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Suspension of Community Eligibility [Docket ID: FEMA-2008-0020; Internal Agency Docket No. FEMA-8095] received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

4719. A letter from the Associate General Counsel for Legislation and Regulation Divisions, Department of Housing and Urban Development, transmitting the Department's final rule — Home Equity Conversion Mortgage (HECM) Counseling Standardization and Roster [Docket No.: FR-4989-F-02] (RIN: 2502-AI34) received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

4720. A letter from the Associate General Counsel for Legislation and Regulation Divisions, Department of Housing and Urban Development, transmitting the Department's final rule — HUD Acquisition Regulation (HUDAR) Debarment and Suspension Procedures; Correcting Amendment [Docket No.: FR-5098-C-03] (RIN: 2535-AA28) received October 27, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

4721. A letter from the Acting Deputy General Counsel, National Credit Union Administration, transmitting the Administration's final rule — Exception to the Maturity Limit on Second Mortgages (RIN: 3133-AD64) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

4722. A letter from the Chief, PRAB, Office of Research and Analysis, Department of Agriculture, transmitting the Department's final rule — Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Vendor Cost Containment [FNS-2009-001] (RIN: 0584-AD71) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

4723. A letter from the Director, Office of Congressional Affairs, Nuclear Regulatory Commission, transmitting the Commission's final rule — List of Approved Spent Fuel Storage Casks: HI-STORM 100 Revision 7 [NRC-2009-0349] (RIN: 3150-AI71) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4724. A letter from the Assistant Legal Advisor for Treaty Affairs, Department of State, transmitting a report prepared by the Department of State concerning international agreements other than treaties entered into by the United States to be transmitted to the Congress within the sixty-day period specified in the Case-Zablocki Act, pursuant to 1 U.S.C. 112b(b); to the Committee on Foreign Affairs.

4725. A letter from the Deputy Secretary of the Treasury, Department of the Treasury, transmitting a six-month periodic report on

the national emergency with respect to Sudan that was declared in Executive Order 13067 of November 3, 1997, pursuant to 50 U.S.C. 1641(c); to the Committee on Foreign Affairs.

4726. A letter from the Co-Chairs, Commission on Wartime Contraction, transmitting Special Report 2 ''Lowest-priced security not good enough for war-zone embassies'', pursuant to Public Law 110-181, section 841(d)(2); to the Committee on Foreign Affairs.

4727. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting a proposed removal from the United States Munitions List of civil aircraft equipped with the JETEYE Counter-MANPADS installation Kit (A-Kit), pursuant to Section 38(f)(1) of the Arms Export Control Act; to the Committee on Foreign Affairs.

4728. A letter from the Librarian of Congress, Library of Congress, transmitting the Annual Report of the Library of Congress, for the fiscal year 2008, pursuant to 2 U.S.C. 139; to the Committee on House Administration.

4729. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries Off West Coast States; Coastal Pelagic Species Fisheries; Closure [Docket No.: 0812171612-9134-02] (RIN: 0648-XR63) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4730. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 630 in the Gulf of Alaska [Docket No.: 09100091344-9056-02] (RIN: 0648-XS04) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4731. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 620 in the Gulf of Alaska [Docket No.: 09100091344-9056-02] (RIN: 0648-XS06) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4732. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Northeastern United States; Black Sea Bass Recreational Fishery; Emergency Rule [Docket No.: 0909101271-91272-01] (RIN: 0648-AY23) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4733. A letter from the Deputy Assistant Administrator for Management and Administration, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Endangered and Threatened Wildlife and Plants; Final Rulemaking To Designate Critical Habitat for the Threatened Southern Distinct Population Segment of North American Green Sturgeon [Docket No.: 080730953-91263-02] (RIN: 0648-AX04) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4734. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Shrimp Fishery off the Southern Atlantic States; Amendment 7 [Docket No.: 071025620-91118-03] (RIN: 0648-AW19) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4735. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Northeastern United States; Scup Fishery; Commercial Quota Harvested for 2009 Summer Period [Docket No.: 0809251266-81485-02] (RIN: 0648-XR94) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4736. A letter from the Acting Assistant Administrator for Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries in the Western Pacific; Bottomfish and Seamount Groundfish Fisheries; 2009-10 Main Hawaiian Islands Bottomfish Total Allowable Catch [Docket No.: 0908131233-91275-02] (RIN: 0648-XQ14) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4737. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Western Alaska Community Development Quota Program, Rockfish Program, Amendment 80 Program; Bering Sea and Aleutian Islands Area Crab Rationalization Program [Docket No.: 080312430-91317-02] (RIN: 0648-AW56) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4738. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Reallocation of Yellowfin Sole in the Bering Sea and Aleutian Islands Management Area [Docket No.: 0810141351-9087-02] (RIN: 0648-XS12) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4739. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Ocean Perch for Vessels in the Bering Sea and Aleutian Islands Trawl Limited Access Fishery in the Western Aleutian District of the Bering Sea and Aleutian Islands Management Area [Docket No.: 0810141351-9087-02] (RIN: 0648-XR78) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4740. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Coastal Migratory Pelagic Resources of the Gulf of Mexico and South Atlantic; Closure [Docket No.: 001005281-0369-02] (RIN: 0648-XR32) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4741. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Atka Mackerel in the Bering Sea and Aleutian Islands Management Area [Docket No.: 0810141351-9087-02] (RIN: 0648-XS11) received October 23, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4742. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 610 in the Gulf of Alaska [Docket No.: 09100091344-9056-02] (RIN: 0648-XS17) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4743. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Cod by Vessels Catching Pacific Cod for Processing by the Inshore Component in the Central Regulatory Area of the Gulf of Alaska [Docket No.: 0910091344-9056-02] (RIN: 0648-XR92) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4744. A letter from the Assistant Attorney General, Department of Justice, transmitting the annual report of the Office of Justice Programs' Bureau of Justice Assistance for Fiscal Year 2006 and 2007, pursuant to 42 U.S.C. 3712(b); to the Committee on the Judiciary.

4745. A letter from the Chairperson, National Commission on Children and Disasters, transmitting An interim report on the Commission's progress, pursuant to Public Law 110-161, section 611(a) (121 Stat. 2217); to the Committee on Transportation and Infrastructure.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. SMITH of Texas (for himself and Mr. COBLE):

H.R. 4113. A bill to amend title 28, United States Code, to clarify the jurisdiction of the Federal courts, and for other purposes; to the Committee on the Judiciary.

By Mrs. MALONEY (for herself, Mr. HELLER, Mr. NADLER of New York, Mr. KENNEDY, Mrs. CAPPS, Mr. WAXMAN, Ms. SPEIER, Mr. MCGOVERN, Mr. ISRAEL, Mr. GRIJALVA, Ms. RICHARDSON, Mr. PERRIELLO, Mr. ENGEL, Mr. DELAHUNT, Mr. COSTA, Ms. WATSON, Mr. HALL of New York, Mr. STARK, Ms. CHU, Ms. NORTON, Mr. MOORE of Kansas, Mr. HOLT, and Mr. SCHIFF):

H.R. 4114. A bill to reduce the rape kit backlog, and for other purposes; to the Committee on the Judiciary.

By Mr. NADLER of New York (for himself, Mr. JOHNSON of Georgia, Mr. CONYERS, Mr. SCOTT of Virginia, Mr. DELAHUNT, Ms. JACKSON-LEE of Texas, Ms. CHU, Mr. MICHAUD, Ms. KILPATRICK of Michigan, and Mr. COHEN):

H.R. 4115. A bill to amend title 28, United States Code, to provide a restoration of notice pleading in Federal courts, and for other purposes; to the Committee on the Judiciary.

By Ms. MOORE of Wisconsin (for herself, Mr. SCHOCK, Mr. SABLAN, and Mrs. BIGGERT):

H.R. 4116. A bill to reauthorize the Family Violence Prevention and Services Act, and for other purposes; to the Committee on Education and Labor.

By Mr. ARCURI (for himself, Mr. LEE of New York, Mr. COURTNEY, and Mr. HOLDEN):

H.R. 4117. A bill to amend the Agricultural Adjustment Act to clarify that the delivery of milk to a handler under a Federal milk marketing order occurs when the raw milk is received at the producer's farm, and the producer may not be charged for transportation-related costs incurred by a handler after the raw milk leaves the farm, and for other purposes; to the Committee on Agriculture.

By Mr. KIRK (for himself and Mr. ROSKAM):

H.R. 4118. A bill to prohibit the Federal Government from holding security interests, and for other purposes; to the Committee on Financial Services.

By Mr. REHBERG:

H.R. 4119. A bill to authorize the construction of the Dry-Redwater Regional Water Authority System in the State of Montana and a portion of McKenzie County, North Dakota, and for other purposes; to the Committee on Natural Resources.

By Mr. LATHAM (for himself, Mr. KING of Iowa, Mr. TERRY, Mr. LUETKEMEYER, Mrs. BACHMANN, Mr. JOHNSON of Illinois, Mr. BLUNT, Ms. JENKINS, Mr. BURTON of Indiana, Mr. TIAHRT, Mr. SHIMKUS, Mr. MORAN of Kansas, Mr. ROSKAM, Mr. FORTENBERRY, Mr. SENSENBRENNER, and Mr. KLINE of Minnesota):

H.R. 4120. A bill to prohibit the transfer of individuals detained at Guantanamo Bay, Cuba, to facilities in Midwestern States, and for other purposes; to the Committee on Armed Services, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HALL of New York (for himself, Mr. BILBRAY, Mr. LAMBORN, Mr. RODRIGUEZ, Mrs. KIRKPATRICK of Arizona, Mrs. HALVORSON, Mr. DONNELLY of Indiana, and Mr. MILLER of Florida):

H.R. 4121. A bill to amend title 38, United States Code, to improve the appeals process of the Department of Veterans Affairs, to establish a commission to study judicial review of the determination of veterans' benefits, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. GEORGE MILLER of California (for himself, Mr. KILDEE, Mr. SCOTT of Virginia, Mr. HINOJOSA, Mr. GRIJALVA, Mr. LOEBSACK, Mr. DAVIS of Illinois, and Mr. FATTAH):

H.R. 4122. A bill to support high-need middle and high schools in order to improve students' academic achievement, graduation rates, postsecondary readiness, and preparation for citizenry; to the Committee on Education and Labor.

By Ms. WATERS (for herself, Mr. BOOZMAN, Mr. MARKEY of Massachusetts, Mr. SMITH of New Jersey, Mr. WOLF, Ms. ROS-LEHTINEN, Ms. LINDA T. SÁNCHEZ of California, Mr. TOWNS, Mrs. CHRISTENSEN, Ms. RICHARDSON, Ms. SHEA-PORTER, Mr. GRIJALVA, Ms. NORTON, Mr. SALAZAR, Mr. KILDEE, Mr. WELCH, Mr. DELAHUNT, Mr. TAYLOR, Mr. GENE GREEN of Texas, Mr. MCGOVERN, Mr. MEEKS of New York, Mr. CARNEY, Mr. MEEK of Florida, Ms. BORDALLO, Mr. BOSWELL, Mr. BLUMENAUER, Mr. HINOJOSA, Mr. BISHOP of Georgia, Mr. MASSA, Ms. KAPTUR, Ms. ROYBAL-ALLARD, Mr. SIRES, Mr. LOBIONDO, Mr. SCHIFF, Mr. KENNEDY, Mr. SCOTT of Virginia, Mr. FRANK of Massachusetts, Mr. NEAL of Massachusetts, Ms. SCHAKOWSKY, Mr. COURTNEY, Mr. COHEN, Mr. CLAY, Mr. RYAN of Ohio, Mr. HASTINGS of Florida, Mr. PAYNE, Mr. KUCINICH, Mr. LEWIS of Georgia, Mr. LOEBSACK, Mr. OLVER, Ms. FUDGE, Mr. HIGGINS, Ms. CORRINE BROWN of Florida, Ms. LEE of California, Mr. MCDERMOTT, Mrs. MALONEY, Mr. PIERLUISI, Mr. BRALEY of Iowa, and Ms. LORETTA SANCHEZ of California):

H.R. 4123. A bill to amend the Public Health Service Act to authorize grants for treatment and support services for Alzheimer's patients and their families; to the Committee on Energy and Commerce.

By Mrs. DAVIS of California (for herself, Ms. RICHARDSON, Mr. LOEBSACK, and Ms. BORDALLO):

H.R. 4124. A bill to amend the Public Health Service Act with respect to the prevention of diabetes, and for other purposes; to the Committee on Energy and Commerce.

By Mr. NYE (for himself, Mr. ELLSWORTH, Ms. VELÁZQUEZ, Mr. SCHRADER, Mr. ALTMIRE, Ms. CLARKE, Mrs. KIRKPATRICK of Arizona, Ms. BEAN, and Mrs. DAHLKEMPER):

H.R. 4125. A bill to amend the Small Business Act to improve services for small business concerns owned and controlled by service-disabled veterans, and for other purposes; to the Committee on Small Business.

By Mr. DOGGETT (for himself, Mr. STARK, Mr. MCDERMOTT, Mr. LEWIS of Georgia, Mr. PASCRELL, Ms. LINDA T. SÁNCHEZ of California, Mr. BRALEY of Iowa, Mr. HINCHEY, Mr. MASSA, Ms. SCHAKOWSKY, Mr. WELCH, Mr. GENE GREEN of Texas, Mr. DEFAZIO, Mr. MCGOVERN, Mr. TIERNEY, Mr. YARMUTH, and Mr. BLUMENAUER):

H.R. 4126. A bill to amend the Internal Revenue Code of 1986 to prevent the overstatement of benefits payable to non-highly compensated employees under qualified plans, and for other purposes; to the Committee on Ways and Means.

By Mr. GOHMERT (for himself, Mr. SMITH of Texas, Mr. DANIEL E. LUNGREN of California, Mr. OLSON, Mr. BROUN of Georgia, Ms. FOXX, Mr. ROE of Tennessee, Ms. FALLIN, Mr. GARRETT of New Jersey, Mr. CARTER, Mr. MARCHANT, Mr. LAMBORN, Mr. CONAWAY, Mr. HALL of Texas, Mr. SHADEGG, Mr. PITTS, Mr. POSEY, Mr. BISHOP of Utah, Mr. ROONEY, Ms. GINNY BROWN-WAITE of Florida, Mrs. SCHMIDT, Mr. COLE, Mr. LATTA, Mrs. LUMMIS, Mr. BONNER, Mr. BURTON of Indiana, Mr. GINGREY of Georgia, Mr. NEUGEBAUER, Mr. PENCE, Mr. CULBERSON, Mrs. BACHMANN, Mr. FRANKS of Arizona, Mr. WILSON of South Carolina, Mr. WITTMAN, Mr. BACHUS, Ms. GRANGER, Mrs. BLACKBURN, Mr. ALEXANDER, Mr. KING of New York, Mr. MCCARTHY of California, Mr. RYAN of Wisconsin, and Mr. SESSIONS):

H.R. 4127. A bill to amend title 10, United States Code, to provide that alien unprivileged enemy belligerents may only be tried by military commissions if tried for alleged conduct for which a term of incarceration or the death penalty may be sought; to the Committee on Armed Services.

By Mr. MCDERMOTT (for himself, Mr. WOLF, Mr. FRANK of Massachusetts, and Mr. PAYNE):

H.R. 4128. A bill to improve transparency and reduce trade in conflict minerals, and for other purposes; to the Committee on Foreign Affairs, and in addition to the Committees on Ways and Means, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. MALONEY (for herself, Mr. SMITH of New Jersey, Mr. CONYERS, and Mr. CARDOZA):

H.R. 4129. A bill to amend the Crime Control Act of 1990 to require certification of State and law enforcement agency reports related to missing children and to require that certain information be provided to individuals reporting a missing child, and for other purposes; to the Committee on the Judiciary.

By Mr. OBEY (for himself, Mr. MURTHA, Mr. LARSON of Connecticut, Ms. ESHOO, Mr. FARR, Mr. FRANK of Massachusetts, Mr. GRIJALVA, Ms. MCCOLLUM, Mr. MCDERMOTT, Mr. MCGOVERN, and Ms. LINDA T. SÁNCHEZ of California):

H.R. 4130. A bill to amend the Internal Revenue Code of 1986 to establish a temporary surtax to offset the costs of the Afghanistan war; to the Committee on Ways and Means.

By Mr. ADLER of New Jersey (for himself and Ms. DEGETTE):

H.R. 4131. A bill to prohibit smoking in and around Federal buildings; to the Committee on Transportation and Infrastructure, and in addition to the Committees on House Administration, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BECERRA (for himself, Ms. GINNY BROWN-WAITE of Florida, Ms. ROYBAL-ALLARD, Mr. PUTNAM, and Ms. RICHARDSON):

H.R. 4132. A bill to amend the Internal Revenue Code of 1986 to provide for clean renewable water supply bonds; to the Committee on Ways and Means.

By Mr. CANTOR (for himself and Mr. DAVIS of Alabama):

H.R. 4133. A bill to amend the Internal Revenue Code of 1986 to exempt public school rehabilitation from the tax-exempt use exception to the rehabilitation credit; to the Committee on Ways and Means.

By Mr. CLAY (for himself, Ms. CLARKE, Mr. GRIJALVA, Mrs. CHRISTENSEN, Ms. BORDALLO, Ms. NORTON, Ms. CORRINE BROWN of Florida, and Mr. DAVIS of Illinois):

H.R. 4134. A bill to require companies submitting offers to the Government for Federal contracts to include subcontracting agreements with the offers, and for other purposes; to the Committee on Oversight and Government Reform, and in addition to the Committee on Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. DELAURO (for herself, Mr. HARE, Mr. HASTINGS of Florida, Mr. TONKO, Ms. NORTON, Ms. WOOLSEY, Ms. LINDA T. SÁNCHEZ of California,

Mr. NADLER of New York, Mr. CAPUANO, and Ms. JACKSON-LEE of Texas):

H.R. 4135. A bill to keep Americans working by strengthening and expanding short-time compensation programs that provide employers with an alternative to layoffs; to the Committee on Ways and Means.

By Mr. ETHERIDGE:

H.R. 4136. A bill to extend the temporary duty suspensions on certain cotton shirting fabrics, and for other purposes; to the Committee on Ways and Means.

By Mr. FRANK of Massachusetts:

H.R. 4137. A bill to authorize the Secretary of the Interior to provide preservation and interpretation assistance for resources associated with the New Bedford Whaling National Historical Park in the Commonwealth of Massachusetts, and for other purposes; to the Committee on Natural Resources.

By Mr. GINGREY of Georgia (for himself, Mr. CASSIDY, Mr. FLEMING, Mr. BOOZMAN, Mr. HERGER, Mr. SESSIONS, Mr. CULBERSON, Mr. HALL of Texas, Mr. WHITFIELD, Mr. SHIMKUS, Mr. BUYER, Mrs. MYRICK, Mr. PAULSEN, Mr. ROONEY, Ms. GRANGER, Mr. ROSKAM, Mrs. BLACKBURN, Mr. PRICE of Georgia, and Mr. ROE of Tennessee):

H.R. 4138. A bill to amend title XVIII of the Social Security Act to provide for an update under the Medicare physician fee schedule, to be fully paid for through medical liability reform, a pathway for biosimilar biological products, and other means; to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HARPER (for himself, Mr. CHILDERS, Mr. THOMPSON of Mississippi, and Mr. TAYLOR):

H.R. 4139. A bill to designate the facility of the United States Postal Service located at 7464 Highway 503 in Hickory, Mississippi, as the ''Sergeant Matthew L. Ingram Post Office''; to the Committee on Oversight and Government Reform.

By Mr. HASTINGS of Florida (for himself, Mrs. CHRISTENSEN, Ms. CLARKE, Mr. CLEAVER, Mr. CONYERS, Mr. AL GREEN of Texas, Mr. GRIJALVA, Ms. JACKSON-LEE of Texas, Mr. MEEKS of New York, Mr. RANGEL, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. TOWNS, Ms. WASSERMAN SCHULTZ, Ms. WATERS, Ms. WATSON, and Mr. WEXLER):

H.R. 4140. A bill to provide for an evidence-based strategy for voluntary screening for HIV/AIDS and other common sexually transmitted infections, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HILL:

H.R. 4141. A bill to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to allow certain individuals and households to be eligible for Federal assistance; to the Committee on Transportation and Infrastructure.

By Mr. HINCHEY:

H.R. 4142. A bill to address the concept of ''Too Big To Fail'' with respect to certain financial entities; to the Committee on Financial Services.

By Mr. INGLIS:

H.R. 4143. A bill to suspend temporarily the duty on silver sodium hydrogen zirconium phosphate; to the Committee on Ways and Means.

By Mr. INSLEE (for himself, Ms. BERKLEY, Ms. BALDWIN, Mr. BLUMENAUER, Mr. BARTLETT, Ms. MCCOLLUM, and Ms. SUTTON):

H.R. 4144. A bill to amend the Internal Revenue Code of 1986 to modify the investment tax credit for combined heat and power system property; to the Committee on Ways and Means.

By Mr. SAM JOHNSON of Texas:

H.R. 4145. A bill to amend title II of the Social Security Act to prohibit the issuance of Social Security account numbers to nonimmigrant aliens who are admitted to the United States as students in order to pursue a full course of study or their spouses or minor children unless such aliens are applicants for or recipients of benefits under a program financed by the Federal Government; to the Committee on Ways and Means.

By Mr. KLINE of Minnesota:

H.R. 4146. A bill to amend title I of the Employee Retirement Income Security Act of 1974 to provide for disclosure regarding compensation for services to pension plans; to the Committee on Education and Labor.

By Mr. LEWIS of Georgia (for himself and Mr. DAVIS of Kentucky):

H.R. 4147. A bill to provide for rollover treatment to traditional IRAs of amounts received in airline carrier bankruptcy; to the Committee on Ways and Means.

By Mr. LOEBSACK (for himself, Mrs. EMERSON, Mr. GRIJALVA, Mrs. DAVIS of California, Mr. POLIS of Colorado, Mr. MCGOVERN, Ms. CHU, Ms. MCCOLLUM, Ms. WOOLSEY, Mr. ANDREWS, Mr. SCOTT of Virginia, and Mr. AL GREEN of Texas):

H.R. 4148. A bill to amend the Richard B. Russell National School Lunch Act to improve and expand direct certification procedures for the national school lunch and school breakfast programs, and for other purposes; to the Committee on Education and Labor, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. MARKEY of Colorado (for herself and Mr. PAULSEN):

H.R. 4149. A bill to amend the Internal Revenue Code of 1986 to provide a renewable electricity integration credit for a utility that purchases or produces renewable power; to the Committee on Ways and Means.

By Mr. NEUGEBAUER:

H.R. 4150. A bill to designate the Department of Veterans Affairs medical center in Big Spring, Texas, as the George H. O'Brien, Jr., Department of Veterans Affairs Medical Center; to the Committee on Veterans' Affairs.

By Ms. NORTON:

H.R. 4151. A bill to amend title XIX of the Social Security Act to increase the Federal medical assistance percentage for the District of Columbia under the Medicaid Program to 75 percent; to the Committee on Energy and Commerce.

By Mr. PALLONE:

H.R. 4152. A bill to authorize the Secretary of Education to make grants to eligible schools to assist such schools to discontinue use of a derogatory or discriminatory name or depiction as a team name, mascot, or nickname, and for other purposes; to the Committee on Education and Labor.

By Mr. PLATTS (for himself and Mrs. MCCARTHY of New York):

H.R. 4153. A bill to amend title 23, United States Code, to establish national standards to prevent distracted driving, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. POMEROY:

H.R. 4154. A bill to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than would benefit from repeal, to retain the estate tax with a $3,500,000 exemption, and for other purposes; to the Committee on Ways and Means.

By Mr. SARBANES:

H.R. 4155. A bill to amend the Internal Revenue Code of 1986 to permit the issuance of tax-exempt bonds for financing clean energy improvements under State and local property assessed clean energy programs; to the Committee on Ways and Means.

By Mr. SIRES:

H.R. 4156. A bill to provide for certain improvements in the laws relating to housing for veterans, and for other purposes; to the Committee on Financial Services.

By Mr. TIAHRT (for himself, Mr. SAM JOHNSON of Texas, Mr. INGLIS, and Mr. SOUDER):

H.R. 4157. A bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program and return all unobligated funds to reduce the public debt; to the Committee on Financial Services.

By Mr. YARMUTH:

H.R. 4158. A bill to suspend temporarily the duty on certain hydrogenated polymers of norbornene derivatives; to the Committee on Ways and Means.

By Ms. JACKSON-LEE of Texas (for herself, Mr. CLAY, Mr. CONYERS, Ms. CLARKE, Mr. DELAHUNT, Mr. AL GREEN of Texas, Mr. GRIJALVA, Mr. HASTINGS of Florida, Mr. RANGEL, and Ms. SPEIER):

H. Con. Res. 215. Concurrent resolution supporting the goals and ideals of World AIDS Day, and for other purposes; to the Committee on Energy and Commerce.

By Mr. SMITH of Texas (for himself, Mr. FRANKS of Arizona, Mr. POE of Texas, Mr. GOHMERT, Mr. COBLE, Mr. GALLEGLY, Mr. CHAFFETZ, Mr. SENSENBRENNER, Mr. HARPER, Mr. JORDAN of Ohio, Mr. ROONEY, Mr. DANIEL E. LUNGREN of California, Mr. ISSA, Mr. KING of Iowa, Mr. GOODLATTE, and Mr. FORBES):

H. Res. 920. A resolution directing the Attorney General to transmit to the House of Representatives all information in the Attorney General's possession regarding certain matters pertaining to detainees held at Naval Station, Guantanamo Bay, Cuba who are transferred into the United States; to the Committee on the Judiciary.

By Mr. LARSON of Connecticut:

H. Res. 921. A resolution electing Members to certain standing committees of the House of Representatives; considered and agreed to.

By Mr. KING of New York (for himself, Mr. SMITH of Texas, Mr. SOUDER, Mr. DANIEL E. LUNGREN of California, Mr. ROGERS of Alabama, Mr. MCCAUL, Mr. DENT, Mr. BILIRAKIS, Mr. BROUN of Georgia, Mrs. MILLER of Michigan, Mr. OLSON, Mr. CAO, and Mr. AUSTRIA):

H. Res. 922. A resolution directing the Secretary of Homeland Security to transmit to the House of Representatives all information

in the possession of the Department of Homeland Security relating to the Department's planning, information sharing, and coordination with any state or locality receiving detainees held at Naval Station, Guantanamo Bay, Cuba on or after January 20, 2009; to the Committee on Homeland Security.

By Mr. HOEKSTRA:

H. Res. 923. A resolution requesting the President to transmit to the House of Representatives all documents in the possession of the President relating to the effects on foreign intelligence collection of the transfer of detainees held at Naval Station, Guantanamo Bay, Cuba, into the United States; to the Committee on Intelligence (Permanent Select).

By Mr. MCKEON:

H. Res. 924. A resolution directing the Secretary of Defense to transmit to the House of Representatives copies of any document, record, memo, correspondence, or other communication of the Department of Defense, or any portion of such communication, that refers or relates to the trial or detention of Khalid Sheikh Mohammed, Walid Muhammad Salih Mubarek Bin 'Attash, Ramzi Binalshibh, Ali Abdul Aziz Ali, or Mustafa Ahmed Adam al Hawsawi; to the Committee on Armed Services.

By Mr. DEFAZIO (for himself, Mr. STEARNS, Mrs. DAVIS of California, Mr. LARSEN of Washington, Mr. MARSHALL, Mr. MASSA, Mr. RODRIGUEZ, Ms. BORDALLO, Mr. LAMBORN, Mr. DOGGETT, Mr. BRALEY of Iowa, Mr. PERLMUTTER, Mr. BLUMENAUER, Ms. KAPTUR, Mr. BOCCIERI, Mr. SCHRADER, Mr. MICHAUD, Mr. COOPER, Mr. FILNER, Mr. FARR, and Mr. DICKS):

H. Res. 925. A resolution expressing the sense of the House of Representatives regarding the meritorious service performed by aviators in the United States Armed Forces who were shot down over, or otherwise forced to land in, hostile territory yet evaded enemy capture or were captured but subsequently escaped; to the Committee on Armed Services.

By Mr. TOWNS:

H. Res. 926. A resolution honoring former Representative Shirley Chisholm, on the occasion of the 85th anniversary of her birth, for her dedication and for providing an example of selfless service; to the Committee on House Administration.

By Mr. BARTON of Texas:

H. Res. 927. A resolution declaring that it shall continue to be the policy of the United States, consistent with the Taiwan Relations Act, to make available to Taiwan such defense articles and services as may be necessary for Taiwan to maintain a sufficient self-defense capability; to the Committee on Foreign Affairs.

By Ms. RICHARDSON (for herself, Mr. OBERSTAR, Ms. LEE of California, Mr. MCDERMOTT, Ms. MOORE of Wisconsin, Mr. STARK, Mr. JOHNSON of Georgia, Mr. RUSH, Ms. JACKSON-LEE of Texas, Mr. CARSON of Indiana, and Mr. FATTAH):

H. Res. 928. A resolution supporting of the goals and ideals of Universal Children's Day to encourage citizens in the United States to share in the mission of improving the lives of all children around the world; to the Committee on Foreign Affairs.

By Ms. RICHARDSON (for herself, Mrs. CHRISTENSEN, Ms. NORTON, Mr. HARE, Mr. JOHNSON of Georgia, Mr. FATTAH, Mr. COHEN, Ms. MOORE of Wisconsin, Ms. JACKSON-LEE of Texas, Mr. GRIJALVA, and Mr. HONDA):

H. Res. 929. A resolution recognizing December 2 as the International Day for the Abolition of Slavery and the 60th anniversary of the adoption by the United Nations General Assembly of the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others and commending the efforts of modern day abolitionists following in the tradition of Frederick Douglass; to the Committee on Foreign Affairs.

By Ms. JACKSON-LEE of Texas:

H. Res. 930. A resolution supporting the goals and ideals of the 20th anniversary celebration of the Harris County Hospital District's Thomas Street Health Center, which coincides with World AIDS Day; to the Committee on Energy and Commerce.

By Mr. CARSON of Indiana:

H. Res. 931. A resolution supporting the goals and ideals of the International Day for the Elimination of Violence against Women; to the Committee on Foreign Affairs, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. CHU (for herself and Ms. MATSUI):

H. Res. 932. A resolution expressing the sense of the Congress that all State public health departments, local public health departments, hospitals, doctor offices, and other health care providers should adhere to guidelines issued from the Centers for Disease Control and Prevention with regard to the H1N1 influenza virus; to the Committee on Energy and Commerce.

By Mr. DINGELL:

H. Res. 933. A resolution commending the Government of Japan for its current policy against currency manipulation and encouraging the Government of Japan to continue in this policy; to the Committee on Ways and Means.

By Mr. DINGELL:

H. Res. 934. A resolution calling on the Government of the Republic of Korea to end unfair trade practices as such practices relate to the automotive industry, expressing the sense of the House of Representatives that it should take into account such unfair trade practices of the Republic of Korea when the House of Representatives considers the United States-Korea Free Trade Agreement, and for other purposes; to the Committee on Ways and Means.

By Ms. ZOE LOFGREN of California (for herself, Mr. HALL of New York, Mr. LEE of New York, and Mr. MINNICK):

H. Res. 935. A resolution honoring John E. Warnock, Charles M. Geschke, Forrest M. Bird, Esther Sans Takeuchi, and IBM Corporation for receiving the 2008 National Medal of Technology and Innovation; to the Committee on Science and Technology.

By Mr. QUIGLEY (for himself, Ms. BEAN, Mrs. BIGGERT, Mr. COSTELLO, Mr. DAVIS of Illinois, Mr. GUTIERREZ, Mr. FOSTER, Mr. HARE, Mrs. HALVORSON, Mr. JACKSON of Illinois, Mr. JOHNSON of Illinois, Mr. KIRK, Mr. LIPINSKI, Mr. MANZULLO, Mr. ROSKAM, Mr. RUSH, Ms. SCHAKOWSKY, and Mr. SHIMKUS):

H. Res. 936. A resolution honoring the citizen-soldiers of the Army National Guard of the State of Illinois, including the 33rd Infantry Brigade Combat Team of the Illinois Army National Guard, which recently returned from deployment to Afghanistan; to the Committee on Armed Services.

By Ms. ROS-LEHTINEN (for herself, Mr. DREIER, Mr. BRADY of Texas, and Mr. HASTINGS of Washington):

H. Res. 937. A resolution recognizing that Colombia is a vital democratic ally of the United States in the fight against extremism and drug trafficking in the Western Hemisphere and further recognizing the extensive and immediate benefits that passage of the United States-Colombia Trade Promotion Agreement would bring to the United States; to the Committee on Foreign Affairs, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. THOMPSON of California (for himself, Mr. GENE GREEN of Texas, Mrs. BONO MACK, and Mr. BILBRAY):

H. Res. 938. A resolution expressing the sense of the House of Representatives that the leaders of Congress and other legislative branch offices should work together to establish and implement a coordinated program for the reuse, recycling, and appropriate disposal of obsolete computers and other electronic equipment used by offices of the legislative branch; to the Committee on House Administration.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 18: Mr. DAVIS of Kentucky.

H.R. 24: Mr. ROYCE, Mr. HOLT, Mr. MEEK of Florida, Mr. AUSTRIA, Mr. RYAN of Wisconsin, and Mr. HODES.

H.R. 39: Mr. BOUCHER.

H.R. 156: Mr. ROGERS of Kentucky.

H.R. 211: Mr. MAFFEI, Mr. HIGGINS, and Mr. BRIGHT.

H.R. 275: Mr. CALVERT and Mr. GARY G. MILLER of California.

H.R. 305: Mr. ACKERMAN.

H.R. 333: Mr. STUPAK.

H.R. 391: Mr. WAMP.

H.R. 422: Mr. BOUSTANY and Ms. JENKINS.

H.R. 571: Ms. SHEA-PORTER and Ms. MARKEY of Colorado.

H.R. 593: Mr. STUPAK.

H.R. 644: Mr. MASSA, Mr. LUJÁN, and Mr. INSLEE.

H.R. 678: Mr. LATOURETTE.

H.R. 690: Mr. TOWNS.

H.R. 705: Mr. SESTAK.

H.R. 803: Mr. CONNOLLY of Virginia.

H.R. 847: Mr. NEAL of Massachusetts, Mr. PATRICK J. MURPHY of Pennsylvania, Mr. UPTON, Mr. FILNER, and Ms. HARMAN.

H.R. 886: Mr. ALEXANDER.

H.R. 916: Ms. EDDIE BERNICE JOHNSON of Texas, Mr. DOGGETT, and Mr. AL GREEN of Texas.

H.R. 932: Mr. LANGEVIN.

H.R. 995: Mr. ELLISON, Mr. MOORE of Kansas, and Mr. WILSON of Ohio.

H.R. 1021: Mr. GONZALEZ and Mr. BISHOP of New York.

H.R. 1028: Mr. HALL of New York, Mr. DOGGETT, and Mr. DEAL of Georgia.

H.R. 1074: Mr. HEINRICH.

H.R. 1126: Ms. ESHOO.

H.R. 1132: Mr. SMITH of Washington and Mr. POSEY.

H.R. 1175: Mr. HALL of New York.

H.R. 1177: Ms. BEAN, Mr. GUTIERREZ, Mr. RANGEL, Mr. RAHALL, Mr. RUSH, Mr. BRALEY of Iowa, Mr. LOEBSACK, Mr. INSLEE, Mr. DICKS, Mr. ALTMIRE, Mr. BACA, Mr. BARROW, Mr. BERRY, Mr. BOYD, Mr. CARDOZA, Mr. CARNEY, Mr. CHANDLER, Mr. CHILDERS, Mr. COOPER, Mr. COSTA, Mr. DAVIS of Tennessee, Mr.

DONNELLY of Indiana, Ms. GIFFORDS, Mr. GORDON of Tennessee, Mr. GRIFFITH, Ms. HARMAN, Mr. HILL, Mr. HOLDEN, Mr. MATHESON, Mr. MELANCON, Mr. NYE, Mr. POMEROY, Mr. ROSS, Mr. SALAZAR, Mr. SCOTT of Georgia, Mr. SHULER, Mr. SPACE, Mr. THOMPSON of California, Mr. WILSON of Ohio, Mr. ELLSWORTH, and Mr. DRIEHAUS.

H.R. 1203: Mr. HALL of Texas.

H.R. 1205: Mr. FORTENBERRY.

H.R. 1207: Mr. CLAY and Mr. LUJÁN.

H.R. 1214: Mr. PETERS.

H.R. 1228: Mr. CALVERT.

H.R. 1250: Mr. LINDER and Mr. DENT.

H.R. 1310: Ms. GIFFORDS.

H.R. 1330: Mr. AL GREEN of Texas.

H.R. 1335: Mr. LEWIS of Georgia.

H.R. 1351: Mr. CARSON of Indiana.

H.R. 1407: Mr. ROSS.

H.R. 1521: Mr. LINDER, Mr. SCHOCK, and Mr. HELLER.

H.R. 1523: Mr. FRANK of Massachusetts.

H.R. 1526: Mr. WAMP.

H.R. 1545: Mr. WELCH.

H.R. 1552: Mr. SNYDER.

H.R. 1557: Mr. DUNCAN and Ms. JENKINS.

H.R. 1584: Ms. ROS-LEHTINEN.

H.R. 1585: Mr. DELAHUNT.

H.R. 1616: Ms. SLAUGHTER and Ms. TITUS.

H.R. 1625: Mr. ALTMIRE.

H.R. 1708: Mrs. DAVIS of California and Ms. MOORE of Wisconsin.

H.R. 1778: Mr. RYAN of Ohio.

H.R. 1806: Ms. SCHAKOWSKY, Mr. CARNEY, and Ms. WASSERMAN SCHULTZ.

H.R. 1831: Mr. BUYER.

H.R. 1836: Mr. AUSTRIA.

H.R. 1869: Ms. MOORE of Wisconsin.

H.R. 1894: Ms. PINGREE of Maine.

H.R. 1956: Mr. SCHRADER.

H.R. 1990: Mrs. KIRKPATRICK of Arizona.

H.R. 2140: Mr. WHITFIELD.

H.R. 2143: Mr. SMITH of Nebraska.

H.R. 2149: Mr. PETERSON and Mr. Nye.

H.R. 2159: Mr. ACKERMAN, Ms. CLARKE, and Mrs. MALONEY.

H.R. 2189: Mr. GARRETT of New Jersey.

H.R. 2194: Mr. LEWIS of California.

H.R. 2222: Mr. PLATTS.

H.R. 2296: Mr. HALL of Texas.

H.R. 2324: Mrs. CAPPS and Ms. JACKSON-LEE of Texas.

H.R. 2365: Ms. ZOE LOFGREN of California.

H.R. 2382: Mr. ABERCROMBIE.

H.R. 2390: Mr. PAYNE and Mr. DOGGETT.

H.R. 2425: Ms. EDWARDS of Maryland.

H.R. 2443: Mr. MURPHY of Connecticut.

H.R. 2455: Mr. WAXMAN, Mr. ABERCROMBIE, Mr. COURTNEY, Ms. JACKSON-LEE of Texas, Mr. DEFAZIO, Mr. MCGOVERN, Mrs. CAPPS, and Ms. ESHOO.

H.R. 2460: Mr. LANGEVIN.

H.R. 2478: Mr. CRENSHAW and Mrs. BONO MACK.

H.R. 2480: Mr. OLVER.

H.R. 2502: Ms. EDWARDS of Maryland.

H.R. 2528: Mr. LARSEN of Washington, Mr. DAVIS of Alabama, and Mr. BOUSTANY.

H.R. 2628: Ms. FUDGE.

H.R. 2698: Mr. PASTOR of Arizona.

H.R. 2699: Mr. PASTOR of Arizona and Mr. MINNICK.

H.R. 2710: Mr. CUELLAR and Mr. WILSON of Ohio.

H.R. 2737: Ms. ZOE LOFGREN of California, Mr. OLSON, Mr. KILDEE, Mr. PRICE of Georgia, and Mr. ALTMIRE.

H.R. 2755: Mr. JACKSON of Illinois.

H.R. 2788: Mr. BARTON of Texas.

H.R. 2807: Mr. JOHNSON of Illinois.

H.R. 2817: Mr. DOGGETT and Mr. WELCH.

H.R. 2829: Mr. ROTHMAN of New Jersey.

H.R. 2866: Mr. KLEIN of Florida and Mr. RYAN of Ohio.

H.R. 2906: Mr. LATHAM.

H.R. 2964: Ms. EDWARDS of Maryland.

H.R. 2999: Mr. WELCH.

H.R. 3004: Mr. SCHOCK.

H.R. 3024: Mr. CLAY, Ms. ROYBAL-ALLARD, and Ms. MCCOLLUM.

H.R. 3037: Mr. KRATOVIL.

H.R. 3077: Mr. DOGGETT and Mr. MARKEY of Massachusetts.

H.R. 3105: Mr. CAMPBELL.

H.R. 3131: Mr. JONES.

H.R. 3185: Ms. FUDGE.

H.R. 3212: Mrs. CAPPS.

H.R. 3226: Mr. CALVERT.

H.R. 3239: Ms. RICHARDSON.

H.R. 3240: Mr. MCCOTTER.

H.R. 3286: Mr. CHANDLER.

H.R. 3315: Mr. RUSH, Mr. FILNER, Mr. PAYNE, and Mrs. CHRISTENSEN.

H.R. 3321: Ms. LEE of California, Ms. CLARKE, Mr. SCOTT of Virginia, and Mr. PAYNE.

H.R. 3343: Mr. JACKSON of Illinois.

H.R. 3355: Mr. SPACE, Mr. WALZ and Mr. LATOURETTE.

H.R. 3359: Mr. HONDA, Mr. GENE GREEN of Texas, and Ms. RICHARDSON

H.R. 3380: Mr. BISHOP of New York and Mr. JOHNSON of Georgia.

H.R. 3382: Mr. LOBIONDO.

H.R. 3401: Ms. LEE of California, Mr. ELLISON, Ms. ESHOO, Mr. COHEN, and Ms. GINNY BROWN-WAITE of Florida.

H.R. 3404: Mr. CARDOZA.

H.R. 3450: Ms. KAPTUR, Mr. JONES, Mr. FILNER, Ms. WATSON, Mr. RUSH, Mr. TOWNS, and Mr. MEEKS of New York.

H.R. 3463: Mr. KING of Iowa.

H.R. 3502: Mr. BRALEY of Iowa.

H.R. 3519: Mr. COLE, Mr. ROE of Tennessee, and Mr. ALEXANDER.

H.R. 3524: Mr. COSTELLO, Mr. BLUMENAUER, and Mr. LANGEVIN.

H.R. 3554: Mr. FRANK of Massachusetts.

H.R. 3578: Mr. SCHIFF.

H.R. 3589: Mr. LOBIONDO and Mr. DOYLE.

H.R. 3613: Mr. CALVERT and Mr. BARTON of Texas.

H.R. 3634: Mr. CAMP.

H.R. 3646: Ms. DEGETTE.

H.R. 3666: Mr. PLATTS.

H.R. 3668: Mr. BUCHANAN.

H.R. 3670: Mrs. DAHLKEMPER.

H.R. 3693: Mr. WAMP and Mr. SOUDER.

H.R. 3703: Mr. SHERMAN.

H.R. 3706: Ms. FOXX, Mr. LAMBORN, Mr. BONNER, Mr. AKIN, Mr. CARTER, Mr. MARCHANT, Mr. BISHOP of Utah, Mr. KING of Iowa, Mr. SHADEGG, Mr. FRANKS of Arizona, Mr. HALL of Texas, Mr. KLINE of Minnesota, Mr. COLE, Mr. GOHMERT, Mr. BROUN of Georgia, Mr. CAMPBELL, Mr. BARTLETT, Mrs. BLACKBURN, Ms. FALLIN, Mr. ROE of Tennessee, and Mr. CONAWAY.

H.R. 3720: Mr. COSTELLO.

H.R. 3724: Mr. THOMPSON of Pennsylvania.

H.R. 3732: Mrs. BONO MACK.

H.R. 3745: Mr. GUTIERREZ.

H.R. 3771: Mr. CUMMINGS.

H.R. 3790: Mr. BROUN of Georgia, Mr. HODES, Mr. ACKERMAN, Ms. ROS-LEHTINEN, and Mr. LATTA.

H.R. 3832: Mr. CANTOR, Mrs. MYRICK, Mr. CONAWAY, Ms. GRANGER, Mr. HALL of Texas, Mr. GOHMERT, Mr. OLSON, Mr. CAMPBELL, Mr. ROE of Tennessee, and Ms. FALLIN.

H.R. 3838: Mr. POLIS.

H.R. 3845: Mr. MICHAUD.

H.R. 3855: Mrs. CHRISTENSEN and Mr. WEINER.

H.R. 3887: Mr. POE of Texas, Mr. CRENSHAW, and Mrs. BONO MACK.

H.R. 3904: Mr. FOSTER.

H.R. 3916: Mr. HOLDEN, Mr. CARNEY, and Mr. ALTMIRE.

H.R. 3926: Ms. EDWARDS of Maryland and Mr. SCOTT of Virginia.

H.R. 3929: Mr. CAO.

H.R. 3936: Mr. KUCINICH, Ms. GINNY BROWN-WAITE of Florida, and Mr. LARSON of Connecticut.

H.R. 3942: Mr. PETERSON and Mr. LATTA.

H.R. 3943: Mr. PETERSON, Mr. NYE, Mr. WELCH, Ms. SUTTON, and Ms. DELAURO.

H.R. 3964: Mr. SCALISE.

H.R. 3986: Mr. COHEN, Mr. RANGEL, Ms. WOOLSEY, Mr. TOWNS, Mr. RUSH, and Mr. FILNER.

H.R. 3995: Mr. DEFAZIO.

H.R. 4014: Ms. ZOE LOFGREN of California and Ms. CHU.

H.R. 4037: Mr. BERMAN and Ms. HIRONO.

H.R. 4042: Mr. NYE.

H.R. 4047: Mr. FLEMING.

H.R. 4051: Mr. THOMPSON of Pennsylvania and Mr. HIGGINS.

H.R. 4053: Mr. CLEAVER.

H.R. 4058: Mr. DICKS and Ms. BORDALLO.

H.R. 4070: Mr. PETERSON, Mr. HOLDEN, Mr. MOORE of Kansas, Mr. SCOTT of Georgia, Mr. WALZ, Mr. POLIS, Mr. LATHAM, and Ms. HIRONO.

H.R. 4073: Mr. PETERSON and Ms. BORDALLO.

H.R. 4085: Mr. WU.

H.R. 4086: Mr. KING of New York.

H.R. 4088: Mr. PLATTS, Mr. WOLF, Mr. GERLACH, Mr. BOSWELL, Mr. SENSENBRENNER, Mr. ROGERS of Kentucky, and Mr. BURGESS.

H.R. 4089: Ms. FUDGE and Ms. JENKINS.

H.R. 4093: Mr. SHIMKUS, Mrs. BIGGERT, Mr. ROYCE, Mr. ROSKAM, and Mr. BURTON of Indiana.

H.R. 4110: Mr. MARIO DIAZ-BALART of Florida, Mr. SHUSTER, Mr. CULBERSON, Mr. SMITH of Texas, and Mr. SAM JOHNSON of Texas.

H.R. 4111: Mr. SAM JOHNSON of Texas, Mrs. BACHMANN, Ms. GRANGER, Mr. CONAWAY, and Mr. ALEXANDER.

H.R. 4112: Ms. Kaptur.

H. J. Res. 42: Ms. GINNY BROWN-WAITE of Florida.

H. Con. Res. 137: Mr. HONDA.

H. Con. Res. 198: Mr. SCOTT of Virginia and Mr. CALVERT.

H. Con. Res. 199: Mr. COHEN and Mr. TAYLOR.

H. Con. Res. 200: Ms. FOXX.

H. Con. Res. 213: Ms. BORDALLO and Ms. MOORE of Wisconsin.

H. Res. 35: Ms. EDWARDS of Maryland, Ms. BORDALLO, Ms. ESHOO, Mr. DOYLE, Ms. HARMAN, Mr. ROSS, Mr. MATHESON, Mr. POE of Texas, Ms. BALDWIN, Mr. ELLISON, Mr. CONYERS, Mr. TANNER, Mr. BOYD, Mr. SHULER, Mr. CHANDLER, Mr. FILNER, Ms. HIRONO, Mr. HINCHEY, Mr. PETERS, Mr. MURPHY of Connecticut, Mr. ROGERS of Kentucky, Ms. WASSERMAN SCHULTZ, Mr. KLEIN of Florida, Mr. HASTINGS of Florida, Mr. HIGGINS, Ms. LINDA T. SÁNCHEZ of California, Mr. SARBANES, and Mr. MCMAHON.

H. Res. 55: Mr. GUTHRIE, Mr. SHUSTER, Mr. YOUNG of Florida, Mr. CULBERSON, Mr. GARRETT of New Jersey, Mr. MCKEON, Mr. SULLIVAN, Mr. SHADEGG, Mr. LATOURETTE, Mr. TIBERI, Mr. LOBIONDO, Mr. STEARNS, Mr. SOUDER, Mr. DUNCAN, Mr. ROGERS of Kentucky, Mr. KING of Iowa, Mr. MANZULLO, Mr. HELLER, Mr. FRANKS of Arizona, Mr. JONES, Ms. ROS-LEHTINEN, Mr. ACKERMAN, Mr. HALL of Texas, Mr. CASSIDY, Mr. BROUN of Georgia, Mr. MACK, Mr. DAVIS of Kentucky, Mr. LATTA, Mr. MICA, Mr. COFFMAN of Colorado, Mr. POE of Texas, Mr. ISSA, Ms. KAPTUR, Mr. PAULSEN, Mr. MCCARTHY of California, Ms. JENKINS, Mr. WEXLER, Mr. WALDEN, Mr. UPTON, Mr. BOUSTANY, Mr. KING of New York, Mr. EHLERS, Mr. ROONEY, Mr. LEE of

New York, Mr. ROSKAM, Mr. MILLER of Florida, Mr. PUTNAM, Mr. POSEY, Mr. THOMPSON of Pennsylvania, Mr. BOOZMAN, Mr. REICHERT, Mr. DEAL of Georgia, Mr. LINDER, Mr. WESTMORELAND, Mr. ROE of Tennessee, Mr. JORDAN of Ohio, Mr. AKIN, Mr. ROHRABACHER, Mrs. CAPITO, Mr. BILIRAKIS, Mr. MARIO DIAZ-BALART of Florida, Mr. LINCOLN DIAZ-BALART of Florida, Mr. SMITH of New Jersey, Mr. SENSENBRENNER, Mr. BISHOP of Utah, Mr. YOUNG of Alaska, Mr. CHAFFETZ, Mr. LANCE, Mr. CONAWAY, Mr. TIAHRT, Ms. GRANGER, Mr. THORNBERRY, Mr. HENSARLING, Mrs. BIGGERT, Mr. KANJORSKI, and Mr. WHITFIELD.

H. Res. 111: Mr. HINCHEY and Mr. KING of Iowa.

H. Res. 278: Mr. DOGGETT.

H. Res. 440: Mr. ALEXANDER.

H. Res. 699: Mr. BOREN.

H. Res. 713: Mr. SCOTT of Virginia, Mr. MASSA, Mr. ROSS, Ms. CORRINE BROWN of Florida, Ms. SCHAKOWSKY, Mr. MELANCON, Mr. PALLONE, Mr. SPRATT, and Ms. BERKLEY.

H. Res. 759: Mr. ROSKAM and Mr. SULLIVAN.

H. Res. 776: Ms. MOORE of Wisconsin and Mr. QUIGLEY.

H. Res. 779: Mr. ISSA, Mr. CALVERT, Mr. LATOURETTE, Mr. YOUNG of Florida, Mr. SCHOCK, Mr. REICHERT, Ms. GINNY BROWN-WAITE of Florida, Mrs. MYRICK, Mr. DAVIS of Kentucky, Mr. PAULSEN, Mrs. MCMORRIS RODGERS, Mr. LATTA, Mr. PETRI, Mr. LANCE, Mr. LEWIS of California, Mr. MANZULLO, Mr. GUTHRIE, Mr. LEE of New York, Mr. CASTLE, Mr. COBLE, Ms. ROS-LEHTINEN, and Mrs. EMERSON.

H. Res. 809: Mr. LUETKEMEYER, Mr. PITTS, Mr. BARTLETT, Mrs. SCHMIDT, Mr. COBLE, Ms. FALLIN, Mr. JORDAN of Ohio, Mr. BONNER, Mr. AKIN, Mr. CARTER, Mr. POSEY, Mr. BISHOP of Utah, Mr. CULBERSON, Mr. CAMPBELL, Mr. DANIEL E. LUNGREN of California, Mr. MARCHANT, Mr. LAMBORN, Mr. KING of Iowa, Mr. SHADEGG, Mr. FRANKS of Arizona, Mr. BOOZMAN, Mr. CONAWAY, Mr. KLINE of Minnesota, Mr. COLE, Ms. GRANGER, Mr. HALL of Texas, Mr. GOHMERT, Mr. BARTON of Texas, and Mr. ROE of Tennessee.

H. Res. 847: Mr. ROGERS of Kentucky.

H. Res. 852: Mr. WILSON of South Carolina.

H. Res. 855: Mr. KLEIN of Florida.

H. Res. 860: Mr. HARE, Mr. HODES, Mr. CARDOZA, Mr. SIRES, and Mr. BOSWELL.

H. Res. 861: Mr. LATTA and Mr. BOSWELL.

H. Res. 873: Mr. GRAVES and Mr. WAMP.

H. Res. 879: Mr. ROSS.

H. Res. 888: Mr. ALEXANDER.

H. Res. 900: Mr. THOMPSON of Pennsylvania and Mr. MCMAHON.

H. Res. 901: Mr. MEEKS of New York, Mr. SCOTT of Virginia, Ms. ZOE LOFGREN of California, Mr. CARDOZA, and Mr. CLEAVER.

H. Res. 904: Mr. TAYLOR, Mr. MARSHALL, and Mr. NYE.

H. Res. 911: Mr. UPTON, Mr. BURGESS, Mr. MCHENRY, Mr. CANTOR, Mr. CARTER, Mr. POE of Texas, Mr. MCCAUL, Ms. GRANGER, Mr. NEUGEBAUER, Mr. GOHMERT, Ms. FOXX, Mr. FORBES, Mr. BOEHNER, Mr. SHIMKUS, Mr. BLUNT, Mr. KING of Iowa, Mr. FLEMING, Mr. PRICE of Georgia, Mr. ROE of Tennessee, Mrs. CAPITO, Mrs. SCHMIDT, Mr. CASSIDY, Mrs. BONO MACK, Mr. SMITH of Texas, Mr. HOEKSTRA, Mr. LAMBORN, Mr. ROSKAM, and Mrs. MILLER of Michigan.

H. Res. 913: Mr. FATTAH.

H. Res. 914: Mr. MILLER of Florida, Mr. EDWARDS of Texas, Ms. DELAURO, Mr. TERRY, Mr. TOWNS, Mr. GRIJALVA, and Ms. FUDGE.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:

H.R. 3904: Mr. LOEBSACK.

DISCHARGE PETITIONS

Under clause 2 of rule XV, the following discharge petitions were filed:

Petition 7, November 18, 2009, by Mr. PETER HOEKSTRA on H.R. 2294, was signed by the following Members: Peter Hoekstra, Howard P. ''Buck'' McKeon, Peter J. Roskam, Lynn A. Westmoreland, Gary G. Miller, Ken Calvert, Tom McClintock, Dana Rohrabacher, Lamar Smith, Virginia Foxx, Howard Coble, Leonard Lance, Mary Bono Mack, Connie Mack, Ted Poe, Elton Gallegly, Jerry Lewis, Bob Goodlatte, Donald A. Manzullo, Mark Steven Kirk, John Abney Culberson, Ralph M. Hall, Louie Gohmert, Greg Walden, Charles W. Boustany, Jr., Mac Thornberry, Zach Wamp, Glenn Thompson, Robert E. Latta, Paul Ryan, Jo Ann Emerson, Pete Olson, Christopher John Lee, Blaine Luetkemeyer, Tom Price, John Linder, Jerry Moran, Devin Nunes, Steve Buyer, Bill Shuster, Bill Posey, John A. Boehner, Roy Blunt, Jo Bonner, Gus M. Bilirakis, Joe Wilson, David G. Reichert, J. Randy Forbes, K. Michael Conaway, John Boozman, John Fleming, Jeff Miller, Todd Russell Platts, Gregg Harper, Sue Wilkins Myrick, Candice S. Miller, John B. Shadegg, Adrian Smith, John R. Carter, Harold Rogers, Geoff Davis, Dave Camp, Ander Crenshaw, Randy Neugebauer, Sam Johnson, Mike Coffman, Lee Terry, Michael K. Simpson, Brett Guthrie, Denny Rehberg, John Campbell, Kay Granger, Rodney Alexander, Steve King, Jim Gerlach, Dan Burton, Frank D. Lucas, Ginny Brown-Waite, Jim Jordan, Daniel E. Lungren, Charles W. Dent, Lincoln Diaz-Balart, Mario Diaz-Balart, W. Todd Akin, Todd Tiahrt, Wally Herger, Thomas J. Rooney, Doug Lamborn, Steve Austria, Steve Scalise, Tom Cole, Cynthia M. Lummis, Erik Paulsen, Michele Bachmann, John L. Mica, Kevin Brady, J. Gresham Barrett, Cliff Stearns, John Kline, Jeb Hensarling, Jason Chaffetz, Michael R. Turner, Judy Biggert, Duncan Hunter, Joseph R. Pitts, Pete Sessions, Tim Murphy, Mike Rogers (AL), Cathy McMorris Rodgers, Spencer Bachus, David P. Roe, Marsha Blackburn, F. James Sensenbrenner, Jr., Frank R. Wolf, Dean Heller, Thaddeus G. McCotter, Adam H. Putnam, Jack Kingston, Patrick J. Tiberi, Brian P. Bilbray, Lynn Jenkins, Eric Cantor, Vern Buchanan, Kenny Marchant, Phil Gingrey, Mark E. Souder, Rob Bishop, Peter T. King, Rodney P. Frelinghuysen, Frank A. LoBiondo, Edward R. Royce, Thomas E. Petri, Robert J. Wittman, Anh ''Joseph'' Cao, C. W. Bill Young, Trent Franks, Paul C. Broun, Bob Inglis, Michael C. Burgess, David Dreier, John Shimkus, Nathan Deal, Jean Schmidt, Jeff Fortenberry, Don Young, Christopher H. Smith, Mary Fallin, George Radanovich, Steve C. LaTourette, Vernon J. Ehlers, Scott Garrett, Ed Whitfield, Tom Latham, Fred Upton, John J. Duncan, Jr., Patrick T. McHenry, Bill Cassidy, Kevin McCarthy, Mike Rogers (MI), Robert B. Aderholt, and Ileana Ros-Lehtinen.

AMENDMENTS

Under clause 8 of rule XVIII, proposed amendments were submitted as follows:

H.R. 3961

OFFERED BY: MR. COFFMAN OF COLORADO

AMENDMENT NO. 1: Page 13, after line 3, insert the following:

SEC. 3. PAYFOR THROUGH USE OF UNUSED STIMULUS FUNDS.

Any unobligated balances, as of the date of the enactment of this Act, of funds made available under division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) are rescinded.

SENATE—*Thursday, November 19, 2009*

The Senate met at 9:30 a.m. and was called to order by the Honorable MARK L. PRYOR, a Senator from the State of Arkansas.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Here we are again, Lord, a people in need of Your presence and power in order to meet life with courage and faith.

Today, strengthen the Members of this body with a faith that will ever choose the harder right over the easy expedient. Give them wisdom to follow Your example of sacrificial service, infusing them with the courage to do right as You give them the light to see it. Lord, lift from them the burden of loss and sorrow when forces beyond their control invade their lives and seek to rob them of Your peace. Bless them with the assurance that they are never alone, for You have promised never to forsake them. Fill their disappointments with Your strengthening presence, transforming their darkness into the glory of Your new dawn of hope and life.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable MARK L. PRYOR led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, November 19, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable MARK L. PRYOR, a Senator from the State of Arkansas, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. PRYOR thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will be in a period of morning business for an hour. Senators during that time will be permitted to speak for up to 10 minutes each. The majority will control the first 30 minutes and the Republicans will control the final 30 minutes.

Following morning business, the Senate will proceed to the consideration of S. 1963, which is the Caregivers and Veterans Omnibus Health Services Act. Debate on the bill will be limited to 30 minutes equally divided and controlled between Senators AKAKA and BURR or their designees. The only amendment in order to the bill is the Coburn amendment relating to the funding priorities in this bill. Debate on the Coburn amendment is limited to 3 hours, with Senator COBURN controlling 2 hours and Senator AKAKA controlling the final hour.

At 2 p.m., the Senate will resume debate on the nomination of David Hamilton to be U.S. circuit judge for the Seventh Circuit. Debate until 2:30 is going to be equally divided and controlled between Senators LEAHY and SESSIONS or their designees.

At 2:30 p.m., the Senate will proceed to a series of three rollcall votes. Those votes will be on confirmation of the Hamilton nomination, in relation to the Coburn amendment, and on passage of the veterans omnibus bill.

HEALTH CARE REFORM

Mr. REID. Mr. President, we have traveled a great distance to get where we stand today. With the bill we unveiled last night, we begin the last leg of this historic journey.

The American people and President Obama have asked us for health insurance reform. There are two things we must have above all: No. 1, make it more affordable for every American to live a healthy life, and No. 2, do so in a fiscally responsible way that helps our economy recover. Senate Democrats have listened, and we have written a bill that will save lives, save money, and save Medicare.

Since yesterday evening, the bill has been on the Internet for all to see. You will find it at democrats.senate.gov, but here is a quick summary of what is in that bill. And I say, Mr. President, this is a big bill. I was at a meeting with some other Senators this morning, and everyone acknowledged that no one can ever remember a bill that affects everybody in America as this bill does. It is a bill that has a lot of pages in it. But, as we know, it is printed the way all bills are printed. If we wanted to print it in smaller fashion—as books are written, for example—it would be much smaller. It is a lot of words, and every word in it is important and necessary. Since yesterday evening, as I have indicated, this bill has been on the Internet. Everyone in the world can see this bill.

As the President asked us to do, this bill will not add a dime to the deficit—quite the opposite, in fact: It will cut it by $130 billion in the first 10 years and by as much as $¾ trillion in the first 20 years. We do this by keeping costs down. This critical reform will cost less than $85 billion a year over the next decade, well under President Obama's goal.

We will make sure every American can afford quality health care. We will make sure more than 30 million Americans who do not have health care today will soon have it. We will not only protect Medicare, but we will make it stronger.

These numbers are as impressive as they are important for our Nation's future, and though we are proud of these numbers, these figures, we cannot afford to overlook what this is really all about. More accurately, we cannot afford to overlook whom this is about.

This is about a parent who cannot take a child to the doctor because insurance is too expensive, their employer canceled it, or they lost their job. That is why we are making sure every American can afford good coverage.

This is about the small business in Nevada or someplace else in the country that had to lay off an employee because it couldn't afford skyrocketing health care premiums. That is why we are cutting those small business taxes.

It is about the woman with high cholesterol or the man with heart disease or the child with hay fever who can't get help and can't get insurance. That is why we are stopping insurance companies from deciding they would rather not give health care to the sick.

This is about the family who has to make a terrible choice between their

mortgage and their medications. When this bill passes, the only choice they will have to make is which insurance company offers them the best coverage. They will have the choice to make, and it is a good choice. The choice is, which best suits their family?

This is also about mothers and sisters and wives and daughters who cannot get the proper testing they need to detect breast cancer. It is inexcusable that women cannot get the tests they need. That is why we are making prevention and wellness a priority.

For these families and these businesses, for our economy's renewal, our children's future, and our Nation's promise, the finish line is in sight. I am confident we will cross it soon. Once again, I am inviting my Republican colleagues to join us on the right side of history.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. McCONNELL. Mr. President, for months we have been warning the American people of the Democrats' plans to raise premiums, raise taxes, and slash Medicare in order to fund more government. Americans know that is not reform, and unfortunately the majority has not been listening.

While two committees have publicly reported legislation, the bill we are being asked to consider was assembled behind closed doors, out of sight, and without input from the public for over the last 6 weeks. We are being told we must rush to pass this legislation, even though most of its provisions will not take effect for another 5 years, until 2014. That is a little bit like being asked to pay your mortgage 4 years before you are allowed to move into your house. Americans reasonably want to know: How much will it cost? Will their premiums go up? What is hidden in the fine print? Are favored interests or States getting sweetheart deals? The American people want to take the time to get this right.

Over here, we have the House bill and the Senate bill together, each of them roughly 2,000 pages. You see this massive bill to rewrite one-sixth of our economy, with stunning unintended consequences for ourselves and for our children and for our grandchildren.

The majority leader's bill is 2,074 pages long. When fully implemented—and the way to look at the true cost of this bill is how much it will cost over a 10-year period when it is fully implemented. What has been skillfully done in order to make it look less expensive, in this proposal, is phasing in benefits and taxes at different times. But when this 2,074-page bill is fully implemented, it will cost $2.5 trillion.

According to CBO, Federal health care spending will actually go up, not down, as a result of this mammoth effort to rewrite one-sixth of our economy. It cuts Medicare by $465 billion—nearly $½ trillion in cuts to a program that is so important to our seniors. Hospitals, Medicare Advantage, nursing homes, home health, hospice—all of those will be slashed in this $465 billion cut to Medicare. It raises taxes $493 billion. So you have here massive cuts in Medicare and massive tax increases.

Who gets hit? Who gets hit with the tax increases? You do. If you have insurance, you get taxed. If you do not have insurance, you get taxed. If you need a lifesaving medical device, you get taxed. If you need prescription medicines, you get taxed. There is also a new Medicare payroll tax.

What is the bottom line here? After weeks of drafting a bill behind closed doors, the majority has produced a bill that increases premiums, raises taxes, and slashes Medicare by $½ trillion, to create a new government program. This is not what the American people want. I do not believe they think this is reform. This is not the direction to take.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will be a period of morning business for 1 hour, with Senators permitted to speak therein for up to 10 minutes each, with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first half and the Republicans controlling the final half.

The Senator from New Mexico is recognized.

Mr. UDALL of New Mexico. Mr. President, I ask unanimous consent, during the time we control for the next half hour, that we be able to engage in a colloquy with other Senators.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. UDALL of New Mexico. Mr. President, for months we have gathered in this Chamber to talk about why we need a public option as part of health care reform. Almost every week the insurance companies provide another example of why a public option is critical to ensuring all Americans have access to quality, affordable health insurance. Our most recent examples come courtesy of two of America's largest insurance companies—Humana and CIGNA. Wall Street just completed its third quarter earnings season, and Humana and CIGNA released their reports a couple weeks ago. Let's just say that both companies did very well last quarter. Humana profits in the third quarter were up 65 percent over the same time last year. CIGNA profits in the third quarter were up 92 percent.

Senator BROWN has focused on the insurance company issue and has seen what is happening to the American people. This is happening at a time when 47 million Americans are without access to affordable health care. I will ask him to speak a little bit about the insurance company issue and what is happening.

Before doing so, the Republican leader was here on the floor, and he was talking about the numbers that were given by CBO. These are number crunchers. They are by nonpartisan folks. These are people who work very hard late at night. They have been working to get out their numbers on the bill that we will have on the floor in a short while. I can't believe we are now hearing they don't like the CBO numbers. Both sides live by CBO numbers. That is the important thing for people to understand.

I yield to Senator BROWN.

Mr. BROWN. Mr. President, we are also joined by Senator REED of Rhode Island and Senator MERKLEY. They helped write the bill in the HELP Committee.

We know Aetna's CEO last year made $24 million. Of the top 10 insurance companies, the average CEO is paid $11 million per year. We know their profits have gone up 400 percent over the last 7 years. It is not so much that CEOs are paid so much. It is not just their profits and their CEO and top executive salaries, it is the business model that gets them there. When you think about what has happened to insurance companies, you are a big insurance company, you hire a bunch of bureaucrats to keep people from buying insurance, to invoke preexisting condition so somebody can't get insurance or to put limits on coverage so people can't get insurance. Then they hire bureaucrats on the other end to deny claims. Thirty percent of claims that are filed when people get sick—they turn their claims in to their insurance company from hospitals, doctors, treatments, they turn them in to the insurance company—30 percent are denied, initially. They are appealed sometimes and then they get reimbursement customers, someone who files a claim. But the fact that they have to fight the insurance companies while they are sick anyway or while they are advocating for their parents or a sister or husband or wife, these huge profits and huge executive

salaries are based in denying care on preexisting conditions, on squeezing profits from customers.

Think of all the small businesses in Rhode Island, Oregon, New Mexico, and Arkansas, all the businesses that say they can't afford insurance anymore. They may have had huge price spikes because 1 person in a company out of 30 employees gets sick.

I don't care all that much about profits and CEO salaries. I do think it is immoral. But what I care about is that those profits and salaries are based on hurting people who have insurance or keeping people from having insurance.

Mr. KAUFMAN. How can a business do this? There is a real reason why they can do it. It is because there is no competition. Other companies can't do that. They can't treat the people who are customers the way the insurance companies do. When you look at the list, you can see why they get away with it. There is no competition. In the top 39 States out of 50, over 53 percent of the market share is with 2 companies. There is no competition right now in health care. That is the big reason why we need the public option. The reason for the public option is it allows us to have competition in these States where there is no competition at the present time. You can have gigantic profits. You can have CEOs making millions of dollars. You can have all these things. You can treat your customers poorly. You can do all these things because you don't have to worry about somebody coming into the business and offering them a good or better deal. That is what the public option does.

Mr. UDALL of New Mexico. I yield to Senator REED. I want to get him involved in this discussion.

Mr. REED. I thank Senator UDALL. Senator KAUFMAN has made an excellent point. What we have seen over the last several years, actually more than a decade, is increasing costs shifted to small business. Just this year, a 15-percent increase in small business premiums is anticipated, much higher than inflation. That is because there is no real competition. Rhode Island is on that map, where two companies control 8 percent of the market. There are forces, which have been illuminated, that drive up this constant increase in cost. One is profits. That is what private companies are organized to achieve. If we were directors of those companies, we would be trying to do that. But those profits drive two things: One, shareholder return, profitability of stock, and also compensation for executives. Those two phenomena will not be in place in a public option. It will be a not-for-profit cooperative arrangement. So the response will not be to shareholders or to self-aggrandizement of executives; it will be to delivering service. That is going to be a check.

What I find ironic in this discussion is the bold proponents of free markets who believe the free market can solve it are afraid of competition. They are afraid of a public option because they say: We can't compete with the Government. Their definition of competition is any competition. They are probably worried about 80 percent shared between two companies. This is a managed environment. Year in and year out, the insurance companies do great and small business does worse and worse.

I thank the Senator for yielding.

Mr. KAUFMAN. One final point. You can tell there is no competition when every year your premiums go up. The only other business I know similar to that—and I don't mean to hurt anybody's feelings—is the cable company and my TV bill. I know every year, no matter whether the inflation rate or the cost of living is down, I will get a notice in December—don't we all—basically saying my health care premiums are going up and my cable costs are going up. The reason is because both these are essentially operating as monopolies.

Mr. UDALL of New Mexico. I don't think the American people realize we have exempted the insurance companies from the antitrust laws. Those are laws you can move in, when there is a lack of competition in the market, when there are too few players in the market, to try to inject additional competition in the market. With the public option, the first thing we are trying to accomplish is to inject competition into the market, to have insurance companies be competing. This public option is going to help drive that cost down in a dramatic way.

Senator MERKLEY, who has worked on this legislation in his committees, joins us today. I hope he can talk a little bit about this issue also.

Mr. MERKLEY. Mr. President, there was a time when our colleagues across the aisle were in favor of competition. Correct me if I am wrong, but in the past, we used to have a highly regulated, noncompetitive airline industry. Was it not our good friends across the aisle who said we need to create competition so consumers have real choice and this will drive the cost of airline tickets down? Am I mixed up on that or is that fairly accurate?

Mr. UDALL of New Mexico. That is an absolutely accurate rendition.

Mr. MERKLEY. We are in a very similar situation here, where we have a noncompetitive industry, costs going through the roof. There is a basic factor at work which is, if we introduce competition in health care, service will improve, costs will come down.

Choice is much more important in this area than just about any other. If you are not satisfied with the cost of your insurance or the service you are receiving, then you should have multiple places to go. That is the underlying point of creating a health care marketplace or exchange, as it is called, so citizens can say: Here are all the plans competing against each other. What are they going to offer? A year later, if you are not happy, you get to switch, which says to every single insurance company, if we don't do well, we are going to lose our customers. That is the marketplace. That is competition. That is what we need in America. It will be helped by having a public option.

Mr. UDALL of New Mexico. Absolutely. No doubt about that.

Mr. MERKLEY. I can tell you a couple stories from Oregon. There was an article in the Bend Bulletin in October about two families.

One individual, Dale Evans, went to his doctor because he was experiencing pain in his chest. His doctor recommended he have an MRI to find out what was going on. The request was made three times. The insurance company turned it down three times. Because he didn't have this test, there was no diagnosis made of the cancerous tumor he had. His tumor proceeded to damage the nerves in his spinal cord and left him unable to walk. Then it became too large to be operated on. Mr. Evans died the following year, in 2008. As a result of the choice made by the insurance company, a for-profit insurance company, the test was not conducted and the individual died.

Richard Paulus of Bend, OR, has a similar case being filed right now. He, fortunately, is still alive. He was denied repeated requests for back surgery. His doctor argued for a second opinion. The request was made, turned down again. One factor is, you want to have an insurance company that is making decisions related to healing, not related to profits. The second factor is, one of the best ways to drive that, if Mr. Evans and Mr. Paulus were not satisfied, if they had a choice, they would be much more likely to create accountability with the company they are with right now.

Mr. UDALL of New Mexico. I wish to ask the Senator about those circumstances because he knows more of the details, but when you have insurance companies, these for-profit insurance companies we have been talking about that are making incredible profits, when you have insurance companies denying these claims, which is what you alluded to, what people need to realize is, what they have done is they have created an entire administrative bureaucracy within the insurance industry. It has flowed over into our medical providers, where doctors now tell me what they have to do is have people calling the insurance company to push to reverse these denials. So they have created a whole system which tamps down the ability of people to get care. What we are talking about

in the public option is, you create a nonprofit. They are not in the business of making a profit. They are going to be in the business of providing health care, of doing the very best they can to provide health care. Why it will make the market competitive is they will not have all this administrative run-around. They will not have this going on.

Is that the Senator's understanding? They will look at the situation you have right there that you have described and they are going to say: It is clear this gentleman needs an MRI because we need to find out what is going on. So they will do the MRI, and then they will move quickly to the care. To me, that is the difference between what the Senator described, where insurance companies are trying to find a way to not pay out, to meet their bottom line, and to raise profits; whereas, a public option would be doing the opposite, focusing on the health care, focusing on future needs, focusing on providing what people need in the health care arena.

Mr. MERKLEY. Your point is well taken. The overhead in the private health care industry is now 25 to 30 percent. That is a whole lot of folks sitting around desks operating with paper rather than nurses and nurse practitioners and doctors practicing the craft of medicine, the craft of healing. Whereas, if you look at Medicare, instead of 25 to 30 percent overhead, it is somewhere around 3 percent—much less and, therefore, a lot more dollars going into actually assisting folks in getting well. Again, competition is going to drive down that overhead.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, the thing the American people should know about the health care plan Senator REID was down here talking about earlier—that we have unveiled here in the Senate—is it has a public option in it. So the public option will be there to provide competition. It will be there to provide the very best care. And it will be there to make sure we keep these insurance companies honest. That is what we are trying to do here: to make sure there is competition in the market, to make sure the insurance companies are honest.

Mr. MERKLEY. Yes. The reason we have lost competition is twofold. One, in many markets, a single company dominates the market. Second, even if you have multiple companies, they are exempt from the antitrust laws and, therefore they can communicate with each other in a way that reduces or even eliminates real competition. That is why this is so important.

There is one feature of this public option that I think is important to recognize. It represents a huge compromise, and that compromise is that many of our Senators said: We are not sure our folks back home are quite sold on this idea, and we do not want to see it ''forced on them.'' Quite frankly, I think it would be good to have competition everywhere in the country, everyone have more choices. But in deference to that Federalist tradition in America, in deference to the laboratory of State experimentation, a provision has been included in Senator REID's merged bill that says if a State does not want to participate, it can opt out.

So there is no Senator in this Chamber who should have any concern about saying my folks back home do not want this, and they are going to be forced to have it, because no State will be put in that position. Any State can choose to say: We do not wish to participate. I think that means we will have a situation where many States—most States, I believe—perhaps virtually all States will say: We do want to participate. But those States that are not so convinced will have a choice to watch this unfold to decide if they wish to join this movement for competition and choice later on.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, I think that is a great example of how we all work here together to find a compromise that works for everyone. I realize there are Democratic Senators and Republican Senators—and the same for Governors—who may want to do things differently in their State. So what we have done here is give them the option of opting out in this public option we are providing.

I personally—looking at the facts, and looking at the situation—do not know why a State would want to opt out. But there is going to be the check and balance there of the legislature having to pass a law, the Governor having to sign it, and say: We do not want to have anything to do with the public option.

But we realize with a public option you bring competition to the market, you expose these high administrative costs you talked about. One of the things people do not realize, on administrative costs, is, the Federal Government runs the Medicare Program. Here you have a program that when I go to town hall meetings, I say: Raise your hand if you are on Medicare. They will put their hand up. And I will say: Keep your hand up if you like Medicare. So they will raise their hand, and they will keep it up.

Ninety-five percent of the people like Medicare. Well, Medicare has a 3-percent—3-percent—administrative cost. As the Senator said earlier, the insurance companies we are dealing with have anywhere from 25 to 30 percent administrative costs. So if you put a public option out there, you are going to make there be competition.

Senator MERKLEY.

Mr. MERKLEY. I say to the Senator, let me give you an example of how that competition can work in a health insurance marketplace. In Oregon, we have a public option in workers compensation, which is health insurance for injuries that occur on the job. We have had this public option for 80 years. It did not work that well. It was not that well designed, and it was not that well managed.

About 20 years ago, a group of businesses got together, and the businesses said: We need a better insurance policy. We need a better competitive market for on-the-job health insurance. So in a deal that was called the Mahonia Hall deal, Mahonia Hall rewrote and improved the management of our public option. The result is, rates today in workers compensation in Oregon are half of what they were 20 years ago, because competition was introduced, efficiencies occurred, service improved. I can tell you, there is not a business in Oregon to be found campaigning to eliminate the State accident insurance fund, which is a public option in work-based health care.

Our colleague SHELDON WHITEHOUSE was involved in establishing a very similar program in Rhode Island. Their workers comp, he told me—and I think he has told this Chamber—introduced by Rhode Island adopting a work-based health care public option resulted in their rates dropping by half.

Wouldn't it be great if competition could reduce health care costs in America rather than having 10 to 15 percent increases every single year?

Mr. UDALL of New Mexico. Yes. I say to the Senator, you hit it on the head. I have been here on the floor with Senator WHITEHOUSE—I know Senator REID was just here—participating in a colloquy.

The point that both of them, I think, make is when you inject a public option into the insurance market—whether it is health insurance, whether it is workers compensation—you inject competition. And by injecting that competition, you make the marketplace work a lot better. That is what we are striving for here today.

Senator MERKLEY.

Mr. MERKLEY. There are folks who have said: Well, now, hold on. Isn't this a government takeover of health care? Since that has been said so many times on this floor by those who oppose health care reform, I think we should address it directly. Introducing a competitor does not have the government taking over health care. It is an option citizens can choose—if they are not satisfied with the current performance—competing on a level playing field. This is exactly what you need when you have markets that have lost their competition.

It is important to note this phrase ''government takeover'' came out of a study that was contracted for by my colleagues across the aisle to say: How can we defeat health care? They polled folks in America and said: What are

the scariest terms we can use—even though we do not know what the plan is; even though we do not know whether the plan is going to invest in prevention; we do not know if the plan is going to invest in disease management; we do not know if the plan is going to have healthy choice incentives that will help improve the quality of life of Americans and decrease health care costs; we do not know if we will have insurance reforms that will get rid of dumping, the practice of throwing people off their health care plan once they get sick; we do not know whether there will be reforms that say there will be guaranteed issue, you cannot be denied the opportunity to have health care because of preexisting conditions. We do not know any of that, but whatever it is, we are going to be against it. So let's do a study now. And they contracted to do the studies. Let's find out how to scare Americans. The result was: Let's call it a government takeover.

I have to tell you, this is too important an issue to the citizens of our Nation. Health care touches every individual, touches every small business trying to succeed. It touches every large business trying to compete around the world, with much more efficient—much more efficient—health care systems in other countries. It is too important than to do studies to try to find words to scare Americans.

How about we try to solve problems in this Chamber? I am going to tell you, I think this bill put forward last night by Majority Leader REID is about solving a problem absolutely critical to our economy, critical to our small businesses, critical to the quality of life of our families.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, you are exactly right. Senator REID has put a merged proposal on the floor, and do you know what the response is we have seen? I like your comments on this. The response we have seen I find amazing, I find absolutely amazing, because here is what we are facing.

The American people want health care reform, so we have announced we are going to put a bill on the floor to reform health care. We have been working on it for months. It is out of two committees. We have brought it together. So what do we have to do in the Senate to move forward? We file a motion to proceed. OK. That is just to proceed. You are not even on the bill.

Do you know what is going to happen? The Republicans are going to step forward, their leadership is going to step forward, and they are going to say: No, no, we are not going to agree to that. We are not going to agree to even proceed to the bill.

So we are going to have to file cloture. When we file a cloture motion today, it is going to take 2 days before that cloture motion ripens. Then we are going to have a cloture vote. Then 30 more hours are going to expire. They are going to require us to use all that time. Even though we may be in a quorum call and not doing any debate, they are going to require that. Then, believe it or not, they are going to require us—these wonderful clerks who work up here—they are going to require them to stand up for 50 hours and read that bill on the floor—50 hours. The normal thing we do to get to something is we waive the reading. But they are going to require it.

What does the Senator think of that approach? I cannot understand that.

Mr. MERKLEY. Many Americans are familiar with the tradition of a filibuster, and they envision it where Senators stand up and speak and speak on an issue of principle. That was used very rarely in the past. In fact, now all that is required is for one Senator to object to unanimous consent, and then you need to have a 60-vote test.

This 60-vote test is most often used at the end of a debate to say: Do we go to a final vote? Are we going to wrap up debate and go to a final vote? But in this case, as the Senator has described it, it is going to be used even to hold a debate on health care in this Chamber.

All my life—I first came to this Chamber when I was an intern for Senator Hatfield in 1976—all my life, I have heard the Senate described as ''the world's greatest deliberative body.'' Well, that is a pretty cool thing. But are you telling me that folks are going to try to block this Chamber from even debating health care?

Mr. UDALL of New Mexico. That is exactly what I am saying. We have worked hard. The majority has worked hard. We put together a bill. We have had hearings—Democrats and Republicans—in those committees. When we file a motion to proceed, we are not even on the bill, we cannot amend the bill. When we file that motion to proceed, they are going to require we take 2 full days, and then another 30 hours, and then demand we read the bill on the Senate floor.

I see Senator ALEXANDER in the Chamber. I know there are good friends of ours on the other side who do not want to see that kind of thing proceed. But a couple of Senators can muck up the whole works here and slow this thing down.

I think the American people want us to move forward with health care. I think they want us to get something done that provides health care for people, that provides choices, that keeps people's doctors, that puts competition in the market—all of those kinds of things.

Senator MERKLEY.

Mr. MERKLEY. I join the Senator in saying to all my colleagues, do not fear debate on health care. We are here, and it is our job to come and debate. It is our job to come and talk about how important it is to have insurance reforms so people are not barred because of preexisting conditions, people are not dumped after a decade of being provided insurance because they get sick.

It is so important we have this debate, and I look forward to having it, and hope all colleagues will join in saying: Yes, no matter which side of this issue you are on, it is time to debate, as our citizens have sent us here to do.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, thank you. Thank you for joining me in this colloquy today.

I thank the Acting President pro tempore and yield back any time at this point.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I wonder if you could let me know when I have consumed 9 minutes.

The ACTING PRESIDENT pro tempore. The Senator will be so notified.

Mr. ALEXANDER. Thank you, Mr. President.

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, I was listening to my friends on the Democratic side. I wish they could have been in the Senate 4 or 5 years ago. Actually that would have reduced our numbers, so as much as I like them, I would not have wished that. If they had been here, they might have been some help in arguing to the Democrats who blocked Miguel Estrada from even having an up-or-down vote, who blocked Judge Pryor of Alabama from having an up-or-down vote. The Democrats at that time seemed to argue a completely different point of view.

What we want on the Republican side is very simple.

You see this bill I am leaning against? This is the new bill. This is the Harry Reid—the distinguished majority leader's health bill. We want to make sure the American people have a chance to read it and they have a chance to know exactly what it costs and they have a chance to know exactly how it affects them. That is not an unreasonable request, we don't think. That is the way the Senate works. That is our job.

When it came to the Defense authorization bill, we spent a couple of weeks doing that. When it came to No Child Left Behind, the Education bill, we spent 7 weeks going through it, and neither of those bills was 2,074 pages long. The Homeland Security bill took 7 weeks. The Energy bill in 2002 took 8 weeks. A farm bill last year took 4 weeks. So we have a little reading to do, a little work to do. We have done some preliminary reading, but what we want to make sure of is that the American people read the bill, know what it costs, and know how it affects them because health care is a very personal matter.

I have done some reading since the bill came out last night. I was also a little bit amused to hear our friends complaining about how we are slowing things down. Well, this bill has been hidden in the majority leader's office for 6 weeks. He wouldn't let any of us read it. I don't know who he has been in there with writing it, but I guess it takes a long time to write a 2,074-page bill. But he didn't bring it out until last night, and now we have it printed out. Now he wants to vote on Saturday.

Well, that is all right with us if he wants to vote on Saturday or Sunday or Monday or Thanksgiving Day. We are going to be here because these are the most important set of votes we are ever likely to take in this body, at least during the time I am here.

Let me give a preliminary report to the American people in terms of the Thanksgiving spirit about this bill. It came out with a lot of fanfare. It has been hidden in the majority leader's office for 6 weeks, but here is my early verdict in terms of the Thanksgiving season. This is the same turkey you saw in August, and it is not going to taste any better in November. It is not much different than what worried you in August. In fact, it has gotten a little bit worse.

If I may, let me give just a few thoughts about the bill. Why would I say it is the same turkey you saw in August, and you didn't like it in August? Well, it is still going to have higher premiums for you to pay. It is still going to have higher taxes for you to pay. There are still going to be big Medicare cuts for seniors to absorb in their program. And while it is a little too early to tell, there is very likely to be more Federal debt. It is still a big bill—more than 2,000 pages—and if you wait until it is fully implemented, it is still somewhere between $2 trillion and $3 trillion over a 10-year period of time.

The Republican Budget Committee staff has looked it over carefully since last night and says it is about $2.5 trillion in spending over 10 years. It still starts taxing you and cutting your benefits immediately if you are on Medicare, but the benefits that come to you for the most part don't start until 2014.

Let me be a little specific about it. It still leaves 24 million Americans uninsured, although it reduces the number of uninsured Americans by 31 million according to the Congressional Budget Office. It still doesn't take care of the physicians reimbursement. One of the most difficult issues we have is what we should do about the amount of money we allow doctors to make when they see patients who are in the government programs. In the Medicare Program, doctors only make about 83 percent of what they would be paid if they were seeing the 177 million of us who have private insurance. We regulate that. Doctors who see Medicaid patients, about 60 million patients in the low-income government program, only get paid about 63 percent, which is set by the state, of what they would get paid if they saw somebody who has a private policy. In fact, 50 percent of doctors will not see new patients in the biggest government program we have—Medicaid. So as you can imagine, a lot of doctors can't see the people in the government program.

This new bill takes care of the doctors reimbursement for only 1 year. It leaves out about $250 billion over the 10-year period of time, so add that in when you are figuring out whether this adds to the debt.

Does it have higher premiums? Yes, it does. The Congressional Budget Office says the new government plan in this bill would have premiums that are higher than private plans. Your common sense would also tell you that, because if we have $800 billion in new taxes somebody is going to have to pay those taxes. If they are on medical devices or insurance policies, do you think the insurance company is just going to pay those taxes? No, they are not. They are going to pass those on to you in the form of premiums. So higher taxes mean higher premiums.

There is also $28 billion in new taxes from employers who have to pay a fine when they don't provide employer-based insurance. Under this bill, the chances are very good—in fact, the Congressional Budget Office says maybe 5 million Americans will lose their insurance. How could they lose their insurance under a bill such as this? The reason would be that the employer will read this big, complicated thing and say: I don't want anything to do with that. I will pay the fine. I will write a check to the government. Then I will write a letter to all of my employees and say: Congratulations, there is a new government plan, and you are in it.

That is going to happen to millions of Americans who have private insurance today through their employers. The employer is going to simply say it is cheaper for them to pay the fine. It is easier for them to pay the fine than deal with this 2,074-page bill.

According to the Congressional Budget Office, 5 million Americans—and others think many millions more—will lose their employer-based insurance, and they will end up in the government plan. I just said in the government plan, the largest one we have, Medicaid for low-income Americans, 50 percent of doctors will not see those patients—new patients—because of the low reimbursement rates. The bill still relies on the States to pay for some of Medicaid. That is not new either. That concerns me greatly as a former Governor. Our current Democratic Governor said the bills he had seen so far would add over $1 billion to State taxes or spending over the next 5 years which, in my way of thinking, would require a new State income tax that would seriously damage higher education or both.

In other words, we are saying give us a pat on the back. Thank you very much for expanding Medicaid, and I am going to send some of the bill to the States and let the States either raise college tuition or raise taxes or cut spending or put in new taxes to pay for it.

There is also a new Medicare tax. The money that is raised from that, the Medicare payroll tax, is not spent on grandma, not spent on Medicare; it is spent on a new program. So we are going to cut Medicare and tax Medicare and not spend it on Medicare, which is going broke in 2015, according to its trustees. We have a new government program. Those are new. But, basically, it is still the same turkey you didn't like in August, and it is not going to taste any better at Thanksgiving dinner on Thursday.

We need to start over. We need to go in the right direction. We need to cut costs. Republicans have offered a number of ways to do that: small business health plans, reducing junk lawsuits against doctors, competition across State lines. All of these steps would cut costs. We don't need a 2,074-page bill. We need to take it step by step in the right direction to cut health care costs, and when we take those five or six steps, we can take five or six more.

I thank the President and yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Nebraska is recognized.

Mr. JOHANNS. Mr. President, I wish to compliment the Senator on his very excellent presentation on a bill we just got in the middle of the night last night. I am a little bit tempted to ask the Senator if I could have a copy of that bill on my desk, but the less we have to handle it, the less we risk bodily injury, so that is all right. Just keep it right there at your desk.

I wish to zero in on one issue today. It is a very important issue to Nebraskans. It is a very important issue to Americans. That is the issue of abortion. An overwhelming majority of Americans suggest—take the position, I should say—that we should not use Federal funds for abortions. Just yesterday, I was looking at an article and it said six in ten Americans favor a ban on using Federal funds for abortions. I have found over and over again that Nebraskans feel the same way.

A constituent in Gretna, NE, said to me, and I am quoting:

> Please know that I do support some health care reform; however, I cannot in good conscience support any legislation that contains any abortion mandates.

Someone from Bellevue, NE, said, and I am quoting again:

> I am writing to urge you to ensure that language is included in any health care reform proposal or bill to explicitly exclude

abortion . . . The use of my tax dollars forces me to support a procedure that is against my conscience.

So as we move forward, we need to focus on what people are saying to us. That is why in this bill we need the exact language in the House bill.

The Stupak amendment is the essence of a continuation of current law. Don't be fooled by those who suggest this is something new and different. The Hyde law prohibits Federal funding of abortion through Federal programs such as Medicaid. It prohibits Federal funding for private health insurance policies that cover abortion. An example is the current Federal Employees Health Benefits Program. The 250 participating health plans do not cover elective abortions. Federal employees pay a share of the cost. The Federal Government pays the balance—or the taxpayers. Federal employees cannot opt for elective abortion coverage because taxpayer dollars are subsidizing the cost of the employee plans.

As many have said during this debate, if it is good enough for Federal employees, well, it should be good enough for the citizens.

The Stupak-Ellsworth-Pitts amendment says: New government subsidies could not be used to purchase an insurance plan that covers abortion. The proposed government insurance plan also could not cover abortion. However, the stark and alarming differences that exist in the Senate bill are immediately obvious.

The Senate bill says: People who receive a new government subsidy could—could—enroll in an insurance plan that covers abortion. It requires—requires—at least one plan on the insurance exchange to offer abortion services.

Supporters say: Don't worry. Public funds would be segregated, so they wouldn't be used for abortion. But this provides no solace whatsoever. It is impossible to segregate funds. How will the government ensure citizens who receive a subsidy to buy a health insurance plan do not use those Federal dollars to pay for health insurance premiums?

Put another way, citizens get charged a premium that includes abortion coverage. The taxpayers pay a percent of the premium. Who can determine what dollar went here or what dollar went there? Well, as many have pointed out already, it is a shell game—nothing more, nothing less.

The Senate bill makes a sharp detour from current law. The very clear line established by the Hyde amendment is obliterated. The Federal Employees Health Benefits Plan does not allow this shell game and neither should this new regime.

National Right to Life is not fooled by this game. They call this provision ''completely unacceptable.'' It was remarkable how quickly they read this language and saw through it. National Right to Life goes on to say that it ''closely mirrors the original House language that was rejected by 64 Democrats.'' I am going to quote:

It tries to conceal that unpopular reality with layers of contrived definitions and hollow bookkeeping requirements.

I stand here today to say to National Right to Life, thank you for standing up for life. I hope more will do the same. You are absolutely correct in saying that it would ''require coverage of any and all abortions throughout the public option program. This would be Federal Government funding of abortion, no matter how hard they try to disguise it.'' They weren't fooled.

My best view of this is that other pro-life leaders will courageously stand up today and tell Americans they should not be fooled either. We have to draw a line. This isn't a partisan issue.

Last week, a Democratic colleague said:

What is clear is that for this bill to be successful, there can be no taxpayer funding for abortion.

Yet the Stupak-Ellsworth-Pitts protections are stripped from this bill. Since it is not in the underlying bill, I want to be very candid, I don't see it in the final bill. I don't believe there are enough pro-life Senators to break a filibuster to make this a part of the final bill. That is why this motion to proceed we will be voting on in hours has become the key vote on abortion. It is the key pro-life vote.

Some say cloture on a motion to proceed is just a procedural effort. It begins debate, and then you can do amendments and potentially even vote the bill down. The facts suggest otherwise. Listen to this, from the Congressional Research Service: Between the 106th and 110th Congress, there were 41 cases in which the U.S. Senate approved a motion to proceed and eventually then voted on final passage; 40 of those 41 bills received final approval. In other words, all but one passed into law. Well, that tells us all we need to know. This motion to proceed on this life issue is critical.

Some of my colleagues would argue that if we don't like the bill, we must not block the opportunity to amend it; therefore, they would say we should vote for the motion to proceed. I don't think any pro-life Senator could take that position, and here is why: If we proceed to the bill, any changes will require 60 votes. I sincerely wish there were 60 pro-life votes in the Senate, but by my count I don't get there; therefore, we won't be able to change this. If there is a Senator willing to suggest otherwise, I respectfully invite him or her to come to the floor and share the list of 60 Senators who are willing to vote for a provision that ensures the Stupak amendment will be there. I don't think that is going to happen.

So it comes down to this: If you don't believe tax dollars should fund abortion, vote against the motion to proceed. It is our last chance to protect life in this debate.

Congressman STUPAK and about 40 of his Democratic colleagues stood strong on their pro-life convictions, and they literally changed the outcome in the House. They stared the Speaker in the eye and said, about this procedural vote: Look, if it is not pro-life, we are not there. And the Speaker had no choice but to put the Stupak amendment up for a vote. Over 40 courageous Congressmen stuck to their convictions, and they made a difference.

Today in the Senate, we don't need 40 Democrats to stand up for what is right; we need just 1. If just one pro-life Democrat would say: I will not vote to move this bill until it is fixed, until it is truly pro-life, that would happen.

Those who say they are pro-life but refuse to take that stand, I worry they are not standing up for life.

I have a record of voting pro-life. I know how I am going to vote on this, because it is the right thing to do. I ask for a pro-life Senator to come down here and stand up on this bill. Pro-life Americans are waiting, and they are not fooled.

I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, here you have it, what we have been waiting for for weeks and weeks, what has been put together behind closed doors. People all across the country have seen the doors behind which people, in secret, have been writing this bill. It is 2,074 pages. Some people call it remarkable; I call it a monstrosity.

The leader of the majority, Senator REID, has said that of all the bills we have seen, it will be the best. Mr. President, it is the best of the worst. It just looks like more of the same. All of the things I have been talking about—it still does those sorts of things. It still raises taxes on Americans, higher payroll taxes—and this is the Associated Press talking, not just me. Companies will pay a fee. That is from the Associated Press as well. It adds an array of tax increases, a rise in payroll taxes. That is from the Washington Post. It relies primarily on a new tax. That comes from the Washington Post as well. Then the New York Times says: New taxes and new fees. It is more of the same. It is the best of the worst.

What about Medicare cuts? Oh, they are in here, too, you better believe it. It is relying on cuts in future Medicare spending to cover costs. That is from the Associated Press. It is financed through billions of dollars in Medicare cuts. That is from the Washington Post. There will be reductions in Medicare. It is all in here—taking away the

health care of the seniors of this country, who have relied on Medicare and have been promised Medicare, to start a brandnew program which is in these 2,074 pages. It is just wrong.

Then look at the budget gimmicks. The costs of this legislation—and the CBO came up with some number, but it is not what the real cost is. This thing is going to cost $2.5 trillion over a 10-year period. They try to get the number down. How do they do it? They start collecting taxes on day one, but until they actually implement the program—the things that are supposed to help Americans, they have delayed those things through 2014. Here we are in 2009, and the people who are watching at home and saying: This is going to help me next week, forget it, wait another 5 years. That is the way they maneuver and manipulate the numbers.

Here we have it—a bill that still raises taxes, still cuts Medicare, uses lots of budget gimmicks, and will cost the American people trillions and trillions of dollars.

Mr. President, obviously health care is one of the most important issues Congress is going to take up this year and maybe in our careers in the Senate. This may be the most important issue and bill we are ever asked to vote upon.

I travel home to Wyoming every weekend. I talk to people. I was there for 5 days over Veterans Day.

I say to them: What do you need? What do you think? What are your thoughts on this?

They say: Deliver to Washington a clear and simple message: Fix what is wrong with the health care system. Whatever you do, don't make things worse for me.

I have town meetings and ask people: Do you think it is going to cost more or less if this is passed? And I have had telephone townhall meetings with folks around Wyoming, and there is a way you can poll and ask people their ideas. People believe it is going to cost them more. I ask: Is your care going to be better or worse? People believe it is going to be worse, that they are going to pay more and get less.

That is not the kind of value the people of Wyoming or anywhere in America want. It is not the kind of work they expect out of Congress. They want us to fix what is wrong with the health care system. As Senator ALEXANDER said earlier, we need a step-by-step approach in the right direction, dealing with the things we can do to improve the system. Whatever you do, they say, don't make matters worse for me. That is what people care about. That is what they care about in the telephone townhall meetings and the meetings we have in person.

They say: What does this mean for me and my family? What will it mean to our health care? What happens if I get sick? That is what people care about. None of them want to read this bill, and probably none of them will read the bill. It is on the Internet, after weeks behind closed doors. I hope the people in Wyoming and around America read it so that they know about the travesties in the bill and the impact it will have on them personally. It is the wrong prescription for America. And it is not just me saying that.

Yesterday, there was an article in the Wall Street Journal, and the dean of Harvard Medical School—it is in Boston, which is where they have this whole Massachusetts health care plan. He said that it is not working in Massachusetts and that this is not going to work for America. He gave the health care bill we are looking at in this Congress a failing grade. It doesn't do a good job in dealing with costs, access, or quality. It misses the boat on all of them.

The people who believe this is going to be helpful collectively are delusional, absolutely wrong. They have no idea how this will be for the health of our Nation. Yet this is what we are looking at. As Senator REID says, what we have seen, of all the bills he has seen, it is the best. It may be, but it is the best of the worst. It looks like more of the same.

Some people in Wyoming in townhall meetings say: Don't take away my freedom to choose the plan I want. Well, this bill sort of does that. If they have something they like, this has a lot of numbers and mandatory sets in there—the sorts of things that will take away freedoms of the people to choose specifically what they want because of all of the mandates this has to cover, and it has to cover this, that, and the next thing. A lot of people don't want that.

People also say: Don't cut my Medicare. I hear that all around Wyoming and around the country. There are 11 million people on Medicare Advantage. That Medicare Advantage Program is actually the only Medicare Program that does a good job of working on preventive care and coordinating care, and that is going to be slashed under this program. So we are going to take away prevention and the things that have to do with coordinated care. Just take a look at this monstrosity of over 2,000 pages.

People say: Don't cut my Medicare or raise my taxes. We are looking at 10.2 percent unemployment right now. This is not the time to raise taxes. It is just not the time. We need to focus on getting jobs moving in the economy and helping people hire new people. With that 10.2 percent unemployment, the last thing you want to do is raise taxes, but that is what this bill will do. That is not just me saying that; it is also the AP, the Washington Post, and the New York Times. All along the way, it is higher payroll taxes, companies paying fees, raising payroll taxes, primarily new taxes and fees—one after another—to pay for something the American people do not want.

The people say: Don't make me pay more for my family's health care. But that is what is going to happen across the board. Premiums are going to increase, the premiums for people who have insurance—the premiums people pay who have insurance. For the 85 percent of Americans who have insurance, those costs will go up. This plan was designed, theoretically, when it was announced a year ago, to get costs down, to get premium costs down. This raises the premiums for the American people.

We are living in a time and in an economy when people say they can't afford this sort of a bill. The American people don't want it.

I travel around the State and visit with people. I visited with a young lady from Cody, WY, who has health insurance through her job, and she likes it. She takes care of her family. She found out that because of increasing premiums—which will get worse if this bill passes—the raises people think they are going to get will not be coming to them. In some places, they have had their pay cut a little bit so they can continue with the health care they have. They like the care, but they don't like the cost of their care. Again, this doesn't get the costs down for American families. Premiums will go up.

This is what we have been seeing all across the country. Whether it is independent people, whether it is people who work for government, whether it is people who sell insurance or those who buy insurance or people who need insurance, across the board, people say these atrocious health care proposals will make matters worse for the families, for the men and women of this country. They are going to be paid for not just by them but also by the young people, as the debt continues to accumulate in our Nation and goes on to impact the young people of this Nation.

The people of Wyoming want practical, commonsense health care reform—the kinds of reforms that will drive down the cost of medical care, that will improve access to providers, that will create more choices. They don't want things that will increase the costs or things that will limit access or things that will take away their choices.

Obviously, the majority leader and the Democrats in Congress have a very different plan in mind. Their legislation is going to force upon Americans higher health insurance costs through higher premiums, higher taxes, Medicare cuts, and more government control over health care decisions. That is not reform.

There are only two physicians in the Senate. The two of us bring a unique

perspective to the health care debate. I practice medicine, taking care of families from all across the great State of Wyoming. I have dedicated my life's work to helping patients live longer, live healthier, and stay well. I can say, without reservation, in this Nation, we do offer some of the finest medical care in the world. I am not blind to the fact that our health care system has failings. I have seen them firsthand. We can fix a broken system in a way that actually works to get costs down, to get more people covered, to give people more choices, not in this plan, not in this atrocious plan which raises taxes, cuts Medicare, and takes away choices from the American people.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 1963, which the clerk will report.

The assistant bill clerk read as follows:

A bill (S. 1963) to amend title 38, United States Code to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

The PRESIDING OFFICER. The Senator from Oklahoma.

AMENDMENT NO. 2785

Mr. COBURN. Mr. President, I call up amendment No. 2785.

The PRESIDING OFFICER. The clerk will report.

The assistant bill clerk read as follows:

The Senator from Oklahoma [Mr. COBURN] proposes an amendment numbered 2785.

Mr. COBURN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To transfer funding for United Nations contributions to offset costs of providing assistance to family caregivers of disabled veterans)

On page 177, after line 10, add the following:

SEC. 1003. REQUIREMENT TO TRANSFER FUNDING FOR UNITED NATIONS CONTRIBUTIONS TO OFFSET COSTS OF PROVIDING ASSISTANCE TO FAMILY CAREGIVERS OF DISABLED VETERANS.

The Secretary of State shall transfer to the Secretary of Veterans Affairs, out of amounts appropriated or otherwise made available in a fiscal year for ''Contributions to International Organizations'' and ''Contributions for International Peacekeeping Activities'', such sums as the Secretaries jointly determine are necessary to carry out the provisions of this Act and the amendments made by this Act.

SEC. 1004. MODIFICATION OF ELIGIBILITY FOR FAMILY CAREGIVER ASSISTANCE.

(a) LIMITATION.—Section 1717A(b), as added by section 102 of this Act, is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) in paragraph (2)(C), by striking the period at the end and inserting ''; and''; and

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

''(3) who, in the absence of personal care services, would require hospitalization, nursing home care, or other residential care.''.

(b) EXPANSION.—Such section 1717A(b) is further amended, in paragraph (1), by striking ''on or after September 11, 2001''.

Mr. COBURN. Inquiry, Mr. President. It is my understanding I am going to have 2 hours during this period of time under unanimous consent.

The PRESIDING OFFICER. The Senator is correct.

Mr. COBURN. I reserve the remainder of my time and yield to the chairman and ranking member.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I ask unanimous consent that I be permitted to use my time on the bill and my time on the amendment as necessary.

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

Mr. AKAKA. Mr. President, as chairman of the Senate Committee on Veterans' Affairs, I had the honor of speaking at the World War II Memorial this past Veterans Day. As I stood there remembering my own comrades and their families, I thought of what the brave men and women in the service give up every day so we can enjoy the freedoms that come with American citizenship.

It is in that spirit that I urge this body to pass S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 without further delay.

The Nation's young veterans coming home from Iraq and Afghanistan have faced a new and terrifying kind of warfare, characterized by improvised explosive devices, sniper fire, and counterinsurgencies. Military medicine, fortunately, is saving more of these young servicemembers' lives than ever before.

In World War II, 30 percent of Americans injured in combat died. In Vietnam, 24 percent died. In the wars in Iraq and Afghanistan, about 10 percent of those injured have died.

As more of the catastrophically disabled are surviving to return home, more will require a lifetime of care. With our decision on S. 1963, we decide whether that care will be in their homes with the help of their family members or in institutions. If we want that care to be in the home, we need to help the families shoulder the burden of providing it.

During the prior administration, the President's Commission on Care for America's Returning Wounded Warriors—known as the Dole-Shalala Commission—found that 21 percent of Active Duty, 15 percent of Reserves, and 24 percent of retired or separated servicemembers who served in the Iraq or Afghanistan conflicts said friends or family members gave up a job to be with them or to act as their caregiver. By giving up a job, caregivers often give up health insurance, when they need it the most.

Studies also show family caregivers experience an increased likelihood of stress, depression, and mortality, compared to their noncaregiving peers.

Without a job, without health insurance, and in very stressful situations, family caregivers have worked to fulfill the Nation's obligation to care for its wounded warriors.

S. 1963 would give these caregivers health care, counseling, support, and a living stipend. The bill would provide caregivers with a stipend equal to what a home health agency would pay an employee to provide similar services. It would give the caregivers health care and make mental health services available to them. The bill also provides for respite care so caregivers can return to care for these veterans with renewed vigor and energy. It lets these young veterans return to their families and not to a nursing home.

While the caregiver program in this legislation will be limited at first to the veterans of the Iraq and Afghanistan wars, other provisions of the bill improve health care for all veterans.

There are provisions which make health care quality a priority, strengthen the credentialing and privileging requirements of VA health care providers, and require the VA to better oversee the quality of care provided in individual VA hospitals and clinics.

The bill will also improve care for homeless veterans, women veterans, veterans who live in rural areas, and veterans who suffer from mental illness.

About 131,000 veterans are homeless. S. 1963 would help these veterans obtain housing, pension benefits, and other supportive services. It would provide financial assistance to organizations that help homeless veterans.

Seventeen percent of servicemembers are now women. This legislation contains a number of provisions which are designed to improve the care and services provided to women veterans.

It would provide for the training of mental health professionals in the treatment of military sexual trauma and provide care for the newborn children of servicewomen. It would give women veterans a quality of care they have earned through their service to this country.

The bill also provides new assistance to veterans who live in rural areas. According to the VA, of the 8 million veterans enrolled in VA health care, about

3 million live in rural areas. This legislation would bring more services into rural communities through telemedicine and increased recruitment and retention incentives for health care providers. It also would increase the VA's ability to use volunteers at vet centers and create centers of excellence for rural health.

Finally, S. 1963 addresses the signature injuries of this war—PTSD and traumatic brain injury. According to a recent RAND report, one-third of veterans returning from Iraq and Afghanistan will develop post-traumatic stress disorder. Countless others will suffer from traumatic brain injury and face significant problems in readjusting to life at home. Many studies have shown the importance of early intervention to the effective treatment of these invisible wounds.

This legislation contains provisions that allow Active-Duty military to seek mental health services at vet centers and increase access to care for veterans with traumatic brain injury.

Before concluding, I wish to share one of the many stories I have heard as I have worked to move this legislation through the Senate.

SGT Ted Wade sustained a severe brain injury after his humvee was hit by an improvised explosive device in Iraq. His right arm was completely severed above the elbow, and he also suffered a fractured leg, broken right foot, and visual impairment, among other injuries.

His wife Sarah Wade became his caregiver and a dedicated advocate for her husband, as well as for others who are providing caregiver services.

In testimony before the House Veterans' Affairs Committee earlier this year, Ms. Wade made the point that:

> Young veterans with catastrophic injuries need support that will be around as long as the injuries they sustained in service to their country. Just like servicemembers need a team in the military to accomplish the mission, they need a team at home for the longer war.

I agree completely with that view. Veterans need all the support we can provide. We, as a country, can give them options that veterans of my generation never had. We can give them the option to really come home.

To those who are concerned about the cost of this legislation, I say we cannot now turn our back on the obligation to care for those who fought in the current wars. When we as a body vote to send American troops to war, we have promised to care for them when they return.

I firmly believe the cost of veterans benefits and services is a true cost of war and must be treated as such.

I ask that our colleagues accept no more delays and act on this important legislation.

Mr. President, I reserve the remainder of my time and yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I thank and congratulate the chairman of the VA Committee. This is important legislation in front of this body. It is my belief that this will move very quickly, as we can see from the short time agreement: one amendment—one amendment that I think is extremely important for all Members of the Senate to consider.

I rise in support of S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009. This is actually the combination of two bills reported out of the Veterans' Affairs Committee this year, and it did enjoy bipartisan support.

The centerpiece of the legislation is the support it would provide to caregivers of severely injured veterans of current wars. The bill would provide counseling, support, living stipends, and health care for those caregivers.

As my colleagues know, family caregivers play an extremely important and, I might say, unique role in helping to meet the severely injured veterans' personal care needs. For some veterans, family members serve as their primary caregiver, some of whom have lost their jobs but, more importantly, have lost their health care as a result of that commitment to that family member.

As the chairman spoke about a servicemember he had remembered in this—Ted Wade is a North Carolinian—he made the same impression with me. I also think about caregivers Edgar and Beth Edmundson from North Carolina as well, the parents of Eric Edmundson, a severely injured veteran from Operation Iraqi Freedom. They have been caring for Eric since the day they took him out of the VA hospital—out of a VA hospital because the VA basically had come to the point where they said they could not improve Eric's life.

After Eric was injured on patrol along the Iraqi/Syrian border, he went into cardiac arrest while he was awaiting transport to Germany. It was in fact that cardiac arrest, that traumatic brain injury, that put Eric in a situation where he couldn't walk and he couldn't talk. As he lay in that long-term care provided by the Veterans' Administration, he got no better. He couldn't walk and he couldn't talk.

Eric's father stepped to the plate and immediately began researching all the options for Eric's treatment. Despite being told his son would not emerge from his vegetative state, Ed Edmundson pushed on. He sold his business, he cashed in his savings and retirement pay, all in an effort to provide Eric 24-hour care as a father.

Under his father's constant attention and relentless pursuit of new options, Eric received the treatment he needed. Without his dad's commitment, without the commitment of the rest of Eric's family—who basically dropped everything else important in life to focus on his needs—Eric would not be doing as well as he is today. I might say he walks and he talks and he continues to make progress every day because his most important caregivers, his parents, believed in him and they believed in what they could accomplish.

Let me tell you the rest of the story. Beth, Eric's mom, recently suffered a compound fracture of her ankle while caring for Eric's daughter Gracie. Because Beth and Ed have no health insurance, they are on the hook for $36,000 worth of medical bills. Had Eric chosen Beth, his mother, as his caregiver, and this legislation was in effect, we would have provided coverage for Beth to have health care coverage. I believe that is what this legislation is about—recognizing the individuals who make life-altering commitments to members of their family or servicemembers who, without that commitment, might not have the quality of life they have.

As I mentioned, assistance to caregivers is just one part of this bill. Other provisions would remove barriers to emergency care provided to veterans at non-VA facilities. It would expand health care services for women veterans, provide additional outreach to veterans in rural communities, provide additional improvements in mental health care services provided to veterans, enhance services to homeless veterans, improve the ability of VA to recruit and retain the needed health care professionals, authorize major medical facility construction projects, test a concept I introduced of providing veterans and their survivors with dental coverage, and much more.

This is a good bill. It is not perfect. It can be better. I urge my Senate colleagues to strongly consider supporting the amendment of Senator COBURN, and let me explain why.

When the committee passed this bill, we did not limit it to current veterans of current wars; we extended it to all veterans. Since it came out of committee in a bipartisan way, we have narrowed it down not to include all veterans. The amendment of Senator COBURN expands it to all veterans.

When the committee considered the caregiver bill, we considered it because we wanted to keep veterans out of nursing homes. That was the goal, to give them an alternative because the traditional role of the nursing long-term care facilities had not worked at improving the quality of care and the quality of life for these veterans. That was our goal.

Senator COBURN brings some definition to who is eligible for this based upon the fact that they would be headed toward a nursing home. We may tinker a little bit with the definition as to

whether it is exclusive or totally as inclusive as we would like, but make no mistake, it is not different from the intent of the committee as to why the committee passed the caregivers act.

Let me mention one probably even more important piece of the amendment of Senator COBURN. It actually pays for what we are doing. We say the Secretary ''shall''—that means he has to implement everything in the caregiver bill. The amendment of Senator COBURN is going to say: You know what. We are going to take some money out of the funds that we pay to the U.N., and we are going to fund our veterans. I, for one, am tired of coming to the floor and spending money we don't have.

Why don't we take some of the money we have already appropriated and let's shift it? This is something novel for the Senate, but it is called prioritizing. Let's prioritize where the Federal investment should go. Let's make sure we pass the Caregivers and Health Care Act. Let's make sure we pay for it with the Coburn amendment, and let's pull that money out of already-appropriated funds so we can not only look at our veterans, but we can look at our children and tell them this is a good bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I yield 10 minutes to the Senator from Washington, Mrs. MURRAY.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, last week many of us spent time back home celebrating our veterans and honoring the great sacrifices they made for our country. I had the opportunity to commemorate Veterans Day at the Tahoma National Cemetery in Kent, WA. It was truly an honor to stand with veterans and their families as we paid tribute to their service.

This recognition is important, it is certainly deserved, but it is not enough. We owe it to our veterans to make sure our commitment to them extends beyond Veterans Day and that they have access to the health care and services they have earned.

Growing up, I saw firsthand the many ways that military service can affect both veterans and their families. My father served in World War II. He was one of the first soldiers to land in Okinawa. He came home as a disabled veteran, and he was awarded the Purple Heart.

Like many soldiers of his generation, my dad did not talk about his experiences to us when he came home. In fact, we only learned about them by reading his journals after he passed away. That experience offered me a much larger lesson about veterans in general.

They are reluctant to call attention to their service. They are reluctant to ask for help. That is why we have to publicly recognize their sacrifices and contributions. It is up to us to make sure they get the recognition they have earned. Our veterans held up their end of the deal, now we have to hold up ours.

As a member of the Veterans' Affairs Committee, I am keenly aware that we have a lot of work to do for the men and women who served us. Not only must we continually strive to keep up our commitments to veterans from all wars, but we have to also respond to the new and very different issues facing veterans who are returning from Iraq and Afghanistan today, wars that are being fought under conditions that are very different from those in the past. That is precisely what the caregivers and veterans omnibus health bill that is before us today aims to do.

One of the changes we have seen in our veterans population recently is the growing number of women veterans who are seeking care at the VA. Today more women are serving in the military than ever before, and over the next 5 years, in fact, the number of women seeking care at the VA is expected to double. Not only are women answering the call to serve at unprecedented levels, they are also serving in a very different capacity.

In Iraq and Afghanistan, we have seen wars that do not have traditional front lines; therefore, all of our servicemembers, including women, find themselves on the front lines. So whether it is working at the check points or helping to search and clear neighborhoods or supporting supply convoys, women servicemembers face many of the same risks from IEDs and ambushes as their male counterparts.

But while the nature of their service has changed, the VA has been very slow to change the nature of the care they provide for these women when they return home. Today at the VA there is an insufficient number of doctors and staff with specific training and experience in women's health issues, and even the VA's own special studies have shown that women veterans are underserved. That is why included in this veterans health bill we are talking about today is a bill I introduced that will enable the VA to better understand and ultimately treat the unique needs of our female veterans. That bill authorizes several new programs and studies, including a comprehensive look at the barriers women currently face in accessing care through the VA. It is a study of women who have served in Iraq and Afghanistan to assess how those conflicts have affected their health.

There is a requirement that the VA implement a program to train and educate and certify VA mental health professionals to care for women with sexual trauma, and there is a pilot program that provides childcare to women veterans who are seeking mental health services at the VA.

This bill is the result of many discussions with women veterans on the unique and very personal problems they face when they return from war. Oftentimes after veterans meetings I held in which male veterans would speak freely about where they believed the VA wasn't meeting their needs, women veterans would approach me afterwards and walk up to me very quietly and whisper about the challenges they face.

Some of these women told me they don't view themselves as a veteran even though they served, and therefore they don't seek care at the VA. Others told me how they believed the lack of privacy at their local VA was very intimidating, or about being forced into a caregiving role that prevented them from seeking care as they would often have to struggle to find a babysitter just in order to keep an appointment. To me and to the bipartisan group of Senators who have cosponsored my women veterans bill, these barriers to care for women veterans were unacceptable.

As more women now begin to transition back home and step back into careers and their lives as moms and wives, the VA has to be there for them. This bill we are talking about today will help the VA modernize to meet their needs.

Another way this bill meets the changing needs of our veterans is in the area of assisting caregivers in the home. As we have all seen in Iraq and Afghanistan, medical advances have helped save the lives of servicemembers who, as we know, in previous conflicts would have perished from the severity of their wounds. But these modern miracles also mean many of those who have been cast catastrophically wounded need round-the-clock care when they come home. In many of our rural areas, where access to health care services is limited, the burden of providing care often falls on the families of those severely injured veterans.

For these family members, providing care for their loved ones becomes a full-time job. Oftentimes we hear they have to quit their current job, forfeiting not only their source of income but often their own health care insurance as well. That is a sacrifice that is far too great, especially for families who have already sacrificed so much. That is why this underlying bill provides those caregivers with health care, with counseling, with support, and, importantly, a stipend.

This bill also takes steps to provide dental insurance to our veterans and survivors and their dependents.

It improves mental health care services and eases the transition from active duty to civilian life. It expands outreach and technology to provide better care to veterans who live in

rural areas. It initiates three programs to address homelessness among veterans at these especially difficult economic times.

This is a bill that is supported by numerous veterans service organizations, by the VA, and it is supported by many leading medical groups. It was passed in the Senate Veterans' Affairs Committee with broad bipartisan support, after hearings with health care experts and VA officials and veterans and their families. Like other omnibus veterans health care bills before us, bills that have often passed on the floor with overwhelming support, it puts veterans before politics. It is a bipartisan bill designed to move swiftly so its programs can be implemented swiftly. It is a bipartisan bill designed to make sure our veterans do not become political pawns. Yet we have faced a lot of delays in getting here. Those delays are all too common here in the Senate. We have seen bipartisan nominations stalled, funding bills slowed down to a crawl. It has taken us months to pass a simple extension of unemployment benefits for people who are out of work.

Providing for our veterans used to be one area where political affiliation and bipartisan bickering fell to the wayside. I hope those days are not behind us. Our aging veterans and the brave men and women who serve in Iraq and Afghanistan need our help now. How we treat them at this critical time is going to send a signal to a generation of young people who today might be considering military service.

As I have said many times, it is so important that we keep our promise to veterans, the same promise Abraham Lincoln made to America's veterans 140 years ago, "to care for the veteran who has borne in battle, his widow and his orphan."

Our veterans have waited long enough for many of the improvements in this bill. We cannot ask them to wait any longer.

I spoke last week on the floor on the eve of Veterans Day urging colleagues to move quickly on this bill. I am so glad progress is now being made toward making that happen. As we wait to pass this bill, our promise goes unfulfilled to many of our Nation's heroes. I urge my colleagues to pass this bill quickly so we can get to the work of providing our veterans with the support and services they have earned.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, the reason we are having the debate now is because nobody would have the debate earlier. It is important for the American people. I don't have any opposition to veterans care. As a matter of fact, I support keeping our commitments. But as this thing wound out, on October 28 it came to the floor. Part of my amendment, when it actually came out of committee, was in the bill. It was taken out before it came to the floor, not by the members of the committee. It was taken out. But the very fact that we make an issue, because somebody wants to debate a bill and offer amendments on a bill, and then we are supposedly antiveteran because we think maybe we ought to pay for some things we do around here, so because we want to pay for it, we are cast aspersions that we don't want it to be debated. The worst thing that happens in this body is we pass bills that the American people have no idea about because we refuse to debate them.

I apologize to no one for having put a hold on this bill for a very good reason. The very good reason is this: Our veterans demonstrate courage greater than we ever demonstrate in this body. We ought to model that same courage. What is the courage I am talking about? The courage to make priorities, to make sure we keep those commitments. This bill, as it is written now, will cost $3.7 billion over the next 5 years. I think we ought to do that for these veterans. But I also think their sacrifice should not be in vain and stolen and paid for by their grandchildren. I believe we ought to pay for what we are going to do.

It is interesting that the Senator from Hawaii mentioned speaking at the World War II memorial. This bill, as written, excludes World War II veterans from the benefit. It excludes gulf war veterans from the benefit. What about them? Is the reason the other veterans, the Vietnam war veterans, the Korean war veterans were not included is because we thought we couldn't afford it? I think that is probably the reason. Which begs the question, if in fact we want to honor veterans, we ought to treat them the same, one, and we ought to have the courage to make hard choices about how we pay for it.

It is easy to charge this money to our grandkids. I have no doubt that is what we will end up doing. But the biggest threat facing our country today is not Islamic fascism and Islamic terrorism. The biggest threat facing the country today is the fact that every young child born today will encounter $400,000 worth of debt for benefits they will get nothing from. When we calculate the interest cost on that, by the time they are 25, they will have been carrying a debt load of $1,119,000.

As I look at my colleagues who want to do this but don't want to pay for it, I am bewildered to think that we can call and honor the courage and service of our veterans without taking some of the same courage to make some hard choices about funding of other things that are not nearly as important as our veterans. We can't do both. We can't continue down the road we are on. We can't continue to spend the money we are spending and borrowing, 43 cents of every dollar we spent this last year, borrowing it from our grandkids. It won't work. We will fail as a nation.

Look at President Obama's recent trip to China. What was the message that emerged? They are worried about us financially. They are worried about our deficit spending. Why are they worried? Because they own close to $1 trillion worth of our debt. They now impact our foreign policy decisions only by the fact that they own so much of our debt.

Can we continue to do this and have a free America? Can we continue to do this and our children have opportunity, at least to the level we have experienced? What are our veterans fighting for? Why did they put their bodies at risk, if it is not for a greater future for the country?

When we think about this past year—and it will be worse next year, it will be 44, 45 cents borrowed of every dollar we spend—do we not have an obligation to our grandchildren as well as our veterans? This isn't even a hard vote. Our entire contribution to the United Nations is wasted in the fraud of the peacekeeping we contribute to. We contribute 25 percent of the United Nations money, and we have reports and studies and leaked documents that show the vast majority of the money we put in the United Nations gets defrauded from the United Nations.

We are going to get to make a choice with this amendment. We will say we will treat all veterans the same, No. 1, and we are actually going to pay for it by saying it is a greater priority to take care of our veterans than to fund a corrupt, fraudulent peacekeeping force as run through the United Nations. That is what we are going to say.

If this amendment passes, it will send a wonderful signal to the United Nations to clean up their act. It will send a wonderful message to our children and grandchildren that we will finally start acting responsibly, and it will send a great message to veterans that we do care and we care enough to make sure the sacrifice they made will not be squandered by us not making hard choices.

We owe a lot to our veterans. The No. 1 thing we owe them is to make sure what they fought for and the future we have is secure in our children and grandchildren's generation. It is not secure today, based on the fiscal situation we find ourselves in.

I reserve the remainder of my time.

The PRESIDING OFFICER (Mrs. MURRAY). The Senator from Hawaii.

Mr. AKAKA. Madam President, I yield 5 minutes to the Senator from Alaska, Mr. BEGICH.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. BEGICH. Madam President, I rise in support of S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009. I am pleased we are now

considering this bill. S. 1963 is comprehensive legislation that addresses many of the needs of our veterans and our Nation's heroes. The bill before us is a compilation of two earlier bills introduced by Chairman AKAKA to improve veterans health care and provide much needed benefits to their caregivers. I thank the chairman of the Veterans' Affairs Committee for his leadership on this bill and in committee. He understands the importance of providing the Department of Veterans Affairs the necessary tools and policies to serve the needs of veterans.

This legislation ensures that wounded warriors returning from Iraq and Afghanistan can receive care in their home by providing caregivers the necessary benefits to stay at home and care for them full time. This is especially important in rural States such as my State of Alaska where obtaining a caregiver from remote areas is extremely challenging. In those areas, families take care of their injured servicemembers. To further help rural veterans, this bill will allow servicemembers who are severely disabled or require emergency care to seek medical attention at non-VA facilities without being billed. For a veteran in one of the many remote villages of Alaska, this is especially important, for they already face many economic challenges.

The bill takes other steps to alleviate shortfalls in rural veterans health care. Telemedicine progam expansion, authority to collaborate with Indian Health Services and community organizations are just some of the additional efforts taken.

In addition to providing for caregivers and improving health care for rural veterans, S. 1963 will finally require the Department of Veterans Affairs to identify and take action on shortfalls in health care for women veterans, mental health care, and outreach to homeless veterans.

Thirteen veteran organizations support S. 1963 as introduced by Chairman AKAKA. Unfortunately, one of my Senate colleagues disagrees with me and my other Senate colleagues and the 13 veteran organizations about this initiative and this bill and whom they serve. My Senate colleague has offered an amendment that almost doubles the cost. Although he claims the bill is discriminatory against veterans from previous wars, the expansion of rural, women's health, mental health, and homeless initiatives are not limited to any particular group of veterans. Additionally, my colleague's amendment offsets the cost of the bill by requiring the Department of State to transfer money to the Department of Veterans Affairs from the United Nations.

Sitting here for a few minutes listening to my colleague, I have to say a couple comments that are not written here. First, my colleague, who voted for the war supplementals that had no funding at all other than to make the cost there and no offset to them, sent people to war. When you do that, you have to also remember the costs associated over the long term. I wasn't here during those votes. I wasn't here when $1 trillion went to the richest of the rich for tax breaks that had not one dime of offset. I am paying for that. My son is paying for that. So it is interesting to hear this debate now.

We have to think long term. We have to think when we go to war, there are costs. If we don't fund them on the front end, we have to deal with them on the back end. That is what we are doing now.

I think his amendment is worthy to a certain degree, but I disagree with the funding source. Listening for the last 2 minutes as a new Member surprises me. My Senate colleague is forcing us to make an inappropriate choice with this amendment that will cost us more in the long run. He is asking us to choose between providing for veterans and maintaining America's essential role in the world. His amendment pays for this bill by breaking U.S. international obligations. If his amendment passes, it would threaten ongoing peace operations in Haiti, Sudan, and Lebanon.

By breaking our international promises, we undermine our national security by opening opportunities for instability, conflict, and strife. If there is instability, conflict, and strife, then it means more troops will have to serve and more come home wounded. Then we will have to pass another bill to pay for those troops and their care when they return.

U.N. peacekeeping operations are eight times less expensive than U.S. forces, according to a GAO study in 2006. If my Senate colleague were truly concerned about costs, he would not have chosen, as I mentioned, to cut accounts, which undermines our national security and breaks international obligations. His amendment just does not make sense. It is fiscally and politically irresponsible. I urge him to withdraw this amendment and to remember he has voted for billions of dollars in funding that was not offset for these wars. Funding the wars is just as important as fulfilling our promises to our veterans when they return.

So many issues facing our veterans today are addressed in S. 1963. Passage of this legislation and its enactment into law will improve and increase services for our veterans and acknowledge the sacrifice of their caregivers.

I urge my colleagues to vote no on the amendment and support passage of S. 1963 as it has been introduced.

Again, I thank the chairman, Senator AKAKA, for his unwavering support and advocacy for our veterans.

Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. AKAKA. Madam President, I yield 3 minutes to the Senator from Montana, Mr. TESTER.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. TESTER. Thank you, Madam President, and I thank Chairman AKAKA.

Madam President, I rise this morning to urge the Senate to pass the Caregivers and Veterans Omnibus Health Services Act of 2009. Chairman AKAKA has done a great job of explaining the particulars of this bill. I thank him and Senator BURR for their leadership in our committee.

I could also echo Senator AKAKA in explaining the reasons to vote for better health care for this county's veterans. But, instead, I am going to boil it down to one reason. Madam President, we promised it—we promised it—to all the men and women who served in our military. We promised it, just as we promised our troops the resources they need when they are in battle. This is not a vote about politics or partisanship; it is about living up to the pledge we made to all our veterans.

Montana is a rural State, which means that all 100,000 veterans there are rural veterans. Many of them live in frontier communities. Sadly, that means they have a tougher time getting the health care they have earned. Many of them still have to pay out-of-pocket travel expenses to get to a VA hospital for their health care. According to some studies, veterans who live in rural America do not live as long as veterans who live in urban places. That is not only sad, it is disgraceful, and it is unacceptable.

This bill contains provisions I included with the help of rural veterans and veterans service organizations in Montana. A vote for this bill is a vote to give veterans in rural America and frontier communities better access to health care. A vote for this bill will lock in an acceptable VA mileage reimbursement rate for disabled veterans who have long distances to travel to get to a VA hospital. A vote for this bill will authorize the VA to award grants to veterans service organizations that drive veterans to their medical appointments. In a place such as Montana, we would be in pretty tough shape without the dozens of volunteers who make that sort of thing happen. A vote for this bill will also improve health care in Indian country, and it will improve mental health care for rural veterans.

Last week, over Veterans Day, I had the honor of attending events across Montana. I had the opportunity to say thank you to our veterans, as we should do every day. A lot of veterans to whom I spoke last week made it clear—made it clear to me—we still have a lot of work to do to live up to the promises we have made to our fighting men and women.

This legislation is not the be-all and end-all, but it is a big step forward that is the result of putting politics aside

and working together to do right by all of the men and women who have served our country.

Passing this legislation is living up to a promise. It is common sense. That is why I urge my colleagues to support it.

With that, Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Oklahoma.

Mr. COBURN. Madam President, may I inquire how much time I have remaining?

The PRESIDING OFFICER. The Senator from Oklahoma controls 112 minutes.

Mr. COBURN. Thank you, Madam President.

I want to go back to the start of this again. The American people need to know what a hold is. What is a hold? A hold says that a bill is trying to go through the Senate without debate, without discussion, that by unanimous consent everybody agrees we ought to pass a bill the way it is. Unfortunately, 70 percent of the bills that go through the Senate pass that way. The American people get to hear no debate, get to have no knowledge about what is in the bill, whether there is controversy about what is in it. As a matter of fact, they do not know that the bill on the floor is actually different from the bill that passed out of committee. It has been modified, not with the vote of the committee but with the direction of the chairman only.

So the purpose of our holds is either you are against the bill—and I have no secret holds. Everybody here knows that. When I hold a bill, everybody knows the bills I hold, and I give a reason for why I hold them. I do not hold them sheepishly. The purpose for a hold is to develop debate, to have the very discussion we are having on the floor.

This bill was filed October 28. It was brought to the floor the week before last without the ability to amend it, debate it, or discuss it. So the reason we are here today is so we can do just that.

I have stated numerous times—I have stated it to the chairman of the committee and the ranking member of the committee and others—I do not oppose—as a matter of fact, I am for providing for our veterans. What I am opposed to is us sinking our grandchildren in debt.

The Senator from Alaska makes the claim or insinuates that I was here when the tax cuts came through. I was not. I believe when you do tax cuts you match them with spending cuts.

There is $350 billion a year in waste, fraud, and abuse that goes through this government every year. Not one amendment out of over 600 that have been offered has been agreed to by this body to eliminate some of that waste—not one.

Everybody who has spoken against this amendment or for this bill, with the exception of Senator BURR, has a 100-percent voting record for spending money. Not once do they vote against any spending bills, not once since I have been in the Senate—5 years. Not one of those who are opposed to paying for this has said: I see something wrong with this spending bill. It is not a priority. We ought to cut it. Therefore, I am not going to vote for it.

I have had criticism because the first year I was here I actually voted for a war supplemental. But at that time, we had a deficit of $110 billion, not $1.4 trillion. At that time, we had an economy that was growing, not an economy on its back. At that time, we had not totally mortgaged our children's future.

It is time for all of us to change. It is time for all of us to make the same decisions everybody outside of Washington has to make every day, which means you have to make a choice. You get to make a choice on what is a priority and what is not. For, you see, our body, the supposed most deliberative body in the world, has a bias. The bias is this: Offend no one. Offend no one. How do you do that? How do you offend no one? You offend no one by taking the government credit card out of your pocket and putting it into the machine and saying: We do not have to make those hard choices. We are not going to offend anybody by cutting programs. We are not going to offend anybody with the $50 billion a year of waste at the Pentagon. The fact is, 2 years ago the Pentagon paid out performance bonuses of over $6 billion to companies that did not meet the performance requirements.

Sadly, not one American, not the Federal Government, got any of that money back. None of it came back because the other side of the story is, we fail to do oversight. We fail to do the hard work that does not give you a headline. That is very hard work to hold the executive branch and agencies accountable. So our veterans do sacrifice.

I am for the Caregivers Act. I am for us doing all these things. But I am only for them if, in fact, we will start making the same hard choices our veterans make, the same hard choices everybody else in this country makes when it comes to making a decision about the future.

You see, a lot of people in our country today are underwater on their mortgages. They are underwater on their mortgages. Guess who else is. We are as a nation. We are underwater. Let me show with this chart, for example, what the financial situation is with our country.

Medicare is broke. Part A will run out of money in 2017. We have 50 million baby boomers—I am one of them—who are going into Medicare in the next 8 to 10 years. So not only is the cost per Medicare patient going to go up, but we are going to add 50 million to it. It is broke.

Medicaid. It is broke. It comes out of your general tax revenue. But the States are broke over their share of Medicaid.

The census. It is broke. It is going to cost 2½ times what the last one did. It is total mismanagement by the Federal Government.

Fanny Mae and Freddie Mac—broke to the tune of $200 billion of your money, each one of them; $400 billion that your kids get to pay back, your grandkids. They do not get the opportunities because they are both broke. We have done such a wonderful job.

Social Security. It is the easiest to fix, but it is essentially broke because we have stolen $2.6 trillion from it. And then we are not being honest with the American public about what our true deficit is because when I said a minute ago that our deficit was $1.43 trillion, that is not true. That is Enron accounting. That is Washington accounting. The real deficit is well over $1.5 trillion because we stole more money from Social Security. Guess what. Next year, for the first time in the history of Social Security, more money will be paid out than will be paid in. For the first time, it runs in the red next year. We owe money, so technically it is not broke yet—until some of that $2-plus trillion goes back into it—but it is essentially broke.

How about the post office? They just announced their loss for this year. They are going to have a bigger loss next year. It is broke.

Cash for clunkers. That was broke when it started.

The highway trust fund. It is broke. We do not have enough money for what we are obligated to pay out. It is broke.

Now we are talking about government-run health care? A $2.5 trillion program? That is what the real number is on it when you get the Enron accounting out of the bill that Senator REID introduced last night—$2.5 trillion.

And now we are saying we do not have the courage to pay to take care of our veterans. I do not think the American people are going to tolerate this much longer, nor do I think they should tolerate it—that we will continue to steal the opportunity and future of our children.

I think the Senator from Alaska can be forgiven for not knowing all the abuse, fraud, and waste in the U.N. because in every country he mentioned, U.N. peacekeepers have been accused of rape and pillaging the very people they were supposed to have been protecting. In every country he mentioned, U.N. peacekeepers we paid for are raping the very citizens they are supposed to be protecting. Yet we do not have the courage to say: Time out. We are not

sending you any more money until you clean up the mess. No, we are not going to do that. We are not about to do that. What we are going to do is we are going to say we will take the money for the veterans from our grandchildren and we will not make the hard choice. I think it would be a wonderful message to send to the United Nations that maybe they ought to start being transparent about where the money goes. Do you realize nobody can know where the money goes? You don't get to know. I, as a Senator, don't get to know. The President pro tempore doesn't get to know where the money goes. Yet your country puts $5 billion a year into that and you have no idea. The only way we find out is occasional leaks.

By the way, of all those U.N. peacekeepers who have raped and pillaged, not one of them has been convicted. Not one of the agencies, in terms of their eight programs that have been incompetent and wasted money, have been convicted. They are immune to conviction. The waste, fraud, and abuse of this country is only exceeded by one organization, and that is the United Nations. Yet we don't have the courage because the State Department is against this amendment, and they sent a letter outlining why they are against it. I am going to put into the RECORD why they are wrong. I ask unanimous consent that at the end of these remarks, my rebuttal statement in response be printed in the RECORD.

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

(See exhibit 1.)

Mr. COBURN. The State Department Bureau of Legislative Affairs opposes this amendment. It lists a number of programs as reasons to support the U.N. and oppose the Coburn amendment. Many of the programs and activities the State Department listed have experienced severe problems in execution or are taking credit for activities by national governments or private entities.

Let's take the recent elections in Afghanistan. The United Nations cannot account for tens of millions of dollars provided to the Afghan election commission, according to two U.N. audits—these are confidential; they weren't released; we just happened to be fortunate enough to have people who would give them to us—and interviews with current and former senior diplomats. The Afghan election commission, with over $20 million in U.N. funding and hundreds of millions of dollars in U.S. funding, facilitated and helped mass election fraud and operated ghost polling places.

Should we keep sending them money for incompetence, waste, and fraud?

''Everybody kept sending money'' to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan.

Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election.

This is a deputy to the senior U.N. official in Afghanistan. He was fired last month. He protested the fraud and he got fired by the U.N., that wonderfully competent organization.

As of April 2009, the U.N. had spent $72.4 million supporting the electoral commission, with $56.7 million of that money coming from the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $263 million in funding for that election.

In one instance, the United Nations Development Programme paid $6.8 million for transportation costs in areas where no U.N. officials were present. We paid transportation costs, but no U.N. officials were present. Why did we pay it? Where did that money go? Where is the money?

Overall, the audits found that U.N. monitoring of U.S. taxpayer funds was ''seriously inadequate.''

In other words, it is there, they send it out, they don't have any idea, but you can bet well-connected people at the U.N. are making millions off U.S. dollars.

How about the monitoring of nuclear programs in North Korea and Iran? In 2002, the North Korean Government used United Nations Development Programme money—UNDP money or aid—to purchase—this is aid for them for development from the U.N.—they purchased conventional arms and ballistic missiles. With money we gave the U.N., the U.N. turns around, gives it to North Korea, and they buy missiles and arms. There is a real problem at the U.N. We will not face up to it.

It also transferred millions of dollars in cash to the Government of North Korea, with no oversight on how the money was spent—no oversight, just handed them millions of dollars in cash.

In September 2009, North Korea announced to the United Nations Security Council that it was almost complete in weaponizing nuclear materials from its nuclear reactor. Last week, North Korea announced the processing was complete.

We helped finance it through the United Nations. We helped finance it through the United Nations.

As of this morning, Iran had rejected the U.N. offer to send enriched uranium out of the country to prevent it from developing nuclear weapons.

We don't know how much U.N. money has gone in there yet, but I promise I will try to find out. But I can guarantee that millions of our dollars have been wasted that could pay for our veterans or we can borrow it from our children.

U.N. contribution: Funding 17 U.N. peacekeeping operations, including those in Haiti, Liberia, Lebanon, Darfur, and the Democratic Republic of Congo.

U.N. peacekeeping operations are plagued by rape and sexual exploitation of refugees. From 1994 forward, 68 separate instances of rape, prostitution, and pedophilia—68 separate times—and we pay half the U.N. peacekeeping costs. We don't manage the money; the U.N. manages the money.

What would happen if U.S. troops were doing that? Yet we have no control.

In 2006, reported BBC News: Peacekeepers in Haiti and Liberia were involved in exploitation of refugees. You can read that in the BBC News of November 30, 2006, if you want to look it up.

In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past 3 years, ranging from rape to assault on minors. Not one of them has been prosecuted, not one.

Just this month, Human Rights Watch reported that Congolese Armed Forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo, have brutally killed hundreds of civilians and committed widespread rape in the past 3 months in a military operation backed by the United Nations. That is this month. Yet we continue to send billions of dollars every year to the United Nations.

Mr. DURBIN. Madam President, will the Senator from Oklahoma yield for a procedural question?

Mr. COBURN. I will be happy to yield for a procedural question.

Mr. DURBIN. I am interested in speaking on behalf of the bill, and I know the Senator has time allocated under the unanimous consent request. I wish to ask him at his convenience if he has a time when he would be able to yield to this side or is he going to speak and use all his time?

Mr. COBURN. I do not plan on consuming all of it at this time. I have about 10 or 15 minutes more to go, and I will be happy—is the Senator wanting time?

Mr. DURBIN. Could I ask unanimous consent that when the Senator breaks or prepares to yield the floor, at least temporarily, that I be recognized next?

Mr. COBURN. I have no objection to that.

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

Mr. DURBIN. I thank the Senator.

Mr. COBURN. Going back to the Congolese, most of the victims were women, children, and the elderly. Some were decapitated. Remember, these are U.N. peacekeeping forces—peacekeeping. Others were chopped to death by machete, beaten to death with clubs as they tried to flee.

They may not have been actual U.N. officers, but the U.N. was supplying all the logistics, all the transportation for this group of people. Where is the oversight?

U.N. contribution: Compiling forecasts of global agriculture production

and identifying areas of likely famine and the risk of severe hunger, to facilitate food assistance. We make a contribution to the U.N. The Food and Agriculture Organization is currently hosting a U.N. conference, a food summit in Rome, where the opening speaker is Zimbabwe President Robert Mugabe who has literally destroyed his Nation, which used to be the bread basket of Africa and which is now dependent on food imports. We are helping to pay for President Mugabe—who can't travel hardly anywhere else in the world because he is such a rogue dictator—we are sponsoring, through our dollars, meetings where he is the headline speaker.

> The meeting was branded a failure within a couple of hours of its start after the 192 participating countries unanimously rebuffed the United Nations' appeal for commitments of billions of dollars in yearly aid to develop agriculture in poor nations.

It is not because they don't care about people having problems with food; it is they recognize the U.N. is ineffective at doing that and they are not going to commit more money, but we continue to commit more money.

The U.N. Environment Programme spends $1 billion a year—20 percent of it our money—on global warming and its effect on agriculture.

The U.N. has coordinated efforts by the global shipping industry and governments to prevent and respond to acts of piracy on the high seas.

It was totally ineffective. Do you know why we decreased the amount of piracy on the high seas? It is because of Task Force 51, which was formed by the U.S. Navy because the United Nations was totally ineffective in accomplishing that purpose.

I could go on and on. But the fact is, the United Nations is not only morally bankrupt in its leadership and efficiency, it is filled with fraud, waste, and, as noted, tremendous acts of violence through the peacekeeping armies it sends throughout the world. Yet we are going to have people say we shouldn't take some of that money away. We are not taking all the money away with this amendment anyway; we are just taking a small portion to pay for our bill.

We are going to have people actually vote to continue to do these things, instead of taking care of our veterans and not steal it from our children.

I heard Senator TESTER speak about the wonderful things in this bill to help people who drive to VA clinics and VA hospitals. There is a better idea. If a veteran is deserving of care, give him a card. Let them go wherever they want. Why should they have to drive 160 miles, when they can get the care right down the street from somebody they trust and they know. But instead we say: We are going to promise you health care, but you can only get it here. Real freedom for our veterans—real health care for our veterans is to honor their commitment by saying: Here is your card, you served our Nation, go get your health care wherever you want. If you want to get it next door or if you want to go to the M.D. Anderson or Mayo Clinic, you can. You can go wherever you want because we are going to honor your commitment.

I recognize our VA hospitals have done a magnificent job in improving their care, but I will tell you the test for the VA hospital system is this: Go ask any doctor coming out of training who experienced part of their time in a VA hospital and ask them to choose for their family: Do you want your family treated at a VA hospital or somewhere else where you trained? Nary a one will pick a VA hospital because the care isn't as good. It is better, and it is getting better all the time, but it is not as good. So we are saying to veterans: Here is where you have to go, when what we should say is: Thank you for your service. Here is what we owe you. Go get care wherever you want to get it or wherever you think you can get the best treatment.

On prosthetics, the VA is the best in the world. Nobody compares. On post-traumatic stress disorder, they are the best in the world. Nobody can compare. They are underfunded in those areas. This bill is right on that. But the real commitment is to give the choice. The veteran fought for freedom. Give them the choice, the freedom to choose what they want for them.

Why is it important we change how the Senate operates in terms of making hard decisions? The reason it is important is there are millions of these little girls out there. I have five of them, five grandkids just like her. She has a little sign around her neck. She says: ''I am already $38,375 in debt and I only own a dollhouse.'' Of course, when you divide up the $12 trillion which we passed this week in directly owned debt; it doesn't count the billions—I mean the trillions—we have borrowed from Social Security and the other trust funds, such as the waterway trust fund and all these other organizations we have stolen from, it doesn't include that. But that is for every man, woman, and child in this country. It is over $30,000 now, this year. I think when you look at her, you have to say, certainly, we ought to be making some changes. By the way, between now and 2019, that number goes to over $96,000 per man, woman, and child. But she is a child. This doesn't apply to veterans, but it applies to almost everything else we are doing.

This is what Thomas Jefferson said:

> The democracy will cease to exist when you take away from those who are willing to work to give to those who would not.

If you think about what is happening in our country right now and how things are being shifted, what we are doing is, we are on the cusp of a dramatic change in our country in terms of balance. This huge bill, which I will talk about later, is a major move in that direction. Senator BYRD and I were talking this morning about this. In this bill is a 5-percent tax on cosmetic surgery. Just the day before yesterday, the U.S. Preventive Task Force Services recommended—because it is not cost effective—that women under 50 not get mammograms unless they have risk factors. You tell that to the thousands of women under 50 who were diagnosed with breast cancer last year with a mammogram. Tell them it is not cost effective. But also in this bill is a 5-percent tax on breast reconstruction surgery after they have had a mastectomy. They are going to tax having their breasts rebuilt after their breasts have been taken off because it is an ''elective'' plastic surgery. It is an elective cosmetic surgery. We are going to have a tax on it because we have taxed elective cosmetic surgery.

We are in trouble as a nation because we have taken our eye off the ball. I see the majority whip is back. I told him I would be happy to yield. At this time, I will reserve the remainder of my time and yield the floor to the majority whip.

EXHIBIT 1

REBUTTAL OF STATE DEPARTMENT TALKING POINTS ON COBURN AMENDMENT 2785

The State Department Bureau of Legislative Affairs opposes the Coburn amendment to S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 (S. 1963). In its formal opposition, it lists a number of programs as reasons to support the U.N. and oppose the Coburn amendment.

Many of the programs and activities that the State Department listed have experienced severe problems in execution or are taking credit for activities by national governments or private entities. (Their document is after the rebuttal).

Below is a list of those ''accomplishments'' and facts that should be considered.

U.N. Contribution: Facilitating and holding elections in Afghanistan and Iraq (U.N. Secretariat).

Response: The United Nations cannot account for tens of millions of dollars provided to the troubled Afghan election commission, according to two confidential U.N. audits and interviews with current and former senior diplomats.

The Afghan election commission, with tens of millions in U.N. funding and hundreds of millions in U.S. funding, facilitated mass election fraud and operated ghost polling places.

''Everybody kept sending money'' to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan. ''Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election.'' Galbraith, a deputy to the senior U.N. official in Afghanistan, was fired last month after protesting fraud in the elections.

As of April 2009, the U.N. spent $72.4 million supporting the electoral commission with $56.7 million coming from the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $263 million in funding for the election.

In one instance, the United Nations Development Program paid $6.8 million for transportation costs in areas where no U.N. officials were present. Overall the audits found that U.N. monitoring of U.S. taxpayer funds was ''seriously inadequate.''

U.N. Contribution: Monitoring nuclear programs in North Korea and Iran.

Response: In 2002, the North Korean government used United Nations Development Program, UNDP, aid to purchase conventional arms, ballistic missiles. It also transferred millions of dollars in cash to the government of North Korea with no oversight of how the money was spent.

In September 2009, North Korea announced to the United Nations Security Council that it was almost complete in ''weaponizing'' nuclear materials from its nuclear reactor. Last week, North Korea announced the processing was complete.

As of this morning, Iran had rejected the U.N. offer to send enriched uranium out of the country to prevent it from developing nuclear weapons.

U.N. Contribution: Funding 17 U.N. Peacekeeping Operations, including those in Haiti, Liberia, Lebanon, Darfur and the Democratic Republic of Congo.

Response: U.N. Peacekeeping operations plagued by rape and sexual exploitation of refugees—In 1994, a draft U.N. report was leaked detailing how peacekeepers in Morocco, Pakistan, Uruguay, Tunis, South Africa and Nepal were involved in 68 cases of rape, prostitution and pedophilia. The report also stated that the investigation into these cases is being undermined by bribery and witness intimidation by U.N. personnel.

In 2006, it was reported that peacekeepers in Haiti and Liberia were involved in sexual exploitation of refugees.

In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past three years ranging from rape to assault on minors. In all of these cases, there is no known evidence of an offending U.N. peacekeeper being prosecuted.

Just this month, Human Rights Watch reported that Congolese armed forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo have brutally killed hundreds of civilians and committed widespread rape in the past three months in a military operation backed by the United Nations.

Most of the victims were women, children, and the elderly. Some were decapitated. Others were chopped to death by machete, beaten to death with clubs, or shot as they tried to flee.

The U.N. peacekeeping mission provides substantial operational and logistics support to the soldiers, including military firepower, transport, rations, and fuel.

The attacking Congolese soldiers made no distinction between combatants and civilians, shooting many at close range or chopping their victims to death with machetes. In one of the hamlets, Katanda, Congolese army soldiers decapitated four young men, cut off their arms, and then threw their heads and limbs 20 meters away from their bodies. The soldiers then raped 16 women and girls, including a 12-year-old girl, later killing four of them.

The U.S. now pays 27 percent of all U.N. peacekeeping operations. Reducing our contribution to these wasteful efforts could help ensure that U.N. peacekeepers are not funding widespread rape and exploitation of refugees.

U.N. Contribution: Compiling forecasts of global agricultural production, identifying areas of likely famine and risk of severe hunger, to facilitate emergency food assistance (FAO).

Response: The FAO (Food and Agriculture Organization) is currently hosting a U.N. food summit in Rome, where the opening speaker is Zimbabwe President Robert Mugabe. Mugabe is barred from travel to most Western countries because of his atrocious human rights record, but receives an exception for U.N. sponsored events. No G–8 leader attended the event save the Prime Minister of Italy, the host nation.

''The meeting was branded a failure within a couple of hours of its start after the 192 participating countries unanimously rebuffed the United Nations' appeal for commitments of billions of dollars in yearly aid to develop agriculture in poor nations.''

The U.N. Environment Program spends over $1 billion annually on global warming initiatives (and weighs in on its effect on agriculture) but there is almost no auditing or oversight being conducted. The U.N. Environment program has one auditor and one assistant to oversee its operations. According to the task force it would take 17 years for the auditor to oversee just the high-risk areas already identified in UNEP's work.

U.N. Contribution: Coordinating tsunami and earthquake relief projects in Indonesia and Pakistan (U.N. Secretariat/OCHA).

Response: The United States is the top contributor to the Office for the Coordination of Humanitarian Affairs (OCHA) for funding disasters after they occur. In addition to billions in supplemental funding (above and beyond normal U.N. contributions) the United States military expends tremendous resources in money and personnel to be the first response for disaster aid.

U.N. Contribution: Coordinating efforts by global shipping industry and governments to prevent and respond to acts of piracy on the high seas (IMO).

Response: The key deterrence factor in combating piracy in Somalia is the creation of Task Force 151, which was formed by the United States Navy.

The United Nations has pushed the U.S. to ratify the United Nations Convention on the Law of the Sea. However, the convention has no way to address piracy issues coming from failed states such as Somalia. Fighting piracy is being conducted by individual states patrolling their own waters and working with other nations to protect sea lanes that are in their national interest.

U.N. Contribution: Creating and maintaining systems to protect the intellectual property rights of American entrepreneurs (WIPO).

Response: Until last year, the Director General of the World Intellectual Property Organization, WIPO, was run by Dr. Kamil Idris, who was appointed to that position in 1997. According to an internal investigation, he falsified his U.N. personnel file to drop nine years from his age—making it possible to extend his time at WIPO and to extend his ability to obtain a lucrative benefit package, including a possible payout of more than $500,000. The scandal was first reported in a leaked U.S. State Department cable authored by former Secretary of State Rice. The cable also states that this official is suspected of using U.N. funds for personal items such as the construction of a swimming pool at his residence.

WIPO has also been criticized for its working culture under Dr. Idris's leadership, with a report by accounting firm Price Waterhouse Coopers citing high levels of absenteeism, incompetence and inadequate disciplinary measures.

U.N. Contribution: Enabling the delivery of mail around the world (UPU).

Response: The Universal Postal Union, UPU, which coordinates international postal policies among nations, was created in 1874 (renamed in 1878). Its creation predates the United Nations by 72 years.

UNITED NATIONS FUNDING

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009 (S. 1963)

Senate Amendment: Senate Amendment No. 2758 submitted by Senator Coburn to S. 1963. To transfer funding for United Nations contributions to offset costs of providing assistance to family caregivers of disabled veterans.

Department Position: Oppose amendment.

Talking Points: U.N. assessed contributions fund a wide range of U.N. activities that support high U.S. foreign policy priorities. Some examples include:

Facilitating and holding elections in Afghanistan and Iraq (U.N. Secretariat);

Monitoring nuclear programs in North Korea and Iran (IAEA);

Funding 17 U.N. Peacekeeping Operations, including those in Haiti, Liberia, Lebanon, Darfur and the Democratic Republic of Congo;

Compiling forecasts of global agricultural production, identifying areas of likely famine and risk of severe hunger, to facilitate emergency food assistance (FAO);

Coordinating tsunami and earthquake relief projects in Indonesia and Pakistan (U.N. Secretariat/OCHA);

Detecting outbreaks of avian flu and H1N1 and other infectious diseases and defending against a world pandemic (WHO, FAO);

Creating and maintaining systems to protect the intellectual property rights of American entrepreneurs (WIPO);

Enabling the delivery of mail around the world (UPU);

Coordinating international aviation safety standards (ICAO);

Coordinating global use of electronic communications frequencies to ensure essential global telecommunications function smoothly (ITU);

Coordinating efforts by global shipping industry and governments to prevent and respond to acts of piracy on the high seas (IMO).

Furthermore, the President has stated his commitment to paying U.S. dues to international organizations in full.

As Ambassador Rice has said, we meet our obligations. As we call upon others to help reform and strengthen the U.N., the United States must do its part—and pay its bills. Our dues to the United Nations and other international organizations are treaty obligations, and we are committed to working with Congress to pay them in full.

With the support of Congress, the U.S. has just cleared our arrears which accumulated over the past decade. The full payment of assessed contributions affects the standing and influence that the U.S. has at these organizations.

Going into arrears undermines U.S. credibility, particularly on matters dealing with budget, finance, and management of IOs, and negatively influences world opinion regarding U.S. respect and appreciation for the role of multilateral organizations that support and advance U.S. foreign policy. Arrears also have a real impact on the organizations, making it more difficult for these organizations to manage cash flows and execute budgets, and thus accomplish their missions.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank my friend and colleague from Oklahoma. Although we disagree on many things, we also agree on many things. We work together and will continue to do so.

We have a difference of opinion on the matter before us. This bill, S. 1963, is the most important piece of veterans legislation this year for several reasons. I congratulate Chairman AKAKA and Ranking Member BURR for bringing this matter to the Senate with a unanimous vote in committee, with both Democrats and Republicans supporting it, and for good reason.

In addition to the provision that was part of an earlier bill I had introduced, there is dramatic change in the law to help women veterans. More and more returning veterans from Iraq and Afghanistan and around the world need special care. Unfortunately, the VA system wasn't providing that care as we believed it should. This bill takes care of that. It is the most dramatic expansion for women veterans and their health needs we have seen.

The same is true for rural health care. I know that. The Presiding Officer is from downstate Illinois, as I am, and he knows the Marion VA Center is a critical part of the treatment of veterans in southern Illinois and the surrounding States. Literally thousands of hard-working people there provide care for veterans, which they desperately need, close to their homes. This bill addresses the enhancement and improvement of rural care for veterans.

The same is true for mental health issues. It is an excellent bill. The part of the bill that is near and dear to me relates to caregivers assistance. It relates to the fact that many veterans who come home are not in institutional settings, not in a hospital, not in a convalescent center; they are home. But they survive every day because of the loving care of a member of their family—a wife, a husband, a mother, a father, a sister, or a brother—who gets up every morning and worries about that veteran and makes sure that veteran receives the medical care needed to survive another day. They are in the setting of their home where they feel secure and happy.

Great sacrifice takes place. I cannot tell you exactly how many of these caregivers there may be. Estimates range as high as 6,000 or 8,000. I have met some of them, and I know them personally. I have heard their stories. They are heroic—just as heroic as the veteran who needs their care. They are literally giving their lives to keep that veteran alive, healthy and happy, at great personal sacrifice. Many times they cannot go to work. Many times they give up a business because they want to stay home with that husband they love.

A young woman came into my office the other day who is moving from North Carolina back to the Chicagoland area after more than 5½ years. She has been the caregiver for her husband who was the victim of a traumatic brain injury in Iraq. For this young woman, who is in her thirties, it is an amazing show of love and sacrifice on her part.

We have also spoken of the family in North Carolina we know very well—the family of Eric Edmundson, a young soldier who was the victim of a traumatic brain injury. He is alive today—I can say this without contradiction—because his dad quit his job, sold his business, and cashed in the value of his home. With his wife, they moved in to take care of their son and little granddaughter. That is the most loving family I can remember seeing, and they are doing it for the son they love, but they are doing it, as well, for a veteran who served our country.

The purpose of this bill is to give these caregivers a helping hand and the medical training they need so they can do what is necessary to keep that veteran alive and as well as possible, improving if possible. It is also to give them a respite maybe for a week or two each year so they can go on vacation and have a visiting nurse or someone who will come and provide assistance. They need that with the stress and burden they are carrying. That needs to be lifted—at least temporarily—so they can recharge their battery and come home and be dedicated once again.

In the discretion of the Veterans' Administration, it can give a monthly stipend or health care as well. The first thing the Edmundson family found when they sold the business was that they couldn't afford to buy health insurance. Mom and dad are taking care of their son under the care of the Veterans' Administration, and they have no health insurance.

We are trying to find a way to provide health insurance for these caregivers. In my mind, it is simply fair and right that we would do this. That is why I thank Senator AKAKA and Senator BURR for including it in this bill.

I also want to address the issue before us, the pending amendment by the Senator from Oklahoma. The Senator from Oklahoma has come to the Senate floor several times and expressed his opposition to this bill, primarily for budgetary reasons. I understand that. But I say to him I was worried this day would come. I was worried the day would come when the war, which we paid for by borrowing money, would generate victims and veterans who needed care, and when it came time to give them the care many of the people who voted to fund the war by going into debt would say: But we can't help the veterans unless we pay for it.

In my mind, it is all the same. If we vote to go to war, we vote to accept the consequences of war. That means an obligation that we have to these veterans. It is a solemn promise we gave them. We said to these men and women if they would hold up their hand, take an oath to defend the United States and risk their lives, we would stand by them when they come home. If they are injured, we will be there. If their family is disadvantaged, we will do our best to help them too. I think that is part of our solemn obligation to these veterans.

Now the question is raised as to whether we can afford to do that, unless we come up with a sum of money to pay for it at this moment. I say to the Senator from Oklahoma, and those who take his position, if we paid for this war to start with by borrowing money, how can we turn our backs on the veterans and caregivers who keep them alive arguing that it is simple budgetary justice? It is just not. It doesn't track. I don't believe those two approaches are acceptable.

Also, the Senator from Oklahoma does two things in this amendment I wish we could do—one I wish we could do. I have talked to him about it on the Senate floor—and that is to expand coverage for caregivers of those who served before 9/11. I would like to do that. Currently, we believe there are about 2,000 caregivers who would qualify for this caregiver amendment, this demonstration project. If we expand it to all veterans caregivers, the number rises to over 52,000. It is a just thing to do. It is something we may ultimately do. But, clearly, if we are going to make that commitment, it is a dramatically larger commitment than this demonstration project, this bill for those who suffered serious injuries since 9/11. To increase the scope of it from 2,000 caregivers to 52,000 caregivers is to increase the cost of it dramatically. That is something we have to measure and decide at some point—whether we want to do that.

I will work with the Senator from Oklahoma to expand that. I think all veterans' caregivers deserve this. I hope we can prove with this approach that it is a reasonable thing to do—that keeping these veterans home where they want to be, in a safe, happy surrounding, is not only right but it is cheaper than institutionalization.

The second part of Senator COBURN's amendment related to this provision says the money would be available for caregivers if the veteran would otherwise be institutionalized. I think that may be drawing a line that is too harsh. I think there are those who need the help of a caregiver but may not technically need to be institutionalized. I think those who are suffering from post-traumatic stress disorder, a traumatic brain injury with seizures—to say they need to be institutionalized may be overstating. To say they need the help of a caregiver and then move

forward to treatment, I understand that may happen. On the one hand, I think the Senator from Oklahoma expanded this bill from 2,000 to 52,000. On the other hand, he draws a line on institutionalization that may go too far. I think what we ought to do in this demonstration project is give the VA the authority to measure this and see what is appropriate. I think there are so many individual cases that, when we generalize like this, it is a mistake.

The Senator from Oklahoma believes the money to pay for this should come from the money set up for international peacekeeping through the U.N. I will not stand here in defense of every decision made by the U.N. It is hard to do that. We make mistakes in the United States, and the U.N. does too. They have been caught and so have we. I want to make sure money is not wasted. We should be vigilant, whether it is money being spent by our government or agencies we support. I worry that the proposal before us by Senator COBURN is going to cut back on international peacekeeping in areas of the world where I think it is critical.

I visited the Democratic Republic of Congo 2 years ago with Senator BROWNBACK of Kansas. But for the U.N. peacekeeping forces there, the massacres of innocent people would go unchecked.

This has been going on for over a decade. During this period of time, innocent men, women, and children have been literally hacked to death and killed. The international peacekeepers make a difference there. They make a difference in Haiti where I visited twice and have seen firsthand the degraded poverty in our own hemisphere and, unfortunately, the fact they are on the verge of violence almost every moment.

I also think it is a mistake for us to cut back on those international agencies that monitor the spread of nuclear weapons. If we want to keep an eye on Iran and make sure they don't develop nuclear weapons to threaten their neighbors in the Middle East and the rest of the world, we need this international force to come in and do its inspection work. They are the only credible third parties that can come in and decide whether the Iranians have gone too far. Their judgment through the United Nations is one that is credible to other nations. To cut back in their efforts at monitoring the spread of nuclear weapons is, in my mind, shortsighted and invites instability in a world that is already too dangerous.

I urge my colleagues to defeat the Coburn amendment. I say to my friend from Oklahoma, at the end of the day, after we start this program, if the Veterans Administration can find the resources through the appropriations to move it forward, I am open to working with him to expand it to caregivers from previous generations of veterans and to see if there is a way to make sure it is spent exactly where it is needed and as we have described it.

That is the nature of this work. We are not perfect in what we do, but we start with good intentions and hard work and try to put the language together. But at this moment, I say to the Senator from Oklahoma, first, I am glad he no longer put a hold on this bill. It is an important bill. I am glad he has had his chance to offer his amendment. I urge my colleagues to defeat it, but I say it in good faith to my friend from Oklahoma.

I will work with him if this bill, in fact, is enacted into law and implemented to make sure it meets the goals we both share—fairness to all veterans and providing care to those who need it. This is a good start, but let us promise to work together, if it is enacted, to make sure we continue in that vein.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, the majority whip is a formidable orator and he is appreciated in lots of ways. We work together on subcommittees on the Judiciary Committee. I have a fondness for him. Although one area he did not agree to work with me is to pay for it.

Never have I said I don't want us to do this for our veterans. Not once. The reason we are on the floor, the only reason we are on the floor having this debate is because of my hold; otherwise, we would never have gotten here to have the debate which I think is valuable for the people in this country.

But there has to come a time—every time I offer an amendment on this floor is never a good time—to start making our choices. That is what we hear all the time. Over 600 times in the last 4½ years, it is never a good time to start making hard choices. That is just what we heard.

The Senator from Illinois referenced Congo. Just this month the Congolese army, with the assistance of the United Nations, slaughtered a bunch of people. And we are supposed to continue?

I put two other things out there. Under Federal law, the Accountability and Transparency Act, the United Nations is required to tell the American people how our money is spent because the State Department is required to find it out and put it online. They have refused to do it. So we have no idea what it is.

Two years ago in the Foreign Ops bill, an amendment was agreed to by 100 Senators that there would be transparency. Our money going to the United Nations would be conditioned on the fact that the United Nations would be transparent on how it was spent. That was voted 100 to 0 in the Senate.

Guess what happened on the way to the bank coming out of the conference committee. It was eliminated. So now we send over $5 billion directly, $5.2 billion, plus billions more through USAID through the United Nations, and we do not have any idea how it is spent.

What we do know is that the United Nations is fiscally and morally bankrupt. It is loaded with fraud, loaded with duplication, and loaded with excess.

It would be a wonderful thing to send the United Nations a wonderful fire shot across the bow that they have to start being accountable for the dollars that the American taxpayer, that this little girl is sending them out of her future every year. It would be a wonderful thing for us to say that.

It is unfortunate, every time when we get down to the point where we have to make a hard choice, we always choose not to make the hard choice. That spells disaster for our country, and it also spells a total lack of leadership on our part to recognize what the real problems are that are confronting this country.

Our veterans deserve us to take care of them. I am for that. Our children deserve for us to do it in a way that protects their future—the very thing for which our veterans serve.

Unfortunately, we will not do that with this amendment or any other time until the American people decide they have had enough of the careerism, the elitism, the lack of integrity, the lack of courage that is so often represented in the votes we cast in this body.

I reserve the remainder of my time, and I yield in my absence any time the Senator from North Carolina wishes to take from my time.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I wish to be recognized under the 6 minutes I currently have available to me, and if the clerk will notify me at the end of that time, then I will go into Senator COBURN's allotted time.

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

Mr. BURR. Mr. President, I wish to reiterate, as the ranking member of the Veterans' Affairs Committee, this bill was reported out unanimously. I think it will receive unanimous support in its passage later this afternoon in the Senate.

Let me restate for Members, when the committee passed this bill out, we passed it out with all caregivers being included. It was after the committee reported it out that we narrowed it to OEF and OIF veterans and their caregivers. It was the intent of the committee to include all the people Senator DURBIN, the majority whip, said we might consider later on but not now. The committee's intent was let's do it in the bill now.

It was also the committee's intent that these were individuals who were targeted for us to provide this caregiver benefit to so we can keep them

out of nursing homes because of the Ted Wades, because of the Eric Edmundsons.

Senator COBURN's amendment is consistent with the bill that was passed out of committee unanimously. The bill says the Secretary ''shall;'' therefore, it means he has to. The Secretary will then have to prioritize spending within the Veterans Administration to fund these programs. The third piece of what Dr. COBURN's amendment does is rather than force the Secretary to prioritize within just VA programs, meaning there are going to be veterans who win and veterans who lose, why not say as a Congress: Why shouldn't we do what we are supposed to do? Why should we not prioritize the spending here?

What my good friend from Illinois suggested was why should we prioritize for the United Nations? Let me say the answer is quite simple: It is our money. The suggestion that the Congress doesn't have a fiduciary responsibility to fund programs we implement at a time we are borrowing 50 cents of every dollar we spend is ridiculous on its face.

To suggest that the Senate, the Congress can operate any differently than a family in America suggests that we ignore the input of everybody who asked us to represent them. We do represent the American people, 100 individuals who represent the entire country. How can we do it differently than any family who is out there struggling to meet their end-of-the-month obligations and when their revenue does not meet their expenses? What do they do? They either cut back their expenses or they find a place to raise more revenue.

Let me suggest this is as simple as, Is it time for us to prioritize where we are placing money? Members will have to decide: Is pulling money from the United Nations an appropriate place for us to pull money from to then spend on our country's veterans?

I believe we have an obligation, I believe we have a promise, even for programs that did not exist prior to this time, that when we see it is in the best benefit of the quality of life of our troops, that we provide that benefit for them. But I believe we also have an obligation to this generation and the next one and the next one to pay for it.

This is not a choice that is tough for Members. If you support the Coburn amendment, you support practically everything the committee supported when we passed the bill out by unanimous consent. If you support the Coburn amendment, you believe we have an obligation to pay for it. The only reason you would vote against the Coburn amendment is because you don't think it is appropriate for us to deprive the United Nations of this money to use as they see fit.

I suggest this is where the disconnect is with the majority of America. They would prefer the Senate to decide where that money went and to use it on these caregivers and these veterans programs.

I encourage my colleagues to support the Coburn amendment, support passage of this bill this afternoon when we take it up.

I wish to shift gears slightly because I think it is somewhat ironic that we are talking about expansion of services to our Nation's veterans at a time when some herald the introduction of a bill that, in all likelihood, will deprive other Americans of the ability to have affordable health care.

We have gone through several months of debate now about health care being accessible and affordable for all Americans. We have talked about reforms; let's change the system; let's reform the system; let's make it accessible and affordable; let's bend the cost curve down. In the last 24 hours, some have come and said we have accomplished that, it is amazing.

Let me remind my colleagues, we have all said health care is unsustainable in its current level of investment, 17 percent of our gross domestic product. I find it somewhat odd that we would start the debate given that it is unsustainable in its current financial investment with how much more money does it cost to reform health care. The obvious answer to me is it should cost zero. If you are already spending too much, we should look at the reforms before we look at the coverage expansion.

I agree every American ought to be covered. As a matter of fact, Dr. COBURN and I have offered comprehensive bills to do that. But it is matched with real reform.

What was heralded in the last 24 hours is, in fact, a $2.5 trillion health care bill—$2.5 trillion—over a 10-year period of collecting the revenues and paying out the expenses. This is where gimmicks, smoke and mirrors—whatever you want to call it—are used in Washington. If you collect revenue for 10 years but you only pay benefits for 6 years, you don't get a true picture of what it is going to cost over 10 years. You get a true impact of the revenue stream which is over $800 billion.

From where will that $800 billion in new revenue appear? Taxes. They go up $493.6 billion—$493.6 billion. We will cut $464.6 billion out of Medicare. A $½ trillion we are going to take from a program with a designated population of beneficiaries of our Nation's seniors and those who are classified as disabled and we are going to take $½ trillion from Medicare and shift it over to meet the new burden of a health care plan yet to be constructed.

Why is this problematic? It is $1,063 per Medicare beneficiary every year. Over the 10-year cycle of this health care plan, we are going to steal from every senior in this country $10,363 worth of health care money. We are going to take it from their program, and we are going to put it over in this new program because it is paid for. Legitimately, when you raise taxes, when you raise fees, when you raise revenue, you are making tough choices. I think when you go in and tax health plans and that raises $149.1 billion; when you increase a penalty for a nonqualified health savings account and you get $1.3 billion—these are revenues. They are legitimate.

It is no smoke and mirrors. I don't think the American people believe for a minute this is deficit neutral. I don't believe for a minute they believe we are going to take $464 billion out of Medicare. If they do believe it, they know we are going to pay it back with future taxes on the American people.

That is fine, if that is the way we want to prioritize. But health care reform affects every American. This is a very personal issue for every American and every family. It touches them unlike anything else we do. The truth is, they know if you take it and you put it in one pocket and you take it out of the other pocket, the effect on them either has not changed or it is negative.

Let me suggest to my colleagues this bill is 2,074 pages. I will admit—I may be the only one—I have not read it since it was introduced at 6 o'clock last night. I am not sure there are many Members who have or could have. But let me suggest there will be a question about whether, for the first time, we use taxpayer money to perform abortions. Personally, I believe that is wrong. I will not support a piece of legislation that does that. This bill does that.

An employer mandate, at a time when American companies are trying to be competitive in a global marketplace? We raised $28 billion in employer mandates. I am not sure that is making U.S. companies more competitive in a global marketplace. I think the economy is the No. 1 challenge we have in America. I think 10.2 percent unemployment and going up—if it were a disease, we would be on the floor of the Senate calling it an epidemic and we would be doing whatever and spending whatever to help turn it around. But we are doing nothing. As a matter of fact, we are doing everything we can to try to drive up unemployment, to dry up the economy, and to make companies less competitive in a global market.

The President said one of the objectives of health care reform was we need to bend the cost curve down, we need to make sure there are cost savings in health care for every American. Let me tell you what the Congressional Budget Office says:

> Under the legislation, federal outlays for health care will increase during the 2010–2019 period, as would the federal budgetary commitment to health care.

That is Washington language for: You know what. Our expenditures on health care are going to go up. What happens when Federal expenditures go up? Everybody's go up. That is a known fact by the American people. The coverage expansion would drive a new increase in government spending on health to the tune of $160 billion over 10 years. Make no mistake, this does not bend the curve down, it bends the curve up. We spend more money.

CBO scored the bill as reducing the deficit by $130 billion over 10 years, 2010–2019. What does it take into account, to come to that calculation? It assumes doctors are going to get cut 23 percent in their reimbursements in 2011. We have less than 1 million doctors to serve 300 million people. Does anybody believe for a minute we are going to allow a 23-percent cut to go in at a time when we are starved—trying to attract people to go into medicine as a profession? If it does go in, we are going to take $247 billion out of the pockets of doctors we rely on to perform the surgeries, to make the diagnosis for us and everybody else in this country.

The new creation of the CLASS Act, long-term care policy, shows in the CBO score a $72 billion savings. Let me explain it like this: Nobody qualifies today because it doesn't exist. People are going to pay premiums to be eligible for this long-term benefit. It takes about 20 years of paying in before somebody is going to be eligible to pull out. It is not similar to Medicare, when we created it, where, even if you never paid in, you started on day one. We are collecting revenues for 20 years before we ever pay out the first dime. It is not hard to understand why you would have a $72 billion surplus out of this.

Let me ask, what happens after that? What happens after you get past that 20-year number? The truth is, it starts to get into the trillions and trillions of dollars for which the Federal Government is obligated, based upon the premiums and the benefits people have assigned to it, that they pay out.

If you eliminated these two gimmicks, just on its face this bill would be $189 billion out of balance, in the red. It would not be paid for.

I suggest that is just two smoke-and-mirror tools. The start date was moved from 2013 to 2014. No longer is our focus on how do we get care delivered as quickly and as efficiently. We just pushed it off a year because we said the Congressional Budget Office says we are short on raising money, and we have raised all we can in fees and taxes. Maybe not all. I think they probably have some things targeted that are still yet to come out. The key thing is, even if you did implement it, there are 24 million Americans who are still without insurance. The objective to cover everybody was not met. There are $25 billion worth of unfunded mandates to our States. I don't know of a State that is in financial health today. There may be one or two.

My State of North Carolina was $4 billion out of balance. Last year, the Federal stimulus was $2 billion of closing the gap. That $2 billion, by the way, we didn't have. We borrowed to give to North Carolina and other States to create jobs. It was used to close budget gaps so they didn't have to make tough decisions. As a matter of fact, we found out this week, on one of the news channels, there is $98 billion that didn't have anything to do with stimulus.

We are the laughingstock of the world on the way we applied the stimulus package. But the sad part is not the fact that it has been uncovered, it is that it didn't do anything to put Americans to work. Now we are saying to the States we are going to put another $25 billion on you.

In Medicare, we are going to cut from the fee-for-service payments $192 billion. So we already have $247 billion over here that we are getting from doctors if we go through with the payment cuts. Now we are targeting another $192 billion out of Medicare reimbursements, right out of the pockets of doctors and hospitals. Is there a community hospital in America that will be able to survive, given the cuts that are getting ready to hit them? We cut Medicare Advantage $118 billion. Some cheer that. I tell you who doesn't cheer it: The 20 percent of America's seniors who chose Medicare Advantage as their preferred choice to traditional Medicare because it required of them less out-of-pocket obligation, it didn't hit them for $750 deductible the day they walked into a hospital. What about those 20 percent of our Nation's seniors when they lose Medicare Advantage?

What about the $43 billion in DSH, disproportionate share payments, we pay the hospitals to make up for the uncompensated care they deliver? I guess the authors of the bill would say we are covering everybody so there is no uncompensated care. Wrong; 24 million are still without insurance. There is going to be uncompensated care, and we are taking away the money we are providing the hospitals to make up for the uncompensated care they delivered, meaning it is coming right out of their hide, that local hospital in the community we live in; $23 billion in unspecified cuts by the Medicare Advisory Board. Is America comfortable with us turning to another advisory board to cut $23 billion? We just had an advisory board say: If you are 40 to 50 and you are female, you don't need to worry about your breasts, don't need to go get a mammogram, don't need to do self-examinations—trust us.

One of the reasons the health care system in America is the best in the world is because we spend money to innovate. We hope companies find breakthroughs. We look at diagnostic abilities in an effort to try to detect early, so the options are greater and so the cost is less. But now, all of a sudden we are saying that is not important.

There are 162 million Americans who currently have employer-based health care. In this bill, regardless of what that employer does, they will not be eligible for subsidy. If they currently have coverage but they may be below income and for some reason their employer has to drop their health care or cut back on the plan because—maybe they are not competitive after this in the global marketplace—even though they would qualify from an income standpoint, they will not qualify because they were provided health care before. Our favorite, the IRS says it will take another $5 to $10 billion so they can actually go out and collect these fees and taxes.

The cost of the subsidies alone in the exchange is estimated by CBO to grow at 8 percent a year. I ask you, if the reason we have gotten into this discussion, had this debate, was we are trying to turn the cost curve down on health care, and we have quoted a 6-percent increase a year and a 5.5-percent increase a year and a 7-percent increase a year, why in the world would we be considering a plan that CBO tells us is going to have a cost increase for the subsidy of 8 percent a year? I would hope, if we had real reforms that worked, the cost of the subsidy would decline 8 percent a year.

I know there are others seeking time. I will not belabor this point. I ask Members: Support the Coburn amendment on the veterans bill. Support passage of the veterans bill. Read the health care bill. Be prepared to debate the health care bill for a very long time and be prepared to stand for the American people on what is right.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, as has been mentioned several times, the majority leader unveiled the Democrats' health care reform bill yesterday around 5 o'clock. This bill was drafted behind closed doors. There was no Republican input. It didn't have any transparency until yesterday at 5 o'clock, despite the promises we have heard that government would be more transparent in this new administration. The 2,000-page bill released yesterday is expected to have a vote to proceed to it within the next 2 days. The bill is 354,654 words. To put it in perspective, the Bill of Rights is stated in 463 words; Lincoln's Gettysburg Address contained 266 words; the Ten Commandments has 297 words. This is over 350,000 words.

Why don't we have time to read this bill, digest it, allow our amendments to be put in the bill language, because, clearly, this bill will need amendments?

The health care of our citizens may be the most personal of all things to every person and every family. We are a democracy and the American people have a right to be heard on all issues but especially on this type of issue. We should be given the opportunity to read and hear what is in this bill, to hear it discussed, to hear from our constituents because it ought to be on the Internet. That is why we have the Internet access to bills that are introduced in the Senate. But by the time our constituents have a chance to read it, we will already have had a vote on whether to proceed to the bill.

Even after a cursory review, I know this bill includes changes that are disastrous to families, health care providers, and the economy. Higher taxes, mandates—especially for small businesses—penalties, cuts to Medicare, higher premiums, restricted choices, a government plan—the list goes on. The bill includes almost $1 trillion in taxes, including a new Medicare payroll tax; $8 billion in taxes on individuals who don't buy coverage; $149 billion in taxes on employers who don't offer the right percentage of coverage to employees; $102 billion in taxes on insurance plans, pharmaceutical companies, and medical device companies which study after study have shown will be passed on to the people who get these services and equipment.

To make matters worse, the bill includes almost $1 trillion in cuts to Medicare. It is guaranteed to reduce choices and coverage for seniors. In my State of Texas, 400,000 people love their Medicare Advantage, or at least they have it and are satisfied. They will lose Medicare Advantage under this bill. The Democrats are touting the cost of the bill as meeting the President's goal of being under $1 trillion because CBO scored it at $849 billion. But this is a budgetary sleight of hand, because what is actually being scored is the years 2010 to 2019. The actual spending in this bill won't take effect until 2014. They are taking the 10 years with 4 years where the bill is not spending anything. If you score it for the 10 years following when it actually comes into being, 2014 to 2023, the bill costs $2.5 trillion, not $849 billion.

Given more time to analyze this bill, who knows what else we would discover? If the Democrats think this is the reform Americans wanted, why rush the bill through the Senate? Why rush it through before we have the ability to review details?

The right approach is available. My colleagues and I have proposed commonsense and fiscally responsible ways to improve affordable access to health care. We need to do that. We have never said we don't need reform. What we have said is we need reform that will give more affordable access for coverage to Americans who do not have that access today.

We should reassess the goals of health care reform and implement policies that we know will reduce costs. For sure, reducing frivolous lawsuits. Study after study has shown the benefits of medical malpractice reform. In Texas, we have tort reform. We have seen a dramatic increase in physicians who are willing to practice medicine. It has lowered the cost of medical malpractice premiums, and doctors have been able to do their work with their patients with much more freedom, knowing they do not need to order unnecessary tests just to cover themselves in case they get sued. The majority insists on rejecting this suggestion that we have medical malpractice reform in the bill. Yet there is probably not anything that will save as much money as medical malpractice reform, that puts commonsense standards in place for frivolous lawsuits or lawsuits at all.

I will offer an amendment, or at least prepare one and hope to be able to offer it, that would cap damages, reduce malpractice premiums, and encourage doctors to practice in medically underserved areas. So many of our underserved areas, especially rural areas, have no doctors. There are counties in Texas that don't have a doctor within hundreds of miles and several counties. That is because the medical malpractice premiums are so high, they cannot afford to do it.

The small business premiums are going to go up, if this bill is passed. Small businesses already have a hard time offering coverage to their employees. Why would we make the problem worse, especially when we have the highest unemployment in decades? We should be allowing small businesses to pool together and buy plans. We have championed that proposal for years in the Senate, but we have never been able to get over the hurdles to pass a small business health plan. If we could do that, we could spread the risk. The bigger risk pools would produce lower premiums and allow more small businesses to have access to and offer their employees affordable health care coverage. Allowing businesses to pool doesn't cost the government anything. Therefore, it would not require tax increases, as we see in the bill before us.

The Democrats are trying to address the problem of unaffordable insurance by offering credits to small businesses to offset the cost of premiums. But the credit only lasts for 2 years. That is hardly anything that is going to encourage businesses to take on the added cost when the credit lasts for 2 years. I will be preparing amendments that at least double that to 4 years, expand the eligibility and duration of these credits so we can help small business people. But even 4 years is not enough. We should offer credits all the way through.

Offering tax incentives. There are small businesses and individuals in this country who have no access to affordable coverage. Why not give every individual who purchases their own health insurance the same tax break a corporation gets for offering health care coverage to their employees? Employees who receive insurance through their place of employment do not pay taxes on the premiums they spend for insurance. Why should individuals who purchase their own health care coverage be treated differently? I have a bill, with Senator DEMINT, that will help provide insurance for more Americans through tax credits and competition. Our approach would be a tax credit for every individual, $2,000 per year, and for families $5,000 per year for their purchase of health insurance. This would allow individuals to purchase their policies and own them so they would not have to be affected by what their employer offers or if they change jobs. This is the kind of reform that could make a difference.

How about creating a transparent marketplace online for consumers to go in and shop and hopefully have bigger risk pools, more competition, bringing the cost down? That is not the kind of marketplace that is in this bill. This exchange has so many mandates on the plans that, like the Massachusetts exchange, it would raise the cost of premiums and would not help in any way bring the cost down so that premiums are more affordable.

These are the ideas that would improve competition in the marketplace.

I can tell you, from the input I have received from my constituents since the bills have been out of committee, before the bill came to the floor or is on its way to the floor yesterday, because there were two committees that wrote bills that were put together and released yesterday, I have listened to what people say. I can tell you they don't want Medicare cuts. They don't want more taxes. Small businesses certainly don't want more mandates. They don't want government-run insurance. They know that a government plan is eventually going to crowd out the private insurance company plans throughout the country.

I am going to be preparing an amendment that will allow States to opt out without penalties, not just of the government insurance plan but of all the harmful measures. Why would we have a government opt-out by States, if they are going to still have to pay the higher taxes, if they are going to have to pay higher premiums to pay for the other States that have the plan? States should not be forced to participate in the government plan, nor subsidize and pay for such a plan through increased taxes.

I will prepare amendments that will exempt individuals and employers from the mandate to buy insurance, if this bill causes premiums to rise above their currently projected values.

The solution to health care issues is not to give more power to the government. The solution is to give more power to the American people. They deserve a system that assures that America will have the best health care in the world.

Which brings me to the new government task force that came out this week that is causing confusion at best and outrage at worst. That is the guidelines regarding screening for breast cancer. Breast cancer is the second leading cause of death in women in this country. Whether and when to screen for breast cancer has been debated for decades. In 1993, the Clinton administration proposed the government takeover of health care. In that proposal put forward by the Clinton administration, there would be no payment for mammograms for women under the age of 50. After the age of 50, there would be payment in the government plan for a mammogram every 2 years, exactly what has just been recommended by the Federal task force.

Since we have had the guidelines, which have been in place for many years, death rates from breast cancer have been declining. Since 1990, there are larger decreases seen in women younger than 50. The American Cancer Society states that these decreases are believed to be the result of early detection and increased awareness. The evidence has repeatedly shown that screening and early detection save lives.

Unbelievably, the United States Preventive Services Task Force has recommended against routine mammograms for women under 50, saying it is not worth subjecting some patients to unnecessary biopsies, radiation, and stress. The task force also recommended against teaching women to do regular self-exams. We have to ask the questions: Why this change? Why now? Nothing substantial in the clinical evidence, but the panel decided to review the data with health care spending in mind. Nearly everyone realizes that fewer screenings mean insurance plans, including a government-run plan, will save money.

This is how rationing begins. I hope America wakes up. This is how rationing begins.

In an article by the Wall Street Journal today, they recognized that. It reads:

> Every Democratic version of ObamaCare makes this Task Force an arbiter of the benefits that private insurers will be required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

That is a quote from the Wall Street Journal today.

The American Cancer Society came out after this incredible recommendation and said, with its new recommendations, the task force is essentially telling women that mammography at age 40 to 49 saves lives, just not enough of them. So if the screening is going to save your life or your mother's or your sister's or your wife's, would that screening be worth it?

Decisions about care must be between a doctor and a patient, not a doctor who has a loyalty to anyone but the patient, not a doctor who is working for the government and having to maintain government task force guidelines, such as the one we have just seen.

That is the crux of the debate on this health care bill that has been released in the last 15 hours. I am so worried we are now beginning to see the handwriting on the wall. The President said once there is no reason we should not be catching diseases such as breast cancer and colon cancer before they get worse. It turns out, there is a reason: cost.

The insurance companies have sort of said in the last day or so that they are not going to stop the coverage of mammograms for women starting at the age of 40. But when the government plan comes into effect, you know that every insurance company is going to say: If we are going to be competitive, we must adhere to the same standards as the government plan. It is going to happen.

We must have time to look at this bill. We must have time to look at what is happening to the choices, to the health care, to Medicare. The cuts in services, the taxes, the mandates are going to overhaul the health care of our country. We must have time to look at this bill before we have a motion to proceed. We must have time to study it. We must let our constituency study it because they will catch things they care about and they will inform us, and that is why we are here.

So I am very concerned that we are pushing too fast on something we should be taking slowly and carefully to assure we are not going to do something we are not sure is right, and where we have the chance, to change what we see is wrong.

Thank you, Mr. President.

The PRESIDING OFFICER (Mr. UDALL of New Mexico). The Senator from Arizona.

Mr. KYL. Mr. President, I wish to compliment the Senator from Texas for sounding this warning. Being from Texas, she is undoubtedly aware of a great country-western song out right now by Brad Paisley called ''Welcome to the Future.'' I think we have seen a glimpse of the future under Obamacare here by this pronouncement of the U.S. Preventive Services Task Force recommending against the routine screening of women between ages 40 and 49 for best cancer.

I want to speak for about 60 seconds about this issue to go into the actual numbers from the study to which Senator HUTCHISON referred. The rationale of the study is that you would need to screen 1,339 women in their fifties to save 1 life, so screening is worthwhile. But since you would need to screen 565 additional women—in other words, 1,904, to be precise—in their forties to save 1 life, screening is not worthwhile. That is the kind of cost-benefit analysis that will result in rationing, and it is precisely Senator HUTCHISON's point that this is how rationing begins.

Welcome to the future.

Mrs. HUTCHISON. Mr. President, if the Senator will yield, I appreciate him giving us these statistics because it is 1 life out of 1,904 to be saved, but the choice is not going to be yours; it is going to be someone else who has never met you, who does not know your family history.

That was in the Clinton government reform, takeover of health care in 1993, and it was soundly rejected. It was soundly rejected. It was part of the reason it was soundly rejected—this mammogram rationing before the age of 50—because we had hearings on this, and every woman in the Senate at the time rejected—rejected—that plan, rejected keeping women under the age of 50 from having mammograms paid for by insurance plans.

So I thank the Senator from Arizona for connecting this and showing the statistics because this is not the American way of looking at our health care coverage. It is not the American way, and we must stop this government takeover of our health care.

Mr. President, I yield the floor.

Mr. KERRY. Madam President, I speak in opposition to amendment No. 2785 to the Caregivers and Veterans Omnibus Health Services Act. This amendment, offered by Senator COBURN, would cut funding for international organizations, including U.S contributions to NATO and the United Nations. This would gravely undermine our vital national security interests at a critical time. We all strongly support strengthening medical care for our Nation's veterans, but Senator COBURN's amendment sets up a completely artificial choice between protecting the health of America's veterans and ensuring that our Nation meets its national security objectives and international obligations.

To be clear, this amendment would cut funding from the contributions to international organizations account, which provides the assessed dues to the U.N. and NATO, APEC, OAS, OECD, and the OPCW, as well as take funding from the contributions to international peacekeeping operations account. That is why I will oppose this amendment, for several critical reasons:

First, we obviously need as much support as we can get from our NATO allies for our joint mission in Afghanistan. We cannot, and should not, carry

this burden alone and how can we ask NATO to do more while we are at the same time cutting our NATO contributions? This would seriously undermine our standing with NATO and with our NATO allies at a time when we can least afford it. We simply cannot allow that to happen.

Several other international organizations are also threatened by this amendment. Funding for the Organization of American States, which addresses threats to hemispheric security, from terrorism to narcotics, would be cut. The Organization for Economic Cooperation and Development, which promotes economic growth in 30 member states and more than 70 other countries, would lose funding. The Asia-Pacific Economic Cooperation, which promotes trade, security, and economic growth throughout the Asia-Pacific region, and which the United States will host in 2011, would also be cut. The Organization for the Prohibition of Chemical Weapons, which ensures worldwide implementation of the Chemical Weapons Convention, as well as the World Trade Organization, which provides the stable framework for international trade that is so critical to the United States, would suffer funding cuts.

Second, our United Nations contributions fund a wide range of U.N. activities in support of key United States foreign policy priorities. U.N. organizations are monitoring nuclear programs in North Korea and Iran. We need the best information possible about the nuclear programs in Iran and North Korea, and the last thing we need to be doing is cutting funding for the very organization that is doing on the ground monitoring. The U.N. is also providing vital assistance for the upcoming elections in Iraq, which will be critical to the future of democracy there. U.N. food and agriculture agencies are compiling forecasts of global agricultural production, identifying areas of likely famine and severe hunger, and facilitating emergency food assistance. U.N. health agencies are on the frontlines of detecting outbreaks of avian flu and H1N1 and defending against a world pandemic. In addition, we work through U.N. organizations to protect a range of U.S. interests, from the intellectual property rights of American entrepreneurs to coordinating international aviation safety standards.

Third, passage of this amendment would directly threaten ongoing peacekeeping operations in nations essential to America's national security interests. There are now over 115,000 peacekeepers the second largest deployed military in the world serving in 17 missions in some of the most dangerous corners of the world. These U.N. peacekeeping operations are working to preserve peace and stability in fragile countries with grave humanitarian situations, including Darfur, Liberia, Lebanon, Haiti, and the Democratic Republic of Congo. U.N. peacekeeping is eight times less expensive than funding a U.S. force, according to the Government Accountability Office, and these peacekeeping operations help shoulder the burden with our military. U.N. peacekeeping missions also help end brutal conflicts, support stability, the transition to democratization, and bring relief for hundreds of millions of people. And if not for U.N. peacekeeping missions, some of these conflicts could require the presence of U.S. soldiers.

Haiti is a good example. The U.N. force in Haiti has dramatically reduced the number of kidnappings that plague the nation and helped deliver food and medicine, clean streets, and maintain security after several successive tropical storms devastated the country. The mission in Haiti is in the midst of a successful transition from keeping the peace to enhancing security for the people of that country. In the 1990s, Florida faced wave after wave of illegal Haitians trying to escape from the failed state. Should this mission be abandoned? Should we abandon the people of Darfur?

Fourth, the President has stated his commitment to paying U.S. dues to international organizations in full. As Ambassador Rice has said, we must meet our obligations. As we call upon others to help reform and strengthen the U.N., the United States must do its part and pay its bills. Our dues to the United Nations and other international organizations are treaty obligations. The full payment of assessed contributions affects the standing and influence that the U.S. has at these organizations. Going into arrears undermines U.S. credibility and negatively influences world opinion regarding U.S. respect and appreciation for the role of multilateral organizations that support and advance U.S. foreign policy.

We all want our veterans and their families to receive the best care possible—they have earned it many times over—but this amendment presents us a false choice between caring for our veterans and protecting our global interests: We must do both. It is for these reasons I oppose Senator COBURN's amendment and urge fellow Members to oppose the amendment as well.

Mrs. BOXER. Mr. President, I rise today in opposition to amendment No. 2785 to the Caregivers and Veterans Omnibus Health Services Act of 2009.

This is a deeply flawed amendment that may hurt certain veterans of the wars in Iraq and Afghanistan. And for that reason, I must vote against it.

Severely injured or disabled veterans often need someone to care for them in the home. The family members of these veterans often shoulder the burden of this care, which can take a significant financial, psychological and emotional toll. This bill would provide a family member caregiver with health care, counseling, support and a monthly stipend.

But amendment No. 2785 actually seeks to shut certain Iraq and Afghanistan veterans out of this new benefit by mandating that only those who require "hospitalization, nursing home care, or other residential care" are eligible.

The Wounded Warrior Project characterized the impact of the amendment as such, stating that it would "set a much higher bar" by requiring that the "veteran be so helpless as to require institutional care if personal care were not available."

This would potentially shut out veterans suffering from severe mental illness, or those learning to adapt to life at home with blindness or amputations.

The Disabled American Veterans also echoed this concern as a reason for opposing this amendment, writing that the amendment's "new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services."

For these reasons, I urge my colleagues to defeat this amendment, which is also opposed by the American Legion, the Iraq and Afghanistan Veterans of America and Swords to Plowshares.

It is long past time to pass the underlying bill. This legislation is too important to our veterans to sit in Congress because of the stall tactics of one lone senator.

It includes important health care improvements for women veterans including requiring the Department of Veterans Affairs to train mental health care specialists on how to better treat military sexual trauma. It also implements pilot programs to provide child care to women veterans who require medical care.

In addition, the bill includes two important provisions from bipartisan legislation that I authored with Senator BOND.

The first gives active duty servicemembers access to vet centers, which are community-based counseling centers run by the Department of Veterans Affairs where veterans can receive mental health care services.

The second provision authorizes vet centers to counsel former servicemembers on their rights to present their medical records for review to ensure that the discharge process they underwent was fair. This is particularly important for servicemembers who may have been discharged improperly with a personality disorder and therefore are not entitled to benefits when in fact they suffer from a combat-related condition such as post-traumatic stress disorder.

We owe our veterans an enormous debt of gratitude, and the best possible treatment and care for injuries sustained in service to our country. This bill is an important step toward fulfilling that obligation.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, can you tell me how much time I have remaining?

The PRESIDING OFFICER. Remaining on the Senator's side is 31 minutes 33 seconds; on the other side, 42 minutes 15 seconds.

Mr. AKAKA. Mr. President, let me make further comments about the pending bill on the floor and speak particularly about the cost of war.

To those who are concerned about the cost of this legislation, let me say I firmly believe we cannot renege on the obligation to care for those who honorably serve our country. When we as a nation vote to send American troops to war, we are promising to care for them when they return. The cost of veterans health care is a true cost of war and must be treated as such. The cost associated with the underlying bill does not need to be offset. The price has already been paid many times over by the service of the brave men and women who wore our Nation's uniform.

Regardless of what my colleagues may think about the United Nations and its role in international affairs, this is not the time or place to be debating those issues. At this moment, we are talking about meeting veterans' needs.

Iraq and Afghanistan Veterans of America agrees. IAVA writes that:

> The amendment to S. 1963 brought to the floor is just the latest in a long series of delaying tactics that plays political games with veterans' health care and services.

This bill would provide family caregivers—who typically have full-time jobs—with health care, counseling, support, and a living stipend. This modest stipend would be equal to what a home health agency would pay an employee to provide similar services.

To assert that this legislation requires excessive spending is simply wrong. This spending is critical when taking into account the sacrifices these men and women have made for the Nation.

The sponsor of the amendment we are considering has expressed the view that S. 1963 unfairly discriminates against veterans because its caregiver assistance provisions focus on OEF and OIF veterans. While it is correct that the caregiver provisions target the veterans of the current conflicts, I do not believe that constitutes discrimination. The reasons for this targeting, at the least, are three: one, the needs and circumstances of the newest veterans in terms of the injuries are different—different—from those of veterans from earlier eras; two, the family situation of the younger veterans is different from that of older veterans; and three, by targeting this initiative on a specific group of veterans, the likelihood of a successful undertaking is enhanced.

I note that most major veterans groups support this bill and the caregiver provisions. I do not believe they would do so if they felt it was discriminatory.

As my colleagues know, I am a veteran of World War II. If we can provide help to the newest veterans in ways that were not available to the veterans of my generation, I support that 100 percent.

Veterans from Iraq and Afghanistan are returning home today to face new and different challenges. In World War II, a third of those injured on the battlefield did not make it home. Today, 90 percent of those injured make it home but often with catastrophic and life-threatening injuries. Some of these injuries leave invisible wounds. Unprecedented rates of post-traumatic stress disorder and other mental illnesses are affecting these young men and women. These veterans will be cared for somewhere, and by what we do today, we may decide whether that care occurs in a nursing home or in their own home. The soldiers of my generation had no such choice. I say, let's help the Nation's newest veterans to really come home, and let's help their families.

According to a report from the Center for Naval Analyses, 84 percent of caregivers for veterans were either working or in school prior to becoming a caregiver. An employed caregiver will lose, on average, more than $600,000 in wages, pension, and Social Security benefits over a ''career'' of caregiving. The younger the veteran's family, the more wages a caregiver will lose. We can no longer ask our newest generation to bear the cost of the Nation's obligation to care for its wounded warriors.

The premise of the amendment seems to be, if it is good for some, it is good for all. But the needs of veterans are not the same, and expanding a benefit to any veteran who might benefit could endanger the entire program. The underlying bill already includes a provision directing VA to report to Congress within 2 years after the law's enactment on the feasibility of expanding the provision of caregiver assistance to family members of veterans of prior service. Such an approach is not discriminatory; it is the responsible way to approach the issue.

I note that other health care improvements which would result from this bill help virtually every group of veterans, including women veterans, homeless veterans, and veterans who live in rural areas.

I urge this body to reject the amendment and pass S. 1963 today for the sake of all our Nation's veterans.

Questions have been raised about the scope of the caregiver provision. When the bill came out of the Veterans' Affairs Committee, it included a 2-year delay before the caregiver benefit could have been expanded. The bill as reported said the Secretary of VA could have expanded it to all veterans if it made sense. Under the bill now before us, the Congress will continue to have the opportunity to expand it beyond OEF and OIF veterans. Nothing has changed. Once VA has experience with the proposed new program, it can be expanded to all veterans.

Mr. President, I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LEMIEUX. Mr. President, 25 years ago—I will never forget this—I came home to my house, I was 15 years old, I was in high school, and my mom and my dad sat me down and my mom told me that she had breast cancer. After that, as any kid would, I worried about whether my mom was going to live and what life would be like without a mother. It was a very difficult time for our family.

The good news is that my mom, through self-examination, found a lump, and she is today, 25 years later, a breast cancer survivor. But I am not sure I could tell this story today and tell about the positive result that occurred if she had not undertaken that self-exam, if she had not received the care she was given so quickly and so effectively because she found the lump after having been trained and encouraged to do self-exams.

So she is a success story, and millions of women across this country are success stories because they have heeded the advice of preventive medicine. They have heeded the advice for many years now from the American Cancer Society and other experts that self-exams and mammograms for women in their forties prevent breast cancer, and they prevent us from losing our moms and our sisters and our daughters. But this week, a task force, a government task force, kind of ironically named the ''U.S. Preventive Services Task Force,'' contradicted their previous recommendations and said women in their forties shouldn't be doing self-exams; that women in their forties shouldn't be having mammograms on a regular basis. That makes absolutely no sense.

We are in a world where everyone agrees the way to reduce health care costs and to increase longevity of our people is through preventive medicine. We know through the success we have had in recent years that self-exams and mammograms save women's lives.

There are going to be what they call false positives, women who find something that turns out not to be a lump. And, sure, they are going to be anxious during that time period while it gets

checked out. But would you rather have your mom, your sister, your daughter be anxious for a couple days and get a good result or would you rather have them, on the other hand, not do the self-exam, not get the mammogram, and get cancer and potentially die? It makes no sense.

We know these mammograms for women in their forties save lives. We know self-exams save lives. It is not just me saying it; the facts show it. The American Cancer Society notes that deaths for breast cancer since 1990 declined by 2.3 percent, and they have declined 3.3 percent for women in their forties and fifties. Lives are being saved.

So why would this government task force that is supposedly focused on prevention want to do away with self-exams and mammograms on a regular basis for women in their forties? What could be the reason?

The reason, as my colleague from Texas so eloquently stated, is cost. It doesn't make sense anymore because we are not saving enough lives for the money that it is costing for mammograms. Our moms and our daughters and our sisters are worth that cost.

If you want to get a picture of where we are going with this new health care proposal and you want to know what the future is for how the government and your insurance company are going to view your health care, just take a look at this recommendation. Are they next going to say the same thing about men getting prostate exams in their forties? Are we going to start making these cost-based decisions or really furthering them to a degree that we haven't seen before? Are we going to lose our family members because we are rationing health care? These are big issues.

The American people, as my colleague from Texas said, need to wake up and they need to watch what is going to happen in this Senate, this great body that debates the important issues. Never has there been an issue as important in modern times as what is going to happen over the next month or 6 or 8 weeks as we discuss these issues that are going to affect our health and our families' well-being.

I sent a letter to Secretary Sebelius yesterday on this issue. I saw her comments yesterday where she disagrees with this panel. I commend her for that. Women do not need to get the message now that they shouldn't be doing self-exams. Women should not be getting the message that they shouldn't be getting regular mammograms in their forties. They need to do both things because it is going to help save their lives. No government task force, based on lack of any new information, should contradict its prior recommendations that they do just that.

I had a chance to speak with the surgeon general of the State of Florida, Dr. Ana Viamonte-Ros, yesterday about this issue, and she concurs with me, as does the American Cancer Society and other groups, including the American College of Obstetricians and Gynecologists, that women should still do self-exams, and they should still get mammograms on a regular basis in their forties.

I wish to read for this Chamber a letter—an e-mail, actually—I received today from a friend of mine down in Broward County from my home State of Florida. She writes:

Please thank the Senator for his efforts on this important issue. I am a breast cancer survivor who was first diagnosed before 50 years of age having a mammogram. Subsequent to the mammogram, my tumor was removed surgically. Unfortunately, within 5 years, I was diagnosed again with breast cancer in the other breast and had to undergo surgery and chemotherapy. The second time I found the tumor through self diagnosis. Every day I thank God that I had a lifesaving mammogram and that my doctor showed me how to do a self examination.

Just recently I learned through TV that there are also recommendations that women should not utilize self exam as a way to detect breast cancer. It's too unreliable. More hogwash. Most of my breast cancer sisters found their tumors through self exam. Please ask the Senator to dispel any efforts or notions that self exam is not a good means of detection.

This is an important issue. We need to get the message out to the women of America that these recommendations are wrong. I only can stand here today with this good story about my mom because if she wouldn't have done that self-exam, she might not be here with us.

So I hope the American people will, as my colleague from Texas said, wake up and see what this means and what this portends for the future.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make further comments on some of the concerns our speakers have had.

The sponsor of the amendment has stated his primary goal is to increase veteran eligibility for caregiver assistance. It appears, however, that the amendment could well have the opposite effect and deny caregiver assistance to many OEF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance.

The amendment would add a provision that would require that in addition to sustaining a serious injury and requiring personal care, a veteran would have to be so helpless as to require institutional care if personal care services were not available. This proposed modification is problematic because not all veterans in need of caregiver assistance would be appropriate for, or in need of, institutional care.

To illustrate, consider the example suggested by the Wounded Warrior Project, one of the principal advocates for the caregiver legislation: A veteran who is recovering from severe wounds, suffers from PTSD and depression, and needs help with feeding, dressing, and getting to the bathroom, under the provisions in S. 1963 this veteran would be eligible for caregiver assistance. However, since the veteran in this example would not necessarily benefit from or require institutional or residential care, the veteran would not be eligible for caregiver assistance under the changes proposed by the amendment. Given the veteran's co-occurring PTSD and depression, however, the VA's failure to provide that assistance could have a severe impact on the veteran's mental health and well-being. PTSD, one of the signature wounds of the current war, is a condition which many long-term institutional care settings and nursing homes are not prepared to handle or treat. As a result, the inclusion of this new eligibility condition would exclude many veterans in critical need of caregiver assistance.

There is another problem raised by the amendment's proposed expansion of the caregiver assistance to all veterans. By expanding eligibility for caregiver assistance to all severely injured veterans, the amendment would convert a manageable initiative targeted on the veterans of the current conflicts into a huge undertaking that would surely encounter many problems.

The reasoning behind initially administering services to a smaller pool allows for greater efficiency and the opportunity to improve before expanding such services to a larger universe of veterans.

I note that the Disabled American Veterans argues against the pending amendment because of its potential impact. DAV writes, and I quote:

While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support the Coburn amendment to S. 1963.

I ask unanimous consent that this letter be printed in the RECORD.

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

DISABLED AMERICAN VETERANS,
November 19, 2009.

Hon. DANIEL K. AKAKA,
Chairman, Senate Veterans' Affairs Committee, Russell Senate Building, Washington, DC.

DEAR CHAIRMAN AKAKA: On behalf of the Disabled American Veterans (DAV), thank you for introducing and quickly bringing to the floor S. 1963, ''The Caregiver and Veterans Omnibus Health Services Act of 2009.'' DAV strongly supports Senate approval of this legislation as introduced, and urges all Senators to support its passage.

S. 1963 combines the content of two prior measures (S. 252 and S. 801) into a single VA

health care omnibus bill that would make significant enhancements in VA health care services. This legislation contains vital provisions to help assure equal access to and quality of medical care for women veterans. S. 1963 would also provide desperately needed support to family caregivers of severely disabled veterans, particularly those returning from Iraq and Afghanistan, as well as expand mental health services, improve traumatic brain injury care and aid homeless veterans.

As we have shared with you in testimony earlier this year, DAV believes that disabled veterans of all eras could benefit from family caregiver support services. While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support this Coburn amendment to S. 1963.

Mr. Chairman, we look forward to continuing to work with you, Ranking Member Burr, your counterparts in the House and others to craft and enact the most expansive and effective caregiver assistance program that we can achieve. Again, thank you for your vigorous leadership on this legislation and for all you have done to support disabled veterans and their loved ones who care for them.

Sincerely,

JOSEPH A. VIOLANTE,
National Legislative Director.

Mr. AKAKA. Mr. President, the proponent of this amendment has expressed the view that this veterans omnibus bill should be paid for and seeks to do so by directing a transfer from the State Department to VA of funds appropriated for ''Contributions to International Organizations'' and ''Contributions for International Peacekeeping Activities,'' both of which are categories of huge U.S. payments to the United Nations.

Regardless of any Senator's beliefs about the role of the United Nations or U.S. support for the U.N., this is neither the time nor place to be debating those issues. For that reason alone, I believe the amendment should be rejected.

I understand from CBO, however, this amendment does not even accomplish what I believe the amendment's author intends. According to CBO, the cost of the bill would still be estimated at the same level. According to CBO, having the State Department transfer funds to the VA is no different than having VA fund it through its own appropriations accounts.

It also appears that the amendment would change nothing with respect to U.S. payments to the U.N. Again, according to CBO, if the amendment's author wishes to have the State Department transfer funds to VA instead of contributing to the U.N., the amendment would have to be made to the State, Foreign Operations, and Related Programs Appropriations Act, and not to the pending measure which is an authorization bill.

This legislation has been delayed too long. To continue to obstruct this vital veterans bill while attempting to link it completely to unrelated U.N. spending is simply unacceptable.

This amendment should be rejected and S. 1963 should be passed by the Senate.

I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I listened very carefully to the chairman of the Veterans' Committee. He misses one major point: If, in fact, we don't send the money to the U.N., we will have money to pay for the veterans—if we don't send the money.

That is what this amendment does. It precludes that money from going from the State Department's budget to the U.N. I admit it is fungible, but that is money we will not send to something that is low priority, that is wasteful, that is nontransparent, and that the vast majority of Americans agree we get very little value from when we send that money to the U.N.

I also take issue with my friend's words that it is time. I think the chairman will agree that this bill was not noticed until October 28. That is when this bill was noticed. When the bill was noticed, the next day a unanimous consent request came through to say pass this without any debate, without any discussion, pass it through the Senate. I said, no, we ought to have a debate. At that time, we offered the Veterans' Committee a list of some 20 options of things that are lower priority than helping our veterans. They were rejected out of hand, which is the problem I have been describing on the floor earlier.

Every time it comes down to making a choice, the majority of this body chooses not to make a choice, not to choose a priority, not to do what we get paid to do, not to do what is in the best interests of the Nation. They choose to not choose. But by choosing not to choose priorities, we still choose, because what we choose is to take the money from our children. We choose to lower the standard of living of our children.

I want to tell you about veterans with whom I have spoken. I have had a lot of calls on this, because how dare somebody hold up a veterans bill before Veterans Day. The vast majority of the calls say we think you ought to support veterans, but we also think you ought to pay for it. Our country can't keep doing what we are going to do. So on the last appropriations bill through this body, I gave you an opportunity. We have heard three Senators today say there is no price we should not give to support our veterans. Direct quotes. ''No price is too great''? There is one price that is too great, because all three of those Senators who spoke those words refused to give up their earmarks to pay for veterans in the VA-MILCON bill. They all voted against paying for it in the MILCON bill by eliminating the unrequested items they had earmarked for them in the VA-MILCON bill. So, yes, there is a price that is too great—the price of helping yourself and your own constituency on a parochial basis and putting that ahead of the best interests for our veterans. So the words ''there is not a price too great'' ring hollow. We put our parochialism ahead of it.

I ask unanimous consent to add Senators INHOFE and BURR as cosponsors of my amendment.

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

Mr. COBURN. Mr. President, as we talk about this debate, as my colleagues know me very well, the debate isn't about veterans; it is not about the veterans bill. It is about reestablishing some fiscal sanity in Washington of which we have none. This bill here—the health care bill that was released last night—over the next 10 years will spend $2.5 trillion. That is what it will spend. We don't know the accuracy of CBO. They certainly haven't done very well in the past on health care, as to whether it saves money. What we do know is that it doesn't cut the cost of health care, which is the problem. It transfers $2.5 trillion under the guise of the control of the Federal Government, which is not efficient.

I have not heard one colleague defend the United Nations. Nobody will get up in this body and defend the atrocities, the waste, and the fraud of the U.N. Nobody will say that. But those same people who actually agree with it but won't do anything about it will vote against this amendment. They will vote against the amendment. They won't defend what has very accurately been described as the behavior, the lack of fiscal sanity, the fraud and theft, the rape and pillage by the peacekeepers, the lack of oversight, and the total lack of transparency. They won't defend that with their words, but they will defend it with their vote. They are going to absolutely defend it with their vote. Once again, they are going to refuse to make the hard choice. Most of them listening to this agree, but it is the wink and nod that we play around this body. They know the U.N. is a big mess. They know it is a big problem. But they won't do anything to fix it. They will vote for complete transparency and vote to condition our funds on transparency, and when they get to conference, they will take it out. They will look good on the outside, but the inside of the cup will be absolutely filthy.

When is it we will see a turnaround in Washington that will match the courage of our veterans and meet the expectation of the citizens of this country? When is that going to happen? I will tell you when it is going to happen: It is going to happen when the

Chinese start selling our bonds or quit buying them. That is when it will happen. Then we are not going to be able to make those decisions based on our choice. They are going to be dictated to us. They are going to be rammed down our throats.

The fact is that $3.7 billion is a lot of money. It is $3,700 million. That is hard to think about when you start talking about billions. Yet we are going to pass it. By the way, this bill that is so critical to get passed right now has no money in it for veterans for this process. Would the chairman agree with that? There is no money there now? It is not going to happen until a year from now, unless we put it in some supplemental program between now and next September 30. So what we are promising isn't going to come due, because we turned down an amendment on the VA-MILCON bill that would have allowed money to be available as soon as the VA-MILCON bill passed the conference committee and the President signs it.

How hollow does that sound? We claim one thing but our actions are totally different. And the VA says, by the way—at least intimated—once they get this bill and the money, it will take at least 180 days to implement it. So add 18 months to right now to when our first veterans will see the benefit, especially the caregivers. And we could have, with the VA-MILCON amendment I offered—which was rejected—made that happen next month—at least the planning in the first 6 months of that—so that by March or April caregivers could actually start receiving this money.

I have tremendous worry for our Nation. If you open your eyes, you will too, because we cannot keep doing what we are doing.

Just some statistics. These are accurate, based on GAO, OMB, and Congressional Budget Office:

Ending September 30, not counting the supplemental, the Federal Government spent $33,880 for every household in this country. But we only collected an average of $18,000 per family. We borrowed, per family, $15,603 last year. Those numbers are going to be bigger next year. We are going to spend more, we are going to borrow more, and we are going to collect less. What is the implication of that? What is the implication of borrowing money we don't have and spending it on things that are not a priority, such as caring for veterans? The implication is that it will come to an abrupt halt in a very damaging and painful way—maybe not for us in this body but certainly for my children and my grandchildren, and certainly for those who follow us.

There is a bigger worry than the financial aspect of it. It is that we are losing, as we do this, the very integral part of what makes our Nation great. It is called ''sacrifice.'' That is why we honor our veterans. It is because they sacrifice, they put themselves on the line. Our heritage has been, from the founding of this country, to the very people who risk their lives and fortunes to initiate this country—the heritage has been of one generation sacrificing so the next generation can have greater opportunity and greater freedom and greater liberty.

As I said earlier, when we come back and get down to the actual voting on this amendment, most people will say: We can't do that. It is not time to make a hard choice.

I want to tell you, those veterans who have closed-head trauma made a hard choice. Those veterans who lost their lives and family made a hard choice. Those veterans who have severe disability and their families made a hard choice.

In a little while, we are going to dishonor that, because we are going to refuse to make a hard choice and rationalize in a way that it isn't going to do any good or make any difference, and we are not going to even attempt to get the out-of-control spending in Washington under control. We will reject the notion that you can, in fact, look at something and see what it is like, such as the corruption, such as the waste, such as the rape and pillaging of the U.N. peacekeeping troops, and we are going to say that is not important, and what is important is that we keep doing it the way we have always done it. We will continue to do it the way we have always done it.

The way we have always done it for the past 20 years does not honor what built this country. It doesn't honor making that sacrifice. It does not honor saying I will make a tough vote, even though the administration doesn't want me to make this vote. I will make a vote that is right for the country, right for the future, right for our kids and our grandkids. I will make that vote.

We will not see that today. We will not see the courage mustered up to choose between veterans and a sloppy, ill-run organization into which this country pours billions of dollars every year and continues unabated and uncontrolled and without oversight because we refuse to make a choice.

So my colleagues get a choice. Here is the choice: Ignore with a blind eye the absolute tragedies that are going on at the United Nations, the absolute waste, the incompetency, the favoritism, the theft that is going on and say you did something good for veterans.

The fact is, the reason our veterans have such severe injuries is because they protect our liberty, protect our freedom, and protect our future. We are not going to choose that today. We are going to choose the opposite. We are going to do the status quo. We are going to say this amendment does not make sense.

When will we muster the courage to make a real choice, to go out and defend that veterans are worth more than the waste at the United Nations? We will not make the choice because we know we can vote against this amendment and still tell the veterans we did it and we don't have to speak to our grandchildren and children. We will be gone. We will be out of here.

When their standard of living is 35 percent below the standard of living we experience today—by the way, that is what is forecast as the government takes over 40 percent of the GDP of this country and as we end up with interest costs in excess of $1 trillion a year just to fund the excesses of what we are doing today, which is less than 5 years away, and we will be spending $1 trillion a year on interest—we will have no recollection of this vote. We will have no recriminations against us. We will have just voted and said that is another amendment to try to make us make a choice, but we refuse to make one.

By voting against this amendment, you are defending the audacity, corruptness, inefficiency, and fraudulent behavior of the United Nations. That is what you are doing. Nothing can be cut. Have you noticed that? Nothing is not important to the politicians of this city. Everybody has an interest group. Oh, we can't go against that. That is an absolute formula for disaster for our country.

I wish to enter into the RECORD some additional information on the United Nations. I only touched the surface on the amount of outlandish things that have gone on in the United Nations. I did not mention Oil for Food, billions of dollars, and of the people who took all that money, none of them got prosecuted. The U.N. Headquarters renovation is going to cost $2 billion. It should cost about $800 million. I did not talk about that or the lack of transparency in terms of the State Department, in terms of reporting how our money is spent at the United Nations.

I ask unanimous consent to have printed in the RECORD this information.

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

AMENDMENT 2785

REDIRECT U.S. DUES TO THE UNITED NATIONS TO THE VETERANS CAREGIVER PROGRAM

The United States taxpayer is the single largest contributor to the United Nations providing over $4 billion annually to the entire United Nations system that is estimated to be at least $20 billion. No one knows for sure how big the U.N. really is—not even the U.N. itself since it operates in an opaque, unaccountable fashion, refusing even the most basic of transparency requests.

The U.S. federal budget that is rife with waste, fraud, and abuse, but the U.N. budget is far worse. Its funding is complicated by diplomatic immunities, spends across international borders, is impossible to audit, and

spent by U.N. agencies that levy taxes and fees on each other.

This amendment to the Veterans' Caregivers Bill reduces the contributions that the United States makes to the United Nations by a sufficient amount to provide caregiver benefits to ALL severely disabled wartime veterans, not just veterans injured after September 11, 2001. The current bill discriminates against veterans injured prior to that as it does not offer the same care it would provide to individuals after that date.

The national debt just passed $12 trillion and the Congress must pass a debt limit increase. Passing the veterans caregivers bill without having the increased spending offset elsewhere is completely irresponsible and further condemning our grandchildren to a lower standard of living.

UN tainted with fraud, waste, and abuse

According to internal U.N. reports, U.N. procurement programs suffer from serious fraud and mismanagement problems that taint almost half of the contracts that were audited. The report from the U.N. procurement task force found that 43% of UN procurement investigated is tainted by fraud. Out of $1.4 billion in contracts internally investigated, $630 million were tainted by ''significant fraud and corruption schemes.''

The U.N. Environment Program spends over $1 billion annually on global warming initiatives but there is almost no auditing or oversight being conducted. The U.N. Environment program has one auditor and one assistant to oversee its operations. According to the task force it would take 17 years for the auditor to oversee just the high-risk areas already identified in UNEP's work.

The United Nations Human Settlements program, knows as UN-Habitat, only has one auditor, and it would take him 11 years to cover the high-risk areas alone. In cases where the U.N. auditors and investigators found evidence of administrative malpractice, the U.N. management has taken little if any action. For example, the managers of the U.N. Department of Economic and Social Affairs abused a $2.6 million trust fund given by the government of Greece. The U.N. auditors recommended that the program repay Greece, but so far, the U.N. has ignored this recommendation.

The U.N. spends $85 million annually for its Public Affairs Office, the sole purpose of which is to promote a positive image of the international body. Further, the $1 billion U.N. Foundation is devoted, in part, to pro-U.N. advocacy efforts all over the world.

United Nations peacekeeping operations

U.N. peacekeeping operations plagued by rape and sexual exploitation of refugees—In 1994, a draft U.N. report was leaked detailing how peacekeepers in Morocco, Pakistan, Uruguay, Tunis, South Africa and Nepal were involved in 68 cases of rape, prostitution and pedophilia. The report also stated that the investigation into these cases is being undermined by bribery and witness intimidation by U.N. personnel.

In 2006, it was reported that peacekeepers in Haiti and Liberia were involved in sexual exploitation of refugees.

In 2007, leaked reports indicate the U.N. has caught 200 peacekeepers for sex offenses in the past three years ranging from rape to assault on minors. In all of these cases, there is no known evidence of an offending U.N. peacekeeper being prosecuted.

Just this month, Human Rights Watch reported that Congolese armed forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo have brutally killed hundreds of civilians and committed widespread rape in the past three months in a military operation backed by the United Nations.

Most of the victims were women, children, and the elderly. Some were decapitated. Others were chopped to death by machete, beaten to death with clubs, or shot as they tried to flee.

The UN peacekeeping mission provides substantial operational and logistics support to the soldiers, including military firepower, transport, rations, and fuel.

The attacking Congolese soldiers made no distinction between combatants and civilians, shooting many at close range or chopping their victims to death with machetes. In one of the hamlets, Katanda, Congolese army soldiers decapitated four young men, cut off their arms, and then threw their heads and limbs 20 meters away from their bodies. The soldiers then raped 16 women and girls, including a 12–year-old girl, later killing four of them.

The U.S. now pays 27% of all UN peacekeeping operations. Reducing our contribution to these wasteful efforts could help ensure that UN peacekeepers are not funding widespread rape and exploitation of refugees.

U.N. wastes millions in funds for critical Afghan presidential election

The United Nations cannot account for tens of millions of dollars provided to the troubled Afghan election commission, according to two confidential U.N. audits and interviews with current and former senior diplomats.

The Afghan election commission, with tens of millions in U.N. funding and hundreds of millions in U.S. funding, facilitated mass election fraud and operated ghost polling places.

''Everybody kept sending money'' to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan. ''Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election.'' Galbraith, a deputy to the senior U.N. official in Afghanistan, was fired last month after protesting fraud in the elections.

As of April 2009, the U.N. spent $72.4 million supporting the electoral commission with $56.7 million coming from the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $263 million in funding for the election.

In one instance, the United Nations Development Program paid $6.8 million for transportation costs in areas where no U.N. officials were present. Overall the audits found that U.N. monitoring of U.S. taxpayer funds was ''seriously inadequate.''

Oil for Food

In 1996, the United Nations (UN) Security Council and Iraq began the Oil for Food program to address Iraq's humanitarian situation after sanctions were imposed in 1990. More than $67 billion in oil revenue was obtained through the program, with $31 billion in humanitarian assistance delivered to Iraq.

The Oil for Food program had weaknesses in the four key internal control standards—risk assessment, control activities, information and communication, and monitoring—that facilitated Iraq's ability to obtain illicit revenues ranging from $7.4 billion to $12.8 billion. In particular, the UN did not provide for timely assessments to address the risks posed by Iraq's control over contracting and the program's expansion from emergency assistance to other areas.

According to GAO, the Oil for Food program was flawed from the outset because it did not have sufficient controls to prevent the former Iraqi regime from manipulating the program.

GAO identified over 700 findings in these reports. Most reports focused on U.N. activities in northern Iraq, the operations of the U.N. Compensation Commission, and the implementation of U.N. inspection contracts. In the north, OIOS audits found problems with coordination, planning, procurement, asset management, and cash management. For example, U.N. agencies had purchased diesel generators in an area where diesel fuel was not readily available and constructed a health facility subject to frequent flooding. An audit of U.N.-Habitat found $1.6 million in excess construction material on hand after most projects were complete. OIOS audits of the U.N. Compensation Commission found poor internal controls and recommended downward adjustments totaling more than $500 million.

UN headquarters renovation

In 2008, the United Nations began construction associated with its Capital Master Plan (CMP) to renovate its headquarters complex in New York City. As the UN's host country and largest contributor, the United States taxpayer has a vested interest in the way funds are spent in renovating these buildings.

The United Nations headquarters renovation, now estimated to cost $2 billion from its original $1.2 billion price tag, was found to be almost $100 million over its budget before breaking ground on the project. Part of the cost increase is due to previously hidden ''scope options'' for ''environment friendly'' options like planting grass on the roof and electricity-producing wind turbines.

First, the U.N. failed to adequately maintain its complex after 50 years of deterioration and decay. The U.N. paid millions of dollars to an Italian design firm that had to be fired under intimations of corruption after never producing a single workable plan for the renovation project.

The UN renovation project is just another example of UN spending out of control. The UN's purported $2 billion renovation budget includes over $550 million for expected increased costs and other ''contingencies.''

U.S. Taxpayers are responsible for at least $485 million in the renovation of the U.N. buildings. However, this figure is likely to rise as GAO has assessed that there exists a high risk that the project will cost much more than anticipated.

Unfortunately, the U.N. renovation program is carried out by the same system responsible for the Oil-for-Food scandal. The U.N.'s own internal audits suggest that the entire procurement system is plagued by corruption.

The current cost of the UN renovation is as follows: $890 million for construction, $350 million budgeted future escalation in costs, $200 million ''contingencies,'' $75 million for redundancies (extra generators, additional fiber optic lines, etc), $40 million ''sustainability'' (wind turbines, grass on roof, etc).

UN European ''palace'' renovation

In addition to housing a massive bureaucracy in New York, the United Nations also keeps a European headquarters, in scenic Geneva, Switzerland. The similarity is striking, as this 70 year old building that used to house the League of Nations is reportedly in need of a billion dollars to fully renovate the ''Palais de Nations,'' as the U.N. building is known, because the building suffers from 70

year old wiring, fire hazards, rusty pipes, asbestos, and a roof caving in.

For cost comparison, $1 billion could build 407,244 square meters of office space in Geneva. That's one and a half times the size of the Empire State Building, and five times the size of the main building at the Palais des Nations.

Keeping the Palais des Nations could cost more than double what it would take to build a new home from scratch.

That $1 billion, relief groups said, is also larger than the entire humanitarian action appeal for all countries served by UNICEF, the United Nations Children's Fund, which requested $850 million to address 39 humanitarian emergencies around the world in 2008.

$1 billion could also go a long way to feed the hungry. Oxfam America reports on its Web site that "$1,000 brings potable water to 22 families in the Rift Valley of Ethiopia," and that "$20 buys enough maize to feed a family of four" there for six months—enough food and water to feed millions and flood the valley.

The Director General in Geneva renovated his office this year, though the U.N. would not say how much the changes cost and did not specify whether a member state paid for the work. A spokeswoman said that his office was often overheated by the sun, and he had an air conditioner installed to cool it.

As the United States is responsible for 22% of the U.N.'s budget, it is entirely reasonable to expect that the U.S. taxpayer would be responsible for at least $220 million in the renovations of the U.N.'s Geneva offices.

Any major work on the Palais de Nations would likely come after the $1.9 billion renovation of the U.N.'s New York headquarters is complete, which is at least 4 years away barring further delays. The director general's figure of one billion dollars isn't on the U.N. budget yet and is an estimate that would have to be evaluated by a team of architects.

Largest money grab in U.N. history while ignoring reforms

Despite these and the dozens of other examples of U.N. mismanagement and fraud and exhortation by the U.N.'s largest donor, the United States, the U.N. refuses to stop wasting U.S. taxpayer dollars. Instead, the U.N. is receiving even increasing amounts of new funding from the U.S. and other donors.

According to the State Department, the U.N. 2008/2009 biennial budget represents the largest increase for a funding request in the U.N.'s history.

The 2008/2009 UN budget is in excess of $5.2 billion. This represents a 25% jump from the 2006/2007 budget that was only $4.17 billion and a 193% increase from the 1998/1999 budget.

The overwhelming majority of the U.N. budget goes to staff salaries and common staff costs including travel to resorts to discuss global warming—rather than direct humanitarian assistance or conflict prevention.

The U.N. has never identified offsets in existing funding in order to pay for new U.N. spending, a position that is supported by a U.N. General Assembly resolution.

Following the U.N. Secretariat's poor example, the ¾ of the U.N. not covered by the U.N. budget have experienced massive budget growth due to a complete inability to control spending. Peacekeeping is growing by 40%, the U.N. tribunals by 15% and numerous other Funds and Programs are no better off.

The State Department is willfully ignoring the law in reporting transparency on U.S. contributions to the United Nations

The U.S. taxpayer should not give billions in funding to the United Nations and then be refused basic information about that contribution. The Office of Management and Budget and the State Department are willfully ignoring the law regarding congressional reporting requirements for U.N. contributions.

In the National Defense Authorization Act of 2007 and the National Defense Authorization Act of 2010, the Director of the Office of Management and Budget (OMB) is now required by law to report annually to Congress the total cash and in-kind contributions to the U.N. from the United States. OMB has passed this responsibility to the State Department, and unfortunately, our lead agency on U.N. matters ignored this law in 2007, and when it finally provided the required funding reports in 2008, it appears that the reports are missing over $1 billion worth of funding information. The State Department has not submitted its report for 2008.

Ranking Member Ileana Ros-Lehtinen of House Foreign Affairs Committee comments on the U.N. lobbying for more contributions from the U.S.

"Last year, American taxpayers ponied up nearly $5 billion for the UN system. The U.S. is by far the world's largest donor to the UN. The U.S. provides other assistance for peacekeeping operations. The U.S. responds to emergency appeals. We are always on deck.

"Yet, the head of the UN comes to Congress and scolds us for not doing enough? He demands yet more money from us while making little progress in cleaning up the badly-broken UN?

"The UN's ineffectiveness is not from a lack of cash, but the result of a corrupt system which wastes money and apologizes for dictatorships.

"The UN has been hijacked by a rogues' gallery that uses our funds to undermine peace and security. Dictatorships use the Human Rights Council and Durban 2 conference process to restrict universal freedoms and protect extremists. The UN Relief and Works Agency (UNRWA) aid violent Islamists and partners with money-laundering banks under U.S. sanctions or under U.S. investigation for financing Islamist militants. The UN Development Program (UNDP) pays the legal fees of its corrupt officials but refuses to protect whistleblowers.

"While Iran, Syria, and North Korea endanger the entire world, the UN is preoccupied with condemning democratic states like the U.S. and Israel.

"The American people are facing serious economic challenges here at home. How can a morally bankrupt UN ask our taxpayers to bail them out?"

Mr. COBURN. Mr. President, I will finish and give the chairman the last word. What the chairman and his committee are attempting to do is honorable. It is the right thing to do to help our veterans and to secure and help those who are helping our veterans. I agree. However, I don't agree that we ought to do that on the backs of our children. I think we ought to do it on our backs. We ought to carry that load. Our children and our grandchildren should not have to carry that load. We ought to be forced to make the sacrifices to pay for the sacrifices they have made for us. This bill does not do that.

This bill takes the easy route. It says you do not have to pay for it, it is not required. There is not anything we can get rid of, after I offered all these options to the committee in terms of what they could get rid of that would pay for it.

If we don't pay for it from what I offered, then get rid of our own earmarks, the things that make us look good. We chose to keep our earmarks and charge it to our grandkids. It is a wonderful choice and a wonderful thing for the American people to see.

On this vote, they are going to see three things. They are going to see all the people who voted to keep their earmarks vote against this amendment. The first thing they are going to say is: My earmarks are more important than paying for veterans, caregivers, and everything else expanded in this bill.

The second thing they are going to see is that we do not have the courage to take on fraud, waste and abuse and lack of transparency at the United Nations. They are going to see us fail to live up to the expectations they have for us.

Everybody in America knows we are in trouble financially. They know the Federal Government is too big. They know the Federal Government is inefficient. They know we can do better. They are just wondering when we are going to start. When will it start? When will be the first time we make a hard choice? I regret it is not going to be on this bill because it is symbolic. If there ever was a bill on which we should start to make the hard choices, it should be on a bill that honors and takes care of the people who have made hard choices for us, the people who have sacrificed their lives and their future and their families for us.

The third thing, regrettably, that they are going to see is that we are going to continue to play the game the way it has been played: Get the votes to defeat the amendment; we will take a little bit of heat; maybe somebody will notice. I will guarantee you, 20 years from now, our kids are going to notice, our grandkids are going to notice.

One final thought. If you are under 25 in this country, pay attention to me right now. If you are under 25—there are 103 million of you. Twenty years from now, you and your children will each be responsible for $1,919,000 worth of debt of this country for which you will have gotten no benefit—none. The cost to carry that will be about $70,000. That is not per family, that is per individual. The cost to carry that will be about $70,000 a year before you pay your first tax.

Ask yourself if you think we are doing a good job when we are going to take away your ability to get a college education, we are going to take away your ability to educate your children, when we are going to take away your ability to own a home, and we are going to take away your ability to have the capital formation to create

jobs in this country. Watch and see. That number is going to grow every time we do something like this without paying for it, without offsets, without getting rid of something less important.

I yield back the time and yield the remainder of my time to the chairman of the committee.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make a point of clarification. This bill, the pending measure, is made up of two bills which is now S. 1963. It was S. 252, which was reported in July, and S. 801, which was reported in mid-October. Both bills were held at the time they went onto the calendar. No amendment was prepared to either bill. The first amendment was proposed on Monday of this week, 2 weeks after the bills were combined as S. 1963.

In closing, the debate about the United Nations is not one which belongs on a veterans bill. The underlying bill is a bipartisan approach to some of the most urgent issues facing all veterans—for women veterans, for homeless veterans, to help with quality issues, to help rural veterans.

This bill, by the way, also includes construction authorization for six major VA construction projects already funded by the VA spending bill.

I urge our colleagues to reject the amendment to S. 1963.

Mr. AKAKA. I yield back my time.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. FRANKEN). The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. LEAHY. I thank the Chair.

EXECUTIVE SESSION

NOMINATION OF DAVID F. HAMILTON TO BE UNITED STATES CIRCUIT JUDGE FOR THE SEVENTH CIRCUIT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to resume consideration of the following nomination, which the clerk will report.

The bill clerk read the nomination of David F. Hamilton, of Indiana, to be United States Circuit Judge for the Seventh Circuit.

Mr. LEAHY. Mr. President, is there a division of time in this matter?

The PRESIDING OFFICER. The time until 2:30 is equally divided.

Mr. LEAHY. Mr. President, I yield myself 10 minutes.

Mr. LEAHY. Mr. President, the Senate is concluding its long-delayed consideration of the nomination of Judge David Hamilton of Indiana to the Seventh Circuit. Early this week, 70 Senators—Democrats, Independents and Republicans—joined together to overcome a filibuster of this nomination. This has been a record year for filibusters by the Republican minority: filibusters of needed legislation, filibusters of executive nominations and filibusters of judicial nominations, which just a few years ago they proclaimed were ''unconstitutional.'' Although their filibuster failed, what they achieved was obstruction and delay. This is a nomination that has been stalled on the Senate Executive Calendar for 5½ months, since June 4. In the days since that bipartisan majority of 70 Senators voted to bring to an end the debate on the Hamilton nomination, and in the more than 30 hours of possible debate time since then, Republican Senators have devoted barely one hour to the Hamilton nomination. Only four Republican Senators have spoken at all and that includes the Senator from Alabama who repeated the claims he had made five times to the Senate since September 17.

As has been reported since the nomination was made in mid-March, President Obama's selection of Judge Hamilton as his first judicial nominee was intended to send a message of bipartisanship. President Obama reached out and consulted with both home State Senators, Senator LUGAR and Senator BAYH, a Republican and a Democrat, in making his selection. This stands in sharp contrast to the methods of his predecessor, who was focused on a narrow ideological effort to pack the Federal courts, often did not consult, and too often tried to force extreme candidates through the Senate. That is what led to filibusters—that and Senate Republicans changing of the rules, procedures and protocols of the Senate.

The nomination of Judge Hamilton is an example of that consultation. Other examples are the recently confirmed nominees to vacancies in South Dakota, who were supported by Senator THUNE, and the nominee confirmed to a vacancy in Florida, supported by Senators MARTINEZ and LEMIEUX. Still others are the President's nomination to the Eleventh Circuit from Georgia, supported by Senators ISAKSON and CHAMBLISS, his recent nominations to the Fourth Circuit from North Carolina, which I expect will be supported by Senator BURR, and the recent nomination to a vacancy in Alabama supported by Senators SHELBY and SESSIONS on which the Judiciary Committee held a hearing 2 weeks ago.

President Obama has respected the Senate's constitutional advice and consent role by engaging in meaningful consultation in making his judicial nominations. He has consulted with home State Senators from both sides of the aisle. This stands in sharp contrast to the methods of his predecessor, who was focused on a narrow ideological effort to pack the Federal courts, often did not consult, and too often tried to force extreme candidates through the Senate. That is what led to filibusters that and Senate Republicans changing of the rules, procedures and protocols of the Senate. In today's Washington Post, columnist E.J. Dionne writes about this occurrence and yesterday's failed attempt at a filibuster. I will ask that a copy of this column be printed in the RECORD.

Yet despite that consultation and the support and endorsement of the senior Republican in the Senate, Senator LUGAR, Republicans have filibustered and now oppose this nomination. Their response to President Obama's outreach and seeking to turn the page and set a new tone in judicial nominations by restoring comity is to attack his well qualified nominees and stall Senate action. In May, just before Judge Hamilton's nomination was reported by the committee, a senior Republican Senator reflected upon the Senate confirmation process for judicial nominees and correctly observed: ''[C]harges come flying in from right and left that are unsupported and false. It's very, very difficult for a nominee to push back. So I think we have a high responsibility to base any criticism that we have on a fair and honest statement of the facts and that nominees should not be subjected to distortions of their record.'' I agree.

Regrettably, however, that is not how Republican Senators have acted. Judge Andre Davis of Maryland, a distinguished African-American judge, was stereotyped as ''anti-law enforcement'' last week by Republican critics, and this week Judge Hamilton, the son of a Methodist minister, is reviled as hostile to Christianity. That is not fair treatment.

The unfair distortions of Judge Hamilton's record by right-wing special interest groups seeking to vilify him have been repeated in editorials in the Washington Times and by Republican opponents in the Senate. They resort to twisting and contorting his judicial record and his views, and ignore the record before the Senate. Those distortions of Judge Hamilton's record were soundly refuted earlier this week by the senior Senator from Indiana, Senator LUGAR. I doubt that I will add to his sound and thoroughgoing rebuttal. Judge Hamilton's critics are wrong and have been wrong all along.

Senator LUGAR and Senator BAYH believe Judge Hamilton is superbly qualified and a mainstream jurist. I agree. Yet Republican critics of Judge Hamilton are determined to ignore the knowledge and endorsement of these home State Senators as well as Judge Hamilton's long, mainstream record on the bench to paint an unfair caricature of him. They are wrong to ignore Judge

Hamilton's record of fairly applying the law in over 8,000 cases and his ''well qualified'' rating by the American Bar Association. These critics ignore Judge Hamilton's testimony before the committee when he said, ''I make decisions based on the facts and applicable law of each case.'' They ignore his statement that ''sympathy for one side or another'' in a case ''has no role in the process'' of judging. Instead, they construct and then seek to impose their own ''litmus tests'' and contort his record and statements in their ends-oriented effort to find him wanting.

Republican Senators did not object when Chief Justice Roberts testified at his confirmation hearing that ''of course, we all bring our life experiences to the bench.'' Republican Senators did not criticize Justice Alito at his confirmation hearings in 2006 for describing the importance of his background when evaluating discrimination cases. Justice Alito said: ''When I get a case about discrimination, I have to think about people in my own family who suffered discrimination because of their ethnic background or because of religion or because of gender. And I do take that into account.''

I recall one nominee who spoke during his confirmation hearing of his personal struggle to overcome obstacles. He made a point of describing his life as:

> [O]ne that required me to at some point touch on virtually every aspect, every level of our country, from people who couldn't read and write to people who were extremely literate, from people who had no money to people who were very wealthy. So, what I bring to this Court, I believe, is an understanding and the ability to stand in the shoes of other people across a broad spectrum of this country.

That is the definition of empathy. And that nominee was Clarence Thomas. Indeed, when President George H.W. Bush nominated Justice Thomas to the Supreme Court he touted him as, ''a delightful and warm, intelligent person who has great empathy and a wonderful sense of humor.'' Justice O'Connor, who had a long and distinguished record of evenhandedness on the Supreme Court, explained recently: ''You do have to have an understanding of how some rule you make will apply to people in the real world. I think that there should be an awareness of the real-world consequences of the principles of the law you apply.''

Yet now Republican Senators seek to apply a newly constructed ''litmus test'' that rejects what they had previously viewed as positive attributes as disqualifying. Their opposition to President Obama is so virulent that they act as if they must oppose anything he supports. If he sees value in judges with real world perspectives who consider the real impact of various readings of the law on everyday Americans, they must react in knee jerk opposition. They use a distorted lens to review a 15-year judicial record in which he has not substituted empathy for the law to somehow conclude that he will if confirmed to the new appointment. It is reminiscent of the Salem witch trials. They see what they want to see.

Senator LUGAR noted this week that the President of the Indiana Federalist Society endorsed Judge Hamilton as an ''excellent jurist and first-rate intellect'' with a judicial philosophy ''well within the mainstream.'' Senator LUGAR's own review of his record, with help from a former Reagan counsel, led him to conclude based on that record that ''Judge Hamilton has not been a judicial activist and has ruled objectively and within the judicial mainstream.'' Senator BAYH reinforced that conclusion with his statements in support of the nomination.

Republican critics are slavishly channeling the talking points of far right narrow special interest groups to twist a handful of the Judge Hamilton's 8,000 cases to make biased and unfair attacks on the character and record of a moderate judge and a good man. For example, they have misrepresented two of his cases, Hinrichs v. Bosma, 2005, and Grossbaum v. Indianapolis-Marion County Bldg. Authority, 1994, to falsely describe Judge Hamilton, the son of a Methodist minister, as hostile to religion, and to Christianity in particular. In fact, these cases show nothing more than that Judge Hamilton has consistently and objectively performed his duty as a judge to apply the law carefully to the case before him.

In Hinrichs v. Bosma, Judge Hamilton did not eliminate prayer, as some critics have charged. In fact, his narrow and carefully considered ruling was that the Indiana Legislature may begin its sessions with any nondenominational, nonsectarian prayers—prayers that do not advance a particular faith. He noted that those prayers ''must be non-sectarian and must not be used to proselytize or advance any one faith or belief or to disparage any other faith or belief.'' Prayers from any religion—be they Christian, Jewish, Muslim or from another religion—that advance a particular faith were not permissible.

The plaintiffs in Hinrichs had challenged the Christian orientation of most of the prayers delivered during the 2005 Indiana House session. So, as part of his analysis, Judge Hamilton reviewed the 45 available transcripts of the 53 opening prayers that were offered during that session. He relied on undisputed testimony of scholars and clerics of different faiths who themselves concluded that ''many of the legislative prayers delivered during the 2005 House session were sectarian, Christian in orientation, and sent a strong message of non-inclusion to those who are not Christian.'' His careful ruling did not depart from settled precedent. It followed the settled law from the Supreme Court and in the Seventh Circuit interpreting the establishment clause of the first amendment of the Constitution.

The critics of Judge Hamilton who have made much of the fact that Judge Hamilton's decision was overturned by the Seventh Circuit ignore the fact that it was overturned only on the technical issue of standing, not on the merits of Judge Hamilton's opinion. In fact, even on this narrow technical point the Seventh Circuit initially upheld Judge Hamilton's 2005 decision that taxpayers had standing to sue the Indiana House of Representatives, challenging the practice of offering sectarian prayers at the beginning of sessions as a violation of establishment clause. The Seventh Circuit only reversed Judge Hamilton on this technical threshold question after the Supreme Court handed down an intervening 2007 decision, Hein v. Freedom from Religion Foundation, 2007, was issued after Judge Hamilton's decision was on appeal. In doing so, the Seventh Circuit acknowledged that it also was reversing its own previous decision in the case that affirmed Judge Hamilton's ruling that plaintiffs had standing.

These same critics have gone so far as to claim that Judge Hamilton favors Muslim prayers to Christian ones by allowing prayers to Allah, while forbidding prayers to Jesus Christ. This slur led to a Washington Times editorial denouncing the nomination. As Judge Hamilton explained in a ruling on a post-trial motion in Hinrichs, closely following Supreme Court precedent from Marsh v. Chambers, 1983, the mere use of the word for ''God'' in another language, such as the ''Arabic Allah, the Spanish Dios, the German Gott, the French Dieu, the Swedish Gud, the Greek Theos, the Hebrew Elohim, the Italian Dio'' does not make a prayer sectarian, because it does not ''advance a particular religion or disparage others.'' However, as Judge Hamilton testified in response to a question from Senator GRAHAM, under the reasoning of his ruling in Hinrichs, ''a prayer asserting that Mohammed was God's prophet would ordinarily be considered a sectarian Muslim prayer'' and impermissible.

Senators who charge that Judge Hamilton's ruling allows Muslim prayers whole forbidding Christian ones have either not read the case or choose to ignore what it says. Judge Hamilton's analysis of the 53 opening prayers that were offered in the Indiana House during the 2005 legislative session, found that all but one were delivered by Christian ministers or ministers identified with Christian churches. He noted that the one prayer that was not, which was delivered by a Muslim man, unlike the vast majority of the prayers from Christian clergy, was ''inclusive

and was not identifiable as distinctly Muslim from its content.''

Judge Hamilton also faithfully applied binding precedent when deciding Grossbaum. In that case, Judge Hamilton correctly relied on then-current Supreme Court and Seventh Circuit precedent interpreting the free speech clause of the first amendment to reach his decision that the Indianapolis building authority acted lawfully in refusing to allow a rabbi to display a menorah in the lobby of the city-county building. His decision relied on a 1990 Seventh Circuit decision, Lubavitch Chabad House, Inc. v. City of Chicago, which upheld a decision by the city of Chicago to put a Christmas tree in the O'Hare Airport and, at the same time, to exclude private displays of religious symbols.

As with Hinrichs, right wing critics point to the Seventh Circuit's reversal of Judge Hamilton's decision to argue that he got it wrong and did not apply the law. What this account leaves out is that the Supreme Court case relied on by the Seventh Circuit to reverse Judge Hamilton did not come down until 1995, after Judge Hamilton issued his decision in Grossbaum. In reversing Judge Hamilton's decision, the Seventh Circuit specifically noted that Judge Hamilton acted without benefit of the Supreme Court's new guidance in this area provided by Rosenberger v. Rector & Visitors of the University of Virginia, 1995.

Had Judge Hamilton ignored the binding precedent in certain religion cases to make his decision based on personal beliefs and not the law, he would have been an activist going beyond his role as a district judge. As I read these cases, I had in mind the words of Senator LUGAR who said when he testified in support of Judge Hamilton:

> I have known David since his childhood. His father, Reverend Richard Hamilton, was our family's pastor at St. Luke's United Methodist Church in Indianapolis, where his mother was the soloist in the choir. Knowing first-hand his family's character and commitment to service, it has been no surprise to me that David's life has borne witness to the values learned in his youth.

Senator LUGAR knows Judge Hamilton's character. And the cases critics would use to savage it show nothing more than that Judge Hamilton understands, again in Senator LUGAR's words, ''the vitally limited, role of the Federal judiciary faithfully to interpret and apply our laws, rather than seeking to impose their own policy views.''

Critics have similarly twisted and disparaged Judge Hamilton's record on reproductive rights to paint him as an agenda-driven ideologue by pointing to a single case, A Woman's Choice v. Newman, 1995, even though in that case he carefully applied Supreme Court precedent.

In A Woman's Choice, Judge Hamilton blocked enforcement of part of an Indiana abortion law that required pregnant women to make two trips to a clinic before having an abortion. Judge Hamilton applied the law set forth by the Supreme Court in Planned Parenthood v. Casey, 1992, and, after carefully examining the facts, concluded that many Indiana women would not be able to make a second trip to a hospital or a clinic. Therefore, under the standard in Casey—the standard that Chief Justice Roberts and Justice Alito pledged to follow as binding precedent when nominees before the Judiciary Committee—Judge Hamilton concluded that the law undermined a woman's constitutionally protected right to choose.

Critics have seized on a split decision from the Seventh Circuit reversing Judge Hamilton's decision to grant a pre-enforcement injunction of the informed consent provision to mischaracterize his decisions in that case as activist. However, in reversing Judge Hamilton on the injunction, noted conservative icon Judge Easterbrook was criticized by another judge on the panel for ''disregard[ing] the standards that were established by the Supreme Court in [Casey]'' and was criticized for ''brush[ing] aside the painstakingly careful findings of fact'' that Judge Hamilton made. Even the concurring opinion recognized that Judge Easterbrook's opinion embraced dissenting opinions in other cases. Critics have also seized on a falsehood that Judge Hamilton blocked enforcement of the law for seven years, ignoring his modification of the initial injunction to permit Indiana to enforce most of its informed consent law after the Indiana Supreme Court ruled on a State law question of first impression that Judge Hamilton had certified so that he could be guided by the State's highest court on a question of State law, and ignoring Indiana's choice not to appeal Judge Hamilton's timely-issued decisions on the injunction until after trial, which Indiana had asked Judge Hamilton to postpone. Judge Hamilton's decisions in that case show that he was a careful judge showing appropriate deference to Indiana when addressing a matter of first impression in that State, not an ideologue or an activist.

Senators painting a false picture of Judge Hamilton's record have also cherry-picked his long record on the bench of handling criminal cases to focus on one or two cases they assert show that he is too lenient on criminals. Like the other charges against Judge Hamilton, this does not hold up to scrutiny. In his 15 years on the bench, the government has appealed only 2 of the approximately 700 criminal sentences Judge Hamilton has handed down. Judge Hamilton's critics ignore cases like U.S. v. Turner, 2006, in which Judge Hamilton sentenced a child pornographer to 100 years in prison. They ignore U.S. v. Clarke, 1999, in which Judge Hamilton sentenced a defendant to 151 months on three counts of drug distribution and an additional 60 months on a firearm charge, denying the defendant's motion for a reduced sentence citing the defendant's ''dangerous role in the distribution network.'' They ignore cases like U.S. v. Garrido-Ortega, 2002, in which Judge Hamilton sentenced a defendant to 70 months imprisonment for possession of counterfeit alien registration receipt cards and for being found in the United States as an alien previously deported after conviction, then denied the defendant's motion for reconsideration of sentence. They ignore decisions like U.S. v. Steele, 2009, U.S. v. Hagerman, 2007, and U.S. v. Ellis, 2007, in which Judge Hamilton imposed heavy sentences for drug dealing, obstruction of justice and for tax evasion. This charge against Judge Hamilton simply does not hold up.

Finally, we have heard repeatedly the falsehood that Judge Hamilton is an activist judge who will try to amend the Constitution through ''footnotes.'' However, Judge Hamilton testified in response to written questions from Senators that he believes that ''judges do not 'add' footnotes to the Constitution'' and that ''constitutional decisions must always stay grounded in the Constitution itself.''

In response to Senator SESSIONS, Senator GRASSLEY and others, Judge Hamilton wrote:

> The phrase ''footnotes to the Constitution,'' described by my late colleague Judge S. Hugh Dillin, refers to the case law interpreting the Constitution. By that phrase, I believe he meant that the general provisions of the Constitution take on their life and meaning in their application to specific cases, that the case law is not the Constitution itself, and that constitutional decisions must always stay grounded in the Constitution itself. In my view, judges do not ''add'' footnotes to the Constitution itself. They apply the Constitution to the facts of the particular case and add to the body.

Further, in response to another question from Senator SESSIONS, Judge Hamilton testified: ''I have not added footnotes to the Constitution. I believe the constitutional decisions I have made have been consistent with the express language and original intent of the Founding Fathers.'' I am hard-pressed to understand why Senators would ask such questions if they do not consider the nominee's clear answers.

I hope that Senators now considering whether to support this well-qualified mainstream nominee resist the partisan effort to build a straw man out of one or two opinions in a 15-year record on the bench. I hope they do not allow right wing talking points to overshadow Judge Hamilton's long and distinguished record on the bench. Instead, I urge Senators to heed the advice of Senator LUGAR who urged that ''confirmation decisions should not be

based on partisan considerations, much less on how we hope or predict a given judicial nominee will 'vote' on particular issues of public moment or controversy.''

This is a nomination that should be confirmed and should have been confirmed months ago. David Hamilton is a fine judge and will make a good addition to the United States Court of Appeals for the Seventh Circuit.

Mr. President, I ask unanimous consent to have a copy of the Washington Post article to which I referred printed in the RECORD.

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

[From the Washington Post, Nov. 19, 2009]

THE GOP'S NO-EXIT STRATEGY

(By E.J. Dionne, Jr.)

Normal human beings—let's call them real Americans—cannot understand why, 10 months after President Obama's inauguration, Congress is still tied down in a procedural torture chamber trying to pass the health-care bill Obama promised in his campaign.

Last year, the voters gave him the largest popular-vote margin won by a presidential candidate in 20 years. They gave Democrats their largest Senate majority since 1976 and their largest House majority since 1992.

Obama didn't just offer bromides about hope and change. He made specific pledges. You'd think that the newly empowered Democrats would want to deliver quickly.

But what do real Americans see? On health care, they read about this or that Democratic senator prepared to bring action to a screeching halt out of displeasure with some aspect of the proposal. They first hear that a bill will pass by Thanksgiving and then learn it might not get a final vote until after the new year.

Is it any wonder that Congress has miserable approval ratings? Is it surprising that independents, who want their government to solve a few problems, are becoming impatient with the current majority?

Democrats in the Senate—the House is not the problem—need to have a long chat with themselves and decide whether they want to engage in an act of collective suicide.

But it's also time to start paying attention to how Republicans, with Machiavellian brilliance, have hit upon what might be called the Beltway-at-Rush-Hour Strategy, aimed at snarling legislative traffic to a standstill so Democrats have no hope of reaching the next exit.

We know what happens when drivers just sit there when they're supposed to be moving. They get grumpy, irascible and start turning on each other, which is exactly what the Democrats are doing.

Republicans know one other thing: Practically nobody is noticing their delay-to-kill strategy. Who wants to discuss legislative procedure when there's so much fun and profit in psychoanalyzing Sarah Palin?

Yet there was a small break in the Curtain of Obstruction this week when Republican senators unashamedly ate every word they had spoken when George W. Bush was in power about the horrors of filibustering nominees for federal judgeships. On Tuesday, a majority of Republicans tried to block a vote on the appointment of David F. Hamilton, a rather moderate jurist, to a federal appeals court.

Sen. Jeff Sessions of Alabama explained the GOP's about-face by saying: ''I think the rules have changed.''

That was actually a helpful comment, because the Republicans have changed the rules on Senate action up and down the line. Hamilton's case is just the one instance that finally got a little play.

Thankfully, this filibuster failed because some Republicans were embarrassed by it. But Republican delaying tactics have made Obama far too wary about judicial nominations for fear of controversy. He is well behind his predecessor in filling vacancies, a shameful capitulation to obstruction. There's also the fact that the nomination of Christopher Schroeder as head of the Justice Department's Office of Legal Policy, which helps to vet judges, is snarled—guess where?—in the Senate.

Republicans are using the filibuster to stall action even on bills that most of them support. Remember: The rule is to keep Democrats from ever reaching the exit.

As of last Monday, the Senate majority had filed 58 cloture motions requiring 32 recorded votes. One of the more outrageous cases involved an extension in unemployment benefits, a no-brainer in light of the dismal economy. The bill ultimately cleared the Senate this month by 98 to 0.

The vote came only after the Republicans launched three filibusters against the bill and tried to lard it with unrelated amendments, delaying passage by nearly a month. And you wonder why it's so hard to pass health care?

Defenders of the Senate always say the Founders envisioned it as a deliberative body that would cool the passions of the House. But Sessions unintentionally blew the whistle on how what's happening now has nothing to do with the Founders' design.

The rules have changed. The extra-constitutional filibuster is being used by the minority, with extraordinary success, to make the majority look foolish, ineffectual and incompetent. By using Republican obstructionism as a vehicle for forcing through their own narrow agendas, supposedly moderate Democratic senators will only make themselves complicit in this humiliation.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, we moved three judges through committee today, and I think, all in all, Senator LEAHY is working us to death. But we are making some progress.

I would note for the record, if anybody would like to know, there are 21 circuit vacancies for circuit courts in America. The President has nominated 10 people for those vacancies. There are 76 district court vacancies, and as of November 16 the President has nominated 10. He has more vacancies than President Bush had at this time and he has nominated fewer people. But a lot of things are happening. They will catch up. You have to do backgrounds on nominees, and they should not just throw up names for the sake of throwing up names.

Most of his nominations are receiving bipartisan support. Unfortunately, I have not been able to support Judge Hamilton, and I would like to explain a few of the things that concern me, particularly about his judicial philosophy and about his rulings. I think they are significant. I wish they weren't. He is not a bad person, but a lot of people in America today have a philosophy that I think is not appropriate for the Federal bench.

In Hinrichs v. Bosma, Judge Hamilton enjoined or issued an order prohibiting the speaker of the Indiana House of Representatives, the duly elected speaker, from allowing a sectarian prayer, as he described it, because some of those prayers had mentioned Jesus Christ and therefore ''might advance a particular religion, contrary to the mandates of the Constitution.''

Judge Hamilton also ordered the speaker to make sure to advise any officiant who is delivering a prayer that a prayer must be nonsectarian, must not advance any one faith or disparage another, and must not use ''Christ's name or title or any other denominational appeal.''

I note parenthetically that every day we have a paid chaplain who commences the Senate with a prayer. Heaven knows we need it. Hopefully we recognize we need it. I notice the words up there on the wall, ''In God We Trust,'' haven't been chiseled out by the secularists as of this date. We are a nation that believes in freedom of religion, and the Constitution says Congress shall make no law respecting the establishment of a religion or prohibiting the free exercise thereof. We have ceased to balance that out, in my opinion, in some of these matters.

So he made that ruling and that injunction to the speaker. In a later ruling denying the speaker's request to stay this injunction, Judge Hamilton produced a novel notion that prayers in the name of Jesus would be sectarian and, therefore, prohibited, but prayers in the name of Allah would not be sectarian and, therefore, would be allowed. They had an Islamic imam pray there in Indiana.

This is what Judge Hamilton wrote:

> Prayers are sectarian in the Christian tradition when they proclaim or otherwise communicate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Saviour, or that he was resurrected, or that he will return on Judgment Day or is otherwise divine.

He went on to say:

> If those offering prayers in the Indiana House of representatives choose to use the Arabic Allah . . . the court sees little risk that the choice of language would advance a particular religion or disparage others.

In other words, that would be OK. I find it hard to justify that position intellectually, frankly. I am not saying he is anti-religion. I am saying this judge's approach to the law is confused about an important legal question involving religion.

The Seventh Circuit reversed Judge Hamilton, finding that the taxpayers lacked standing to bring the lawsuit in the first place. The court of appeals did not reach the merits of the case, but

the question naturally arises: Why did Judge Hamilton skip over the very basic preliminary legal issue of standing and instead move directly to the merits of the case, if the standing didn't exist? I submit he perhaps desired to rule on the merits because he favored the outcome he produced.

In A Woman's Choice v. Newman, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for 7 years, an Indiana law. In 1995, the Indiana Legislature enacted a statute that required certain medical information to be provided to women seeking an abortion at least 18 hours prior to the procedure. The Supreme Court, in Planned Parenthood v. Casey, a very important case, had already held very similar requirements were constitutional and did not restrict the right to an abortion. It just required that the information provided to you 18 hours in advance. Notwithstanding the Supreme Court precedent, Judge Hamilton granted a preliminary injunction against enforcement of the law. In other words, he stopped the law from going into effect. He assumed the role of a legislator. He took out his judicial pen and struck some of the language from the statute, language he didn't like.

The statute required that women receive this information in person, not through some third person. Judge Hamilton modified the injunction so as to prevent the State from enforcing the requirement that the information be provided ''in the presence of'' the pregnant woman. He later entered a permanent injunction that prohibited enforcement of the law, in essence vetoing the law.

Finally, the case reached the Seventh Circuit. In an opinion by Judge Easterbrook, the court reversed, concluding that Judge Hamilton had abused his discretion. A Federal judge with a lifetime appointment has power over the States. If he says the Constitution is violated by what a State does, the judge has the power to invalidate what the State does. But this is an awesome power and ought to be used carefully. When this case reached the Seventh Circuit, this is what the opinion said:

> [F]or 7 years, Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the fifth circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey . . . Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own consequences.

If it is a bad law, the people would change it. They have the power to do so.

I suggest that is a pretty stark criticism and a very serious one. One single judge has frustrated a law that was constitutional for 7 years.

In U.S. v. Woolsey, Judge Hamilton disregarded a defendant's prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence of life imprisonment for persons convicted of a third felony drug offense. Here the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 pounds of methamphetamine—and that is a lot of methamphetamine—a cache of guns, and $16,000 in currency. Because the defendant had two prior felony drug convictions, the defendant was subject to recidivism penalties under Federal law. Judge Hamilton was reversed because he ignored one of those prior convictions, reversed unanimously by the circuit court on which he now wants to sit.

This is what they said about his willfulness:

> [W]e have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court deemed them unwise or an inappropriate response to repeat drug offenders.

They were saying: Judge, you have been letting your own personal views override what you are required to do by the law. You are a judge. You are supposed to follow the law. The oath you take is to serve under the Constitution and the laws of the United States. You are not above it.

The opinion makes clear that Judge Hamilton either made several unnecessary errors or intentionally ignored the law.

In Grossbaum v. Indianapolis-Marion County Building Authority, Judge Hamilton denied a request by a rabbi to place a menorah in a county building. A unanimous panel of the Seventh Circuit reversed Judge Hamilton's ruling, noting that two Supreme Court cases were directly on point.

For 8 years the plaintiff in this case had been able to display a menorah during Chanukah until the ACLU challenged the display as violative of the first amendment. Because of the ACLU's challenge in 1993, Marion County unanimously adopted a ''policy on seasonal displays.'' They set up a policy to try to make everybody happy. It was done to try to keep the courts happy by preventing a menorah from being displayed.

In 1994, when the plaintiffs submitted a request to display the menorah, they were denied.

Mr. President, I know my time is up, and I ask unanimous consent for 1 additional minute.

Mr. LEAHY. Provided there is another minute on this side.

Mr. SESSIONS. I understand.

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

Mr. SESSIONS. Mr. President, there are other matters that I don't have time to go into in detail. Any nominee is entitled to a fair hearing. They ought not have their record distorted. As the Senator said, people can make mistakes sometimes. But I think the pattern is such that it indicates to me there are extraordinary circumstances that justify an objection to the nomination because the nominee has shown a willfulness to override the law. A judge must be under the law.

I offer the following more detailed explanation to try to go into even more detail and to fairly analyze the judge's rulings and why I think they are unacceptable.

There have been some accusations that we have mischaracterized Judge Hamilton's record, and, specifically, some of his cases. I would like to take just a few moments to explain why I am concerned about Judge Hamilton's judicial philosophy and demonstrate how we have not mischaracterized his rulings.

In *Hinrichs* v. *Bosma,* 400 F. Supp. 2d 1103, S.D. Ind. 2005, the Indiana ACLU, representing some taxpayers, brought suit against the Speaker of the Indiana House of Representatives claiming that ''most'' of the prayers that opened legislative sessions were sectarian Christian prayers in violation of the first amendment. Although 29 out of 45 of the prayers for which there were transcripts were Christian, many prayers were offered by state legislators, a rabbi, and a Muslim imam.

Nevertheless, Judge Hamilton enjoined the speaker from allowing sectarian prayers because some of them mentioned Jesus Christ and therefore might ''advance a particular religion, contrary to the mandate of the Establishment Clause.'' Judge Hamilton also ordered the speaker to advise any officiant that a prayer must be nonsectarian, must not advance any one faith or disparage another, and must not use ''Christ's name or title or any other denominational appeal.''

In so holding, Judge Hamilton relied on what I think is a flawed reading of the Supreme Court's decision in *Marsh* v. *Chambers*, 463 U.S. 783, 1983, which held that a legislative body may open its session with a prayer, much like we do here in the Senate every day. Judge Hamilton said that the *Marsh* case did not expressly permit prayers that were ''explicitly Christian or explicitly Jewish.'' But the Supreme Court in *Marsh* said:

> The content of the prayer is not of concern to judges where . . . there is no indication that the prayer opportunity has been exploited to proselytize or advance any one, or to disparage any other, faith or belief. That being so, it is not for us to embark on a sensitive evaluation or to parse the content of a particular prayer.

Judge Hamilton ignored the Supreme Court's clear directive that the content of such prayers should not be of concern to a judge. He had no concerns about whether he would parse through

the content by dictating from the bench what constitutes sectarian prayer. In fact, in a later ruling denying the speaker's request to stay the permanent injunction, Judge Hamilton came up with the radical notion that prayers in the name of Jesus Christ would be sectarian and therefore prohibited, but prayers in the name of Allah would not be sectarian and therefore allowed. He said:

> Prayers are sectarian in the Christian tradition when they proclaim or otherwise communicate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Savior, or that he was resurrected, or that he will return on Judgment Day or is otherwise divine. . . .

He went on to say:

> If those offering prayers in the Indiana House of Representatives choose to use the Arabic Allah . . . the court sees little risk that the choice of language would advance a particular religion or disparage others.

I find it hard to believe that anyone would not associate a reference to Allah with Islam.

After full briefing and oral argument, the Seventh Circuit reversed Judge Hamilton's decision, finding that the taxpayers lacked standing to bring the lawsuit in the first place. The court of appeals did not reach the merits of the case, but the question naturally arises: Why did Judge Hamilton skip over the very basic, preliminary issue of standing and instead move directly to the merits of this case? I submit that Judge Hamilton wanted to get to the merits because he sought this particular outcome.

In *A Woman's Choice* v. *Newman*, 904 F. Supp. 1434, S.D. Ind. 1995, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for 7 years. In 1995, the Indiana legislature enacted a statute that required women seeking an abortion to receive certain medical information at least 18 hours prior to the abortion being performed. Specifically, the statute required that the women be informed of the following information:

1. The name of the physician performing the abortion.
2. The nature of the proposed procedure or treatment.
3. The risks of and alternatives to the procedure or treatment.
4. The probable gestational age of the fetus.
5. The medical risks associated with carrying the fetus to term.
6. The availability of fetal ultrasound imaging.
7. That medical assistance benefits may be available for prenatal care . . . from the county office of the division of family resources.
8. That the father of the unborn fetus is legally required to assist in the support of the child.
9. That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.

The Supreme Court in *Planned Parenthood* v. *Casey*, 505 U.S. 833, 1992, had already held that very similar requirements did not restrict the access to abortions and that is an important point here.

Despite the Casey decision, and an almost identical Seventh Circuit opinion upholding a Wisconsin statute, the plaintiffs filed a lawsuit challenging the constitutionality of the Indiana law on the grounds that it was likely to impose an undue burden on a woman's right to choose. I am not sure how knowing the name of the doctor who is performing an abortion imposes an undue burden. In support of their argument, the plaintiffs presented evidence that the law was likely to prevent abortions for approximately 11 to 14 percent of women who would otherwise choose to have them and the ''medical emergency'' exception would probably fail to meet constitutional standards as unduly narrow.

Judge Hamilton granted the plaintiffs a preliminary injunction with certified questions to the Supreme Court of Indiana concerning the interpretation of the ''medical emergency'' exception under State law.

The Indiana Supreme Court answered the certified questions and basically held that Indiana's law did not violate the Supreme Court holding in Casey. The Indiana Supreme Court concluded:

> the medical emergency provision of Public Law 187 permits dispensing with the informed consent requirements when the attending physician, in the exercise of her clinical judgment in light of all factors relevant to a woman's life or health, concludes in good-faith that medical complications in her patient's pregnancy indicate the necessity of treatment by therapeutic abortion. We add that the physician may do so with respect to serious and permanent mental health issues. A physician may not, however, dispense with the informed consent provisions as to health problems when they are temporary.

This holding by the Indiana. Supreme Court should have resolved the matter.

Notwithstanding, Judge Hamilton assumed the role of a legislator, took out his judicial pen and struck some language from the Indiana statute. The statute required that women receive this information in person. Judge Hamilton modified the preliminary injunction that he had issued so as to prevent the State from enforcing the requirement that the information be provided ''in the presence'' of the pregnant woman. Judge Hamilton later entered a permanent injunction that prohibited enforcement of the law—in essence vetoing the law.

Finally, the case reached the Seventh Circuit, which reversed Judge Hamilton's ruling. In a 2–1 opinion by Judge Easterbrook, the court concluded that Judge Hamilton abused his discretion:

> [F]or seven years Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the fifth circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey . . . Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own consequences.

In a concurring opinion, Judge Coffee concluded:

> [Judge Hamilton's opinion which was] pronounced without the support of even one citation to the record, invades the legitimate province of the legislative and executive branches and places a straitjacket upon their power to regulate and control abortion practice. As a result, literally thousands of Indiana women have undergone abortions since 1995 without having had the benefit of receiving the necessary information to ensure that their momentous choice is premised upon the wealth of information available to make a well-informed and educated life-or-death decision. I remain convinced that [Judge Hamilton] abused his discretion when depriving the sovereign State of Indiana of its lawful right to enforce the statute before us. I can only hope that the number of women in Indiana who may have been harmed by the judge's decision is but few in number.

Three different courts, including the Indiana Supreme Court, had looked at the Indiana statute and similar laws and concluded they passed constitutional muster. This apparently did not satisfy Judge Hamilton and so he ignored the precedent and ruled based on his own policy preferences.

In *United States* v. *Woolsey*, 535 F.3d 540 (7th Cir. 2008), Judge Hamilton disregarded a defendant's prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence of life imprisonment for persons convicted of a third felony drug offense. Judge Hamilton was reversed by a unanimous Seventh Circuit:

> [W]e have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court deems them unwise or an inappropriate response to repeat drug offenders.

Here, the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home, where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 pounds of methamphetamine, a cache of guns and $16,000 in currency. Because the defendant had two prior felony drug convictions in 1997 and 1974, the defendant was subject to recidivism penalties under Federal statute.

At sentencing, the government properly filed an enhancement information detailing the two prior convictions, which should have triggered a mandatory term of life imprisonment. Although the defendant conceded that his 1997 drug conviction would count for enhancement purposes, he contested the eligibility of the 1974 conviction. The defendant argued that he believed the 1974 conviction—possession with intent to distribute 125 pounds of marijuana—should have been set aside upon successful completion of his probation pursuant to the Federal Youth Corrections Act. The Federal Youth Corrections Act allows previous sentences to

be set aside in cases where there was an early discharge of probation and where the probationer had ''demonstrate[ed] good behavior to the sentencing court before the probationary period ended.''

Here, the Arizona district court that had sentenced the defendant did not grant the early discharge. The defendant claimed this was an oversight, so Judge Hamilton postponed the defendant's sentencing to give him a chance to petition the Arizona court to have the 1974 conviction cleared. According to the opinion reversing Judge Hamilton, ''the Arizona court was not inclined to grant the request.'' We know the defendant had another conviction beyond 1974, so perhaps he did not meet the good behavior requirement.

The Seventh Circuit also noted that the Federal statute:

bars any challenge to the validity of any prior conviction alleged under this section which occurred more than five years before the date of the information alleging such prior conviction . . . [The defendant] never denied the 1974 conviction, and the five-year window closed some time ago.

At sentencing, Judge Hamilton chose to disregard the 1974 conviction and not impose a life sentence. He stated:

I believe it is also appropriate under these circumstances to not count the 1974 marijuana conviction for this purpose. On that issue, with respect to both the guidelines and the [federal statute], I will say that it seems to me that there is no apparent reason in this record why the defendant should not have been discharged early as to what is the customary practice as was intended and, in essence, the Court ought to treat as having been done what should have been done under general equitable powers.

The Seventh Circuit vacated the sentence and admonished Judge Hamilton: ''[the] Indiana district court was not free to ignore Woolsey's earlier conviction. . . . as Tuten makes clear, the court that imposed a sentence under the YCA should be the one to exercise the discretion afforded by the Act.'' The court further stated:

sentencing is not the right time to collaterally attack a prior conviction unless the prior conviction was obtained in violation of the right to counsel-which [the defendant] does not suggest. . . . Accordingly, the decision to disregard [the defendant's] prior conviction in light of what the court believed 'should have been done' three decades earlier was incorrect.

I think this opinion makes it clear that Judge Hamilton either made several unnecessary errors in his ruling or intentionally ignored the rule of law because he did not like the sentence. I believe it was the latter of the two.

In *Grossbaum* v. *Indianapolis-Marion County Building Authority*, 870 F. Supp. 1450 (S.D. Ind. 1994), Judge Hamilton denied a request by a rabbi to place a menorah in a county building. A unanimous panel of the Seventh Circuit reversed Hamilton's ruling and noted that two Supreme Court cases were directly on point.

For 8 years the plaintiffs in this case had been able to display a menorah during Chanukah until the ACLU challenged the display as violative of the First Amendment. Because of the ACLU's challenge, in 1993 Marion County unanimously adopted a ''policy on seasonal displays'' that prevented the menorah from being displayed. So in 1994 when the plaintiffs submitted a request to display the menorah, their request was denied. The plaintiffs responded by filing a motion for a preliminary injunction to require the county building manager to allow them to display a menorah in the non-public-forum lobby of the building, something they had been allowed to do every holiday season between 1985 and 1992.

Judge Hamilton denied the motion, stating that the First Amendment's free speech clause did not require Marion County to allow the display and that the county was reasonable in believing the establishment clause prohibited it from doing so. He refused to apply controlling Supreme Court precedent and instead embraced what appears to be an evolving standard based on something other than the law. He said: ''[o]ne of the challenges . . . is to keep the structure of abstract analytic categories and logical tests in touch with the practical realities before the courts.''

Judge Hamilton also ruled that Marion County's policy was a permissible ''subject matter restriction'' under the first amendment, rather than prohibited ''viewpoint discrimination.'' Specifically, he decided that the county could put up its own ''secular holiday symbol,'' a Christmas tree, while excluding anyone from expressing a religious view of the holiday season. He then concluded that the county could choose to avoid the controversy that might be provoked by the display of religious symbols and that ''practical considerations'' justified his reading of the Constitution. Indeed, Judge Hamilton stated that the plaintiff's position could not be correct because, if it were, the result would be that:

every time a government [put] up a Christmas tree (or perhaps a wreath or some evergreen branches) in a ''nonpublic forum,'' that government [would have] extended an open invitation to all interested private parties to display the religious symbols of their choice in the same area. As a practical matter, that result would be dramatic.

In an opinion by Judge Ripple, the Seventh Circuit unanimously reversed. The court rejected Judge Hamilton's attempts to distinguish the case from the Supreme Court's decisions in Rosenberger and Lamb's Chapel, holding that the prohibition of the menorah's message because of its religious perspective was unconstitutional viewpoint discrimination. The court found that the county's policy:

''clearly concerns 'seasonal displays' in its government building. The policy . . . clearly is a prohibition of one type of seasonal display, namely religious displays and symbols.''

The Seventh Circuit also said:

the court's colloquy with counsel at oral argument made it quite clear that the policy challenged here was to prevent one thing: seasonal holiday displays of a religious character.

Because neutrality and equal access to the nonpublic forum lobby avoided establishment clause problems, the Seventh Circuit held the county's establishment clause defense was insufficient.

The Seventh Circuit saw very clearly what Judge Hamilton seems to have been far too distracted by ''practical realities'' to realize—that the government policy in question was based solely on the viewpoint expressed and, thus, was unconstitutional. Judge Hamilton, by all accounts, has a talented legal mind. Therefore, I can only conclude that the ''practical reality'' Judge Hamilton was so concerned with was, in fact, the result he wanted to reach.

Finally, in *United States* v. *Rinehart*, 2007 U.S. Dist. LEXIS 19498, S.D. Ind. February 2, 2007, the defendant, a police officer who filmed himself having sex with a minor and took pictures of another minor, pled guilty to two counts of producing child pornography. Although Judge Hamilton sentenced him to the mandatory minimum of 15 years in prison, he took the highly unusual step of issuing a separate written opinion ''so that it may be of assistance in the event of an application for executive clemency,'' an action that Judge Hamilton called ''appropriate.''

The defendant, a 32-year-old cop, engaged in ''consensual'' sexual relations with two young girls, ages 16 and 17. According to Judge Hamilton's opinion, the sexual relationships were legal under State and Federal law. However, the defendant took photos and videos of himself and the girls engaged in ''sexually explicit conduct'' and sexual relations. These images were found on his home computer and he was charged under the Child Protection Act of 1984.

In his written opinion, Judge Hamilton noted his disapproval of the mandatory minimum and concluded by expressly injecting his personal views into the case:

This case, involving sexual activity with victims who were 16 and 17 years old and who could and did legally consent to the sexual activity, is very different. But because of the mandatory minimum 15 year sentence required by [the Child Protection Act of 1984] this court could not impose a just sentence in this case. The only way that Rinehart's punishment could be modified to become just is through an exercise of executive clemency by the President. The court hopes that will happen.

That last sentence embodies precisely the type of activist philosophy that I have been talking about. But here, we do not need to read between the lines. We do not need to infer a

thing. Judge Hamilton laid it on in an opinion. And the opinion had the express aim of urging the executive to adopt his policy preferences. When a judge steps outside of his coinstitutional role of interpreting and applying the law as written, he undermines the entire justice system.

These are just a few of the problematic cases in Judge Hamilton's record. To date, the Seventh Circuit has been able to reverse these errors, but if he is elevated, only the Supreme Court will be able to reverse most of his errors. I am afraid the Supreme Court might not hear some of them. This body should elevate those judges who have performed admirably during lower court service, not those who have performed poorly.

I yield the floor.

Mr. CORNYN. Mr. President, I will not support Judge David Hamilton's elevation to the Court of Appeals for the Seventh Circuit. After close review, I believe Judge Hamilton's writings and statements show an unwillingness to serve as a neutral arbiter of the law.

At the time he was appointed to the district court for the Southern District of Indiana, the American Bar Association rated Judge Hamilton ''not qualified.'' This rating is still apt.

In numerous opinions written during his tenure on the district court, Judge Hamilton has displayed a lack of impartiality, a disregard for precedent, and a willingness to legislate from the bench. His writings also evince his propensity to value ''an understanding of the world from another's point of view'' above an understanding of the facts of a case.

For instance, in striking down Indiana's popularly enacted informed-consent abortion law, Judge Hamilton radically ruled that the law unconstitutionally imposed an ''undue burden'' on the right to an abortion because it qallegedly forced ''women to make two trips to a clinic.'' *A Woman's Choice* v. *Newman*, 132 F.Supp.2d 1150, 1151, S.D. Ind. 2001. In making this ruling, Judge Hamilton flaunted the directly applicable precedents of the Supreme Court and the Seventh Circuit. He also, according to Seventh Circuit opinion that reversed his ruling, relied on a ''faulty study by biased researchers who operated in a vacuum of speculation.'' *A Woman's Choice* v. *Newman*, 305 F.3d 684, 689, 7th Cir. 2002.

Similarly, in a case where a child's complaint to school officials about her mother's drug abuse led to the mother's arrest, Judge Hamilton suppressed the drug evidence against the mother on the ground that the police had violated her substantive due process right to ''family integrity.'' *United States* v. *McCotry*, 2006 U.S. Dist. LEXIS 62777, S.D. Ind., July 13, 2006. To reach this conclusion, Judge Hamilton ignored controlling Seventh Circuit law and relied instead on the dissenting opinions of Ninth Circuit judges. And when the Seventh Circuit reversed Judge Hamilton, it chastised him for not properly considering the wrongs of the mother in the case, who ''risked her relationship with her nine-year old daughter by dealing drugs.'' *United States* v. *Hollingsworth*, 495 F.3d 795, 803 n.3, 7th Cir. 2007.

In these cases, and many more, Judge Hamilton has shown an unvarnished result-orientation and has confirmed his reputation as ''one of the more liberal judges in the district.'' Almanac of the Federal Judiciary. This record has not earned him the honor of elevation to a higher court.

As President Obama's first nominee, there is no doubt that Judge Hamilton possesses the empathy and desire to write ''footnotes to the Constitution'' that catch the eye of liberal activists and partisan politicians. But these qualities are not ones that a Circuit Judge of the United States should possess. Accordingly, I will vote no on the confirmation of Judge David Hamilton.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Mr. President, as I sit here and listen, I wonder who in Heaven's name they are talking about. Judge Hamilton had 8,000 cases. Apparently, there is no problem with any of them except for a tiny handful of cases, and those have been so distorted by Judge Hamilton's opponents that I don't even understand them. Basically, I think they are saying what he should have done is gone by his personal beliefs and not the law. Of course, then they could say he was an activist judge.

He is in a situation where they will try and get him either way. A judge can follow the law, do what they are supposed to do, try 8,000 cases, get strong support from people from the right to the left, and get the highest possible rating a judge can get. But don't worry. We are going to take some case or two out of context from their 15 years on the bench. We will ignore 8,000 cases. We will call them a gender-driven ideologue. We will point to a single case, even though in that case they carefully applied Supreme Court precedent.

Come on. Let's be fair. Eight thousand cases, the highest rating possible, endorsed by everybody who knows him, and strongly backed by Senators LUGAR and BAYH. Judge Hamilton is not an ideologue. Apparently, there is no problem with any of his 8,000 cases except a couple that people have taken out of context. We should be the conscience of the Nation. We are above that, and we should vote for his confirmation.

AMENDMENT NO. 2785

Mr. President, I also want to take a couple of minutes to speak against Senator COBURN's amendment to the veterans health bill we will be voting on shortly.

Senator AKAKA has already explained that we do not need the Coburn amendment to fund the programs in this veterans health bill. So do not be misled by the suggestion that we need to cut funding for the United Nations to care for our veterans. That is a false choice.

This is nothing more than a ploy to take a swipe at the United Nations. Senator COBURN spoke earlier, and his statement consisted of a laundry list of factual inaccuracies about the United Nations.

Is the United Nations perfect? Far from it. But legitimate criticism is one thing. Inventing facts is another. To say that the U.N. Development Program provided millions of dollars to North Korea which used the funds to ''purchase conventional arms and ballistic missiles,'' when there is no proof of that, does not belong in this debate..

I would say to those Senators who think the United States should not fulfill its treaty obligations to the United Nations, who think we should renege on our commitments to support U.N. peacekeeping missions, and who favor walking away from our pledges to NATO, the International Atomic Energy Agency, the World Health Organization, and many other organizations we were instrumental in creating, then vote for this misguided amendment.

But if Senators believe that United States leadership in the world means paying our share and being able to use our influence, then I urge Senators to oppose it.

Our assessed contributions to the United Nations, which the Coburn amendment would cut, support a wide range of activities that advance our own national interests. That was as true during the Bush Administration, which would have opposed this amendment, as it is today. The State Department opposes this amendment.

Here are some examples of what the funds are used for by the U.N. and other international organizations that Senator COBURN's amendment would cut:

Preparing for and holding elections in Iraq.

Monitoring nuclear programs in North Korea and Iran. Do we really want to cut funding for the international nuclear inspectors who Iran finally allowed into one of their facilities?

Supporting NATO. I can't imagine any Senator wants to cut our contribution to NATO, when we are asking our NATO allies to do more in Afghanistan.

Funding 17 U.N. peacekeeping missions, including in Haiti, Liberia, Lebanon, Darfur and the Congo. We don't contribute troops for these missions other nations like Bangladesh and Morocco do. But they rely on us to pay our share of the cost, and it is a lot less expensive than sending our own troops.

Supporting the Food and Agriculture Organization's forecasts of global food

production, identifying areas of drought and famine, to provide emergency food assistance.

Coordinating tsunami and earthquake relief in Indonesia and Pakistan.

Supporting the World Health Organization's work to detect outbreaks of avian flu and Swine Flu and other infectious diseases and defending against a world pandemic.

Creating and maintaining protections for the intellectual property rights of American companies.

Coordinating international aviation safety standards.

Coordinating efforts by the global shipping industry and governments to prevent and respond to acts of piracy on the high seas.

These are organizations that are advancing our own interests.

President Obama has stated his commitment that the U.S. will pay its dues to U.N. peacekeeping and international organizations. The Appropriations Committee has acted on that commitment. We are once again in good financial standing at the United Nations. This amendment would put us back in arrears.

Our dues to the United Nations and other international organizations are treaty obligations. Not paying is not an option.

Let's stop acting like the United States doesn't matter. Let's not say that because the U.N. isn't perfect, we should cut our dues.

We are the world's leading military and economic power, and there is much we can achieve on our own. But we cannot stop genocide in Darfur alone any more than we can stop the spread of HIV/AIDS without the cooperation of other nations.

We need to lead by example in the United Nations, in NATO, at the World Health Organization, the International Atomic Energy Agency, the Organization for the Prevention of Chemical Weapons, the Food and Agriculture Organization, the World Intellectual Property Organization. We can't do that without paying what we owe.

This body has already voted for the funds to support United Nations peacekeeping and these international organizations. Senator COBURN's amendment would cut those funds.

I also want to set the record straight on another misstatement of Senator COBURN's. He said his amendment to the fiscal year 2008 State and Foreign Operations appropriations bill was unanimously passed and then dropped in conference. It was not dropped in conference.

His amendment would have withheld all U.S. contributions to international organizations. The House and Senate conferees did not support that. What emerged from conference was a 10 percent withholding of funds, still tens of millions of dollars, tied to audits, budget reports, and oversight. It also withheld 20 percent of the U.S. contribution to the U.N. Development Program.

Was it everything Senator COBURN wanted? No. Was it dropped in conference? No. The substance of his amendment was included in the conference agreement, and for the benefit of anyone who cares to read it, it is section 668 of Public Law 110–161.

I agree with Senator AKAKA and urge Senators to oppose the Coburn amendment.

Mr. President, I strongly join Senators LUGAR and BAYH in the support of Judge Hamilton.

I yield back any time.

The PRESIDING OFFICER (Mr. BEGICH). All time is expired.

The question is, Will the Senate advise and consent to the nomination of David F. Hamilton, of Indiana, to be U.S. circuit judge for the Seventh Circuit?

Mr. LEAHY. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Montana (Mr. BAUCUS), and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 59, nays 39, as follows:

[Rollcall Vote No. 350 Ex.]

YEAS—59

Akaka	Hagan	Murray
Bayh	Harkin	Nelson (NE)
Begich	Inouye	Nelson (FL)
Bennet	Johnson	Pryor
Bingaman	Kaufman	Reed
Boxer	Kerry	Reid
Brown	Kirk	Rockefeller
Burris	Klobuchar	Sanders
Cantwell	Kohl	Schumer
Cardin	Landrieu	Shaheen
Carper	Lautenberg	Specter
Casey	Leahy	Stabenow
Conrad	Levin	Tester
Dodd	Lieberman	Udall (CO)
Dorgan	Lincoln	Udall (NM)
Durbin	Lugar	Warner
Feingold	McCaskill	Webb
Feinstein	Menendez	Whitehouse
Franken	Merkley	Wyden
Gillibrand	Mikulski	

NAYS—39

Alexander	Crapo	LeMieux
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Inhofe	Thune
Collins	Isakson	Vitter
Corker	Johanns	Voinovich
Cornyn	Kyl	Wicker

NOT VOTING—2

Baucus	Byrd

The nomination was confirmed.

The PRESIDING OFFICER. The President will be immediately notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009—Continued

AMENDMENT NO. 2785

The PRESIDING OFFICER. There will now be 2 minutes of debate equally divided on the amendment offered by the Senator from Oklahoma, Mr. COBURN.

The Senator from Oklahoma is recognized.

Mr. COBURN. This is a straightforward amendment. You get to decide whether you want to continue to send money to an organization that is bankrupt, fraudulent; has peacekeeping troops that rape men, women, and children; has absolutely no transparency in spite of our law that demands it, or to pay for the courage and the support of people who do deserve it.

We always find a reason not to make the hard choice. I suspect we will find a good reason not to make the hard choice this time. But for $3.7 billion to help the people who help us and quit sending money that goes down the tube—half of everything we send to the United Nations gets wasted or defrauded—it is time for us to make the hard choice. That is what the amendment is about. There are a lot of reasons you can find to vote against it. It will take real courage to vote for it.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I urge our colleagues to reject the pending amendment. For one thing, it appears that the amendment could end up denying caregiver assistance to many OEF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance. While the amendment seeks to ''pay for'' the costs associated with this bill, I understand from CBO, however, that this amendment does not even accomplish what I believe the amendment's author intends.

Every major veterans group supports the underlying bill because of what it means for all veterans—for women veterans, for homeless veterans, and for veterans of every era.

I urge a ''no'' vote on the amendment, followed by a vote to pass S. 1963.

The PRESIDING OFFICER. All time has expired.

The question is on agreeing to the amendment.

Mr. LEMIEUX. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Montana (Mr. BAUCUS) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER (Ms. KLOBUCHAR). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 32, nays 66, as follows:

[Rollcall Vote No. 351 Leg.]

YEAS—32

Alexander	DeMint	McCain
Barrasso	Ensign	McConnell
Bayh	Enzi	Murkowski
Bennett	Graham	Risch
Brownback	Hatch	Roberts
Bunning	Hutchison	Sessions
Burr	Inhofe	Shelby
Chambliss	Isakson	Thune
Coburn	Johanns	Vitter
Cornyn	Kyl	Wicker
Crapo	LeMieux	

NAYS—66

Akaka	Gillibrand	Mikulski
Begich	Grassley	Murray
Bennet	Gregg	Nelson (NE)
Bingaman	Hagan	Nelson (FL)
Bond	Harkin	Pryor
Boxer	Inouye	Reed
Brown	Johnson	Reid
Burris	Kaufman	Rockefeller
Cantwell	Kerry	Sanders
Cardin	Kirk	Schumer
Carper	Klobuchar	Shaheen
Casey	Kohl	Snowe
Cochran	Landrieu	Specter
Collins	Lautenberg	Stabenow
Conrad	Leahy	Tester
Corker	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Voinovich
Durbin	Lugar	Warner
Feingold	McCaskill	Webb
Feinstein	Menendez	Whitehouse
Franken	Merkley	Wyden

NOT VOTING—2

Baucus	Byrd

The amendment (No. 2785) was rejected.

Mrs. MURRAY. Madam President, I move to reconsider the vote.

Mr. DURBIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mrs. MURRAY. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on passage of the bill.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Montana (Mr. BAUCUS) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 352 Leg.]

YEAS—98

Akaka	Feingold	Menendez
Alexander	Feinstein	Merkley
Barrasso	Franken	Mikulski
Bayh	Gillibrand	Murkowski
Begich	Graham	Murray
Bennet	Grassley	Nelson (NE)
Bennett	Gregg	Nelson (FL)
Bingaman	Hagan	Pryor
Bond	Harkin	Reed
Boxer	Hatch	Reid
Brown	Hutchison	Risch
Brownback	Inhofe	Roberts
Bunning	Inouye	Rockefeller
Burr	Isakson	Sanders
Burris	Johanns	Schumer
Cantwell	Johnson	Sessions
Cardin	Kaufman	Shaheen
Carper	Kerry	Shelby
Casey	Kirk	Snowe
Chambliss	Klobuchar	Specter
Coburn	Kohl	Stabenow
Cochran	Kyl	Tester
Collins	Landrieu	Thune
Conrad	Lautenberg	Udall (CO)
Corker	Leahy	Udall (NM)
Cornyn	LeMieux	Vitter
Crapo	Levin	Voinovich
DeMint	Lieberman	Warner
Dodd	Lincoln	Webb
Dorgan	Lugar	Whitehouse
Durbin	McCain	Wicker
Ensign	McCaskill	Wyden
Enzi	McConnell	

NOT VOTING—2

Baucus	Byrd

The bill (S. 1963) was passed, as follows:

S. 1963

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Caregivers and Veterans Omnibus Health Services Act of 2009''.

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

Sec. 1. Short title; table of contents.
Sec. 2. References to title 38, United States Code.

TITLE I—CAREGIVER SUPPORT

Sec. 101. Waiver of charges for humanitarian care provided to family members accompanying certain severely injured veterans as they receive medical care.
Sec. 102. Family caregiver assistance.
Sec. 103. Lodging and subsistence for attendants.
Sec. 104. Survey of informal caregivers.

TITLE II—WOMEN VETERANS HEALTH CARE MATTERS

Sec. 201. Report on barriers to receipt of health care for women veterans.
Sec. 202. Plan to improve provision of health care services to women veterans.
Sec. 203. Independent study on health consequences of women veterans of military service in Operation Iraqi Freedom and Operation Enduring Freedom.
Sec. 204. Training and certification for mental health care providers on care for veterans suffering from sexual trauma.
Sec. 205. Pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.
Sec. 206. Report on full-time women veterans program managers at medical centers.
Sec. 207. Service on certain advisory committees of women recently separated from service in the Armed Forces.
Sec. 208. Pilot program on subsidies for child care for certain veterans receiving health care.
Sec. 209. Care for newborn children of women veterans receiving maternity care.

TITLE III—RURAL HEALTH IMPROVEMENTS

Sec. 301. Enhancement of Department of Veterans Affairs Education Debt Reduction Program.
Sec. 302. Visual impairment and orientation and mobility professionals education assistance program.
Sec. 303. Inclusion of Department of Veterans Affairs facilities in list of facilities eligible for assignment of participants in National Health Service Corps Scholarship Program.
Sec. 304. Teleconsultation and telemedicine.
Sec. 305. Demonstration projects on alternatives for expanding care for veterans in rural areas.
Sec. 306. Program on provision of readjustment and mental health care services to veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom.
Sec. 307. Improvement of care of American Indian veterans.
Sec. 308. Travel reimbursement for veterans receiving treatment at facilities of the Department of Veterans Affairs.
Sec. 309. Office of Rural Health five-year strategic plan.
Sec. 310. Oversight of contract and fee-basis care.
Sec. 311. Enhancement of Vet Centers to meet needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom.
Sec. 312. Centers of excellence for rural health research, education, and clinical activities.
Sec. 313. Pilot program on incentives for physicians who assume inpatient responsibilities at community hospitals in health professional shortage areas.
Sec. 314. Annual report on matters related to care for veterans who live in rural areas.
Sec. 315. Transportation grants for rural veterans service organizations.
Sec. 316. Modification of eligibility for participation in pilot program of enhanced contract care authority for health care needs of certain veterans.

TITLE IV—MENTAL HEALTH CARE MATTERS

Sec. 401. Eligibility of members of the Armed Forces who serve in Operation Iraqi Freedom or Operation Enduring Freedom for counseling and services through Readjustment Counseling Service.
Sec. 402. Restoration of authority of Readjustment Counseling Service to provide referral and other assistance upon request to former members of the Armed Forces not authorized counseling.

Sec. 403. Study on suicides among veterans.
Sec. 404. Transfer of funds to Secretary of Health and Human Services for Graduate Psychology Education program.

TITLE V—OTHER HEALTH CARE MATTERS

Sec. 501. Repeal of certain annual reporting requirements.
Sec. 502. Modifications to annual Gulf War research report.
Sec. 503. Payment for care furnished to CHAMPVA beneficiaries.
Sec. 504. Disclosures from certain medical records.
Sec. 505. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care.
Sec. 506. Enhancement of quality management.
Sec. 507. Reports on improvements to Department health care quality management.
Sec. 508. Pilot program on use of community-based organizations and local and State government entities to ensure that veterans receive care and benefits for which they are eligible.
Sec. 509. Specialized residential care and rehabilitation for certain veterans.
Sec. 510. Expanded study on the health impact of Project Shipboard Hazard and Defense.
Sec. 511. Use of non-Department facilities for rehabilitation of individuals with traumatic brain injury.
Sec. 512. Inclusion of federally recognized tribal organizations in certain programs for State veterans homes.
Sec. 513. Pilot program on provision of dental insurance plans to veterans and survivors and dependents of veterans.
Sec. 514. Expansion of veteran eligibility for reimbursement by Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility.
Sec. 515. Prohibition on collection of copayments from veterans who are catastrophically disabled.

TITLE VI—DEPARTMENT PERSONNEL MATTERS

Sec. 601. Enhancement of authorities for retention of medical professionals.
Sec. 602. Limitations on overtime duty, weekend duty, and alternative work schedules for nurses.
Sec. 603. Improvements to certain educational assistance programs.
Sec. 604. Standards for appointment and practice of physicians in Department of Veterans Affairs medical facilities.

TITLE VII—HOMELESS VETERANS MATTERS

Sec. 701. Pilot program on financial support for entities that coordinate the provision of supportive services to formerly homeless veterans residing on certain military property.
Sec. 702. Pilot program on financial support of entities that coordinate the provision of supportive services to formerly homeless veterans residing in permanent housing.
Sec. 703. Pilot program on financial support of entities that provide outreach to inform certain veterans about pension benefits.
Sec. 704. Assessment of pilot programs.

TITLE VIII—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

Sec. 801. General authorities on establishment of corporations.
Sec. 802. Clarification of purposes of corporations.
Sec. 803. Modification of requirements for boards of directors of corporations.
Sec. 804. Clarification of powers of corporations.
Sec. 805. Redesignation of section 7364A of title 38, United States Code.
Sec. 806. Improved accountability and oversight of corporations.

TITLE IX—CONSTRUCTION AND NAMING MATTERS

Sec. 901. Authorization of medical facility projects.
Sec. 902. Designation of Robley Rex Department of Veterans Affairs Medical Center.
Sec. 903. Merril Lundman Department of Veterans Affairs Outpatient Clinic.
Sec. 904. Modification on restriction of alienation of certain real property in Gulf Port, Mississippi.

TITLE X—OTHER MATTERS

Sec. 1001. Expansion of authority for Department of Veterans Affairs police officers.
Sec. 1002. Uniform allowance for Department of Veterans Affairs police officers.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—CAREGIVER SUPPORT

SEC. 101. WAIVER OF CHARGES FOR HUMANITARIAN CARE PROVIDED TO FAMILY MEMBERS ACCOMPANYING CERTAIN SEVERELY INJURED VETERANS AS THEY RECEIVE MEDICAL CARE.

The text of section 1784 is amended to read as follows:

''(a) IN GENERAL.—The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases.

''(b) REIMBURSEMENT.—Except as provided in subsection (c), the Secretary shall charge for care and services provided under subsection (a) at rates prescribed by the Secretary.

''(c) WAIVER OF CHARGES.—(1) Except as provided in paragraph (2), the Secretary shall waive the charges required by subsection (b) for care or services provided under subsection (a) to an attendant of a covered veteran if such care or services are provided to such attendant for an emergency that occurs while such attendant is accompanying such veteran while such veteran is receiving approved inpatient or outpatient treatment at—

''(A) a Department facility; or

''(B) a non-Department facility—

''(i) that is under contract with the Department; or

''(ii) at which the veteran is receiving fee-basis care.

''(2) If an attendant is entitled to care or services under a health-plan contract (as that term is defined in section 1725(f) of this title) or other contractual or legal recourse against a third party that would, in part, extinguish liability for charges described by subsection (b), the amount of such charges waived under paragraph (1) shall be the amount by which such charges exceed the amount of such charges covered by the health-plan contract or other contractual or legal recourse against the third party.

''(d) DEFINITIONS.—In this section:

''(1) The term 'attendant', with respect to a veteran, includes the following:

''(A) A family member of the veteran.

''(B) An individual eligible to receive ongoing family caregiver assistance under section 1717A(e)(1) of this title for the provision of personal care services to the veteran.

''(C) Any other individual whom the Secretary determines—

''(i) has a relationship with the veteran sufficient to demonstrate a close affinity with the veteran; and

''(ii) provides a significant portion of the veteran's care.

''(2) The term 'covered veteran' means any veteran with a severe injury incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001.

''(3) The term 'family member' shall have such meaning as the Secretary shall determine by policy or regulation.

''(4) The term 'severe injury', in the case of a covered veteran, means any physiological, psychological, or neurological condition that renders a veteran unable to live independently as determined by the Secretary.''.

SEC. 102. FAMILY CAREGIVER ASSISTANCE.

(a) REQUIREMENT.—

(1) IN GENERAL.—Subchapter II of chapter 17 is amended by inserting after section 1717 the following new section:

''§ 1717A. Family caregiver assistance

''(a) IN GENERAL.—(1) As part of home health services provided under section 1717 of this title, the Secretary shall, upon the joint application of an eligible veteran and a family member of such veteran (or other individual designated by such veteran), furnish to such family member (or designee) family caregiver assistance in accordance with this section. The purpose of providing family caregiver assistance under this section is—

''(A) to reduce the number of veterans who are receiving institutional care, or who are in need of institutional care, whose personal care service needs could be substantially satisfied with the provision of such services by a family member (or designee); and

''(B) to provide eligible veterans with additional options so that they can choose the setting for the receipt of personal care services that best suits their needs.

''(2) The Secretary shall only furnish family caregiver assistance under this section to a family member of an eligible veteran (or other individual designated by such veteran) if the Secretary determines it is in the best interest of the eligible veteran to do so.

''(b) ELIGIBLE VETERANS.—For purposes of this section, an eligible veteran is a veteran (or member of the Armed Forces undergoing medical discharge from the Armed Forces)—

''(1) who has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001; and

''(2) whom the Secretary determines, in consultation with the Secretary of Defense as necessary, is in need of personal care services because of—

''(A) an inability to perform one or more independent activities of daily living;

''(B) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury; or

''(C) such other matters as the Secretary shall establish in consultation with the Secretary of Defense as appropriate.

''(c) EVALUATION OF ELIGIBLE VETERANS AND FAMILY CAREGIVERS.—(1) The Secretary shall evaluate each eligible veteran who makes a joint application under subsection (a)(1)—

''(A) to identify the personal care services required by such veteran; and

''(B) to determine whether such requirements could be significantly or substantially satisfied with the provision of personal care services from a family member (or other individual designated by the veteran).

''(2) The Secretary shall evaluate each family member of an eligible veteran (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) to determine—

''(A) the basic amount of instruction, preparation, and training such family member (or designee) requires, if any, to provide the personal care services required by such veteran; and

''(B) the amount of additional instruction, preparation, and training such family member (or designee) requires, if any, to be the primary personal care attendant designated for such veteran under subsection (e).

''(3) An evaluation carried out under paragraph (1) may be carried out—

''(A) at a Department facility;

''(B) at a non-Department facility determined appropriate by the Secretary for purposes of such evaluation; and

''(C) at such other locations as the Secretary considers appropriate.

''(d) TRAINING AND APPROVAL.—(1) Except as provided in subsection (a)(2), the Secretary shall provide each family member of an eligible veteran (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) the basic instruction, preparation, and training determined to be required by such family member (or designee) under subsection (c)(2)(A).

''(2) The Secretary may provide to a family member of an eligible veteran (or other individual designated by the veteran) the additional instruction, preparation, and training determined to be required by such family member (or designee) under subsection (c)(2)(B) if such family member (or designee)—

''(A) is approved as a personal care attendant for the veteran under paragraph (3); and

''(B) requests, with concurrence of the veteran, such additional instruction, preparation, and training.

''(3) Upon the successful completion by a family member of an eligible veteran (or other individual designated by the veteran) of basic instruction, preparation, and training provided under paragraph (1), the Secretary shall approve the family member as a personal care attendant for the veteran.

''(4) If the Secretary determines that a primary personal care attendant designated under subsection (e) requires additional training to maintain such designation, the Secretary shall make such training available to the primary personal care attendant.

''(5) The Secretary shall, subject to regulations the Secretary shall prescribe, provide for necessary travel, lodging, and per diem expenses incurred by a family member of an eligible veteran (or other individual designated by the veteran) in undergoing training under this subsection.

''(6) If the participation of a family member of an eligible veteran (or other individual designated by the veteran) in training under this subsection would interfere with the provision of personal care services to the veteran, the Secretary shall, subject to regulations as the Secretary shall prescribe and in consultation with the veteran, provide respite care to the veteran during the provision of such training to the family member so that such family caregiver (or designee) can participate in such training without interfering with the provision of such services.

''(e) DESIGNATION OF PRIMARY PERSONAL CARE ATTENDANT.—(1) For each eligible veteran with at least one family member (or other individual designated by the veteran) who is described by subparagraphs (A) through (E) of paragraph (2), the Secretary shall designate one family member of such veteran (or other individual designated by the veteran) as the primary personal care attendant for such veteran to be the primary provider of personal care services for such veteran.

''(2) A primary personal care attendant designated for an eligible veteran under paragraph (1) shall be selected from among family members of such veteran (or other individuals designated by such veteran) who—

''(A) are approved under subsection (d)(3) as a personal care attendant for such veteran;

''(B) complete all additional instruction, preparation, and training, if any, provided under subsection (d)(2);

''(C) elect to provide the personal care services to such veteran that the Secretary determines such veteran requires under subsection (c)(1);

''(D) has the consent of such veteran to be the primary provider of such services for such veteran; and

''(E) the Secretary considers competent to be the primary provider of such services for such veteran.

''(3)(A) An eligible veteran receiving personal care services from a family member (or other individual designated by the veteran) designated as the primary personal care attendant for the veteran under paragraph (1) may revoke consent with respect to such family member (or designee) under paragraph (2)(D).

''(B) An eligible veteran may revoke the designation of a primary personal care attendant under subparagraph (A) at any time, except that such revocation may not occur more frequently than once every six months unless the Secretary determines it is in the best interest of the eligible veteran to permit such revocation to occur more frequently.

''(4) If an individual designated as the primary personal care attendant of an eligible veteran under paragraph (1) subsequently fails to meet the requirements set forth in paragraph (2), the Secretary—

''(A) shall immediately revoke the individual's designation under paragraph (1); and

''(B) may designate, in consultation with the eligible veteran or the eligible veteran's surrogate appointed under subsection (g), a new primary personal care attendant for the veteran under such paragraph.

''(5) The Secretary shall take such actions as may be necessary to ensure that the revocation of a designation under paragraph (1) does not interfere with the provision of personal care services required by a veteran.

''(f) ONGOING FAMILY CAREGIVER ASSISTANCE.—(1) Except as provided in subsection (a)(2) and subject to the provisions of this subsection, the Secretary shall provide ongoing family caregiver assistance to family members of eligible veterans (or other individuals designated by such veterans) as follows:

''(A) To each family member of an eligible veteran (or designee) who is approved under subsection (d)(3) as a personal care attendant for the veteran the following:

''(i) Direct technical support consisting of information and assistance to timely address routine, emergency, and specialized caregiving needs.

''(ii) Counseling.

''(iii) Access to an interactive Internet website on caregiver services that addresses all aspects of the provision of personal care services under this section.

''(B) To each family member of an eligible veteran (or designee) who is designated as the primary personal care attendant for the veteran under subsection (e) the following:

''(i) The ongoing family caregiver assistance described in subparagraph (A).

''(ii) Mental health services.

''(iii) Respite care of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite.

''(iv) Medical care under section 1781 of this title if such family member (or designee) is not entitled to care or services under a health-plan contract (as defined in section 1725(f) of this title).

''(v) A monthly personal caregiver stipend.

''(2)(A) The Secretary shall provide respite care under paragraph (1)(B)(iii), at the election of the Secretary—

''(i) through facilities of the Department that are appropriate for the veteran; or

''(ii) through contracts under section 1720B(c) of this title.

''(B) If the primary personal care attendant of an eligible veteran designated under subsection (e)(1) determines in consultation with the veteran or the veteran's surrogate appointed under subsection (g), and the Secretary concurs, that the needs of the veteran cannot be accommodated through the facilities and contracts described in subparagraph (A), the Secretary shall, in consultation with the primary personal care attendant and the veteran (or the veteran's surrogate), provide respite care through other facilities or arrangements that are medically and age appropriate.

''(3) If the Secretary determines that the Department lacks the capacity to furnish medical care under clause (iv) of paragraph (1)(B), the Secretary may contract, in accordance with such regulations as the Secretary shall prescribe, for such insurance, medical services, or health plans as the Secretary considers appropriate to furnish such medical care.

''(4)(A) The Secretary shall provide monthly personal caregiver stipends under paragraph (1)(B)(v) in accordance with a schedule established by the Secretary that specifies stipends provided based upon the amount and degree of personal care services provided.

''(B) The Secretary shall ensure, to the extent practicable, that the schedule required by subparagraph (A) specifies that the amount of the personal caregiver stipend provided to a primary personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran is not less than the amount a commercial home health care entity would pay an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.

''(C) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary may establish the schedule required by subparagraph (A) with respect to the veteran by considering the costs of commercial providers of personal care services in geographic areas other than the geographic area of the veteran with similar costs of living.

''(5) Provision of ongoing family caregiver assistance under this subsection for provision of personal care services to an eligible veteran shall terminate if the veteran no longer requires the personal care services.

''(g) SURROGATES.—If an eligible veteran lacks the capacity to submit an application, provide consent, make a request, or concur with a request under this section, the Secretary may, in accordance with regulations and policies of the Department regarding the appointment of guardians or the use of powers of attorney, appoint a surrogate for the veteran who may submit applications, provide consent, make requests, or concur with requests on behalf of the veteran under this section.

''(h) OVERSIGHT.—(1) The Secretary shall enter into contracts with appropriate entities to provide oversight of the provision of personal care services under this section by primary personal care attendants designated under subsection (e)(1).

''(2) The Secretary shall ensure that each eligible veteran receiving personal care services under this section from a primary personal care attendant designated under subsection (e)(1) is visited in the veteran's home by an entity providing oversight under paragraph (1) at such frequency as the Secretary shall determine under paragraph (3).

''(3)(A) Except as provided in subparagraph (B), the Secretary shall determine the manner of oversight provided under paragraph (1) and the frequency of visits under paragraph (2) for an eligible veteran as the Secretary considers commensurate with the needs of such veteran.

''(B) The frequency of visits under paragraph (2) for an eligible veteran shall be not less frequent than once every six months.

''(4)(A) An entity visiting an eligible veteran under paragraph (2) shall submit to the Secretary the findings of the entity with respect to each visit, including whether the veteran is receiving the care the veteran requires.

''(B) If an entity finds under subparagraph (A) that an eligible veteran is not receiving the care the veteran requires, the entity shall submit to the Secretary a recommendation on the corrective actions that should be taken to ensure that the veteran receives the care the veteran requires, including, if the entity considers appropriate, a recommendation for revocation of a caregiver's approval under subsection (d)(3) or revocation of the designation of an individual under subsection (e)(1).

''(5) After receiving findings and recommendations, if any, under paragraph (4) with respect to an eligible veteran, the Secretary may take such actions as the Secretary considers appropriate to ensure that the veteran receives the care the veteran requires, including the following:

''(A) Revocation of a caregiver's approval under subsection (d)(3).

''(B) Revocation of the designation of an individual under subsection (e)(1).

''(6) If the Secretary terminates the provision of ongoing family caregiver assistance under subsection (f) to a family member of an eligible veteran (or other individual designated by the veteran) because of findings of an entity submitted to the Secretary under paragraph (4), the Secretary may not provide compensation to such entity for the provision of personal care services to such veteran, unless the Secretary determines it would be in the best interest of such veteran to provide compensation to such entity to provide such services.

''(i) OUTREACH.—The Secretary shall carry out a program of outreach to inform eligible veterans and their family members of the availability and nature of family caregiver assistance under this section.

''(j) CONSTRUCTION.—(1) A decision by the Secretary under this section affecting the furnishing of family caregiver assistance shall be considered a medical determination.

''(2) Nothing in this section shall be construed to create an employment relationship between the Secretary and an individual in receipt of family caregiver assistance under this section.

''(3) Nothing in this section shall be construed to create any entitlement to any services or stipends provided under this section.

''(k) DEFINITIONS.—In this section:

''(1) The term 'family caregiver assistance' includes the instruction, preparation, training, and approval provided under subsection (d) and the ongoing family caregiver assistance provided under subsection (f).

''(2) The term 'family member' shall have such meaning as the Secretary shall determine by policy or regulation.

''(3) The term 'personal care services', with respect to a veteran, includes the following:

''(A) Supervision of the veteran.

''(B) Protection of the veteran.

''(C) Services to assist the veteran with one or more independent activities of daily living.

''(D) Such other services as the Secretary considers appropriate.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to section 1717 the following new item:

''1717A. Family caregiver assistance.''.

(3) AUTHORIZATION FOR PROVISION OF HEALTH CARE TO PERSONAL CARE ATTENDANTS.—Section 1781(a) is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) by inserting after paragraph (1) the following new paragraph (2):

''(2) a family member of a veteran (or other individual designated by the veteran) designated as the primary personal care attendant for such veteran under section 1717A(e) of this title who is not entitled to care or services under a health-plan contract (as defined in section 1725(f) of this title),''.

(4) CONSTRUCTION.—Any family caregiver assistance furnished under section 1717A of title 38, United States Code, as added by paragraph (1), is in addition to any family caregiver assistance furnished under other programs of the Department of Veterans Affairs as of the date of the enactment of this Act.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date that is 270 days after the date of the enactment of this Act.

(b) IMPLEMENTATION PLAN AND REPORT.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(A) develop a plan for the implementation of section 1717A of title 38, United States Code, as added by subsection (a)(1); and

(B) submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on such plan.

(2) CONSULTATION.—In developing the plan required by paragraph (1)(A), the Secretary shall consult with the following:

(A) Veterans described in section 1717A(b) of title 38, United States Code, as added by subsection (a)(1).

(B) Family members of veterans who provide personal care services to such veterans.

(C) Veterans service organizations, as recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(D) National organizations that specialize in the provision of assistance to individuals with the types of disabilities that personal care attendants will encounter while providing personal care services under section 1717A of title 38, United States Code, as so added.

(E) Such other organizations with an interest in the provision of care to veterans as the Secretary considers appropriate.

(F) The Secretary of Defense with respect to matters concerning personal care services for members of the Armed Forces undergoing medical discharge from the Armed Forces who are eligible to benefit from family caregiver assistance furnished under section 1717A of title 38, United States Code, as so added.

(3) REPORT CONTENTS.—The report required by paragraph (1)(B) shall contain the following:

(A) The plan required by paragraph (1)(A).

(B) A description of the veterans, caregivers, and organizations consulted by the Secretary under paragraph (2).

(C) A description of such consultations.

(D) The recommendations of such veterans, caregivers, and organizations, if any, that were not incorporated into the plan required by paragraph (1)(A).

(E) The reasons the Secretary did not incorporate such recommendations into such plan.

(c) ANNUAL EVALUATION REPORT.—

(1) IN GENERAL.—Not later than two years after the date described in subsection (a)(5) and annually thereafter, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a comprehensive report on the implementation of section 1717A of title 38, United States Code, as added by subsection (a)(1).

(2) CONTENTS.—The report required by paragraph (1) shall include the following:

(A) The number of family members (or other designated individuals) of veterans or members of the Armed Forces that received family caregiver assistance under such section 1717A.

(B) A description of the outreach activities carried out by the Secretary in accordance with subsection (i) of such section 1717A.

(C) The resources expended by the Secretary under such section 1717A.

(D) An assessment of the manner in which resources are expended by the Secretary under such section 1717A, particularly with respect to the provision of monthly personal caregiver stipends under subsection (f) of such section.

(E) A description of the outcomes achieved by, and any measurable benefits of, carrying out the requirements of such section 1717A.

(F) A justification of any determination made under subsection (b)(2) of such section 1717A.

(G) An assessment of the effectiveness and the efficiency of the implementation of such section 1717A.

(H) An assessment of how the provision of family caregiver assistance fits into the continuum of home health care services and

benefits provided to veterans in need of such services and benefits.

(I) Such recommendations, including recommendations for legislative or administrative action, as the Secretary considers appropriate in light of carrying out the requirements of such section 1717A.

(d) REPORT ON FEASIBILITY AND ADVISABILITY OF EXPANDING CAREGIVER ASSISTANCE.—

(1) IN GENERAL.—Not later than two years after the date of the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2009, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of expanding the provision of family caregiver assistance under section 1717A of title 38, United States Code, as added by subsection (a)(1), to family members of veterans (or other individuals designated by such veterans) who—

(A) have a serious injury described in subsection (b)(1) of such section 1717A incurred or aggravated before September 11, 2001; and

(B) are described in paragraph (2) of such subsection.

(2) RECOMMENDATIONS.—The report required by paragraph (1) shall include such recommendations as the Secretary considers appropriate with respect to the expansion described in such paragraph.

SEC. 103. LODGING AND SUBSISTENCE FOR ATTENDANTS.

Section 111(e) is amended—

(1) by striking ''When any'' and inserting ''(1) When any'';

(2) in paragraph (1), as designated by paragraph (1) of this subsection—

(A) by inserting ''(including lodging and subsistence)'' after ''expenses of travel''; and

(B) by inserting before the period at the end the following: ''for the period consisting of travel to and from a treatment facility and the duration of the treatment episode at that facility''; and

(3) by adding at the end the following:

''(2) The Secretary may prescribe regulations to carry out this subsection. Such regulations may include provisions—

''(A) to limit the number of individuals that may receive expenses of travel under paragraph (1) for a single treatment episode of a person; and

''(B) to require attendants to use certain travel services.

''(3) In this subsection:

''(A) The term 'attendant' includes, with respect to a person described in paragraph (1), the following:

''(i) A family member of the person.

''(ii) An individual approved as a personal care attendant under section 1717A(d)(3) of this title.

''(iii) Any other individual whom the Secretary determines—

''(I) has a preexisting relationship with the person; and

''(II) provides a significant portion of the person's care.

''(B) The term 'family member' shall have such meaning as the Secretary shall determine by policy or regulation.''.

SEC. 104. SURVEY OF INFORMAL CAREGIVERS.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense, conduct a national survey of family caregivers of seriously disabled veterans and members of the Armed Forces to better understand the size and characteristics of the population of such caregivers and the types of care they provide such veterans and members.

(b) REPORT.—Not later than 540 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense, submit to Congress a report containing the findings of the Secretary with respect to the survey conducted under subsection (a). Results of the survey shall be disaggregated by the following:

(1) Veterans and members of the Armed Forces.

(2) Veterans and members of the Armed Forces who served in Operation Iraqi Freedom or Operation Enduring Freedom.

(3) Veterans and members of the Armed Forces who live in rural areas.

TITLE II—WOMEN VETERANS HEALTH CARE MATTERS

SEC. 201. REPORT ON BARRIERS TO RECEIPT OF HEALTH CARE FOR WOMEN VETERANS.

(a) REPORT.—Not later than June 1, 2010, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the barriers to the receipt of comprehensive health care through the Department of Veterans Affairs that are encountered by women veterans, especially veterans of Operation Iraqi Freedom and Operation Enduring Freedom.

(b) ELEMENTS.—The report required by subsection (a) shall include the following:

(1) An identification and assessment of the following:

(A) Any stigma perceived or associated with seeking mental health care services through the Department of Veterans Affairs.

(B) The effect on access to care through the Department of driving distance or availability of other forms of transportation to the nearest appropriate facility of the Department.

(C) The availability of child care.

(D) The receipt of health care through women's health clinics, integrated primary care clinics, or both.

(E) The extent of comprehension of eligibility requirements for health care through the Department, and the scope of health care services available through the Department.

(F) The quality and nature of the reception of women veterans by Department health care providers and other staff.

(G) The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department.

(H) The sensitivity of Department health care providers and other staff to issues that particularly affect women.

(I) The effectiveness of outreach on health care services of the Department that are available to women veterans.

(J) Such other matters as the Secretary identifies for purposes of the assessment.

(2) Such recommendations for administrative and legislative action as the Secretary considers appropriate in light of the report.

(c) FACILITY OF THE DEPARTMENT DEFINED.—In this section, the term ''facility of the Department'' has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. PLAN TO IMPROVE PROVISION OF HEALTH CARE SERVICES TO WOMEN VETERANS.

(a) PLAN TO IMPROVE SERVICES.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall develop a plan—

(A) to improve the provision of health care services to women veterans; and

(B) to plan appropriately for the future health care needs, including mental health care needs, of women serving on active duty in the Armed Forces in the combat theaters of Operation Iraqi Freedom and Operation Enduring Freedom.

(2) REQUIRED ACTIONS.—In developing the plan required by this subsection, the Secretary of Veterans Affairs shall—

(A) identify the types of health care services to be available to women veterans at each Department of Veterans Affairs medical center; and

(B) identify the personnel and other resources required to provide such services to women veterans under the plan at each such medical center.

(b) SUBMITTAL OF PLAN TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives the plan required by this section, along with such recommendations for administrative and legislative action as the Secretary considers appropriate in light of the plan.

SEC. 203. INDEPENDENT STUDY ON HEALTH CONSEQUENCES OF WOMEN VETERANS OF MILITARY SERVICE IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) STUDY REQUIRED.—The Secretary of Veterans Affairs shall enter into an agreement with a non-Department of Veterans Affairs entity for the purpose of conducting a study on health consequences for women veterans of service on active duty in the Armed Forces in deployment in Operation Iraqi Freedom and Operation Enduring Freedom.

(b) SPECIFIC MATTERS STUDIED.—The study under subsection (a) shall include the following:

(1) A determination of any association of environmental and occupational exposures and combat in Operation Iraqi Freedom or Operation Enduring Freedom with the general health, mental health, or reproductive health of women who served on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom.

(2) A review and analysis of published literature on environmental and occupational exposures of women while serving in the Armed Forces, including combat trauma, military sexual trauma, and exposure to potential teratogens associated with reproductive problems and birth defects.

(c) REPORT.—

(1) IN GENERAL.—Not later than 18 months after entering into the agreement for the study under subsection (a), the entity described in subsection (a) shall submit to the Secretary of Veterans Affairs and to Congress a report on the study containing such findings and determinations as the entity considers appropriate.

(2) RESPONSIVE REPORT.—Not later than 90 days after the receipt of the report under paragraph (1), the Secretary shall submit to Congress a report setting forth the response of the Secretary to the findings and determinations of the entity described in subsection (a) in the report under paragraph (1).

SEC. 204. TRAINING AND CERTIFICATION FOR MENTAL HEALTH CARE PROVIDERS ON CARE FOR VETERANS SUFFERING FROM SEXUAL TRAUMA.

(a) PROGRAM REQUIRED.—Section 1720D is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (c) the following new subsections:

''(d)(1) The Secretary shall implement a program for education, training, certification, and continuing medical education for

mental health professionals to specialize in the provision of counseling and care to veterans eligible for services under subsection (a). In carrying out the program, the Secretary shall ensure that all such mental health professionals have been trained in a consistent manner and that such training includes principles of evidence-based treatment and care for sexual trauma.

''(2) The Secretary shall determine the minimum qualifications necessary for mental health professionals certified by the program under paragraph (1) to provide evidence-based treatment and therapy to veterans eligible for services under subsection (a) in facilities of the Department.

''(e) The Secretary shall submit to Congress each year a report on the counseling, care, and services provided to veterans under this section. Each report shall include data for the preceding year with respect to the following:

''(1) The number of mental health professionals and primary care providers who have been certified under the program under subsection (d), and the amount and nature of continuing medical education provided under such program to professionals and providers who have been so certified.

''(2) The number of women veterans who received counseling, care, and services under subsection (a) from professionals and providers who have been trained or certified under the program under subsection (d).

''(3) The number of training, certification, and continuing medical education programs operating under subsection (d).

''(4) The number of trained full-time equivalent employees required in each facility of the Department to meet the needs of veterans requiring treatment and care for sexual trauma.

''(5) Such other information as the Secretary considers appropriate.''.

(b) STANDARDS FOR PERSONNEL PROVIDING TREATMENT FOR SEXUAL TRAUMA.—The Secretary of Veterans Affairs shall establish education, training, certification, and staffing standards for Department of Veterans Affairs health-care facilities for full-time equivalent employees who are trained to provide treatment and care to veterans for sexual trauma.

SEC. 205. PILOT PROGRAM ON COUNSELING IN RETREAT SETTINGS FOR WOMEN VETERANS NEWLY SEPARATED FROM SERVICE IN THE ARMED FORCES.

(a) PILOT PROGRAM REQUIRED.—

(1) IN GENERAL.—Commencing not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall carry out, through the Readjustment Counseling Service of the Veterans Health Administration, a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services described in subsection (b) in group retreat settings to women veterans who are recently separated from service in the Armed Forces after a prolonged deployment.

(2) PARTICIPATION AT ELECTION OF VETERAN.—The participation of a veteran in the pilot program under this section shall be at the election of the veteran.

(b) COVERED SERVICES.—The services provided to a woman veteran under the pilot program shall include the following:

(1) Information on reintegration into the veteran's family, employment, and community.

(2) Financial counseling.

(3) Occupational counseling.

(4) Information and counseling on stress reduction.

(5) Information and counseling on conflict resolution.

(6) Such other information and counseling as the Secretary considers appropriate to assist a woman veteran under the pilot program in reintegration into the veteran's family and community.

(c) LOCATIONS.—The Secretary shall carry out the pilot program at not fewer than five locations selected by the Secretary for purposes of the pilot program.

(d) DURATION.—The pilot program shall be carried out during the two-year period beginning on the date of the commencement of the pilot program.

(e) REPORT.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall contain the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Veterans Affairs for each of fiscal years 2010 and 2011, $2,000,000 to carry out the pilot program.

SEC. 206. REPORT ON FULL-TIME WOMEN VETERANS PROGRAM MANAGERS AT MEDICAL CENTERS.

The Secretary shall, acting through the Under Secretary for Health, submit to Congress a report on employment of full-time women veterans program managers at Department of Veterans Affairs medical centers to ensure that health care needs of women veterans are met. Such report should include an assessment of whether there is at least one full-time employee at each Department medical center who is a full-time women veterans program manager.

SEC. 207. SERVICE ON CERTAIN ADVISORY COMMITTEES OF WOMEN RECENTLY SEPARATED FROM SERVICE IN THE ARMED FORCES.

(a) ADVISORY COMMITTEE ON WOMEN VETERANS.—Section 542(a)(2)(A) is amended—

(1) in clause (ii), by striking ''and'' at the end;

(2) in clause (iii), by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (iii) the following new clause:

''(iv) women veterans who are recently separated from service in the Armed Forces.''.

(b) ADVISORY COMMITTEE ON MINORITY VETERANS.—Section 544(a)(2)(A) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv), by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (iv) the following new clause:

''(v) women veterans who are minority group members and are recently separated from service in the Armed Forces.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appointments made on or after the date of the enactment of this Act.

SEC. 208. PILOT PROGRAM ON SUBSIDIES FOR CHILD CARE FOR CERTAIN VETERANS RECEIVING HEALTH CARE.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of providing, subject to subsection (b), subsidies to qualified veterans described in subsection (c) to obtain child care so that such veterans can receive health care services described in such subsection.

(b) LIMITATION ON PERIOD OF PAYMENTS.—A subsidy may only be provided to a qualified veteran under the pilot program for receipt of child care during the period that the qualified veteran—

(1) receives the types of health care services referred to in subsection (c) at a facility of the Department; and

(2) requires to travel to and return from such facility for the receipt of such health care services.

(c) QUALIFIED VETERANS.—In this section, the term ''qualified veteran'' means a veteran who is the primary caretaker of a child or children and who is receiving from the Department one or more of the following health care services:

(1) Regular mental health care services.

(2) Intensive mental health care services.

(3) Such other intensive health care services that the Secretary determines that payment to the veteran for the provision of child care would improve access to those health care services by the veteran.

(d) LOCATIONS.—The Secretary shall carry out the pilot program in no fewer than three Veterans Integrated Service Networks (VISNs) selected by the Secretary for purposes of the pilot program.

(e) DURATION.—The pilot program shall be carried out during the two-year period beginning on the date of the commencement of the pilot program.

(f) EXISTING MODEL.—To the extent practicable, the Secretary shall model the pilot program after the Department of Veterans Affairs Child Care Subsidy Program that was established pursuant to section 630 of the Treasury and General Government Appropriations Act, 2002 (Public Law 107–67; 115 Stat. 552), using the same income eligibility standards and payment structure.

(g) REPORT.—Not later than six months after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall include the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Veterans Affairs for each of fiscal years 2010 and 2011, $1,500,000 to carry out the pilot program.

SEC. 209. CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE.

(a) IN GENERAL.—Subchapter VIII of chapter 17 is amended by adding at the end the following new section:

''SEC. 1786. CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE.

''(a) IN GENERAL.—The Secretary may furnish health care services described in subsection (b) to a newborn child of a woman veteran who is receiving maternity care furnished by the Department for not more than 7 days after the birth of the child if the veteran delivered the child in—

''(1) a facility of the Department; or

''(2) another facility pursuant to a Department contract for services relating to such delivery.

''(b) COVERED HEALTH CARE SERVICES.—Health care services described in this subsection are all post-delivery care services, including routine care services, that a newborn requires.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1785 the following new item:

''1786. Care for newborn children of women veterans receiving maternity care.''.

TITLE III—RURAL HEALTH IMPROVEMENTS

SEC. 301. ENHANCEMENT OF DEPARTMENT OF VETERANS AFFAIRS EDUCATION DEBT REDUCTION PROGRAM.

(a) ENHANCED MAXIMUM ANNUAL AMOUNT.—Paragraph (1) of section 7683(d) is amended by striking ''$44,000'' and all that follows through ''fifth years of participation in the Program'' and inserting ''the total amount of principle and interest owed by the participant on loans referred to in subsection (a)''.

(b) NOTICE TO POTENTIAL EMPLOYEES OF ELIGIBILITY AND SELECTION FOR PARTICIPATION.—Section 7682 is amended by adding at the end the following new subsection:

''(d) NOTICE TO POTENTIAL EMPLOYEES.—In each offer of employment made by the Secretary to an individual who, upon acceptance of such offer would be treated as eligible to participate in the Education Debt Reduction Program, the Secretary shall, to the maximum extent practicable, include the following:

''(1) A notice that the individual will be treated as eligible to participate in the Education Debt Reduction Program upon the individual's acceptance of such offer.

''(2) A notice of the determination of the Secretary whether or not the individual will be selected as a participant in the Education Debt Reduction Program as of the individual's acceptance of such offer.''.

(c) SELECTION OF EMPLOYEES WHO RECEIVE NOTICE OF SELECTION WITH EMPLOYMENT OFFER.—Section 7683 is further amended by adding at the end the following new subsection:

''(e) SELECTION OF PARTICIPANTS.—(1) The Secretary shall select for participation in the Education Debt Reduction Program each individual eligible for participation in the Education Debt Reduction Program who—

''(A) the Secretary provided notice with an offer of employment under section 7682(d) of this title that indicated the individual would, upon the individual's acceptance of such offer of employment, be—

''(i) eligible to participate in the Education Debt Reduction Program; and

''(ii) selected to participate in the Education Debt Reduction Program; and

''(B) accepts such offer of employment.

''(2) The Secretary may select for participation in the Education Debt Reduction Program an individual eligible for participation in the Education Debt Reduction Program who is not described by subparagraphs (A) and (B) of paragraph (1).''.

SEC. 302. VISUAL IMPAIRMENT AND ORIENTATION AND MOBILITY PROFESSIONALS EDUCATION ASSISTANCE PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Part V is amended by inserting after chapter 74 the following new chapter:

''CHAPTER 75—VISUAL IMPAIRMENT AND ORIENTATION AND MOBILITY PROFESSIONALS EDUCATION ASSISTANCE PROGRAM

''Sec.
''7501. Establishment of scholarship program; purpose.
''7502. Application and acceptance.
''7503. Amount of assistance; duration.
''7504. Agreement.
''7505. Repayment for failure to satisfy requirements of agreement.

''§ 7501. Establishment of scholarship program; purpose

''(a) ESTABLISHMENT.—Subject to the availability of appropriations, the Secretary shall establish and carry out a scholarship program to provide financial assistance in accordance with this chapter to an individual—

''(1) who is accepted for enrollment or currently enrolled in a program of study leading to a degree or certificate in visual impairment or orientation and mobility, or a dual degree or certification in both such areas, at an accredited (as determined by the Secretary) educational institution that is in a State; and

''(2) who enters into an agreement with the Secretary as described in section 7504 of this chapter.

''(b) PURPOSE.—The purpose of the scholarship program established under this chapter is to increase the supply of qualified blind rehabilitation specialists for the Department and the Nation.

''(c) OUTREACH.—The Secretary shall publicize the scholarship program established under this chapter to educational institutions throughout the United States, with an emphasis on disseminating information to such institutions with high numbers of Hispanic students and to Historically Black Colleges and Universities.

''§ 7502. Application and acceptance

''(a) APPLICATION.—(1) To apply and participate in the scholarship program under this chapter, an individual shall submit to the Secretary an application for such participation together with an agreement described in section 7504 of this chapter under which the participant agrees to serve a period of obligated service in the Department as provided in the agreement in return for payment of educational assistance as provided in the agreement.

''(2) In distributing application forms and agreement forms to individuals desiring to participate in the scholarship program, the Secretary shall include with such forms the following:

''(A) A fair summary of the rights and liabilities of an individual whose application is approved (and whose agreement is accepted) by the Secretary.

''(B) A full description of the terms and conditions that apply to participation in the scholarship program and service in the Department.

''(b) APPROVAL.—(1) Upon the Secretary's approval of an individual's participation in the scholarship program, the Secretary shall, in writing, promptly notify the individual of that acceptance.

''(2) An individual becomes a participant in the scholarship program upon such approval by the Secretary.

''§ 7503. Amount of assistance; duration

''(a) AMOUNT OF ASSISTANCE.—The amount of the financial assistance provided for an individual under this chapter shall be the amount determined by the Secretary as being necessary to pay the tuition and fees of the individual. In the case of an individual enrolled in a program of study leading to a dual degree or certification in both the areas of study described in section 7501(a)(1) of this chapter, the tuition and fees shall not exceed the amounts necessary for the minimum number of credit hours to achieve such dual certification or degree.

''(b) RELATIONSHIP TO OTHER ASSISTANCE.—Financial assistance may be provided to an individual under this chapter to supplement other educational assistance to the extent that the total amount of educational assistance received by the individual during an academic year does not exceed the total tuition and fees for such academic year.

''(c) MAXIMUM AMOUNT OF ASSISTANCE.—(1) In no case may the total amount of assistance provided under this chapter for an academic year to an individual who is a full-time student exceed $15,000.

''(2) In the case of an individual who is a part-time student, the total amount of assistance provided under this chapter shall bear the same ratio to the amount that would be paid under paragraph (1) if the participant were a full-time student in the program of study being pursued by the individual as the coursework carried by the individual to full-time coursework in that program of study.

''(3) In no case may the total amount of assistance provided to an individual under this chapter exceed $45,000.

''(d) MAXIMUM DURATION OF ASSISTANCE.—The Secretary may provide financial assistance to an individual under this chapter for not more than six years.

''§ 7504. Agreement

''An agreement between the Secretary and a participant in the scholarship program under this chapter shall be in writing, shall be signed by the participant, and shall include—

''(1) the Secretary's agreement to provide the participant with financial assistance as authorized under this chapter;

''(2) the participant's agreement—

''(A) to accept such financial assistance;

''(B) to maintain enrollment and attendance in the program of study described in section 7501(a)(1) of this chapter;

''(C) while enrolled in such program, to maintain an acceptable level of academic standing (as determined by the educational institution offering such program under regulations prescribed by the Secretary); and

''(D) after completion of the program, to serve as a full-time employee in the Department for a period of three years, to be served within the first six years after the participant has completed such program and received a degree or certificate described in section 7501(a)(1) of this chapter; and

''(3) any other terms and conditions that the Secretary determines appropriate for carrying out this chapter.

''§ 7505. Repayment for failure to satisfy requirements of agreement

''(a) IN GENERAL.—An individual who receives educational assistance under this chapter shall repay to the Secretary an amount equal to the unearned portion of such assistance if the individual fails to satisfy the requirements of the agreement entered into under section 7504 of this chapter, except in circumstances authorized by the Secretary.

''(b) AMOUNT OF REPAYMENT.—The Secretary shall establish, by regulations, procedures for determining the amount of the repayment required under this subsection and the circumstances under which an exception to the required repayment may be granted.

''(c) WAIVER OR SUSPENSION OF COMPLIANCE.—The Secretary shall prescribe regulations providing for the waiver or suspension of any obligation of an individual for service or payment under this chapter (or an agreement under this chapter) whenever noncompliance by the individual is due to circumstances beyond the control of the individual or whenever the Secretary determines that the waiver or suspension of compliance is in the best interest of the United States.

''(d) OBLIGATION AS DEBT TO UNITED STATES.—An obligation to repay the Secretary under this section is, for all purposes, a debt owed the United States. A discharge in bankruptcy under title 11 does not discharge a person from such debt if the discharge order is entered less than five years

after the date of the termination of the agreement or contract on which the debt is based.''.

(b) CLERICAL AMENDMENTS.—The tables of chapters at the beginning of title 38, and of part V of title 38, are each amended by inserting after the item relating to chapter 74 the following new item:

''75. Visual Impairment and Orientation and Mobility Professionals Education Assistance Program ... 7501.''.

(c) EFFECTIVE DATE.—The Secretary of Veterans Affairs shall implement chapter 75 of title 38, United States Code, as added by subsection (a), not later than six months after the date of the enactment of this Act.

SEC. 303. INCLUSION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES IN LIST OF FACILITIES ELIGIBLE FOR ASSIGNMENT OF PARTICIPANTS IN NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.

The Secretary of Veterans Affairs shall transfer $20,000,000 from accounts of the Veterans Health Administration to the Secretary of Health and Human Services to include facilities of the Department of Veterans Affairs in the list maintained by the Health Resources and Services Administration of facilities eligible for assignment of participants in the National Health Service Corps Scholarship Program.

SEC. 304. TELECONSULTATION AND TELEMEDICINE.

(a) TELECONSULTATION AND TELERETINAL IMAGING.—

(1) IN GENERAL.—Subchapter I of chapter 17 is amended by adding at the end the following new section:

''§ 1709. Teleconsultation and teleretinal imaging

''(a) TELECONSULTATION.—(1) The Secretary shall carry out a program of teleconsultation for the provision of remote mental health and traumatic brain injury assessments in facilities of the Department that are not otherwise able to provide such assessments without contracting with third party providers or reimbursing providers through a fee-basis system.

''(2) The Secretary shall, in consultation with appropriate professional societies, promulgate technical and clinical care standards for the use of teleconsultation services within facilities of the Department.

''(b) TELERETINAL IMAGING.—The Secretary shall carry out a program of teleretinal imaging in each Veterans Integrated Services Network (VISN).

''(c) ANNUAL REPORTS.—In each fiscal year beginning with fiscal year 2010 and ending with fiscal year 2015, the Secretary shall submit to Congress a report on the programs required by subsections (a) and (b). Such report shall include the following:

''(1) A description of the efforts made by the Secretary to make teleconsultation available in rural areas and to utilize teleconsultation in rural areas.

''(2) The rates of utilization of teleconsultation by Veterans Integrated Services Network disaggregated by each fiscal year for which a report is submitted under this subsection.

''(d) DEFINITIONS.—In this section:

''(1) The term 'teleconsultation' means the use by a health care specialist of telecommunications to assist another health care provider in rendering a diagnosis or treatment.

''(2) The term 'teleretinal imaging' means the use by a health care specialist of telecommunications, digital retinal imaging, and remote image interpretation to provide eye care.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to section 1708 the following new item:

''1709. Teleconsultation and teleretinal imaging.''.

(b) TRAINING IN TELEMEDICINE.—The Secretary of Veterans Affairs shall require each Department of Veterans Affairs facility that is involved in the training of medical residents to work with each university concerned to develop an elective rotation in telemedicine for such residents.

(c) ENHANCEMENT OF VERA.—

(1) INCENTIVES FOR PROVISION OF TELECONSULTATION, TELERETINAL IMAGING, TELEMEDICINE, AND TELEHEALTH SERVICES.—The Secretary of Veterans Affairs shall modify the Veterans Equitable Resource Allocation system to provide Veterans Integrated Services Networks with incentives to utilize teleconsultation, teleretinal imaging, telemedicine, and telehealth coordination services.

(2) INCLUSION OF TELEMEDICINE VISITS IN WORKLOAD REPORTING.—The Secretary shall modify the Veterans Equitable Resource Allocation system to require the inclusion of all telemedicine visits in the calculation of facility workload.

(d) DEFINITIONS.—In this section:

(1) The terms ''teleconsultation'' and ''teleretinal imaging'' have the meanings given such terms in section 1709 of title 38, United States Code, as added by subsection (a).

(2) The term ''telemedicine'' means the use by a health care provider of telecommunications to assist in the diagnosis or treatment of a patient's medical condition.

(3) The term ''telehealth'' means the use of telecommunications to collect patient data remotely and send data to a monitoring station for interpretation.

SEC. 305. DEMONSTRATION PROJECTS ON ALTERNATIVES FOR EXPANDING CARE FOR VETERANS IN RURAL AREAS.

(a) IN GENERAL.—The Secretary of Veterans Affairs, through the Director of the Office of Rural Health, may carry out demonstration projects to examine the feasibility and advisability of alternatives for expanding care for veterans in rural areas, which may include the following:

(1) Establishing a partnership between the Department of Veterans Affairs and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services to coordinate care for veterans in rural areas at critical access hospitals (as designated or certified under section 1820 of the Social Security Act (42 U.S.C. 1395i–4)).

(2) Establishing a partnership between the Department of Veterans Affairs and the Department of Health and Human Services to coordinate care for veterans in rural areas at community health centers.

(3) Expanding coordination between the Department of Veterans Affairs and the Indian Health Service to expand care for Indian veterans.

(b) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that the demonstration projects carried out under subsection (a) are located at facilities that are geographically distributed throughout the United States.

(c) REPORT.—Not later than two years after the date of the enactment of this Act, the Secretary shall submit a report on the results of the demonstration projects conducted under subsection (a) to—

(1) the Committee on Veterans' Affairs and the Committee on Appropriations of the Senate; and

(2) the Committee on Veterans' Affairs and the Committee on Appropriations of the House of Representatives.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $5,000,000 for fiscal year 2010 and each fiscal year thereafter.

SEC. 306. PROGRAM ON PROVISION OF READJUSTMENT AND MENTAL HEALTH CARE SERVICES TO VETERANS WHO SERVED IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) PROGRAM REQUIRED.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish a program to provide—

(1) to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, particularly veterans who served in such operations while in the National Guard and the Reserves—

(A) peer outreach services;

(B) peer support services;

(C) readjustment counseling and services described in section 1712A of title 38, United States Code; and

(D) mental health services; and

(2) to members of the immediate family of such a veteran, during the three-year period beginning on the date of the return of such veteran from deployment in Operation Iraqi Freedom or Operation Enduring Freedom, education, support, counseling, and mental health services to assist in—

(A) the readjustment of such veteran to civilian life;

(B) in the case such veteran has an injury or illness incurred during such deployment, the recovery of such veteran; and

(C) the readjustment of the family following the return of such veteran.

(b) CONTRACTS WITH COMMUNITY MENTAL HEALTH CENTERS AND QUALIFIED ENTITIES FOR PROVISION OF SERVICES.—In carrying out the program required by subsection (a), the Secretary shall contract with community mental health centers and other qualified entities to provide the services required by such subsection only in areas the Secretary determines are not adequately served by other health care facilities or vet centers of the Department of Veterans Affairs. Such contracts shall require each contracting community health center or entity—

(1) to the extent practicable, to use telehealth services for the delivery of services required by subsection (a);

(2) to the extent practicable, to employ veterans trained under subsection (c);

(3) to participate in the training program conducted in accordance with subsection (d);

(4) to comply with applicable protocols of the Department before incurring any liability on behalf of the Department for the provision of the services required by subsection (a);

(5) for each veteran for whom a community mental health center or other qualified entity provides mental health services under such contract, to provide the Department with such clinical summary information as the Secretary shall require;

(6) to submit annual reports to the Secretary containing, with respect to the program required by subsection (a) and for the last full calendar year ending before the submission of such report—

(A) the number of the veterans served, veterans diagnosed, and courses of treatment provided to veterans as part of the program required by subsection (a); and

(B) demographic information for such services, diagnoses, and courses of treatment; and

(7) to meet such other requirements as the Secretary shall require.

(c) TRAINING OF VETERANS FOR THE PROVISION OF PEER-OUTREACH AND PEER-SUPPORT SERVICES.—In carrying out the program required by subsection (a), the Secretary shall contract with a national not-for-profit mental health organization to carry out a national program of training for veterans described in subsection (a) to provide the services described in subparagraphs (A) and (B) of paragraph (1) of such subsection.

(d) TRAINING OF CLINICIANS FOR PROVISION OF SERVICES.—The Secretary shall conduct a training program for clinicians of community mental health centers or entities that have contracts with the Secretary under subsection (b) to ensure that such clinicians can provide the services required by subsection (a) in a manner that—

(1) recognizes factors that are unique to the experience of veterans who served on active duty in Operation Iraqi Freedom or Operation Enduring Freedom (including their combat and military training experiences); and

(2) utilizes best practices and technologies.

(e) REPORTS REQUIRED.—

(1) INITIAL REPORT ON PLAN FOR IMPLEMENTATION.—Not later than 45 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report containing the plans of the Secretary to implement the program required by subsection (a).

(2) STATUS REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the implementation of the program. Such report shall include the following:

(A) Information on the number of veterans who received services as part of the program and the type of services received during the last full calendar year completed before the submission of such report.

(B) An evaluation of the provision of services under paragraph (2) of subsection (a) and a recommendation as to whether the period described in such paragraph should be extended to a five-year period.

SEC. 307. IMPROVEMENT OF CARE OF AMERICAN INDIAN VETERANS.

(a) INDIAN HEALTH COORDINATORS.—

(1) IN GENERAL.—Subchapter II of chapter 73 is amended by adding at the end the following new section:

"§ 7330B. Indian Veterans Health Care Coordinators

''(a) IN GENERAL.—(1) The Secretary shall assign at each of the 10 Department Medical Centers that serve communities with the greatest number of Indian veterans per capita an official or employee of the Department to act as the coordinator of health care for Indian veterans at such Medical Center. The official or employee so assigned at a Department Medical Center shall be known as the 'Indian Veterans Health Care Coordinator' for the Medical Center.

''(2) The Secretary shall, from time to time—

''(A) survey the Department Medical Centers for purposes of identifying the 10 Department Medical Centers that currently serve communities with the greatest number of Indian veterans per capita; and

''(B) utilizing the results of the most recent survey conducted under subparagraph (A), revise the assignment of Indian Veterans Health Care Coordinators in order to assure the assignment of such coordinators to appropriate Department Medical Centers as required by paragraph (1).

''(b) DUTIES.—The duties of an Indian Veterans Health Care Coordinator shall include the following:

''(1) Improving outreach to tribal communities.

''(2) Coordinating the medical needs of Indian veterans on Indian reservations with the Veterans Health Administration and the Indian Health Service.

''(3) Expanding the access and participation of the Department of Veterans Affairs, the Indian Health Service, and tribal members in the Department of Veterans Affairs Tribal Veterans Representative program.

''(4) Acting as an ombudsman for Indian veterans enrolled in the health care system of the Veterans Health Administration.

''(5) Advocating for the incorporation of traditional medicine and healing in Department treatment plans for Indian veterans in need of care and services provided by the Department.

''(c) INDIAN DEFINED.—In this section, the term 'Indian' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to section 7330A the following new item:

''7330B. Indian Veterans Health Coordinators.''.

(b) INTEGRATION OF ELECTRONIC HEALTH RECORDS WITH INDIAN HEALTH SERVICE.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health and Human Services shall enter into a memorandum of understanding to ensure that the health records of Indian veterans may be transferred electronically between facilities of the Indian Health Service and the Department of Veterans Affairs.

(c) TRANSFER OF MEDICAL EQUIPMENT TO THE INDIAN HEALTH SERVICE.—

(1) IN GENERAL.—The Secretary of Veterans Affairs may transfer to the Indian Health Service such surplus Department of Veterans Affairs medical and information technology equipment as the Secretary of Veterans Affairs and the Secretary of Health and Human Services jointly consider appropriate for purposes of the Indian Health Service.

(2) TRANSPORTATION AND INSTALLATION.—In transferring medical or information technology equipment under this subsection, the Secretary of Veterans Affairs may transport and install such equipment in facilities of the Indian Health Service.

(d) REPORT ON JOINT HEALTH CLINICS WITH INDIAN HEALTH SERVICE.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health and Human Services shall jointly submit to Congress a report on the feasability and advisability of the joint establishment and operation by the Veterans Health Administration and the Indian Health Service of health clinics on Indian reservations to serve the populations of such reservations, including Indian veterans.

SEC. 308. TRAVEL REIMBURSEMENT FOR VETERANS RECEIVING TREATMENT AT FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) ENHANCEMENT OF ALLOWANCE BASED UPON MILEAGE TRAVELED.—Section 111 is amended—

(1) in subsection (a), by striking ''traveled,'' and inserting ''(at a rate of 41.5 cents per mile),''; and

(2) by amending subsection (g) to read as follows:

''(g)(1) Beginning one year after the date of the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2009, the Secretary may adjust the mileage rate described in subsection (a) to be equal to the mileage reimbursement rate for the use of privately owned vehicles by Government employees on official business (when a Government vehicle is available), as prescribed by the Administrator of General Services under section 5707(b) of title 5.

''(2) If an adjustment in the mileage rate under paragraph (1) results in a lower mileage rate than the mileage rate otherwise specified in subsection (a), the Secretary shall, not later than 60 days before the date of the implementation of the mileage rate as so adjusted, submit to Congress a written report setting forth the adjustment in the mileage rate under this subsection, together with a justification for the decision to make the adjustment in the mileage rate under this subsection.''.

(b) COVERAGE OF COST OF TRANSPORTATION BY AIR.—Subsection (a) of section 111, as amended by subsection (a)(1), is further amended by inserting after the first sentence the following new sentence: ''Actual necessary expense of travel includes the reasonable costs of airfare if travel by air is the only practical way to reach a Department facility.''.

(c) ELIMINATION OF LIMITATION BASED ON MAXIMUM ANNUAL RATE OF PENSION.—Subsection (b)(1)(D)(i) of such section is amended by inserting ''who is not traveling by air and'' before ''whose annual''.

(d) DETERMINATION OF PRACTICALITY.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

''(4) In determining for purposes of subsection (a) whether travel by air is the only practical way for a veteran to reach a Department facility, the Secretary shall consider the medical condition of the veteran and any other impediments to the use of ground transportation by the veteran.''.

(e) NO EXPANSION OF ELIGIBILITY FOR BENEFICIARY TRAVEL.—The amendments made by subsections (b) and (d) of this section may not be construed as expanding or otherwise modifying eligibility for payments or allowances for beneficiary travel under section 111 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act.

(f) CLARIFICATION OF RELATION TO PUBLIC TRANSPORTATION IN VETERANS HEALTH ADMINISTRATION HANDBOOK.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall revise the Veterans Health Administration Handbook to clarify that an allowance for travel based on mileage paid under section 111(a) of title 38, United States Code, may exceed the cost of such travel by public transportation regardless of medical necessity.

SEC. 309. OFFICE OF RURAL HEALTH FIVE-YEAR STRATEGIC PLAN.

(a) STRATEGIC PLAN.—Not later than 180 days after the date of the enactment of this Act, the Director of the Office of Rural Health of the Department of Veterans Affairs shall develop a five-year strategic plan for the Office of Rural Health.

(b) CONTENTS.—The plan required by subsection (a) shall include the following:

(1) Specific goals for the recruitment and retention of health care personnel in rural

areas, developed in conjunction with the Director of the Health Care Retention and Recruitment Office of the Department of Veterans Affairs.

(2) Specific goals for ensuring the timeliness and quality of health care delivery in rural communities that are reliant on contract and fee-basis care, developed in conjunction with the Director of the Office of Quality and Performance of the Department.

(3) Specific goals for the expansion and implementation of telemedicine services in rural areas, developed in conjunction with the Director of the Office of Care Coordination Services of the Department.

(4) Incremental milestones describing specific actions to be taken for the purpose of achieving the goals specified under paragraphs (1) through (3).

SEC. 310. OVERSIGHT OF CONTRACT AND FEE-BASIS CARE.

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by inserting after section 1703 the following new section:

"§ 1703A. Oversight of contract and fee-basis care

"(a) RURAL OUTREACH COORDINATORS.—The Secretary shall designate a rural outreach coordinator at each Department community based outpatient clinic at which not less than 50 percent of the veterans enrolled at such clinic reside in a highly rural area. The coordinator at a clinic shall be responsible for coordinating care and collaborating with community contract and fee-basis providers with respect to the clinic.

"(b) INCENTIVES TO OBTAIN ACCREDITATION OF MEDICAL PRACTICE.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department to encourage such providers to obtain accreditation of their medical practice from recognized accrediting entities.

"(2) In making adjustments under paragraph (1), the Secretary shall consider the increased overhead costs of accreditation described in paragraph (1) and the costs of achieving and maintaining such accreditation.

"(c) INCENTIVES FOR PARTICIPATION IN PEER REVIEW.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department that do not provide such services as part of a medical practice accredited by a recognized accrediting entity to encourage such providers to participate in peer review under subsection (e).

"(2) The Secretary shall provide incentives under paragraph (1) to a provider of health care services under the Department in an amount which may reasonably be expected (as determined by the Secretary) to encourage participation in the voluntary peer review under subsection (d).

"(d) PEER REVIEW.—(1) The Secretary shall provide for the voluntary peer review of providers of health care services under the Department who provide such services on a fee basis as part of a medical practice that is not accredited by a recognized accrediting entity.

"(2) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, the Chief Quality and Performance Officer in each Veterans Integrated Services Network (VISN) shall select a sample of patient records from each participating provider in the Officer's Veterans Integrated Services Network to be peer reviewed by a facility designated under paragraph (3).

"(3) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall designate Department facilities in such network for the peer review of patient records submitted under this subsection.

"(4) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, each provider who elects to participate in the program shall submit the patient records selected under paragraph (2) to a facility selected under paragraph (3) to be peer reviewed by such facility.

"(5) Each Department facility designated under paragraph (3) that receives patient records under paragraph (4) shall—

"(A) peer review such records in accordance with policies and procedures established by the Secretary;

"(B) ensure that peer reviews are evaluated by the Peer Review Committee; and

"(C) develop a mechanism for notifying the Under Secretary for Health of problems identified through such peer review.

"(6) The Under Secretary for Health shall develop a mechanism by which the use of fee-basis providers of health care are terminated when quality of care concerns are identified with respect to such providers.

"(7) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall be responsible for the oversight of the program of peer review under this subsection in that network.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to section 1703 the following new item:

"1703A. Oversight of contract and fee-basis care.".

SEC. 311. ENHANCEMENT OF VET CENTERS TO MEET NEEDS OF VETERANS OF OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) VOLUNTEER COUNSELORS.—

(1) IN GENERAL.—Subsection (c) of section 1712A is amended—

(A) by striking "The Under Secretary" and inserting "(1) The Under Secretary";

(B) in paragraph (1), as designated by paragraph (1), by striking ", and, in carrying" and all that follows through "screening activities"; and

(C) by adding at the end the following new paragraphs:

"(2) In carrying out this section, the Under Secretary may utilize the services of the following:

"(A) Paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 3485 of this title) in initial intake and screening activities.

"(B) Eligible volunteer counselors in the provision of counseling and related mental health services.

"(3) For purposes of this subsection, an eligible volunteer counselor is an individual—

"(A) who—

"(i) provides counseling services without compensation at a center;

"(ii) is a licensed psychologist or social worker;

"(iii) has never been named in a tort claim arising from professional activities; and

"(iv) has never had, and has no pending, disciplinary action taken with respect to any license or certification qualifying that individual to provide counseling services; or

"(B) who is otherwise credentialed and privileged to perform counseling services by the Secretary.

"(4) Eligible volunteer counselors shall be issued credentials and privileges for the provision of counseling and related mental health services under this section on an expedited basis in accordance with such procedures as the Secretary shall establish. Such procedures shall provide for the completion by the Secretary of the processing of an application for such credentials and privileges not later than 60 days after receipt of the application.".

(2) PROCEDURES FOR ISSUING CREDENTIALS AND PRIVILEGES TO VOLUNTEER COUNSELORS.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish the procedures described in section 1712A(c)(4), as added by paragraph (1).

(b) OUTREACH.—Subsection (e) of such section is amended—

(1) by striking "The Secretary" and inserting "(1) The Secretary"; and

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

"(2) Each center shall develop an outreach plan to ensure that the community served by the center is aware of the services offered by the center.".

SEC. 312. CENTERS OF EXCELLENCE FOR RURAL HEALTH RESEARCH, EDUCATION, AND CLINICAL ACTIVITIES.

(a) IN GENERAL.—Subchapter II of chapter 73, as amended by section 307 of this Act, is further amended by adding at the end the following new section:

"§ 7330C. Centers of excellence for rural health research, education, and clinical activities

"(a) ESTABLISHMENT OF CENTERS.—The Secretary, through the Director of the Office of Rural Health, shall establish and operate at least one and not more than five centers of excellence for rural health research, education, and clinical activities, which shall—

"(1) conduct research on the furnishing of health services in rural areas;

"(2) develop specific models to be used by the Department in furnishing health services to veterans in rural areas;

"(3) provide education and training for health care professionals of the Department on the furnishing of health services to veterans in rural areas; and

"(4) develop and implement innovative clinical activities and systems of care for the Department for the furnishing of health services to veterans in rural areas.

"(b) USE OF RURAL HEALTH RESOURCE CENTERS.—In selecting locations for the establishment of centers of excellence under subsection (a), the Secretary may select a rural health resource center that meets the requirements of subsection (a).

"(c) GEOGRAPHIC DISPERSION.—The Secretary shall ensure that the centers established under this section are located at health care facilities that are geographically dispersed throughout the United States.

"(d) FUNDING.—(1) There are authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account of the Department of Veterans Affairs such sums as may be necessary for the support of the research and education activities of the centers operated under this section.

"(2) There shall be allocated to the centers operated under this section, from amounts authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account by paragraph (1), such amounts as the Under Secretary of health considers appropriate for such centers. Such amounts shall be allocated through the Director of the Office of Rural Health.

"(3) Activities of clinical and scientific investigation at each center operated under this section—

''(A) shall be eligible to compete for the award of funding from funds appropriated for the Medical and Prosthetics Research Account; and

''(B) shall receive priority in the award of funding from such account to the extent that funds are awarded to projects for research in the care of rural veterans.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73, as amended by section 307 of this Act, is further amended by inserting after the item relating to section 7330B the following new item:

''7330C. Centers of excellence for rural health research, education, and clinical activities.''.

SEC. 313. PILOT PROGRAM ON INCENTIVES FOR PHYSICIANS WHO ASSUME INPATIENT RESPONSIBILITIES AT COMMUNITY HOSPITALS IN HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasability and advisability of each of the following:

(1) The provision of financial incentives to eligible physicians who obtain and maintain inpatient privileges at community hospitals in health professional shortage areas in order to facilitate the provision by such physicians of primary care and mental health services to veterans at such hospitals.

(2) The collection of payments from third-party providers for care provided by eligible physicians to nonveterans while discharging inpatient responsibilities at community hospitals in the course of exercising the privileges described in paragraph (1).

(b) ELIGIBLE PHYSICIANS.—For purposes of this section, an eligible physician is a primary care or mental health physician employed by the Department of Veterans Affairs on a full-time basis.

(c) DURATION OF PROGRAM.—The pilot program shall be carried out during the three-year period beginning on the date of the commencement of the pilot program.

(d) LOCATIONS.—

(1) IN GENERAL.—The pilot program shall be carried out at not less than five community hospitals in each of not less than two Veterans Integrated Services Networks (VISNs). The hospitals shall be selected by the Secretary utilizing the results of the survey required under subsection (e).

(2) QUALIFYING COMMUNITY HOSPITALS.—A community hospital may be selected by the Secretary as a location for the pilot program if—

(A) the hospital is located in a health professional shortage area; and

(B) the number of eligible physicians willing to assume inpatient responsibilities at the hospital (as determined utilizing the result of the survey) is sufficient for purposes of the pilot program.

(e) SURVEY OF PHYSICIAN INTEREST IN PARTICIPATION.—

(1) IN GENERAL.—Not later than 120 days after the date of the enactment of this Act, the Secretary shall conduct a survey of eligible physicians to determine the extent of the interest of such physicians in participating in the pilot program.

(2) ELEMENTS.—The survey shall disclose the type, amount, and nature of the financial incentives to be provided under subsection (h) to physicians participating in the pilot program.

(f) PHYSICIAN PARTICIPATION.—

(1) IN GENERAL.—The Secretary shall select physicians for participation in the pilot program from among eligible physicians who—

(A) express interest in participating in the pilot program in the survey conducted under subsection (e);

(B) are in good standing with the Department; and

(C) primarily have clinical responsibilities with the Department.

(2) VOLUNTARY PARTICIPATION.—Participation in the pilot program shall be voluntary. Nothing in this section shall be construed to require a physician working for the Department to assume inpatient responsibilities at a community hospital unless otherwise required as a term or condition of employment with the Department.

(g) ASSUMPTION OF INPATIENT PHYSICIAN RESPONSIBILITIES.—

(1) IN GENERAL.—Each eligible physician selected for participation in the pilot program shall assume and maintain inpatient responsibilities, including inpatient responsibilities with respect to nonveterans, at one or more community hospitals selected by the Secretary for participation in the pilot program under subsection (d).

(2) COVERAGE UNDER FEDERAL TORT CLAIMS ACT.—If an eligible physician participating in the pilot program carries out on-call responsibilities at a community hospital where privileges to practice at such hospital are conditioned upon the provision of services to individuals who are not veterans while the physician is on call for such hospital, the provision of such services by the physician shall be considered an action within the scope of the physician's office or employment for purposes of chapter 171 of title 28, United States Code (commonly referred to as the ''Federal Tort Claims Act'').

(h) COMPENSATION.—

(1) IN GENERAL.—The Secretary shall provide each eligible physician participating in the pilot program with such compensation (including pay and other appropriate compensation) as the Secretary considers appropriate to compensate such physician for the discharge of any inpatient responsibilities by such physician at a community hospital for which such physician would not otherwise be compensated by the Department as a full-time employee of the Department.

(2) WRITTEN AGREEMENT.—The amount of any compensation to be provided a physician under the pilot program shall be specified in a written agreement entered into by the Secretary and the physician for purposes of the pilot program.

(3) TREATMENT OF COMPENSATION.—The Secretary shall consult with the Director of the Office of Personnel Management on the inclusion of a provision in the written agreement required under paragraph (2) that describes the treatment under Federal law of any compensation provided a physician under the pilot program, including treatment for purposes of retirement under the civil service laws.

(i) COLLECTIONS FROM THIRD PARTIES.—In carrying out the pilot program for the purpose described in subsection (a)(2), the Secretary shall implement a variety and range of requirements and mechanisms for the collection from third-party payors of amounts to reimburse the Department for health care services provided to nonveterans under the pilot program by eligible physicians discharging inpatient responsibilities under the pilot program.

(j) INPATIENT RESPONSIBILITIES DEFINED.—In this section, the term ''inpatient responsibilities'' means on-call responsibilities customarily required of a physician by a community hospital as a condition of granting privileges to the physician to practice in the hospital.

(k) REPORT.—Not later than one year after the date of the enactment of this Act and annually thereafter, the Secretary shall submit to Congress a report on the pilot program, including the following:

(1) The findings of the Secretary with respect to the pilot program.

(2) The number of veterans and nonveterans provided inpatient care by physicians participating in the pilot program.

(3) The amounts collected and payable under subsection (i).

(l) HEALTH PROFESSIONAL SHORTAGE AREA DEFINED.—In this section, the term ''health professional shortage area'' has the meaning given the term in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a)).

SEC. 314. ANNUAL REPORT ON MATTERS RELATED TO CARE FOR VETERANS WHO LIVE IN RURAL AREAS.

(a) ANNUAL REPORT.—The Secretary of Veterans Affairs shall submit to Congress each year, together with documents submitted to Congress in support of the budget of the President for the fiscal year beginning in such year (as submitted pursuant to section 1105 of title 31, United States Code), an assessment, current as of the fiscal year ending in the year before such report is submitted, of the following:

(1) The implementation of the provisions of sections 209 through 213, including the amendments made by such sections.

(2) The establishment and functions of the Office of Rural Health under section 7308 of title 38, United States Code.

(b) ADDITIONAL REQUIREMENTS FOR INITIAL REPORT.—The first report submitted under subsection (a) shall also include the following:

(1) The assessment of fee-basis health-care program required by section 212(b) of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109–461; 120 Stat. 3422).

(2) An assessment of the outreach program required by section 213 of such Act (120 Stat. 3422; 38 U.S.C. 6303 note).

SEC. 315. TRANSPORTATION GRANTS FOR RURAL VETERANS SERVICE ORGANIZATIONS.

(a) GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall establish a grant program to provide innovative transportation options to veterans in highly rural areas.

(2) ELIGIBLE RECIPIENTS.—The following may be awarded a grant under this section:

(A) State veterans service agencies.

(B) Veterans service organizations.

(3) USE OF FUNDS.—A State veterans service agency or veterans service organization awarded a grant under this section may use the grant amount to—

(A) assist veterans in highly rural areas to travel to Department of Veterans Affairs medical centers; and

(B) otherwise assist in providing medical care to veterans in highly rural areas.

(4) MAXIMUM AMOUNT.—The amount of a grant under this section may not exceed $50,000.

(5) NO MATCHING REQUIREMENT.—The recipient of a grant under this section shall not be required to provide matching funds as a condition for receiving such grant.

(b) REGULATIONS.—The Secretary shall prescribe regulations for—

(1) evaluating grant applications under this section; and

(2) otherwise administering the program established by this section.

(c) DEFINITIONS.—In this section:

(1) HIGHLY RURAL.—The term ''highly rural'', in the case of an area, means that the area consists of a county or counties having

a population of less than seven persons per square mile.

(2) VETERANS SERVICE ORGANIZATION.—The term ''veterans service organization'' means any organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 for each of fiscal years 2010 through 2014 to carry out this section.

SEC. 316. MODIFICATION OF ELIGIBILITY FOR PARTICIPATION IN PILOT PROGRAM OF ENHANCED CONTRACT CARE AUTHORITY FOR HEALTH CARE NEEDS OF CERTAIN VETERANS.

Section 403(b) of the Veterans' Mental Health and other Care Improvements Act of 2008 (Public Law 110–387; 122 Stat. 4125; 38 U.S.C. 1703 note) is amended to read as follows:

''(b) COVERED VETERANS.—For purposes of the pilot program under this section, a covered veteran is any veteran who—

''(1) is—

''(A) enrolled in the system of patient enrollment established under section 1705(a) of title 38, United States Code, as of the date of the commencement of the pilot program under subsection (a)(2); or

''(B) eligible for health care under section 1710(e)(3)(C) of title 38, United States Code; and

''(2) resides in a location that is—

''(A) more than 60 minutes driving distance from the nearest Department health care facility providing primary care services, if the veteran is seeking such services;

''(B) more than 120 minutes driving distance from the nearest Department health care facility providing acute hospital care, if the veteran is seeking such care; or

''(C) more than 240 minutes driving distance from the nearest Department health care facility providing tertiary care, if the veteran is seeking such care.''.

TITLE IV—MENTAL HEALTH CARE MATTERS

SEC. 401. ELIGIBILITY OF MEMBERS OF THE ARMED FORCES WHO SERVE IN OPERATION IRAQI FREEDOM OR OPERATION ENDURING FREEDOM FOR COUNSELING AND SERVICES THROUGH READJUSTMENT COUNSELING SERVICE.

(a) IN GENERAL.—Any member of the Armed Forces, including a member of the National Guard or Reserve, who serves on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom is eligible for readjustment counseling and related mental health services under section 1712A of title 38, United States Code, through the Readjustment Counseling Service of the Veterans Health Administration.

(b) NO REQUIREMENT FOR CURRENT ACTIVE DUTY SERVICE.—A member of the Armed Forces who meets the requirements for eligibility for counseling and services under subsection (a) is entitled to counseling and services under that subsection regardless of whether or not the member is currently on active duty in the Armed Forces at the time of receipt of counseling and services under that subsection.

(c) REGULATIONS.—The eligibility of members of the Armed Forces for counseling and services under subsection (a) shall be subject to such regulations as the Secretary of Defense and the Secretary of Veterans Affairs shall jointly prescribe for purposes of this section.

(d) SUBJECT TO AVAILABILITY OF APPROPRIATIONS.—The provision of counseling and services under subsection (a) shall be subject to the availability of appropriations for such purpose.

SEC. 402. RESTORATION OF AUTHORITY OF READJUSTMENT COUNSELING SERVICE TO PROVIDE REFERRAL AND OTHER ASSISTANCE UPON REQUEST TO FORMER MEMBERS OF THE ARMED FORCES NOT AUTHORIZED COUNSELING.

Section 1712A is amended—

(1) by redesignating subsections (c) through (f) as subsections (d) through (g), respectively; and

(2) by inserting after subsection (b) the following new subsection (c):

''(c) Upon receipt of a request for counseling under this section from any individual who has been discharged or released from active military, naval, or air service but who is not otherwise eligible for such counseling, the Secretary shall—

''(1) provide referral services to assist such individual, to the maximum extent practicable, in obtaining mental health care and services from sources outside the Department; and

''(2) if pertinent, advise such individual of such individual's rights to apply to the appropriate military, naval, or air service, and to the Department, for review of such individual's discharge or release from such service.''.

SEC. 403. STUDY ON SUICIDES AMONG VETERANS.

(a) STUDY REQUIRED.—The Secretary of Veterans Affairs shall conduct a study to determine the number of veterans who died by suicide between January 1, 1999, and the date of the enactment of this Act.

(b) COORDINATION.—In carrying out the study under subsection (a) the Secretary of Veterans Affairs shall coordinate with—

(1) the Secretary of Defense;

(2) Veterans Service Organizations;

(3) the Centers for Disease Control and Prevention; and

(4) State public health offices and veterans agencies.

(c) REPORT TO CONGRESS.—The Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the study required under subsection (a) and the findings of the Secretary.

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

SEC. 404. TRANSFER OF FUNDS TO SECRETARY OF HEALTH AND HUMAN SERVICES FOR GRADUATE PSYCHOLOGY EDUCATION PROGRAM.

(a) TRANSFER OF FUNDS.—Not later than September 30, 2010, the Secretary of Veterans Affairs shall transfer $5,000,000 from accounts of the Veterans Health Administration to the Secretary of Health and Human Services for the Graduate Psychology Education program established under section 755(b)(1)(J) of the Public Health Service Act (42 U.S.C. 294e(b)(1)(J)).

(b) USE OF FUNDS TRANSFERRED.—Funds transferred under subsection (a) shall be used to award grants to support the training of psychologists in the treatment of veterans with post traumatic stress disorder, traumatic brain injury, and other combat-related disorders.

(c) PREFERENCE FOR DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FACILITIES.—In the awarding of grants under subsection (b), the Graduate Psychology Education program shall give preference to health care facilities of the Department of Veterans Affairs and graduate programs of education that are affiliated with such facilities.

TITLE V—OTHER HEALTH CARE MATTERS

SEC. 501. REPEAL OF CERTAIN ANNUAL REPORTING REQUIREMENTS.

(a) NURSE PAY REPORT.—Section 7451 is amended—

(1) by striking subsection (f); and

(2) by redesignating subsection (g) as subsection (f).

(b) LONG-TERM PLANNING REPORT.—

(1) IN GENERAL.—Section 8107 is repealed.

(2) CONFORMING AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by striking the item relating to section 8107.

SEC. 502. MODIFICATIONS TO ANNUAL GULF WAR RESEARCH REPORT.

Section 707(c)(1) of the Persian Gulf War Veterans' Health Status Act (title VII of Public Law 102–585; 38 U.S.C. 527 note) is amended by striking ''Not later than March 1 of each year'' and inserting ''Not later than July 1, 2010, and July 1 of each of the five following years''.

SEC. 503. PAYMENT FOR CARE FURNISHED TO CHAMPVA BENEFICIARIES.

Section 1781 is amended at the end by adding the following new subsection:

''(e) Payment by the Secretary under this section on behalf of a covered beneficiary for medical care shall constitute payment in full and extinguish any liability on the part of the beneficiary for that care.''.

SEC. 504. DISCLOSURES FROM CERTAIN MEDICAL RECORDS.

Section 7332(b)(2) is amended by adding at the end the following new subparagraph:

''(F)(i) To a representative of a patient who lacks decision-making capacity, when a practitioner deems the content of the given record necessary for that representative to make an informed decision regarding the patient's treatment.

''(ii) In this subparagraph, the term 'representative' means an individual, organization, or other body authorized under section 7331 of this title and its implementing regulations to give informed consent on behalf of a patient who lacks decision-making capacity.''.

SEC. 505. DISCLOSURE TO SECRETARY OF HEALTH-PLAN CONTRACT INFORMATION AND SOCIAL SECURITY NUMBER OF CERTAIN VETERANS RECEIVING CARE.

(a) IN GENERAL.—Subchapter I of chapter 17 is amended by adding at the end the following new section:

''§ 1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care

''(a) REQUIRED DISCLOSURE OF HEALTH-PLAN CONTRACTS.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary such current information as the Secretary may require to identify any health-plan contract (as defined in section 1729(i) of this title) under which such individual is covered, to include, as applicable—

''(A) the name, address, and telephone number of such health-plan contract;

''(B) the name of the individual's spouse, if the individual's coverage is under the spouse's health-plan contract;

''(C) the plan number; and

''(D) the plan's group code.

''(2) The care described in this paragraph is—

''(A) hospital, nursing home, or domiciliary care;

''(B) medical, rehabilitative, or preventive health services; or

''(C) other medical care under laws administered by the Secretary.

''(b) REQUIRED DISCLOSURE OF SOCIAL SECURITY NUMBER.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

''(A) the individual's social security number; and

''(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

''(2) The care described in this paragraph is—

''(A) hospital, nursing home, or domiciliary care;

''(B) medical, rehabilitative, or preventive health services; or

''(C) other medical care under laws administered by the Secretary.

''(3) This subsection does not require an individual to furnish the Secretary with a social security number for any individual to whom a social security number has not been assigned.

''(c) FAILURE TO DISCLOSE SOCIAL SECURITY NUMBER.—(1) The Secretary shall deny an individual's application for, or may terminate an individual's enrollment in, the system of patient enrollment established by the Secretary under section 1705 of this title, if such individual does not provide the social security number required or requested to be submitted pursuant to subsection (b).

''(2) Following a denial or termination under paragraph (1) with respect to an individual, the Secretary may, upon receipt of the information required or requested under subsection (b), approve such individual's application or reinstate such individual's enrollment (if otherwise in order), for such medical care and services provided on and after the date of such receipt of information.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as authority to deny medical care and treatment to an individual in a medical emergency.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter 17 is amended by inserting after the item relating to section 1708 the following new item:

''1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care.''.

SEC. 506. ENHANCEMENT OF QUALITY MANAGEMENT.

(a) ENHANCEMENT OF QUALITY MANAGEMENT THROUGH QUALITY MANAGEMENT OFFICERS.—

(1) IN GENERAL.—Subchapter II of chapter 73 is amended by inserting after section 7311 the following new section:

''§ 7311A. Quality management officers

''(a) NATIONAL QUALITY MANAGEMENT OFFICER.—(1) The Under Secretary for Health shall designate an official of the Veterans Health Administration to act as the principal quality management officer for the quality-assurance program required by section 7311 of this title. The official so designated may be known as the 'National Quality Management Officer of the Veterans Health Administration' (in this section referred to as the 'National Quality Management Officer').

''(2) The National Quality Management Officer shall report directly to the Under Secretary for Health in the discharge of responsibilities and duties of the Officer under this section.

''(3) The National Quality Management Officer shall be the official within the Veterans Health Administration who is principally responsible for the quality-assurance program referred to in paragraph (1). In carrying out that responsibility, the Officer shall be responsible for the following:

''(A) Establishing and enforcing the requirements of the program referred to in paragraph (1).

''(B) Developing an aggregate quality metric from existing data sources, such as the Inpatient Evaluation Center of the Department, the National Surgical Quality Improvement Program, and the External Peer Review Program of the Veterans Health Administration, that could be used to assess reliably the quality of care provided at individual Department medical centers and associated community based outpatient clinics.

''(C) Ensuring that existing measures of quality, including measures from the Inpatient Evaluation Center, the National Surgical Quality Improvement Program, System-Wide Ongoing Assessment and Review reports of the Department, and Combined Assessment Program reviews of the Office of Inspector General of the Department, are monitored routinely and analyzed in a manner that ensures the timely detection of quality of care issues.

''(D) Encouraging research and development in the area of quality metrics for the purposes of improving how the Department measures quality in individual facilities.

''(E) Carrying out such other responsibilities and duties relating to quality management in the Veterans Health Administration as the Under Secretary for Health shall specify.

''(4) The requirements under paragraph (3) shall include requirements regarding the following:

''(A) A confidential system for the submittal of reports by Veterans Health Administration personnel regarding quality management at Department facilities.

''(B) Mechanisms for the peer review of the actions of individuals appointed in the Veterans Health Administration in the position of physician.

''(b) QUALITY MANAGEMENT OFFICERS FOR VISNS.—(1) The Regional Director of each Veterans Integrated Services Network (VISN) shall appoint an official of the Network to act as the quality management officer of the Network.

''(2) The quality management officer for a Veterans Integrated Services Network shall report to the Regional Director of the Veterans Integrated Services Network, and to the National Quality Management Officer, regarding the discharge of the responsibilities and duties of the officer under this section.

''(3) The quality management officer for a Veterans Integrated Services Network shall—

''(A) direct the quality management office in the Network; and

''(B) coordinate, monitor, and oversee the quality management programs and activities of the Administration medical facilities in the Network in order to ensure the thorough and uniform discharge of quality management requirements under such programs and activities throughout such facilities.

''(c) QUALITY MANAGEMENT OFFICERS FOR MEDICAL FACILITIES.—(1) The director of each Veterans Health Administration medical facility shall appoint a quality management officer for that facility.

''(2) The quality management officer for a facility shall report directly to the director of the facility, and to the quality management officer of the Veterans Integrated Services Network in which the facility is located, regarding the discharge of the responsibilities and duties of the quality management officer under this section.

''(3) The quality management officer for a facility shall be responsible for designing, disseminating, and implementing quality management programs and activities for the facility that meet the requirements established by the National Quality Management Officer under subsection (a).

''(d) AUTHORIZATION OF APPROPRIATIONS.—(1) Except as provided in paragraph (2), there are authorized to be appropriated such sums as may be necessary to carry out this section.

''(2) There are authorized to be appropriated to carry out the provisions of subparagraphs (B), (C), and (D) of subsection (a)(3), $25,000,000 for the two-year period of fiscal years beginning after the date of the enactment of this section.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to section 7311 the following new item:

''7311A. Quality management officers.''.

(b) REPORTS ON QUALITY CONCERNS UNDER QUALITY-ASSURANCE PROGRAM.—Section 7311(b) is amended by adding at the end the following new paragraph:

''(4) As part of the quality-assurance program, the Under Secretary for Health shall establish mechanisms through which employees of Veterans Health Administration facilities may submit reports, on a confidential basis, on matters relating to quality of care in Veterans Health Administration facilities to the quality management officers of such facilities under section 7311A(b) of this title. The mechanisms shall provide for the prompt and thorough review of any reports so submitted by the receiving officials.''.

(c) REVIEW OF CURRENT HEALTH CARE QUALITY SAFEGUARDS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall conduct a comprehensive review of all current policies and protocols of the Department of Veterans Affairs for maintaining health care quality and patient safety at Department medical facilities. The review shall include a review and assessment of the National Surgical Quality Improvement Program (NSQIP), including an assessment of—

(A) the efficacy of the quality indicators under the program;

(B) the efficacy of the data collection methods under the program;

(C) the efficacy of the frequency with which regular data analyses are performed under the program; and

(D) the extent to which the resources allocated to the program are adequate to fulfill the stated function of the program.

(2) REPORT.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the review conducted under paragraph (1), including the findings of the Secretary as a result of the review and such recommendations as the Secretary considers appropriate in light of the review.

SEC. 507. REPORTS ON IMPROVEMENTS TO DEPARTMENT HEALTH CARE QUALITY MANAGEMENT.

(a) REPORT.—Not later than December 15, 2010, and each year thereafter through 2012, the Secretary of Veterans Affairs shall submit to the congressional veterans affairs committees a report on the implementation

of sections 604 and 506 of this Act and the amendments made by such sections during the preceding fiscal year. Each report shall include, for the fiscal year covered by such report, the following:

(1) A comprehensive description of the implementation of sections 604 and 506 of this Act and the amendments made by such sections.

(2) Such recommendations as the Secretary considers appropriate for legislative or administrative action to improve the authorities and requirements in such sections and the amendments made by such sections or to otherwise improve the quality of health care and the quality of the physicians in the Veterans Health Administration.

(b) CONGRESSIONAL VETERANS AFFAIRS COMMITTEES DEFINED.—In this section, the term ''congressional veterans affairs committees'' means—

(1) the Committees on Veterans' Affairs and Appropriations of the Senate; and

(2) the Committees on Veterans' Affairs and Appropriations of the House of Representatives.

SEC. 508. PILOT PROGRAM ON USE OF COMMUNITY-BASED ORGANIZATIONS AND LOCAL AND STATE GOVERNMENT ENTITIES TO ENSURE THAT VETERANS RECEIVE CARE AND BENEFITS FOR WHICH THEY ARE ELIGIBLE.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of using community-based organizations and local and State government entities—

(1) to increase the coordination of community, local, State, and Federal providers of health care and benefits for veterans to assist veterans who are transitioning from military service to civilian life in such transition;

(2) to increase the availability of high quality medical and mental health services to veterans transitioning from military service to civilian life;

(3) to provide assistance to families of veterans who are transitioning from military service to civilian life to help such families adjust to such transition; and

(4) to provide outreach to veterans and their families to inform them about the availability of benefits and connect them with appropriate care and benefit programs.

(b) DURATION OF PROGRAM.—The pilot program shall be carried out during the two-year period beginning on the date of the enactment of this Act.

(c) PROGRAM LOCATIONS.—

(1) IN GENERAL.—The pilot program shall be carried out at five locations selected by the Secretary for purposes of the pilot program.

(2) CONSIDERATIONS.—In selecting locations for the pilot program, the Secretary shall consider the advisability of selecting locations in—

(A) rural areas;

(B) areas with populations that have a high proportion of minority group representation;

(C) areas with populations that have a high proportion of individuals who have limited access to health care; and

(D) areas that are not in close proximity to an active duty military installation.

(d) GRANTS.—The Secretary shall carry out the pilot program through the award of grants to community-based organizations and local and State government entities.

(e) SELECTION OF GRANT RECIPIENTS.—

(1) IN GENERAL.—A community-based organization or local or State government entity seeking a grant under the pilot program shall submit to the Secretary of Veterans Affairs an application therefor in such form and in such manner as the Secretary considers appropriate.

(2) ELEMENTS.—Each application submitted under paragraph (1) shall include the following:

(A) A description of how the proposal was developed in consultation with the Department of Veterans Affairs.

(B) A plan to coordinate activities under the pilot program, to the greatest extent possible, with the local, State, and Federal providers of services for veterans to reduce duplication of services and to increase the effect of such services.

(f) USE OF GRANT FUNDS.—The Secretary shall prescribe appropriate uses of grant funds received under the pilot program.

(g) REPORT ON PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program.

(B) An assessment of the benefits to veterans of the pilot program.

(C) The recommendations of the Secretary as to the advisability of continuing the pilot program.

SEC. 509. SPECIALIZED RESIDENTIAL CARE AND REHABILITATION FOR CERTAIN VETERANS.

Section 1720 is amended by adding at the end the following new subsection:

''(g) The Secretary may contract with appropriate entities to provide specialized residential care and rehabilitation services to a veteran of Operation Enduring Freedom or Operation Iraqi Freedom who the Secretary determines suffers from a traumatic brain injury, has an accumulation of deficits in activities of daily living and instrumental activities of daily living, and because of these deficits, would otherwise require admission to a nursing home even though such care would generally exceed the veteran's nursing needs.''.

SEC. 510. EXPANDED STUDY ON THE HEALTH IMPACT OF PROJECT SHIPBOARD HAZARD AND DEFENSE.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract with the Institute of Medicine of the National Academies to conduct an expanded study on the health impact of Project Shipboard Hazard and Defense (Project SHAD).

(b) COVERED VETERANS.—The study required by subsection (a) shall include, to the extent practicable, all veterans who participated in Project Shipboard Hazard and Defense.

(c) UTILIZATION OF EXISTING STUDIES.—The study required by subsection (a) may use results from the study covered in the report entitled ''Long-Term Health Effects of Participation in Project SHAD'' of the Institute of Medicine of the National Academies.

SEC. 511. USE OF NON-DEPARTMENT FACILITIES FOR REHABILITATION OF INDIVIDUALS WITH TRAUMATIC BRAIN INJURY.

Section 1710E is amended—

(1) by redesignating subsection (b) as subsection (c);

(2) by inserting after subsection (a) the following new subsection (b):

''(b) COVERED INDIVIDUALS.—The care and services provided under subsection (a) shall be made available to an individual—

''(1) who is described in section 1710C(a) of this title; and

''(2)(A) to whom the Secretary is unable to provide such treatment or services at the frequency or for the duration prescribed in such plan; or

''(B) for whom the Secretary determines that it is optimal with respect to the recovery and rehabilitation for such individual.''; and

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

''(d) STANDARDS.—The Secretary may not provide treatment or services as described in subsection (a) at a non-Department facility under such subsection unless such facility maintains standards for the provision of such treatment or services established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury.''.

SEC. 512. INCLUSION OF FEDERALLY RECOGNIZED TRIBAL ORGANIZATIONS IN CERTAIN PROGRAMS FOR STATE VETERANS HOMES.

(a) TREATMENT OF TRIBAL ORGANIZATION HEALTH FACILITIES AS STATE HOMES.—Section 8138 is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection (e):

''(e)(1) A health facility (or certain beds in a health facility) of a tribal organization is treatable as a State home under subsection (a) in accordance with the provisions of that subsection.

''(2) Except as provided in paragraph (3), the provisions of this section shall apply to a health facility (or certain beds in such facility) treated as a State home under subsection (a) by reason of this subsection to the same extent as health facilities (or beds) treated as a State home under subsection (a).

''(3) Subsection (f) shall not apply to the treatment of health facilities (or certain beds in such facilities) of tribal organizations as a State home under subsection (a).''.

(b) STATE HOME FACILITIES FOR DOMICILIARY, NURSING, AND OTHER CARE.—

(1) IN GENERAL.—Chapter 81 is further amended—

(A) in section 8131, by adding at the end the following new paragraph:

''(5) The term 'tribal organization' has the meaning given such term in section 3765 of this title.'';

(B) in section 8132, by inserting ''and tribal organizations'' after ''the several States''; and

(C) by inserting after section 8133 the following new section:

''§ 8133A. Tribal organizations

''(a) AUTHORITY TO AWARD GRANTS.—The Secretary may award a grant to a tribal organization under this subchapter in order to carry out the purposes of this subchapter.

''(b) MANNER AND CONDITION OF GRANT AWARDS.—(1) Grants to tribal organizations under this section shall be awarded in the same manner, and under the same conditions, as grants awarded to the several States under the provisions of this subchapter, subject to such exceptions as the Secretary shall prescribe for purposes of this subchapter to take into account the unique circumstances of tribal organizations.

''(2) For purposes of according priority under subsection (c)(2) of section 8135 of this title to an application submitted under subsection (a) of such section, an application submitted under such subsection (a) by a tribal organization of a State that has previously applied for award of a grant under

this subchapter for construction or acquisition of a State nursing home shall be considered under subparagraph (C) of such subsection (c)(2) an application from a tribal organization that has previously applied for such a grant.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 81 is amended by inserting after the item relating to section 8133 the following new item:

''8133A. Tribal organizations.''.

SEC. 513. PILOT PROGRAM ON PROVISION OF DENTAL INSURANCE PLANS TO VETERANS AND SURVIVORS AND DEPENDENTS OF VETERANS.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of providing a dental insurance plan to veterans and survivors and dependents of veterans described in subsection (b).

(b) COVERED VETERANS AND SURVIVORS AND DEPENDENTS.—The veterans and survivors and dependents of veterans described in this subsection are as follows:

(1) Any veteran who is enrolled in the system of annual patient enrollment under section 1705 of this title.

(2) Any survivor or dependent of a veteran who is eligible for medical care under section 1781 of this title.

(c) DURATION OF PROGRAM.—The pilot program shall be carried out during the three-year period beginning on the date of the enactment of this Act.

(d) PILOT PROGRAM LOCATIONS.—The pilot program shall be carried out in not less than two and not more than four Veterans Integrated Services Networks (VISNs) selected by the Secretary of Veterans Affairs for purposes of the pilot program.

(e) ADMINISTRATION.—The Secretary of Veterans Affairs shall contract with a dental insurer to administer the dental plan provided under the pilot program.

(f) BENEFITS.—The dental insurance plan under the pilot program shall provide such benefits for dental care and treatment as the Secretary considers appropriate for the dental insurance plan, including diagnostic services, preventative services, endodontics and other restorative services, surgical services, and emergency services.

(g) ENROLLMENT.—

(1) VOLUNTARY.—Enrollment in the dental insurance plan under this section shall be voluntary.

(2) MINIMUM PERIOD.—Enrollment in the dental insurance plan shall be for such minimum period as the Secretary shall prescribe for purposes of this section.

(h) PREMIUMS.—

(1) IN GENERAL.—Premiums for coverage under the dental insurance plan under the pilot program shall be in such amount or amounts as the Secretary of Veterans Affairs shall prescribe to cover all costs associated with the pilot program.

(2) ANNUAL ADJUSTMENT.—The Secretary shall adjust the premiums payable under the pilot program for coverage under the dental insurance plan on an annual basis. Each individual covered by the dental insurance plan at the time of such an adjustment shall be notified of the amount and effective date of such adjustment.

(3) RESPONSIBILITY FOR PAYMENT.—Each individual covered by the dental insurance plan shall pay the entire premium for coverage under the dental insurance plan, in addition to the full cost of any copayments.

(i) VOLUNTARY DISENROLLMENT.—

(1) IN GENERAL.—With respect to enrollment in the dental insurance plan under the pilot program, the Secretary shall—

(A) permit the voluntary disenrollment of an individual in the dental insurance plan if the disenrollment occurs during the 30-day period beginning on the date of the enrollment of the individual in the dental insurance plan; and

(B) permit the voluntary disenrollment of an individual in the dental insurance plan for such circumstances as the Secretary shall prescribe for purposes of this subsection, but only to the extent such disenrollment does not jeopardize the fiscal integrity of the dental insurance plan.

(2) ALLOWABLE CIRCUMSTANCES.—The circumstances prescribed under paragraph (1)(B) shall include the following:

(A) If an individual enrolled in the dental insurance plan relocates to a location outside the jurisdiction of the dental insurance plan that prevents utilization of the benefits under the dental insurance plan.

(B) If an individual enrolled in the dental insurance plan is prevented by a serious medical condition from being able to obtain benefits under the dental insurance plan.

(C) Such other circumstances as the Secretary shall prescribe for purposes of this subsection.

(3) ESTABLISHMENT OF PROCEDURES.—The Secretary shall establish procedures for determinations on the permissibility of voluntary disenrollments under paragraph (1)(B). Such procedures shall ensure timely determinations on the permissibility of such disenrollments.

(j) RELATIONSHIP TO DENTAL CARE PROVIDED BY SECRETARY.—Nothing in this section shall affect the responsibility of the Secretary to provide dental care under section 1712 of title 38, United States Code, and the participation of an individual in the dental insurance plan under the pilot program shall not affect the individual's entitlement to outpatient dental services and treatment, and related dental appliances, under that section.

(k) REGULATIONS.—The dental insurance plan under the pilot program shall be administered under such regulations as the Secretary shall prescribe.

SEC. 514. EXPANSION OF VETERAN ELIGIBILITY FOR REIMBURSEMENT BY SECRETARY OF VETERANS AFFAIRS FOR EMERGENCY TREATMENT FURNISHED IN A NON-DEPARTMENT FACILITY.

(a) EXPANSION OF ELIGIBILITY.—Subsection (b)(3)(C) of section 1725 is amended by striking '', in whole or in part,''.

(b) LIMITATIONS ON REIMBURSEMENT.—Section 1725 is further amended—

(1) in subsection (c), by adding at the end the following new paragraph:

''(4)(A) If the veteran has contractual or legal recourse against a third party that would, in part, extinguish the veteran's liability to the provider of the emergency treatment and payment for the treatment may be made both under subsection (a) and by the third party, the amount payable for such treatment under such subsection shall be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party, except that the amount payable may not exceed the maximum amount payable established under paragraph (1)(A).

''(B) In any case in which a third party is financially responsible for part of the veteran's emergency treatment expenses, the Secretary shall be the secondary payer.

''(C) A payment in the amount payable under subparagraph (A) shall be considered payment in full and shall extinguish the veteran's liability to the provider.

''(D) The Secretary may not reimburse a veteran under this section for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract.''; and

(2) in subsection (f)(3)—

(A) in subparagraph (A), by inserting before the period at the end the following: '', including the Secretary of Health and Human Services with respect to the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.)''; and

(B) in subparagraph (B), by inserting before the period at the end the following: '', including a State Medicaid agency with respect to payments made under a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act, and shall apply with respect to emergency treatment furnished on or after that date.

(2) REIMBURSEMENT FOR TREATMENT BEFORE EFFECTIVE DATE.—The Secretary of Veterans Affairs may provide reimbursement under section 1725 of title 38, United States Code, as amended by this subsection, for emergency treatment furnished before the date of the enactment of this Act if the Secretary determines that, under the circumstances applicable with respect to the veteran, it is appropriate to do so.

SEC. 515. PROHIBITION ON COLLECTION OF COPAYMENTS FROM VETERANS WHO ARE CATASTROPHICALLY DISABLED.

(a) IN GENERAL.—Subchapter III of chapter 17 is amended by adding at the end the following new section:

''§ 1730A. Prohibition on collection of copayments from catastrophically disabled veterans

''Notwithstanding subsections (f) and (g) of section 1710 and section 1722A(a) of this title or any other provision of law, the Secretary may not require a veteran who is catastrophically disabled to make any copayment for the receipt of hospital care or medical services under the laws administered by the Secretary.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1730 the following new item:

''1730A. Prohibition on collection of copayments from catastrophically disabled veterans.''.

TITLE VI—DEPARTMENT PERSONNEL MATTERS

SEC. 601. ENHANCEMENT OF AUTHORITIES FOR RETENTION OF MEDICAL PROFESSIONALS.

(a) SECRETARIAL AUTHORITY TO EXTEND TITLE 38 STATUS TO ADDITIONAL POSITIONS.—

(1) IN GENERAL.—Paragraph (3) of section 7401 is amended by striking ''and blind rehabilitation outpatient specialists.'' and inserting the following: ''blind rehabilitation outpatient specialists, and such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention needs of the Department subject to the following requirements:

''(A) Such other classes of health care occupations—

''(i) are not occupations relating to administrative, clerical, or physical plant maintenance and protective services;

''(ii) that would otherwise receive basic pay in accordance with the General Schedule under section 5332 of title 5;

''(iii) provide, as determined by the Secretary, direct patient care services or services incident to direct patient services; and

''(iv) would not otherwise be available to provide medical care or treatment for veterans.

''(B) Not later than 45 days before the Secretary appoints any personnel for a class of health care occupations that is not specifically listed in this paragraph, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Office of Management and Budget notice of such appointment.

''(C) Before submitting notice under subparagraph (B), the Secretary shall solicit comments from any labor organization representing employees in such class and include such comments in such notice.''.

(2) APPOINTMENT OF NURSE ASSISTANTS.—Such paragraph is further amended by inserting ''nurse assistants,'' after ''licensed practical or vocational nurses,''.

(b) PROBATIONARY PERIODS FOR REGISTERED NURSES.—Section 7403(b) is amended—

(1) in paragraph (1), by striking ''Appointments'' and inserting ''Except as otherwise provided in this subsection, appointments'';

(2) by redesignating paragraph (2) as paragraph (4); and

(3) by inserting after paragraph (1) the following new paragraphs:

''(2) With respect to the appointment of a registered nurse under this chapter, paragraph (1) shall apply with respect to such appointment regardless of whether such appointment is on a full-time basis or a part-time basis.

''(3) An appointment described in subsection (a) on a part-time basis of a person who has previously served on a full-time basis for the probationary period for the position concerned shall be without a probationary period.''.

(c) PROHIBITION ON TEMPORARY PART-TIME REGISTERED NURSE APPOINTMENTS IN EXCESS OF TWO YEARS.—Section 7405 is amended by adding at the end the following new subsection:

''(g)(1) Except as provided in paragraph (3), employment of a registered nurse on a temporary part-time basis under subsection (a)(1) shall be for a probationary period of two years.

''(2) Except as provided in paragraph (3), upon completion by a registered nurse of the probationary period described in paragraph (1)—

''(A) the employment of such nurse shall—

''(i) no longer be considered temporary; and

''(ii) be considered an appointment described in section 7403(a) of this title; and

''(B) the nurse shall be considered to have served the probationary period required by section 7403(b).

''(3) This subsection shall not apply to appointments made on a term limited basis of less than or equal to three years of—

''(A) nurses with a part-time appointment resulting from an academic affiliation or teaching position in a nursing academy of the Department;

''(B) nurses appointed as a result of a specific research proposal or grant; or

''(C) nurses who are not citizens of the United States and appointed under section 7407(a) of this title.''.

(d) WAIVER OF OFFSET FROM PAY FOR CERTAIN REEMPLOYED ANNUITANTS.—

(1) IN GENERAL.—Section 7405, as amended by subsection (c), is further amended by adding at the end the following new subsection:

''(h)(1) The Secretary may waive the application of sections 8344 and 8468 of title 5 (relating to annuities and pay on reemployment) or any other similar provision of law under a Government retirement system on a case-by-case basis for an annuitant reemployed on a temporary basis under the authority of subsection (a) in a position described under paragraph (1) of that subsection.

''(2) An annuitant to whom a waiver under paragraph (1) is in effect shall not be considered an employee for purposes of any Government retirement system.

''(3) An annuitant to whom a waiver under paragraph (1) is in effect shall be subject to the provisions of chapter 71 of title 5 (including all labor authority and labor representative collective bargaining agreements) applicable to the position to which appointed.

''(4) In this subsection:

''(A) The term 'annuitant' means an annuitant under a Government retirement system.

''(B) The term 'employee' has the meaning under section 2105 of title 5.

''(C) The term 'Government retirement system' means a retirement system established by law for employees of the Government of the United States.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date that is 180 days after the date of the enactment of this Act, and shall apply to pay periods beginning on or after such effective date.

(e) RATE OF BASIC PAY FOR APPOINTEES TO THE OFFICE OF THE UNDER SECRETARY FOR HEALTH SET TO RATE OF BASIC PAY FOR SENIOR EXECUTIVE SERVICE POSITIONS.—

(1) IN GENERAL.—Section 7404(a) is amended—

(A) by striking ''The annual'' and inserting ''(1) The annual'';

(B) by striking ''The pay'' and inserting the following:

''(2) The pay'';

(C) by striking ''under the preceding sentence'' and inserting ''under paragraph (1)''; and

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

''(3)(A) The rate of basic pay for a position to which an Executive order applies under paragraph (1) and is not described by paragraph (2) shall be set in accordance with section 5382 of title 5 as if such position were a Senior Executive Service position (as such term is defined in section 3132(a) of title 5).

''(B) A rate of basic pay for a position may not be set under subparagraph (A) in excess of—

''(i) in the case the position is not described in clause (ii), the rate of basic pay payable for level III of the Executive Schedule; or

''(ii) in the case that the position is covered by a performance appraisal system that meets the certification criteria established by regulation under section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule.

''(C) Notwithstanding the provisions of subsection (d) of section 5307 of title 5, the Secretary may make any certification under that subsection instead of the Office of Personnel Management and without concurrence of the Office of Management and Budget.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the first day of the first pay period beginning after the day that is 180 days after the date of the enactment of this Act.

(f) SPECIAL INCENTIVE PAY FOR DEPARTMENT PHARMACIST EXECUTIVES.—Section 7410 is amended—

(1) by striking ''The Secretary may'' and inserting the following:

''(a) IN GENERAL.—The Secretary may''; and

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

''(b) SPECIAL INCENTIVE PAY FOR DEPARTMENT PHARMACIST EXECUTIVES.—(1) In order to recruit and retain highly qualified Department pharmacist executives, the Secretary may authorize the Under Secretary for Health to pay special incentive pay of not more than $40,000 per year to an individual of the Veterans Health Administration who is a pharmacist executive.

''(2) In determining whether and how much special pay to provide to such individual, the Under Secretary shall consider the following:

''(A) The grade and step of the position of the individual.

''(B) The scope and complexity of the position of the individual.

''(C) The personal qualifications of the individual.

''(D) The characteristics of the labor market concerned.

''(E) Such other factors as the Secretary considers appropriate.

''(3) Special incentive pay under paragraph (1) for an individual is in addition to all other pay (including basic pay) and allowances to which the individual is entitled.

''(4) Except as provided in paragraph (5), special incentive pay under paragraph (1) for an individual shall be considered basic pay for all purposes, including retirement benefits under chapters 83 and 84 of title 5, and other benefits.

''(5) Special incentive pay under paragraph (1) for an individual shall not be considered basic pay for purposes of adverse actions under subchapter V of this chapter.

''(6) Special incentive pay under paragraph (1) may not be awarded to an individual in an amount that would result in an aggregate amount of pay (including bonuses and awards) received by such individual in a year under this title that is greater than the annual pay of the President.''.

(g) PAY FOR PHYSICIANS AND DENTISTS.—

(1) NON-FOREIGN COST OF LIVING ADJUSTMENT ALLOWANCE.—Section 7431(b) is amended by adding at the end the following new paragraph:

''(5) The non-foreign cost of living adjustment allowance authorized under section 5941 of title 5 for physicians and dentists whose pay is set under this section shall be determined as a percentage of base pay only.''.

(2) MARKET PAY DETERMINATIONS FOR PHYSICIANS AND DENTISTS IN ADMINISTRATIVE OR EXECUTIVE LEADERSHIP POSITIONS.—Section 7431(c)(4)(B)(i) is amended by adding at the end the following: ''The Secretary may exempt physicians and dentists occupying administrative or executive leadership positions from the requirements of the previous sentence.''.

(3) EXCEPTION TO PROHIBITION ON REDUCTION OF MARKET PAY.—Section 7431(c)(7) is amended by striking ''concerned.'' and inserting ''concerned, unless there is a change in board certification or reduction of privileges.''.

(h) ADJUSTMENT OF PAY CAP FOR NURSES.—Section 7451(c)(2) is amended by striking ''level V'' and inserting ''level IV''.

(i) EXEMPTION FOR CERTIFIED REGISTERED NURSE ANESTHETISTS FROM LIMITATION ON AUTHORIZED COMPETITIVE PAY.—Section 7451(c)(2) is further amended by adding at the

end the following new sentence: ''The maximum rate of basic pay for a grade for the position of certified registered nurse anesthetist pursuant to an adjustment under subsection (d) may exceed the maximum rate otherwise provided in the preceding sentence.''.

(j) INCREASED LIMITATION ON SPECIAL PAY FOR NURSE EXECUTIVES.—Section 7452(g)(2) is amended by striking ''$25,000'' and inserting ''$100,000''.

(k) LOCALITY PAY SCALE COMPUTATIONS.—

(1) EDUCATION, TRAINING, AND SUPPORT FOR FACILITY DIRECTORS IN WAGE SURVEYS.—Section 7451(d)(3) is amended by adding at the end the following new subparagraph:

''(F) The Under Secretary for Health shall provide appropriate education, training, and support to directors of Department health care facilities in the conduct and use of surveys, including the use of third-party surveys, under this paragraph.''.

(2) INFORMATION ON METHODOLOGY USED IN WAGE SURVEYS.—Section 7451(e)(4) is amended—

(A) by redesignating subparagraph (D) as subparagraph (E); and

(B) by inserting after subparagraph (C) the following new subparagraph (D):

''(D) In any case in which the director conducts such a wage survey during the period covered by the report and makes adjustment in rates of basic pay applicable to one or more covered positions at the facility, information on the methodology used in making such adjustment or adjustments.''.

(3) DISCLOSURE OF INFORMATION TO PERSONS IN COVERED POSITIONS.—Section 7451(e), as amended by paragraph (2) of this subsection, is further amended by adding at the end the following new paragraph:

''(6)(A) Upon the request of an individual described in subparagraph (B) for a report provided under paragraph (4) with respect to a Department health-care facility, the Under Secretary for Health or the director of such facility shall provide to the individual the most current report for such facility provided under such paragraph.

''(B) An individual described in this subparagraph is—

''(i) an individual in a covered position at a Department health-care facility; or

''(ii) a representative of the labor organization representing that individual who is designated by that individual to make the request.''.

(l) ELIGIBILITY OF PART-TIME NURSES FOR ADDITIONAL NURSE PAY.—

(1) IN GENERAL.—Section 7453 is amended—

(A) in subsection (a), by striking ''a nurse'' and inserting ''a full-time nurse or part-time nurse'';

(B) in subsection (b)—

(i) in the first sentence—

(I) by striking ''on a tour of duty'';

(II) by striking ''service on such tour'' and inserting ''such service''; and

(III) by striking ''of such tour'' and inserting ''of such service''; and

(ii) in the second sentence, by striking ''of such tour'' and inserting ''of such service'';

(C) in subsection (c)—

(i) by striking ''on a tour of duty''; and

(ii) by striking ''service on such tour'' and inserting ''such service''; and

(D) in subsection (e)—

(i) in paragraph (1), by striking ''eight hours in a day'' and inserting ''eight consecutive hours''; and

(ii) in paragraph (5)(A), by striking ''tour of duty'' and inserting ''period of service''.

(2) EXCLUSION OF APPLICATION OF ADDITIONAL NURSE PAY PROVISIONS TO CERTAIN ADDITIONAL EMPLOYEES.—Paragraph (3) of section 7454(b) is amended to read as follows:

''(3) Employees appointed under section 7408 of this title performing service on a tour of duty, any part of which is within the period commencing at midnight Friday and ending at midnight Sunday, shall receive additional pay in addition to the rate of basic pay provided such employees for each hour of service on such tour at a rate equal to 25 percent of such employee's hourly rate of basic pay.''.

(m) ENHANCED AUTHORITY TO INCREASE RATES OF BASIC PAY TO OBTAIN OR RETAIN SERVICES OF CERTAIN PERSONS.—Section 7455(c) is amended to read as follows:

''(c)(1) Subject to paragraph (2), the amount of any increase under subsection (a) in the minimum rate for any grade may not (except in the case of nurse anesthetists, licensed practical nurses, licensed vocational nurses, nursing positions otherwise covered by title 5, pharmacists, and licensed physical therapists) exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5 or similar provision of law) for the grade or level by more than 30 percent.

''(2) No rate may be established under this section in excess of the rate of basic pay payable for level IV of the Executive Schedule.''.

SEC. 602. LIMITATIONS ON OVERTIME DUTY, WEEKEND DUTY, AND ALTERNATIVE WORK SCHEDULES FOR NURSES.

(a) OVERTIME DUTY.—

(1) IN GENERAL.—Subchapter IV of chapter 74 is amended by adding at the end the following new section:

''§ 7459. Nursing staff: special rules for overtime duty

''(a) LIMITATION.—Except as provided in subsection (c), the Secretary may not require nursing staff to work more than 40 hours (or 24 hours if such staff is covered under section 7456 of this title) in an administrative work week or more than eight consecutive hours (or 12 hours if such staff is covered under section 7456 or 7456A of this title).

''(b) VOLUNTARY OVERTIME.—(1) Nursing staff may on a voluntary basis elect to work hours otherwise prohibited by subsection (a).

''(2) The refusal of nursing staff to work hours prohibited by subsection (a) shall not be grounds to discriminate (within the meaning of section 704(a) of the Civil Rights Act of 1964 (42 U.S.C. 2000e–3(a))) against the staff, dismissal or discharge of the staff, or any other adverse personnel action against the staff.

''(c) OVERTIME UNDER EMERGENCY CIRCUMSTANCES.—(1) Subject to paragraph (2), the Secretary may require nursing staff to work hours otherwise prohibited by subsection (a) if—

''(A) the work is a consequence of an emergency that could not have been reasonably anticipated;

''(B) the emergency is non-recurring and is not caused by or aggravated by the inattention of the Secretary or lack of reasonable contingency planning by the Secretary;

''(C) the Secretary has exhausted all good faith, reasonable attempts to obtain voluntary workers;

''(D) the nurse staff have critical skills and expertise that are required for the work; and

''(E) the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure.

''(2) Nursing staff may not be required to work hours under this subsection after the requirement for a direct role by the staff in responding to medical needs resulting from the emergency ends.

''(d) NURSING STAFF DEFINED.—In this section, the term 'nursing staff' includes the following;

''(1) A registered nurse.

''(2) A licensed practical or vocational nurse.

''(3) A nurse assistant appointed under this chapter or title 5.

''(4) Any other nurse position designated by the Secretary for purposes of this section.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 is amended by inserting after the item relating to section 7458 the following new item:

''7459. Nursing staff: special rules for overtime duty.''.

(b) WEEKEND DUTY.—Section 7456 is amended—

(1) by striking subsection (c); and

(2) by redesignating subsection (d) as subsection (c).

(c) ALTERNATE WORK SCHEDULES.—

(1) IN GENERAL.—Section 7456A(b)(1)(A) is amended by striking ''three regularly scheduled'' and all that follows through the period at the end and inserting ''six regularly scheduled 12-hour tours of duty within a 14-day period shall be considered for all purposes to have worked a full 80-hour pay period.''.

(2) CONFORMING AMENDMENTS.—Section 7456A(b) is amended—

(A) in the subsection heading, by striking ''36/40'' and inserting ''72/80'';

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''40-hour basic work week'' and inserting ''80-hour pay period'';

(ii) in subparagraph (B), by striking ''regularly scheduled 36-hour tour of duty within the work week'' and inserting ''scheduled 72-hour tour of duty within the bi-weekly pay period'';

(iii) in subparagraph (C)—

(I) in clause (i), by striking ''regularly scheduled 36-hour tour of duty within an administrative work week'' and inserting ''scheduled 72-hour tour of duty within an administrative pay period'';

(II) in clause (ii), by striking ''regularly''; and

(III) in clause (iii), by striking ''regularly scheduled 36-hour tour of duty work week'' and inserting ''scheduled 72-hour tour of duty pay period''; and

(iv) in subparagraph (D), by striking ''regularly''; and

(C) in paragraph (3), by striking ''regularly''.

SEC. 603. IMPROVEMENTS TO CERTAIN EDUCATIONAL ASSISTANCE PROGRAMS.

(a) REINSTATEMENT OF HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE SCHOLARSHIP PROGRAM.—

(1) IN GENERAL.—Section 7618 is amended by striking ''December 31, 1998'' and inserting ''December 31, 2014''.

(2) EXPANSION OF ELIGIBILITY REQUIREMENTS.—Section 7612(b)(2) is amended by striking ''(under section'' and all that follows through ''or vocational nurse.'' and inserting the following: ''as an appointee under paragraph (1) or (3) of section 7401 of this title.''.

(b) IMPROVEMENTS TO EDUCATION DEBT REDUCTION PROGRAM.—

(1) INCLUSION OF EMPLOYEE RETENTION AS PURPOSE OF PROGRAM.—Section 7681(a)(2) is amended by inserting ''and retention'' after ''recruitment'' the first time it appears.

(2) ELIGIBILITY.—Section 7682 is amended—

(A) in subsection (a)(1), by striking ''a recently appointed'' and inserting ''an''; and

(B) by striking subsection (c).

(c) LOAN REPAYMENT PROGRAM FOR CLINICAL RESEARCHERS FROM DISADVANTAGED BACKGROUNDS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs may, in consultation with the Secretary of Health and Human Services, utilize the authorities available in section 487E of the Public Health Service Act (42 U.S.C. 288–5) for the repayment of the principal and interest of educational loans of appropriately qualified health professionals who are from disadvantaged backgrounds in order to secure clinical research by such professionals for the Veterans Health Administration.

(2) LIMITATIONS.—The exercise by the Secretary of Veterans Affairs of the authorities referred to in paragraph (1) shall be subject to the conditions and limitations specified in paragraphs (2) and (3) of section 487E(a) of the Public Health Service Act (42 U.S.C. 288–5(a)(2) and (3)).

(3) FUNDING.—Amounts for the repayment of principal and interest of educational loans under this subsection shall be derived from amounts available to the Secretary of Veterans Affairs for the Veterans Health Administration for Medical Services.

SEC. 604. STANDARDS FOR APPOINTMENT AND PRACTICE OF PHYSICIANS IN DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES.

(a) STANDARDS.—

(1) IN GENERAL.—Subchapter I of chapter 74 is amended by inserting after section 7402 the following new section:

''§ 7402A. Appointment and practice of physicians: standards

''(a) IN GENERAL.—The Secretary shall, acting through the Under Secretary for Health, prescribe standards to be met by individuals in order to qualify for appointment in the Veterans Health Administration in the position of physician and to practice as a physician in medical facilities of the Administration. The standards shall incorporate the requirements of this section.

''(b) DISCLOSURE OF CERTAIN INFORMATION BEFORE APPOINTMENT.—Each individual seeking appointment in the Veterans Health Administration in the position of physician shall do the following:

''(1) Provide the Secretary a full and complete explanation of the following:

''(A) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence.

''(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

''(C) Each investigation or disciplinary action taken against the individual relating to the individual's performance as a physician.

''(2) Provide the Secretary a written authorization that permits the State licensing board of each State in which the individual holds or has held a license to practice medicine to disclose to the Secretary any information in the records of such State on the following:

''(A) Each lawsuit, civil action, or other claim brought against the individual for medical malpractice or negligence covered by paragraph (1)(A) that occurred in such State.

''(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

''(C) Each medical malpractice judgment against the individual by the courts or administrative agencies or bodies of such State.

''(D) Each disciplinary action taken or under consideration against the individual by an administrative agency or body of such State.

''(E) Any change in the status of the license to practice medicine issued the individual by such State, including any voluntary or nondisciplinary surrendering of such license by the individual.

''(F) Any open investigation of the individual by an administrative agency or body of such State, or any outstanding allegation against the individual before such an administrative agency or body.

''(G) Any written notification by the State to the individual of potential termination of a license for cause or otherwise.

''(c) DISCLOSURE OF CERTAIN INFORMATION FOLLOWING APPOINTMENT.—(1) Each individual appointed in the Veterans Health Administration in the position of physician after the date of the enactment of this section shall, as a condition of service under the appointment, disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

''(A) A judgment against the individual for medical malpractice or negligence.

''(B) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed under paragraph (1) or (2) of subsection (b).

''(C) Any disposition of or material change in a matter disclosed under paragraph (1) or (2) of subsection (b).

''(D) Any lawsuit, disciplinary action, or claim filed or undertaken after the date of the disclosures under subsection (b).

''(2) Each individual appointed in the Veterans Health Administration in the position of physician as of the date of the enactment of this section shall do the following:

''(A) Not later than the end of the 60-day period beginning on the date of the enactment of this section and as a condition of service under the appointment after the end of that period, submit the request and authorization described in subsection (b)(2).

''(B) Agree, as a condition of service under the appointment, to disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

''(i) A judgment against the individual for medical malpractice or negligence.

''(ii) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed pursuant to subparagraph (A) or under this subparagraph.

''(iii) Any disposition of or material change in a matter disclosed pursuant to subparagraph (A) or under this subparagraph.

''(3) Each individual appointed in the Veterans Health Administration in the position of physician shall, as part of the biennial review of the performance of the physician under the appointment, submit the request and authorization described in subsection (b)(2). The requirement of this paragraph is in addition to the requirements of paragraph (1) or (2), as applicable.

''(d) INVESTIGATION OF DISCLOSED MATTERS.—(1) The Director of the Veterans Integrated Services Network (VISN) in which an individual is seeking appointment in the Veterans Health Administration in the position of physician shall perform an investigation (in such manner as the standards required by this section shall specify) of each matter disclosed under subsection (b) with respect to the individual.

''(2) The Director of the Veterans Integrated Services Network in which an individual is appointed in the Veterans Health Administration in the position of physician shall perform an investigation (in a manner so specified) of each matter disclosed under subsection (c) with respect to the individual.

''(3) The results of each investigation performed under this subsection shall be fully documented.

''(e) APPROVAL OF APPOINTMENTS BY DIRECTORS OF VISNS.—(1) An individual may not be appointed in the Veterans Health Administration in the position of physician without the approval of the Director of the Veterans Integrated Services Network in which the individual will first serve under the appointment, unless the medical center director and credentialing and privileging manager of the facility hiring the physician certify in writing that—

''(A) a full investigation was carried out in compliance with section 104 of this title; and

''(B) an investigation did not disclose any actions described in subsections (b), (c), and (d) of such section.

''(2) In approving the appointment under this subsection of an individual for whom any matters have been disclosed under subsection (b), a Director shall—

''(A) certify in writing the completion of the performance of the investigation under subsection (d)(1) of each such matter, including the results of such investigation; and

''(B) provide a written justification why any matters raised in the course of such investigation do not disqualify the individual from appointment.

''(f) ENROLLMENT OF PHYSICIANS WITH PRACTICE PRIVILEGES IN PROACTIVE DISCLOSURE SERVICE.—Each medical facility of the Department at which physicians are extended the privileges of practice shall enroll each physician extended such privileges in the Proactive Disclosure Service of the National Practitioner Data Bank.

''(g) ENCOURAGING HIRING OF PHYSICIANS WITH BOARD CERTIFICATION.—(1) The Secretary shall, for each performance contract with a Director of a Veterans Integrated Services Network (VISN), include in such contract a provision that encourages such director to hire physicians who are board eligible or board certified in the specialty in which the physicians will practice.

''(2) The Secretary may determine the nature and manner of the provision described in paragraph (1).''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 is amended by inserting after the item relating to section 7402 the following new item:

''7402A. Appointment and practice of physicians: standards.''.

(b) EFFECTIVE DATE AND APPLICABILITY.—

(1) EFFECTIVE DATE.—Except as provided in paragraphs (2) and (3), the amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) APPLICABILITY OF CERTAIN REQUIREMENTS TO PHYSICIANS PRACTICING ON EFFECTIVE DATE.—In the case of an individual appointed to the Veterans Health Administration in the position of physician as of the date of the enactment of this Act, the requirements of section 7402A(f) of title 38, United States Code, as added by subsection (a) of this section, shall take effect on the date that is 60 days after the date of the enactment of this Act.

(3) APPLICABILITY OF REQUIREMENTS RELATED TO HIRING OF PHYSICIANS WITH BOARD CERTIFICATION.—The requirement of section 7402A(g) of such title, as added by subsection (a), shall begin with the first cycle of performance contracts for directors of Veterans Integrated Services Networks beginning after the date of the enactment of this Act.

TITLE VII—HOMELESS VETERANS MATTERS

SEC. 701. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS RESIDING ON CERTAIN MILITARY PROPERTY.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing that is located on qualifying property described in subsection (b).

(2) NUMBER OF GRANTS.—The Secretary may make grants at up to 10 qualifying properties under the pilot program.

(b) QUALIFYING PROPERTY.—Qualifying property under the pilot program is property that—

(1) was part of a military installation that was closed in accordance with—

(A) decisions made as part of the 2005 round of defense base closure and realignment under the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510; 10 U.S.C. 2687 note); and

(B) subchapter III of chapter 5 of title 40, United States Code; and

(2) the Secretary of Defense determines, after considering any redevelopment plans of any local redevelopment authority relating to such property, may be used to assist the homeless in accordance with such redevelopment plan.

(c) CRITERIA FOR GRANTS.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(d) DURATION OF PROGRAM.—The authority of the Secretary to provide grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(e) VERY LOW INCOME DEFINED.—In this section, the term ''very low income'' has the meaning given that term in the Resident Characteristics Report issued annually by the Department of Housing and Urban Development.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated from amounts made available under the heading ''General Operating Expenses'', not more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 702. PILOT PROGRAM ON FINANCIAL SUPPORT OF ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING.

(a) ESTABLISHMENT OF PILOT PROGRAM.—

(1) IN GENERAL.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing.

(2) NUMBER OF GRANTS.—The Secretary may make grants at up to 10 qualifying properties under the pilot program.

(b) QUALIFYING PROPERTY.—Qualifying property under the pilot program is any property in the United States on which permanent housing is provided or afforded to formerly homeless veterans, as determined by the Secretary.

(c) CRITERIA FOR GRANTS.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(d) DURATION OF PILOT PROGRAM.—The authority of the Secretary to provide grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(e) VERY LOW INCOME DEFINED.—In this section, the term ''very low income'' has the meaning given that term in the Resident Characteristics Report issued annually by the Department of Housing and Urban Development.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated from amounts made available under the heading ''General Operating Expenses'', not more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 703. PILOT PROGRAM ON FINANCIAL SUPPORT OF ENTITIES THAT PROVIDE OUTREACH TO INFORM CERTAIN VETERANS ABOUT PENSION BENEFITS.

(a) AUTHORITY TO MAKE GRANTS.—In addition to the outreach authority provided to the Secretary of Veterans Affairs by section 6303 of title 38, United States Code, the Secretary may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) for services to provide outreach to inform low-income and elderly veterans and their spouses who reside in rural areas of benefits for which they may be eligible under chapter 15 of such title.

(b) CRITERIA FOR GRANTS.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(c) DURATION OF PILOT PROGRAM.—The authority of the Secretary to provide grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated from amounts made available under the heading ''General Operating Expenses'', not more than $1,275,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 704. ASSESSMENT OF PILOT PROGRAMS.

(a) PROGRESS REPORTS.—Not less than one year before the expiration of the authority to carry out a pilot program authorized by sections 501 through 503, the Secretary of Veterans Affairs shall submit to Congress a progress report on such pilot program.

(b) CONTENTS.—Each progress report submitted for a pilot program under subsection (a) shall include the following:

(1) The lessons learned by the Secretary of Veterans Affairs with respect to such pilot program that can be applied to other programs with similar purposes.

(2) The recommendations of the Secretary on whether to continue such pilot program.

(3) The number of veterans and dependents served by such pilot program.

(4) An assessment of the quality of service provided to veterans and dependents under such pilot program.

(5) The amount of funds provided to grant recipients under such pilot program.

(6) The names of organizations that have received grants under such pilot program.

TITLE VIII—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

SEC. 801. GENERAL AUTHORITIES ON ESTABLISHMENT OF CORPORATIONS.

(a) AUTHORIZATION OF MULTI-MEDICAL CENTER RESEARCH CORPORATIONS.—

(1) IN GENERAL.—Section 7361 is amended—

(A) by redesignating subsection (b) as subsection (e); and

(B) by inserting after subsection (a) the following new subsection (b):

''(b)(1) Subject to paragraph (2), a corporation established under this subchapter may facilitate the conduct of research, education, or both at more than one medical center. Such a corporation shall be known as a 'multi-medical center research corporation'.

''(2) The board of directors of a multi-medical center research corporation under this subsection shall include the official at each Department medical center concerned who is, or who carries out the responsibilities of, the medical center director of such center as specified in section 7363(a)(1)(A)(i) of this title.

''(3) In facilitating the conduct of research, education, or both at more than one Department medical center under this subchapter, a multi-medical center research corporation may administer receipts and expenditures relating to such research, education, or both, as applicable, performed at the Department medical centers concerned.''.

(2) EXPANSION OF EXISTING CORPORATIONS TO MULTI-MEDICAL CENTER RESEARCH CORPORATIONS.—Such section is further amended by adding at the end the following new subsection:

''(f) A corporation established under this subchapter may act as a multi-medical center research corporation under this subchapter in accordance with subsection (b) if—

''(1) the board of directors of the corporation approves a resolution permitting facilitation by the corporation of the conduct of research, education, or both at the other Department medical center or medical centers concerned; and

''(2) the Secretary approves the resolution of the corporation under paragraph (1).''.

(b) RESTATEMENT AND MODIFICATION OF AUTHORITIES ON APPLICABILITY OF STATE LAW.—

(1) IN GENERAL.—Section 7361, as amended by subsection (a) of this section, is further amended by inserting after subsection (b) the following new subsection (c):

''(c) Any corporation established under this subchapter shall be established in accordance with the nonprofit corporation laws of the State in which the applicable Department medical center is located and shall, to the extent not inconsistent with any Federal law, be subject to the laws of such State. In the case of any multi-medical center research corporation that facilitates the conduct of research, education, or both at Department medical centers located in different States, the corporation shall be established in accordance with the nonprofit corporation laws of the State in which one of such Department medical centers is located.''.

(2) CONFORMING AMENDMENT.—Section 7365 is repealed.

(c) CLARIFICATION OF STATUS OF CORPORATIONS.—Section 7361, as amended by this section, is further amended—

(1) in subsection (a), by striking the second sentence; and

(2) by inserting after subsection (c) the following new subsection (d):

''(d)(1) Except as otherwise provided in this subchapter or under regulations prescribed by the Secretary, any corporation established under this subchapter, and its officers, directors, and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives that apply generally to private nonprofit corporations.

''(2) A corporation under this subchapter is not—

''(A) owned or controlled by the United States; or

''(B) an agency or instrumentality of the United States.''.

(d) REINSTATEMENT OF REQUIREMENT FOR 501(C)(3) STATUS OF CORPORATIONS.—Subsection (e) of section 7361, as redesignated by subsection (a)(1) of this section, is further amended by inserting ''section 501(c)(3) of'' after ''exempt from taxation under''.

SEC. 802. CLARIFICATION OF PURPOSES OF CORPORATIONS.

(a) CLARIFICATION OF PURPOSES.—Subsection (a) of section 7362 is amended—

(1) in the first sentence—

(A) by striking ''Any corporation'' and all that follows through ''facilitate'' and inserting ''A corporation established under this subchapter shall be established to provide a flexible funding mechanism for the conduct of approved research and education at one or more Department medical centers and to facilitate functions related to the conduct of''; and

(B) by inserting before the period at the end the following: ''or centers''; and

(2) in the second sentence, by inserting ''or centers'' after ''at the medical center''.

(b) MODIFICATION OF DEFINED TERM RELATING TO EDUCATION AND TRAINING.—Subsection (b) of such section is amended in the matter preceding paragraph (1) by striking ''the term 'education and training' '' and inserting ''the term 'education' includes education and training and''.

(c) REPEAL OF ROLE OF CORPORATIONS WITH RESPECT TO FELLOWSHIPS.—Paragraph (1) of subsection (b) of such section is amended by striking the flush matter following subparagraph (C).

(d) AVAILABILITY OF EDUCATION FOR FAMILIES OF VETERAN PATIENTS.—Paragraph (2) of subsection (b) of such section is amended by striking ''to patients and to the families'' and inserting ''and includes education and training for patients and families''.

SEC. 803. MODIFICATION OF REQUIREMENTS FOR BOARDS OF DIRECTORS OF CORPORATIONS.

(a) REQUIREMENTS FOR DEPARTMENT BOARD MEMBERS.—Paragraph (1) of section 7363(a) is amended to read as follows:

''(1) with respect to the Department medical center—

''(A)(i) the director (or directors of each Department medical center, in the case of a multi-medical center research corporation);

''(ii) the chief of staff; and

''(iii) as appropriate for the activities of such corporation, the associate chief of staff for research and the associate chief of staff for education; or

''(B) in the case of a Department medical center at which one or more of the positions referred to in subparagraph (A) do not exist, the official or officials who are responsible for carrying out the responsibilities of such position or positions at the Department medical center; and''.

(b) REQUIREMENTS FOR NON-DEPARTMENT BOARD MEMBERS.—Paragraph (2) of such section is amended—

(1) by inserting ''not less than two'' before ''members''; and

(2) by striking ''and who'' and all that follows through the period at the end and inserting ''and who have backgrounds, or business, legal, financial, medical, or scientific expertise, of benefit to the operations of the corporation.''.

(c) CONFLICTS OF INTEREST.—Subsection (c) of section 7363 is amended by striking '', employed by, or have any other financial relationship with'' and inserting ''or employed by''.

SEC. 804. CLARIFICATION OF POWERS OF CORPORATIONS.

(a) IN GENERAL.—Section 7364 is amended to read as follows:

''§ 7364. General powers

''(a) IN GENERAL.—(1) A corporation established under this subchapter may, solely to carry out the purposes of this subchapter—

''(A) accept, administer, retain, and spend funds derived from gifts, contributions, grants, fees, reimbursements, and bequests from individuals and public and private entities;

''(B) enter into contracts and agreements with individuals and public and private entities;

''(C) subject to paragraph (2), set fees for education and training facilitated under section 7362 of this title, and receive, retain, administer, and spend funds in furtherance of such education and training;

''(D) reimburse amounts to the applicable appropriation account of the Department for the Office of General Counsel for any expenses of that Office in providing legal services attributable to research and education agreements under this subchapter; and

''(E) employ such employees as the corporation considers necessary for such purposes and fix the compensation of such employees.

''(2) Fees charged under paragraph (1)(C) for education and training described in that paragraph to individuals who are officers or employees of the Department may not be paid for by any funds appropriated to the Department.

''(3) Amounts reimbursed to the Office of General Counsel under paragraph (1)(D) shall be available for use by the Office of the General Counsel only for staff and training, and related travel, for the provision of legal services described in that paragraph and shall remain available for such use without fiscal year limitation.

''(b) TRANSFER AND ADMINISTRATION OF FUNDS.—(1) Except as provided in paragraph (2), any funds received by the Secretary for the conduct of research or education at a Department medical center or centers, other than funds appropriated to the Department, may be transferred to and administered by a corporation established under this subchapter for such purposes.

''(2) A Department medical center may reimburse the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 5.

''(3) A Department medical center may retain and use funds provided to it by a corporation established under this subchapter. Such funds shall be credited to the applicable appropriation account of the Department and shall be available, without fiscal year limitation, for the purposes of that account.

''(c) RESEARCH PROJECTS.—Except for reasonable and usual preliminary costs for project planning before its approval, a corporation established under this subchapter may not spend funds for a research project unless the project is approved in accordance with procedures prescribed by the Under Secretary for Health for research carried out with Department funds. Such procedures shall include a scientific review process.

''(d) EDUCATION ACTIVITIES.—Except for reasonable and usual preliminary costs for activity planning before its approval, a corporation established under this subchapter may not spend funds for an education activity unless the activity is approved in accordance with procedures prescribed by the Under Secretary for Health.

''(e) POLICIES AND PROCEDURES.—The Under Secretary for Health may prescribe policies and procedures to guide the spending of funds by corporations established under this subchapter that are consistent with the purpose of such corporations as flexible funding mechanisms and with Federal and State laws and regulations, and executive orders, circulars, and directives that apply generally to the receipt and expenditure of funds by nonprofit organizations exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENT.—Section 7362(a), as amended by section 802(a)(1) of this Act, is further amended by striking the last sentence.

SEC. 805. REDESIGNATION OF SECTION 7364A OF TITLE 38, UNITED STATES CODE.

(a) REDESIGNATION.—Section 7364A is redesignated as section 7365.

(b) CLERICAL AMENDMENTS.—The table of sections at the beginning of chapter 73 is amended—

(1) by striking the item relating to section 7364A; and

(2) by striking the item relating to section 7365 and inserting the following new item:

''7365. Coverage of employees under certain Federal tort claims laws.''.

SEC. 806. IMPROVED ACCOUNTABILITY AND OVERSIGHT OF CORPORATIONS.

(a) ADDITIONAL INFORMATION IN ANNUAL REPORTS.—Subsection (b) of section 7366 is amended to read as follows:

''(b)(1) Each corporation shall submit to the Secretary each year a report providing a detailed statement of the operations, activities, and accomplishments of the corporation during that year.

''(2)(A) A corporation with revenues in excess of $300,000 for any year shall obtain an audit of the corporation for that year.

''(B) A corporation with annual revenues between $10,000 and $300,000 shall obtain an audit of the corporation at least once every three years.

''(C) Any audit under this paragraph shall be performed by an independent auditor.

''(3) The corporation shall include in each report to the Secretary under paragraph (1) the following:

''(A) The most recent audit of the corporation under paragraph (2).

''(B) The most recent Internal Revenue Service Form 990 'Return of Organization Exempt from Income Tax' or equivalent and the applicable schedules under such form.''.

(b) CONFIRMATION OF APPLICATION OF CONFLICT OF INTEREST REGULATIONS TO APPROPRIATE CORPORATION POSITIONS.—Subsection (c) of such section is amended—

(1) by striking ''laws and'' each place it appears;

(2) in paragraph (1)—

(A) by inserting ''each officer and'' after ''under this subchapter,''; and

(B) by striking '', and each employee of the Department'' and all that follows through ''during any year''; and

(3) in paragraph (2)—

(A) by inserting ‘‘, officer,’’ after ‘‘verifying that each director’’; and

(B) by striking ‘‘in the same manner’’ and all that follows before the period at the end.

(c) ESTABLISHMENT OF APPROPRIATE PAYEE REPORTING THRESHOLD.—Subsection (d)(3)(C) of such section is amended by striking ‘‘$35,000’’ and inserting ‘‘$50,000’’.

TITLE IX—CONSTRUCTION AND NAMING MATTERS

SEC. 901. AUTHORIZATION OF MEDICAL FACILITY PROJECTS.

(a) AUTHORIZATION OF FISCAL YEAR 2010 MAJOR MEDICAL FACILITY PROJECTS.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2010, with each project to be carried out in the amount specified for each project:

(1) Construction (including acquisition of land) for the realignment of services and closure projects at the Department of Veterans Affairs Medical Center in Livermore, California, in an amount not to exceed $55,430,000.

(2) Construction of a Multi-Specialty Care Facility in Walla Walla, Washington, in an amount not to exceed $71,400,000.

(3) Construction (including acquisition of land) for a new medical facility at the Department of Veterans Affairs Medical Center in Louisville, Kentucky, in an amount not to exceed $75,000,000.

(4) Construction (including acquisition of land) for a clinical expansion for a Mental Health Facility at the Department of Veterans Affairs Medical Center in Dallas, Texas, in an amount not to exceed $15,640,000.

(5) Construction (including acquisition of land) for a replacement bed tower and clinical expansion at the Department of Veterans Affairs Medical Center in St. Louis, Missouri, in an amount not to exceed $43,340,000.

(b) EXTENSION OF AUTHORIZATION FOR MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS PREVIOUSLY AUTHORIZED.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2010, as follows with each project to be carried out in the amount specified for that project:

(1) Replacement of the existing Department of Veterans Affairs Medical Center in Denver, Colorado, in an amount not to exceed $800,000,000.

(2) Construction of Outpatient and Inpatient Improvements in Bay Pines, Florida, in an amount not to exceed $194,400,000.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2010, or the year in which funds are appropriated, for the Construction, Major Projects account—

(A) $260,810,000 for the projects authorized in subsection (a); and

(B) $994,400,000 for the projects authorized in subsection (b).

(2) LIMITATION.—The projects authorized in subsections (a) and (b) may only be carried out using—

(A) funds appropriated for fiscal year 2010 pursuant to the authorization of appropriations in paragraph (1) of this section;

(B) funds available for Construction, Major Projects for a fiscal year before fiscal year 2010 that remain available for obligation;

(C) funds available for Construction, Major Projects for a fiscal year after fiscal year 2010 that remain available for obligation;

(D) funds appropriated for Construction, Major Projects for fiscal year 2010 for a category of activity not specific to a project;

(E) funds appropriated for Construction, Major Projects for a fiscal year before 2010 for a category of activity not specific to a project; and

(F) funds appropriated for Construction, Major Projects for a fiscal year after 2010 for a category of activity not specific to a project.

SEC. 902. DESIGNATION OF ROBLEY REX DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.

(a) DESIGNATION.—The Department of Veterans Affairs Medical Center in Louisville, Kentucky, and any successor to such medical center, shall after the date of the enactment of this Act be known and designated as the ‘‘Robley Rex Department of Veterans Affairs Medical Center’’.

(b) REFERENCES.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the medical center referred to in subsection (a) shall be considered to be a reference to the Robley Rex Department of Veterans Affairs Medical Center.

SEC. 903. MERRIL LUNDMAN DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC.

(a) IN GENERAL.—The Department of Veterans Affairs outpatient clinic in Havre, Montana, shall after the date of the enactment of this Act be known and designated as the ‘‘Merril Lundman Department of Veterans Affairs Outpatient Clinic’’.

(b) REFERENCES.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the outpatient clinic referred to in subsection (a) shall be considered to be a reference to the Merril Lundman Department of Veterans Affairs Outpatient Clinic.

SEC. 904. MODIFICATION ON RESTRICTION OF ALIENATION OF CERTAIN REAL PROPERTY IN GULF PORT, MISSISSIPPI.

(a) IN GENERAL.—Section 2703(b) of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (Public Law 109–234; 120 Stat. 469), as amended by section 231 of the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2009 (division E of Public Law 110–329; 122 Stat. 3713), is further amended by inserting after ‘‘the City of Gulfport’’ the following: ‘‘, or its urban renewal agency,’’.

(b) MEMORIALIZATION OF MODIFICATION.—The Secretary of Veterans Affairs shall take appropriate actions to modify the quitclaim deeds executed to effectuate the conveyance authorized by section 2703 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006 (Public Law 109–234) in order to accurately reflect and memorialize the amendment made by subsection (a).

TITLE X—OTHER MATTERS

SEC. 1001. EXPANSION OF AUTHORITY FOR DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS.

Section 902 is amended—

(1) in subsection (a)—

(A) by amending paragraph (1) to read as follows:

‘‘(1) Employees of the Department who are Department police officers shall, with respect to acts occurring on Department property—

‘‘(A) enforce Federal laws;

‘‘(B) enforce the rules prescribed under section 901 of this title;

‘‘(C) enforce traffic and motor vehicle laws of a State or local government (by issuance of a citation for violation of such laws) within the jurisdiction of which such Department property is located as authorized by an express grant of authority under applicable State or local law;

‘‘(D) carry the appropriate Department-issued weapons, including firearms, while off Department property in an official capacity or while in an official travel status;

‘‘(E) conduct investigations, on and off Department property, of offenses that may have been committed on property under the original jurisdiction of Department, consistent with agreements or other consultation with affected local, State, or Federal law enforcement agencies; and

‘‘(F) carry out, as needed and appropriate, the duties described in subparagraphs (A) through (E) of this paragraph when engaged in duties authorized by other Federal statutes.’’;

(B) by striking paragraph (2) and redesignating paragraph (3) as paragraph (2); and

(C) in paragraph (2), as redesignated by subparagraph (B) of this paragraph, by inserting ‘‘, and on any arrest warrant issued by competent judicial authority’’ before the period; and

(2) by amending subsection (c) to read as follows:

‘‘(c) The powers granted to Department police officers designated under this section shall be exercised in accordance with guidelines approved by the Secretary and the Attorney General.’’.

SEC. 1002. UNIFORM ALLOWANCE FOR DEPARTMENT OF VETERANS AFFAIRS POLICE OFFICERS.

Section 903 is amended—

(1) by amending subsection (b) to read as follows:

‘‘(b)(1) The amount of the allowance that the Secretary may pay under this section is the lesser of—

‘‘(A) the amount currently allowed as prescribed by the Office of Personnel Management; or

‘‘(B) estimated costs or actual costs as determined by periodic surveys conducted by the Department.

‘‘(2) During any fiscal year no officer shall receive more for the purchase of a uniform described in subsection (a) than the amount established under this subsection.’’; and

(2) by striking subsection (c) and inserting the following new subsection (c):

‘‘(c) The allowance established under subsection (b) shall be paid at the beginning of a Department police officer’s employment for those appointed on or after October 1, 2008. In the case of any other Department police officer, an allowance in the amount established under subsection (b) shall be paid upon the request of the officer.’’.

Mrs. MURRAY. Madam President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Washington is recognized.

MORNING BUSINESS

Mrs. MURRAY. Madam President, I ask unanimous consent the Senate proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

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

Mrs. MURRAY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

HEALTH CARE REFORM

Mr. GRASSLEY. Madam President, we have been waiting for many weeks while the Democratic leadership worked behind closed doors to write a new health care reform bill. Rather than trying to build consensus for a bill that could get broad-based support, they toiled in secret, but at long last this new health care reform plan is finally public. They have come forward to at last reveal the legislative language for a health care reform bill that the Democrats intend to bring to the floor.

We know where they started. We know the changes they made along the way. Those in this Chamber will recall that we worked for months in the Senate Finance Committee on health reform. Senator BAUCUS and I worked very carefully in committee to try to develop a bipartisan reform plan.

Health care, as everybody knows, is one-sixth of the economy. If that economic fact is obscure to people, $1 out of every $6 in the United States is spent on health care.

We are, of course, to spend upward of $33 trillion on health care in this country over the next decade—$33 trillion. Already our health care system is on an unsustainable path. Our current health care entitlement programs, at least the two, Medicare and Medicaid, are both on very unsound financial footing. Not only are both programs in jeopardy financially, but the magnitude of the problem is a real threat to the Federal budget.

Starting in 2008, the Medicare Program began spending more out of the hospital insurance trust fund than it is taking in. That deficit spending at the trust fund is the beginning of the end of Medicare unless Congress steps in and does something to maintain that trust fund. The Medicare trustees have been warning us for years that the hospital insurance fund—the trust fund, that is—is going to go broke. They now predict that year of going broke is 2017. To keep Medicare going for future retirees means finding a way to bridge the gap for the $75 trillion of unfunded liability, and this must be done in a manner that does not worsen the health care quality or access for beneficiaries.

Likewise, the Medicaid Program, which serves 59 million low-income pregnant women as well as children and the families, is on a very shaky financial ground.

We have the Government Accountability Office reporting to Congress that States—meaning the 50 States—are reaching a crisis with their part of the Medicaid Program. The Government Accountability Office models predict that State spending will grow faster than State revenues for at least the next 10 years. The impact of declining revenues is very clear. I quote what the GAO has said about this situation:

> Since most state and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulations suggest that, without intervention, these governments would need to make substantial policy changes to avoid growing fiscal imbalances.

This, too, is the crisis facing the Medicaid Program today. So both of the two major Federal health care programs are in very serious trouble. These are major problems with some of the most significant implications for our entire country and the 300 or more million people who live here. If reforms to health care are not done carefully—and I say ''carefully'' because I am not saying they should not be done—this is going to make the situation far worse, not better. Anyone listening would have no doubt of the ability of Congress to make it worse.

These dire economic implications are not the only thing at stake with health care reform. Besides the significant economic implications of health care reform, this is a bill that affects everyone in another very important way. It affects everyone's health by changing the way we get health care in this country. It touches the lives of every family, every senior, every child, every student. In plain language, it affects everybody: the 306 million people who live here now and the many more people who will be living here in the future.

It makes changes to health care that will be nearly impossible to undo. The reforms these bills contemplate will make long lasting changes to our health care system. These are changes all of us will have to live with for decades to come. Health reform presents this Chamber with a bill that has significant economic implications at a time when all eyes are focused on the economy, so focused on the economy that it almost reminds me of how President Clinton got elected on the campaign slogan, ''It's the economy, stupid.'' This health care reform bill is a bill that will make permanent changes to our system of health care.

For all of these reasons, it makes it all the more important that changes of this magnitude be done with broad-based support in this Chamber and across the country. This broad-based support was something Senator BAUCUS and I focused on in our work on the Finance Committee, as we were trying to bring forth a bill that would be bipartisan.

In the Finance Committee, we believed strongly that a bill of such significance should be done with broad-based support; in other words, health care is a life-or-death issue for every American, and it affects $1 out of every $6 spent in America. Because it is so big, that is the basis for that statement ''broad-based support.''

Under the leadership of Senator BAUCUS, chairman of the Finance Committee, we started last year with a bipartisan health care reform summit. We held 20 hearings. We held three public forums this year on options for financing, coverage, and delivery system reform. We invited in experts from across the country. We invited anyone to submit input to the committee on those options, and we received over 600 sets of comments on the option papers.

Senator BAUCUS and I developed the broad outlines of what we believed would be a good reform package. That broad outline reflected the input we had from that very open and public process. We took that outline, and we sat down with four other leaders on the issue of health care in this very Chamber. That group soon became known as the group of six. That group began meeting in June to take that framework and finish the important details. We met for untold hours. We consulted with experts at the Congressional Budget Office and the Joint Committee on Taxation. We invested a tremendous amount of time and effort to develop a bipartisan package.

Then what happens around here too often? People get impatient. In this case, the Democratic leaders got impatient. They wanted the reform bill to be finished faster. They were more concerned with health care reform getting done right now rather than getting done right. We said we needed to give the process the time it needed. We said we were not going to be bound by arbitrary deadlines. We wanted to get the job done right. But when the first of September rolled around, they were not willing to give the group of six any more time.

As a result, the Democratic leaders pulled the plug on that bipartisan work, and the hope for a bill with broad bipartisan support ended at that point. Ultimately, the Finance Committee reported out a bill that did not have that broad bipartisan support, the support we had hoped for earlier in the year. The bigger and far more liberal agenda driven by the White House and the Democratic leadership went beyond where the true consensus on reform exists.

Now the next step in this process has been to merge together the bills from the HELP Committee and the Finance Committee. That job fell to the Democratic leader and the chairmen of the two committees. But, ultimately, their

leader even excluded the chairmen from the process. That process began on October 2. So the rest of the Senate has been waiting ever since that time to see what would emerge from behind closed doors just across the hall.

But then people started to complain about how long it was taking to develop the merged bill. When that happened, lo and behold, we started to hear from the Democratic leader what the group of six had been saying. That leader, too, started saying he was not going to be bound by any artificial timeline. He, too, started saying he was going to take whatever time he needed. Imagine our shock and dismay when we heard this. All the impatience we heard about how long our bipartisan process was taking, the criticism we took.

So they pulled the plug on that effort out of impatience. My suspicion is that only now is there a realization of how hard it is to assemble a comprehensive health care reform plan. Now at long last, that merged bill is before us. Now we know what is in it. The bill has undergone many changes since the Democrats decided to do a partisan bill. They are not positive. They have moved more and more to not only a partisan agenda, they have moved to an extreme agenda. It is an agenda so extreme, they are having difficulty finding votes among Democratic Members. They have 60-vote control of this body. They have an overwhelming majority in the House. Yet they are trying to blame Republicans for slowing down the process.

Surely they don't expect 100 Senators to get this done faster than it took a leader behind closed doors to get the bill done, to put together the two bills between the Finance Committee and the HELP Committee, what we have before us or will eventually have before us. But it is not Republicans who are slowing this down. It is not because of Republicans that it took so long to merge these two Senate bills. It is not because of Republicans that it took the House so long after July to finally vote on the bill.

The reason for the difficulties is that their leftwing is driving the health reform agenda so far to the extreme left. It is so far to the left that they are having trouble getting everyone on their side to support that agenda? In the other body, 39 Democrats voted against Speaker PELOSI's plan, and you can be sure that we would have seen a bill in the Senate much sooner than now if all Democrats were lined up behind this effort.

But this is where we are. Now let's look at what has been produced, what changes have been made to produce the merged bill. I will highlight a few of the changes I find most disturbing. As I highlight these issues, it will be clear that this bill is already sliding rapidly down the slippery slope to more and more government control of health care. It still has the biggest expansion of Medicaid since the program was created in 1965. It still imposes an unprecedented and intrusive Federal mandate for coverage backed by the enforcement authority of the Internal Revenue Service. It still increases the size of the government by $2.5 trillion when fully implemented. It has gotten even more expensive since the Finance Committee started. It still gives the Secretary of Health and Human Services the power to set prices and define benefits for private health plans. That is a lot of government power in Washington over people's lives. It still will cause health care premiums for millions to go up.

As I said when this process started, the bill released by the Finance Committee was an incomplete but comprehensive, good-faith attempt to reach bipartisan agreement. But ever since that moment, the bill has moved further and further away from that approach on several key issues. Now we can see clearly that the bill continues its march leftward. It continues to take shape into an extreme agenda driven by the far left. This far left partisan change is precisely what my party feared would occur at later stages in the legislative process.

Today we see these fears were legitimate and justified. Nevertheless, I still hold out hope that at some point the doorway for bipartisanship will again open. I hope at some point the White House and leadership will want to correct the mistakes they made by ending our collaborative, bipartisan work of 3 months during the summer. I hope at some point they will want to let that bipartisan work begin again. Then they need to back that effort and give it the time needed to get it right rather than getting it done right now. It is clear that today is not the day that is going to happen.

I yield the floor.

The PRESIDING OFFICER (Mrs. MCCASKILL). The Senator from Colorado.

Mr. BENNET. Madam President, I am pleased to be here today with my colleague from New Hampshire to talk about fiscal accountability in the context of the health care reform discussion we have been having.

Back in Colorado, people are not talking about far-left or far-right or Democratic or Republican. That is not what concerns them. What concerns them is that for the last 10 years they have seen double-digit increases in the cost of their health insurance, year-in and year-out, at a time, by the way, when their incomes actually declined.

Even before we were in the worst recession since the Great Depression—which we are in today—during the last recovery, the Bush recovery, it was the first recovery in the history of the United States when median family income actually declined. It was, in effect, for a working family a recession, and they are now having to recover not just from the greatest recession since the Great Depression but from a 10-year period when they actually fell behind in terms of their income. What was happening at the same time their income was going down? The cost of health insurance was going up, by 97 percent in my State. By the way, higher education was going up by 50 percent during this same period.

What we have said to working families before this recession and now in the depths of this recession is that they are expected to do more with less. They are threatened by politics in Washington that for decades has allowed special interests to get in the way of our passing meaningful health care reform for working families and small businesses. At the same time, we have tripled our Federal budget deficits and added to the national debt, as we have been unable to deliver for families all across the United States.

Well, today we are closer than ever to meaningful health care reform that lowers costs, reduces the Nation's long-term deficits, and improves access to quality, affordable care for Colorado's families. With the release of the Patient Protection and Affordable Care Act, we have taken a major step forward. This bill will help put our Nation back on a track to fiscal responsibility.

There is much more we need to do to get us where we need to be. I am the father of three little girls who are 10, 8, and 5, and I am desperate about the amount of debt we have loaded up on our Federal Government, about the size of our Federal budget deficit. While reforming health care is not sufficient to fix that problem, it is a very important step forward. Our Nation's annual deficits are enormous and our debt is staggering. Health care reform, as I said, must help solve that problem, not make it worse.

I, for one, have said from the very beginning of this debate that I would not support a health care reform bill that added a dollar to our deficit. I am very pleased to see that the bill the leader has produced does not do that.

We must pass effective reform that will rein in skyrocketing costs in both the public and private sectors and help to solve the fiscal problems that threaten our economy and our kids' futures. Without reform, if we just hold on to the status quo, if we listen to the siren call of special interests, out-of-control health care costs will place an ever higher burden on government expenditures and create structural deficits that could persist for decades as a drag on economic recovery and growth, with deficits and debt for as far as our eyes can see.

Rising health care costs—especially Medicare costs—are the largest driver of our deficits. Our Nation's health

care spending today is 17 percent of our gross domestic product. It is slated to grow to over 20 percent in the blink of an eye. Health care will soon account for one-fifth of our economy. That might not be such a big deal if every other industrialized country in the world was not devoting less than half of that as a percentage of their GDP to health care. It is like having two small businesses, one across the street from the other, and one is spending a fifth of their revenue on their light bill and the one across the street is spending less than half that. You do not need an MBA to know which of those small businesses is going to be able to invest in their business plan and grow. If we expect to be able to compete in the global economy, we need to devote a smaller percentage of our GDP to health care.

Since 1970, every year for almost 40 years—year-in and year-out—Medicare spending per person has risen by over 8 percent a year and private insurance spending per person has risen by over 9 percent a year. We cannot expect reform to begin at the private or employer-based level. We must drive these costs down at the Federal level by reorienting our Medicare incentive structure.

The Congressional Budget Office Director, Doug Elmendorf, has said that the ''rising costs for health care represent the single greatest challenge to balancing the federal budget.'' If you are embracing the status quo, you are embracing skyrocketing deficits.

The White House Budget Director, Peter Orszag, agrees, saying:

The single most important thing—

''The single most important thing''—

we can do to put the nation on a sounder long-term fiscal footing is to reduce the rate of growth of health care costs. Period.

Meanwhile, the cost of health insurance is eating into family budgets faster and faster. About 20 years ago, the cost of an average family health care policy was $4,700 in Colorado, representing 12 percent of the average family's income. Today, an average family's health care policy costs roughly $12,000, amounting to 20 percent of the family's income, going, by 2016, if we do nothing, to 40 percent of their income.

Middle-class wages are not even close to keeping up with these rising insurance costs. In fact, median family income in this country fell by $300 as health care costs increased by 80 percent just while the last administration was in office.

Looking outside the confines of the budget context, health care reform will contribute significantly to economic growth. Health care reform will rein in skyrocketing health care costs and achieve close to $2 trillion of savings through the entire health care system—savings that will result in real economic gains to families and businesses. The Council of Economic Advisers estimates that slowing health care costs will increase gross domestic product by 2 percent in 2020 and by 8 percent in 2030.

After 8 years of irresponsible deficit spending, this legislation will be budget neutral and will put us on course to reduce the deficit over the long term. It is no wonder that people doubt this is actually happening because it has been so long since this body was actually able to do something that was deficit neutral. In this case, we are actually going to improve our deficit situation.

The Congressional Budget Office report confirms that the Senate bill is fiscally responsible and will reduce the deficit. Specifically, the report says the bill cuts the budget deficit by $130 billion over 10 years; cuts the budget deficit by $650 billion in the second decade; extends coverage to over 94 percent of Americans, including a 31 million-person reduction in the uninsured; costs $849 billion; and achieves almost $1 trillion in cost savings.

Just this week, a bipartisan group of more than 20 leading economists released a letter urging passage of meaningful health reform. The economists said our provisions to improve delivery system reform and slow the growth of health care costs ''will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing.''

The challenges facing our health care system are not new. They are old. But if we fail to act, they will surely get worse, meaning higher premiums, skyrocketing costs, and deeper instability for those Americans who have coverage.

Today, thanks to a lot of hard work from a lot of people, we are closer than ever to enacting solutions to these problems and getting a finished bill to President Obama's desk as soon as possible.

Now is the time for us to set aside the childish politics that put us here. Now is the time to ignore the siren song of special interests. Now is the time for us to create a meaningful health care reform for working families and small businesses all across the United States.

Madam President, I yield the floor and look forward to hearing the remarks of my colleague from New Hampshire.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mrs. SHAHEEN. Thank you very much, Madam President.

I rise to join my colleague, Senator BENNET from Colorado, to express my strong support for moving forward to consider the Patient Protection and Affordable Care Act.

My office has responded to thousands of letters and phone calls about health care since we began this debate. I have traveled all across my home State of New Hampshire, talked to small business owners, talked to families who are desperate for help and to health care providers who are frustrated with our current system. Time and time again, what we have heard is that our health care system is not working. Costs are too high. Access is too limited. The status quo is not sustainable.

Now is the time to act. To put it very simply, our health care system is too expensive for families, for workers, for business owners, and for our Nation's economy. I think Senator BENNET laid out very clearly why, if we are going to be fiscally responsible, we have to address health care reform now. It is critical for the Senate to act.

I thank Majority Leader REID and Senators BAUCUS, DODD, and HARKIN, who have led the effort to bring forward the Patient Protection and Affordable Care Act. This is a very good starting point, and contrary to what we have heard, it incorporates many of the changes that have been offered by our Republican colleagues over these past months we have been working on health care.

This bill will help ensure Americans have greater access to quality affordable health care, and it will help begin the transformation within the health care system that is necessary if we are going to contain costs to accomplish the fiscal improvements Senator BENNET talked about.

I think particularly important is the fact that the Patient Protection and Affordable Care Act is fully paid for, so it will not increase the deficit one dime. In fact, by eliminating waste, fraud, and inefficiencies, by doing a more cost-effective job of providing health care, the bill is projected to reduce the deficit by almost $130 billion over the next 10 years. That is what I want to talk about this afternoon—some of those ways in which we can provide health care more cost-effectively and also improve health outcomes for people.

Research shows us that spending on health care does not necessarily translate into better health care. I am proud of the Dartmouth Institute for Health Policy, which is in my home State of New Hampshire, because it has been leading the way on some of this important research. What Dartmouth's research shows us is that when patients are engaged in their treatment decisions, they will choose the less invasive and less costly procedures 40 percent of the time. So almost half of the time, we know patients, when they are involved, are going to choose the less costly procedures—not only that, they are going to be happier about those treatment decisions. We know, based on this research, that the health care system can do better in so many cases for less and that we can recoup savings in our system.

One example of that, which I have worked hard on, along with Senator COLLINS from Maine, is something we call the Medicare Transitional Care Act. Experts estimate that we can save $5,000 per Medicare beneficiary if we can reduce costly readmissions. That is what our work shows. Medicare costs can be reduced and we can offer better support and coordination of care to Medicare patients if we keep seniors who are discharged from the hospital from unnecessarily returning. We know that 30 percent of seniors who are discharged from the hospital, who are on Medicare, are going to get readmitted within 90 days because we do not do a good job of providing for that transition. If we add a benefit through Medicare that helps with that transition, we have a commonsense solution that will improve the quality of health care for our seniors and save taxpayers money. I am very pleased that this provision is included in the health care bill that is before us now or that we hope will be before us soon.

We can also contain health care costs by improving access to lower cost generic drugs. Again, that is something that is in the health care reform bill we are going to be considering. It gives people access to those lower cost generic drugs in a way that saves, generally, anywhere from 25 to 35 percent for generic drugs. It also sets up a process to give people access to lower cost biologic drugs—something we do not yet have, the ability to set up a process to give people access to generic biologics. So that is going to be able to save people money.

This legislation we hope to be able to work on will help Americans access lower cost medications. It will save taxpayers money. This is our opportunity to improve the quality of care available to Americans and to control costs at the same time. It is critical we achieve this for the citizens of New Hampshire and for all Americans. The Patient Protection and Affordable Care Act is a very important step forward. I hope all my colleagues will, as we debate this bill, look at the important changes we are making and decide this is our opportunity to get real, meaningful health care reform done.

Thank you, and I yield the floor.

The PRESIDING OFFICER. The Senator from Missouri is recognized.

SEPTEMBER 11 TERRORISTS' TRIALS

Mr. BOND. Madam President, faith has written many painful chapters in America's history. Each is sharply engraved in our memories. Many involve military conflict: the British burning of Washington, the Civil War, Pearl Harbor, Iwo Jima, Pork Chop Hill.

Others were singular acts of aggression, such as the bombing of the Oklahoma City Federal Building, the assassinations of Martin Luther King and Presidents Lincoln, McKinley, and Kennedy.

September 11, 2001, is the latest painful chapter in American history, one that forever will be burned into our memories as a day of horror unlike any we have experienced before. The sheer magnitude and deliberate evil of the attacks that day defy comprehension. Who among us will soon forget the wrenching images of passenger planes used as missiles aimed at the World Trade Center Towers and the Pentagon or the people diving out of 70-story windows to avoid being burned again, and the heroic and selfless final acts of passengers aboard Flight 93 as it headed toward the Nation's Capital? Who among us will forget the pictures and the hopeful messages that sprang up around the area where the World Trade Center once proudly stood as relatives searched in vain for loved ones?

Three thousand men and women perished that day at the hands of terrorists who cared nothing for the innocent lives they stole. As the towers fell, their comrades and sympathizers, including Khalid Shaikh Mohammed, diabolically cheered the devastation.

It is these memories of 9/11 that make last week's decision by the Obama Justice Department to give the mastermind of these attacks and his associates all the rights and benefits of a civilian trial in New York City unexplainable and compel me to rise to voice my strong objection to that decision.

It is an insult to the memories of those who were brutally murdered on September 11 that the perpetrator of these cowardly acts will sit in a courtroom blocks away from Ground Zero and reap the full benefits and protections of the U.S. Constitution. Even worse than the insult to the victims and their families is the dangerous precipice the Obama Justice Department has now crossed with this foolhardy decision. Earlier this year, the Homeland Security Secretary signaled an alarming change of perspective about the nature of the enemy we face. No longer would we call the acts of terrorism what they are: acts of war. Instead, according to Secretary Napolitano, the accepted terminology for an attack such as 9/11 would now be a ''man-caused disaster.'' Apparently, 9/11 was no different than a forest fire started by an arsonist.

This initial change in terminology was troubling enough, but trying Khalid Shaikh Mohammed and his 9/11 associates in civilian Federal court sends a loud and clear signal that this administration is now comfortable recasting certain acts of terrorism as simply what the Attorney General calls ''extraordinary crimes.'' I have to wonder if the Attorney General thinks Pearl Harbor was an extraordinary crime. In the logic of this administration, murdering 3,000 civilians, including servicemembers at the Pentagon, is an extraordinary crime, justifying trial in a civilian court. Yet killing 17 servicemembers aboard the USS Cole is an act of war or the murder of 13 servicemembers at Fort Hood justifies continued proceedings before the military commissions. This arbitrary distinction makes no sense and shows a disturbing lack of understanding of the nature of this war.

It also creates a perverse incentive for terrorists to attack civilians so they may benefit from our treasured constitutional protections. KSM understood the benefits of these protections when, as former CIA Director George Tenet has said, KSM defiantly told CIA interrogators after his capture: ''I'll talk to you guys after I get to New York and see my lawyer.'' He was counting on going to New York to get the protections of our Constitution.

Words are simply words, but the mentality that these words represent is dangerously naive. Whether it is called a man-caused disaster or extraordinary crime, refusing to treat the September 11 perpetrators as terrorists, deserving only of a trial before a military commission, is a dangerous throwback to the pre-9/11 mentality that resulted in the attack on the USS Cole, the bombings of our embassies, and the first World Trade Center bombing.

Ordinarily, I support the concept of prosecutorial discretion and the right of the executive branch to bring criminal actions against perpetrators as supported by the facts. But in this instance, this discretion must give way to the larger national security interests of our country. In spite of the stated intention of KSM to plead guilty in the military commission, the Attorney General has asserted he believes there is a greater chance of success against these 9/11 coconspirators in civilian court. This belief—one I do not share—does not justify the enhanced risks to our security and the dangerous precedent for the treatment of future terrorists this trial will bring.

That this case will establish a very bad precedent was made clear by the Attorney General in his testimony before the Senate Judiciary Committee, when he summarily dismissed concerns that the decision to bring 9/11 coconspirators into the Federal justice system would preclude an intelligence community interrogation of Osama bin Laden if he were captured. The Attorney General refused to say whether bin Laden would be given Miranda warnings upon capture and claimed ''the case against him is so overwhelming'' that there would be no need to rely on any statements he might make after capture. Mr. Holder called the concerns about not being able to interrogate bin

Laden a ''red herring.'' Well, unfortunately, the Attorney General's testimony shows a complete lack of understanding that the purpose of intelligence interrogations is to stop planned attacks and to take down terrorist networks, not to elicit confessions for use in a criminal trial.

It is beyond troubling that the Attorney General, as the head of the Department of Justice, the Justice Department's FBI National Security Division—the very people charged with preventing terrorist attacks, such as those disrupted in New York, Illinois, and North Carolina, seem to have no interest in obtaining valuable intelligence from bin Laden. As the leader of al-Qaida, bin Laden clearly has considerable knowledge of its network, its members, its methods, and its potential plots to kill more Americans. So what the Attorney General calls a red herring, I call a red flag.

Some have hailed the administration's decision as a way to showcase our judicial system for the world, but the Attorney General has confirmed that in the event KSM or one of his associates is acquitted, he will still be detained indefinitely. Are you sure, Mr. Attorney General, that a court will not order him released?

This begs the question: Why should we incur the time, expense, and risk our national security on a show trial if we are just going to detain these terrorists forever anyway? Rather than showcasing our judicial system, this strange logic seems to make a mockery of the civilian judicial system. While the Attorney General has declared that failure is not an option, he does not control judicial rulings, nor the facts and perceptions that may sway any one of 12 jurors who will decide KSM's fate. A conviction will be expected, but there can be no guarantees.

Make no mistake, America is still at war. The war on terror is real. It will not go away just by calling it another name. We cannot afford to bury our heads in the sand. While Khalid Shaikh Mohammed may ultimately be convicted, our success in the war against terror will only be final when we have hunted these terrorists into extinction. We need look no further than the terror plots disrupted earlier this fall in New York, Colorado, Illinois, and at Quantico, to name a few, to understand the threats we faced on September 11 are still very real. For the men and women massacred in cold blood at Fort Hood, the ongoing threat of terrorism is all too real.

The Obama administration is standing at a crossroads of history. It can either persist in downplaying the reality that we are at war with terrorists or it can affirm that its top priority is to keep Americans safe by winning this war on terror.

Madam President, success in this war on terror cannot simply be defined as getting a guilty verdict against KSM in a civilian Federal court. If the Department of Justice jeopardizes our intelligence sources and methods, incurs unnecessary security risks, and creates a high-profile public platform for KSM to spew his hatred and espouse hirabah, they will only increase the likelihood that these detainees will proselytize fellow inmates in Federal prisons and convert followers worldwide. That is not success; that is failure of the worst kind—an avoidable failure.

These are not the hypothetical gambles that some on the left have dismissed casually. As former Attorney General Michael Mukasey, who presided as a judge over one of the trials, has stated, we know these domestic terror trials have exposed sensitive classified information and given important intelligence information to al-Qaida, allowing them to go undetected in more ways than they need.

A few examples:

The east Africa Embassy bombing trials made Osama bin Laden aware that cell phones were being intercepted, prompting al-Qaida to alter its methods of communication.

The trial of the World Trade Center bomber, Ramzi Yousef, tipped off terrorists to a communications link that provided ''enormously valuable intelligence,'' but was ''shut down'' after the disclosure.

Within days of being provided to the defense in the Omar Abdel-Rahman trial, the blind shaikh, a list of unindicted coconspirators, including Osama bin Laden, was provided to bin Laden.

During the trial of Zacarias Moussaoui, 48 classified documents—reports of FBI interviews with witnesses—were inadvertently provided to Moussaoui as part of the government's pretrial discovery response. In ordering the U.S. Marshals to seize the documents from Moussaoui's cell, the judge noted that ''significant national security interests of the United States could be compromised if the defendant were to retain copies of this classified information.''

I believe these examples provide ample evidence that public trials of these types of terrorism cases are a clear win for terrorists seeking to learn more about our intelligence sources and methods.

Were there no alternatives, we would proceed with this type of trial, despite the risk, because our Nation values due process. However, the military commissions process, first approved by Congress in 2006, and again last month, ensures a fair trial with rights to counsel, discovery, and appeal, but without the costs and risks of Federal civilian trials.

The concept of military commissions is one our Nation has relied upon before. When Congress created the military commissions process after September 11, it established a framework to ensure that intelligence sources and methods would not be jeopardized. While changes have been made over the years to the process itself in light of Supreme Court decisions, the general framework and principles remain solidly in place.

This process isn't new to this administration either. The administration is not only using this process, the Attorney General announced that the USS *Cole* bomber will still be tried under the commission. They worked with Congress to make the changes to it themselves.

Yet in the case of the 9/11 conspirators, the administration has chosen to reject the tried and true method of prosecuting enemy combatants in a venue where intelligence sources and methods are unlikely to be compromised in favor of circuses that will make the trial of Zacarias Moussaoui, with its endless motions and Moussaoui's challenge of a duel to former Attorney General Ashcroft, seem like a mundane proceeding.

This is an unnecessarily dangerous gamble. While the decision to take this gamble with our national security is clearly a matter for the executive branch, the administration has found a willing ally in many of my colleagues in Congress. Earlier this month, I joined 44 other Senators, from both sides of the aisle, in supporting an amendment to prohibit taxpayer funds from being used to prosecute in a civilian court the 9/11 perpetrators. Unfortunately, we were outvoted. The amendment didn't pass.

I encourage my colleagues to rethink their opposition. When the appropriate time comes, I hope they will reaffirm that our national security interests must have priority over politically correct prosecutions.

America is rightfully a different nation today than it was before September 11. We were attacked in a way and at a magnitude that we hope never to experience again. But we simply cannot rely on hope alone. Following these terrorist attacks, we took critical steps to try to ensure we are never attacked like this again. We made sure that we gave our intelligence professionals the tools they needed to fight terrorists, not just criminals. We gave them the tools they needed to fight a war and keep America safe.

We must always remember the lessons of September 11. We owe it to the victims of these and other terrorist attacks to keep our Nation safe. I call on the President from this floor to reverse this disastrous decision by the Attorney General and reaffirm his commitment to our national security and to winning this war against terrorism.

I yield the floor.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Madam President, I apologize to the Republican leader. I was detained in my office talking to another Senator, so I apologize for not being here and his having to wait.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. REID. Madam President, I ask unanimous consent that on Friday, November 20, at 10 a.m., the Senate proceed to a period of debate on the motion to proceed to H.R. 3590, until 11 p.m., with the time controlled in alternating 1-hour blocks, with the majority controlling the first hour; and at 10 p.m., Friday, there be 30-minute blocks until 11 p.m., with the majority controlling the first 30 minutes; further, that on Saturday, November 21, at 10 a.m., the Senate continue with controlled debate in alternating blocks until 6 p.m., with the majority controlling the first hour block; that at 6 p.m., the majority control the time until 6:30 p.m., the Republicans then control 6:30 to 7:15 p.m., the majority control 7:15 p.m. to 7:30 p.m., the Republican leader controls 7:30 to 7:45, and the majority leader controls 7:45 to 8 p.m.; that at 8 p.m., the Senate proceed to vote on the motion to invoke cloture on the motion to proceed to H.R. 3590; that if cloture is invoked on the motion, then all postcloture time be yielded back, the motion to proceed be agreed to, and the motion to reconsider be laid upon the table; that after the bill is reported, the majority leader be recognized to call up his amendment and that it be reported by number only.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED

CLOTURE MOTION

Mr. REID. Madam President, I move to proceed to Calendar No. 175, H.R. 3590, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to proceed to Calendar No. 175, H.R. 3590.

Harry Reid, Tom Harkin, Jack Reed, Edward E. Kaufman, Jeff Merkley, Roland W. Burris, Daniel K. Akaka, Patty Murray, Richard Durbin, Sherrod Brown, Michael F. Bennet, Jeanne Shaheen, Sheldon Whitehouse, Bill Nelson, Mark Udall, Benjamin L. Cardin, Christopher J. Dodd, Patty Murray.

Mr. REID. I ask that the mandatory quorum required under rule XXII be waived.

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

Mr. REID. I thank the Chair.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. FRANKEN. Madam President, I ask unanimous consent that I be allowed to speak in morning business for up to 5 minutes.

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

COBRA SUBSIDY EXTENSION AND ENHANCEMENT ACT

Mr. FRANKEN. Madam President, I rise today to urge my colleagues to support S. 2730, the COBRA Subsidy Extension and Enhancement Act.

As you may know, COBRA allows jobless workers to keep their health care as they look for new work. The Recovery Act included a COBRA subsidy through the end of this year, but if we fail to act, millions of Americans currently looking for work will be faced with a further unbearable burden—the tripling of their COBRA payments.

I am very pleased with the Senate Patient Protection and Affordable Care Act that was released yesterday. This bill will help bring down health care costs for families and the Federal Government. We will invest in prevention and provide incentives to doctors to provide high-quality health care. I commend Leader REID, Chairman HARKIN, Chairman BAUCUS, and Chairman DODD for moving us one critical step closer to secure, affordable health care for all Americans. But while health care reform will bring long-term relief, the proposed COBRA extension will help us bridge the gap before health care reform is fully implemented.

Take, for example, the situation of one of my constituents, Gregory, from Lakeville, MN, southeast of the Twin Cities. Gregory has built a professional career in the printing industry, the same industry my dad was in. He was a printing salesman for 30 years. The printing industry has been especially hard hit by our current recession. Gregory's wife depends on him for health insurance. She has rheumatoid arthritis. My mom had rheumatoid arthritis. Gregory also has two daughters in school.

Gregory was laid off this March and has been tirelessly looking for a job ever since. But there aren't any jobs to be found. Now he has accepted that he may have to change fields, but he is 57 years old. A career change at 57 isn't easy. Unless Congress passes a COBRA extension, his premiums will nearly triple, going from $350 a month to $940 a month. In today's dismal economy, who has $940 each month to spend on health care insurance, especially if you don't have a job?

Gregory has explored the option of a private insurance plan, but his wife's preexisting rheumatoid arthritis makes private plans an impossibility. Gregory is hopeful, as am I, that passing a health care reform bill will eliminate this problem of preexisting conditions. But in the meantime, what are families like Gregory's supposed to do?

Gregory's family is not alone in this plight. CBO estimates that 7 million workers and their families have used the COBRA subsidies in 2009. That includes thousands and thousands of Minnesotans. The expiration of the subsidy will make premiums so expensive that many families will be forced to drop their coverage, adding further to the number of uninsured Americans. Now is not the time to put another burden on struggling families.

The COBRA Subsidy Extension and Enhancement Act will provide relief to families by extending the COBRA subsidy another 6 months, through June of 2010. By that time, our economy will have made significant progress in job creation, and many Americans will be back on the job. The extension will also include an increase in the subsidy—from 65 percent to 75 percent—allowing more families to retain coverage. During this recession, the last thing Congress should do is pull the plug on benefits before folks have had a chance to get back on their feet.

I know my colleagues Senators BROWN and CASEY share the same goal of passing meaningful health care reform this year. But they also know the importance of providing a stopgap measure to deliver relief to families who are struggling in the current downturn. I thank them for their leadership on these critical issues.

I urge my colleagues to swiftly enact the COBRA Subsidy Extension and Enhancement Act and allow more families to maintain health care insurance coverage as they look for work.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

APPROPRIATIONS BILLS

Mr. COCHRAN. Madam President, in the coming weeks and months, the Senate is scheduled to complete action on bills that will have a profound impact on Federal spending for many years to come. I rise to express my concerns about the manner in which new spending is being proposed in that legislation.

Congress has sent 5 of the 12 annual appropriations bills to the President for his signature. Four other bills are in conference with the House. The Senate has not yet acted upon the three remaining bills under our jurisdiction.

Last year, Congress completely abandoned the appropriations process. The year before that, only a few bills were acted upon by the Senate before all of the bills but one were bundled into an omnibus bill and sent to the President.

Thus far this year, we have not been able to complete action on all 12 appropriations bills, but we have made significant progress. The Senate has debated a stand-alone Agriculture appropriations bill and an Interior appropriations bill for the first time in 4 years. Ideally, these bills should be subjected to the scrutiny of the full Senate every year. This year, there have been hearings in each subcommittee, and the bills have been subjected to subcommittee and full committee markups. We have tried to get the bills to the floor individually so all Senators have an opportunity to offer amendments, and so we can avoid the necessity of grouping the bills into an omnibus bill.

The chairman, who is the distinguished Senator from Hawaii, Mr. INOUYE, deserves the credit for these improvements. All Senators on the committee have cooperated, though.

Despite the many difficulties associated with enacting the appropriations bills, the process compels us to hear testimony, analyze programs, and consider funding needs and priorities on an annual basis. It is not always a smooth or easy process, but it has the benefit of compelling us to continually reevaluate the level of Federal spending. That is not the case when we create long-term or permanent mandatory spending programs.

I don't mean to criticize the oversight of the authorizing committees. Many of them do excellent work in this regard, holding agencies and funding recipients accountable for their management decisions. But once a funding stream is made mandatory, it is difficult to reduce or cut off the spending or to use the leverage of future funding to motivate more efficient management of Federal programs or activities.

One of the justifications often cited for creating mandatory spending programs is that the funding recipients need predictability to properly and efficiently manage programs. While there may be some truth to this, in itself it is not a sufficient reason to make a new program mandatory or to change an existing program from discretionary to mandatory.

If increased predictability is the goal, Congress should make greater efforts to get the annual appropriations bills done as close to on time as possible and in an open and orderly fashion that allows scrutiny of the proposed spending.

Failure to process the appropriations bills in this manner has the effect of driving interest groups to seek the predictability of long-term mandatory funding streams. In effect, we create a situation whereby Congress must take proactive steps to reduce or eliminate spending as opposed to proactive steps to continue spending.

As a general matter, we should be very careful about moving programs in that direction, in my opinion. As I look at the major legislation that Congress is slated to consider over the coming months, I am greatly concerned. Of most immediate concern is the health care bill on which we will soon begin debate.

The bill reported by the Senate Finance Committee creates new programs with direct appropriations that should be funded or not funded through the annual appropriations process. There are mandatory programs for maternal, infant, and early childhood home visitation and for personal responsibility education for adulthood training. There are grants for school-based health centers, a demonstration program for emergency psychiatric care, and a demonstration program to address the health profession's workforce needs.

A previously authorized childhood obesity program is directly funded with a mandatory appropriation. Many of these programs are funded for only a few years, just enough time to get funding recipients invested in the program, after which expectations will be overwhelming that the programs be continued with annual appropriations.

As ranking member on the Labor, Health and Human Services Subcommittee, I might be inclined to support funding some of them, but beginning new programs with short-term, mandatory funding is a recipe for trouble. It results in hiding the long-term costs of these programs and provides no opportunity upfront to consider tradeoffs between the new programs and existing programs.

The health care bill reported by the HELP Committee includes a new prevention and public health fund to support an ''expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.'' That is a quote from the bill. The bill appropriates $2 billion for this purpose in fiscal year 2010 alone and increases that amount to $10 billion by fiscal year 2014 and thereafter.

This has long been a priority of the Senator from Iowa, Mr. HARKIN. To the committee's credit, the bill provides some latitude for the Appropriations Committee to allocate funds among various prevention and wellness programs in the outyears.

At its heart, however, this provision implies that we know today what the appropriate Federal investment for wellness programs will be 10 or 20 years from now. I just don't think that is plausible. If prevention and wellness programs are that important, let's call up the Labor, Health and Human Services appropriations bill and either increase the size of the bill or reallocate money within the bill to support wellness programs. When the fiscal year 2011 appropriations process begins, let's analyze how those programs are working and consider, once again, the appropriate funding levels for the coming year.

Beyond the health care bill, there is legislation to address global climate change. Here, again, we face the prospect of massive new annual Federal expenditures being established on a mandatory basis, effectively being put on autopilot right from the beginning. While nobody knows the value of the carbon allowances that would be auctioned under some climate bills, it is clear that tens of billions of dollars from such auctions would be plowed directly back into an array of programs administered by Federal, State, and local government agencies.

Some of the programs have a more obvious relationship to climate change than others. Just to list a few, the Senate-reported bill directly funds clean vehicle technology, building retrofits, advanced energy research, nuclear worker training, coastal preservation, and Federal land acquisition.

Many programs that would be funded by this bill are identical or similar to programs already funded in annual appropriations bills. Others are entirely new.

Are we truly confident in the year 2016 it will be prudent to spend 4.3 percent of an unknowable amount of auction revenues on international deforestation efforts? Are we sure that in the year 2030 we should be spending .74 percent of auction proceeds on worker assistance programs?

Congress should protect its ability to reconsider support or opposition to such spending annually, or at least periodically, based on program performance and our current national interests.

What about funding of Federal land acquisition? I have supported some Federal land acquisitions in my State of Mississippi, sometimes to incorporate important resources into our National Park System, sometimes to preserve sensitive habitats by including them in our national wildlife refuge system or in our national forests. I have had other Senators request specifically that we not approve the Federal acquisition of a particular piece of property. This has been a particularly sensitive issue for our western colleagues, particularly in whose States Federal land ownership is already extensive. Yet in the climate bill, we are being asked to allocate funding to the executive branch on a long-term basis for unspecified Federal land acquisition projects, all with no apparent mechanism for congressional oversight.

Are any Senators really comfortable with that arrangement? This is just one example of why Congress should consider programs on an annual basis through an open process rather than

putting programs on autopilot and then struggling against the tide of entrenched interests to react when things do not go as expected.

In July, the House passed an education bill, the Student Aid and Fiscal Responsibility Act. The bill terminates the programs that authorized private lenders to make federally guaranteed loans to students and provides that future student loans will be provided only through direct Federal loans from the U.S. Department of Education.

My concern with this is that the House-passed bill establishes a number of new mandatory education programs and expands several existing programs with mandatory funding streams. The Congressional Budget Office estimates the House-passed bill would reduce mandatory spending by $87 billion over the next decade. But the House bill directly spends all but $8 billion of that amount on new and expanded programs. It directly funds a new college access and completion innovation fund. It establishes mandatory funding streams for school modernization, renovation, and repair, including a program of supplemental grants for States along the gulf coast. It establishes mandatory programs for early childhood education and for reforming community colleges and improving training for workforce development.

In many cases, these are new programs. In some cases, the mandatory amounts are meant to supplement funding currently provided through annual appropriations.

Regardless of the merits of these programs, the fact remains that we are faced with a debt problem of huge proportions. We have now closed the books on fiscal year 2009, finishing the year with a budget deficit of $1.4 trillion. We began fiscal year 2010 with a deficit of $176 billion for the month of October. Our national debt has hit $12 trillion, and soon Congress will have to act to raise the Federal debt ceiling again.

President Obama's own budget, optimistic in many respects, forecasts that our national debt will be rising to 66 percent of the gross domestic product by 2013. The Congressional Budget Office forecasts debt reaching 87 percent of GDP in 2020 and increasing thereafter to even more alarming levels.

Given this set of facts, is it responsible to enact a bill that is expected to produce—not guaranteed to produce but expected to produce—a savings of $87 billion in mandatory spending but then in the same legislation spends all but $8 billion of that anticipated savings on new programs or expansions of existing programs that could just as well be achieved through the annual appropriations process?

Is it responsible to advance a climate bill that spends tens of billions of dollars on new mandatory programs and to allocate funding among those programs for decades into the future when we have no ability to judge whether those programs are needed or effective or what different programs might be necessary depending on how climate legislation would affect our economy, our workforce, and our environment?

Can we afford to enact a health care bill that is long on new costly mandatory programs but short on cost savings that we all know must be found within our health care system?

Certainly, there are situations where mandatory funding is an appropriate mechanism to deliver government services. In cases where our goal is to provide a service to a certain group of eligible people, regardless of how many people may be eligible in a given year, a mandatory appropriation may be the most efficient means of achieving that goal.

Given our Nation's fiscal situation, however, it seems to me we should strongly favor a procedure that requires Congress to consider programmatic spending every year. This is the very principle stated in paragraph 13 of rule XXVI of the Standing Rules of the Senate. This is not a question of which committee has the power over the purse. It is a question of whether Congress will maintain the power over the purse and deliberately exercise it.

Every year in appropriations bills, programs are terminated, reduced, or expanded based on performance and the availability of resources, pursuant to the budget resolution. Interest groups and program beneficiaries are required to give us their views annually. The competition for available dollars is intense. But so what? Whether it is health care, climate change, education, or other legislation, Congress should be very cautious about establishing new, long-term, mandatory funding streams because it fundamentally weakens our ability to control Federal spending at a time when we greatly need to exercise that control.

I hope my colleagues will keep this in mind as we proceed with the business before us.

The PRESIDING OFFICER (Mr. WHITEHOUSE). The Senator from Maryland is recognized.

Mr. CARDIN. Mr. President, shortly we will have an opportunity to vote on moving forward and considering health care reform in this country. I thank the majority leader, Senator REID, for putting together the bill that came out of our two committees that accomplishes what I think are the three goals we need to accomplish in health care reform. I have been asked by the people of Maryland whether I would support a particular bill. I told them in order for me to vote for a bill, it has to do three things: First, it needs to bring down the cost of health care in America; second, it needs to provide an affordable quality insurance option to every American; and, third, it must be done in a fiscally responsible way.

The bill Senator REID is bringing forward accomplishes those three goals. First, it brings down the cost of health care in America by about $1 trillion. It does it by investing in prevention and healthy lifestyles; by cracking down on fraud, waste, and abuse; and by eliminating unnecessary administrative costs in our health care system. That is the way we should bring down health care costs in America. That will improve quality but bring down costs.

Second, this bill allows every American to have access to affordable health insurance and health care. The Congressional Budget Office estimates the bill will reduce the number of uninsured in America by 31 million. We will be able to get 98 percent of Americans who are in this country legally, citizens, covered by health insurance as a result of this legislation.

Third, this bill moves forward in a fiscally responsible way by not only staying within our budget but by actually reducing our budget deficit by $127 billion with no new tax burdens on middle-income families.

I am particularly pleased this bill will help middle-income families in America. Mr. President, I know you have received letters from your constituents. I have received letters from my constituents that tell us the status quo is unacceptable for middle-income families in America.

Let me give two examples of people who wrote to me. I got hundreds of letters from Marylanders telling me they cannot make it under the status quo. This is from Meg, from Rock Hall, MD. Rock Hall, MD, is on the eastern shore. She is a healthy, active 62-year-old woman. She plays tennis four times a week. She is not on prescription medicines and has never had a major medical issue.

She wanted to change her insurance coverage. She has insurance, but she wanted to go to a more affordable insurance plan for her family. She was denied coverage. Why? Because she had received counseling 3 years earlier due to a stressful family situation and because she had a slightly elevated cholesterol level. Her cholesterol has been brought under control taking over-the-counter medication, and she has not had counseling in over a year.

She writes to me, and how do I answer that? It says:

> If I am considered high-risk, where does that leave Maryland residents who have serious health conditions, are on medications, or require on-going care?

Meg is absolutely right. The bill the leader is bringing forward will deal with middle-income families such as Meg's by telling health insurance companies they cannot participate in such discriminatory practices, by restricting preexisting conditions. In fact, Meg doesn't have preexisting conditions, but they are using that to deny her full coverage.

Earlier this week, Cynthia and Eric Cathcart came to us, came to this Capitol to tell us their stories. I must tell you, I was shocked to hear of their circumstance.

Here are two individuals who are self-employed, trying to make it. They have two children. They are trying to get along. Eric told us he is basically giving up on his business and is going to have to work for a larger company because he can't afford health insurance. Cynthia, who is a piano instructor, tells us the same story. Listen to this.

Here are a husband and wife, two children, and they cannot get an insurance policy to cover their whole family because of the preexisting condition restrictions. These are small business owners who are going to have to literally give up their businesses.

Today they have two separate insurance plans: one for the husband and child, one for the wife and child, because that is the only way they can get it. They have to pay two separate deductibles because they couldn't get an insurance plan to cover the family. The amount of money they are paying for health insurance is prohibitively expensive.

The status quo is not acceptable for the Cathcarts and should not be acceptable for any of us. Under the health care bill the leader is bringing forward, though, discriminatory practices by private insurance companies would be prohibited, and the Cathcarts would have the option of a lot of different plans they could choose from to cover their entire family without separate deductibles for different members of their family.

That is the type of health care reform we need that will help middle-income families in America. It will help middle-income families by bringing down the cost of health care. The cost of health care in America is growing at way too fast a rate. Ten years ago in Maryland it cost an average family about $6,000 for health insurance. Maybe their employer paid part; maybe they paid part. Today that is $12,000 a family. By 2016 it will be $24,000 a family if we do not take action. We need to help middle-income families. We need to move forward with health care reform.

The average family in Maryland today is paying $1,100 per family for the cost of those who do not have health insurance. Those who have health insurance are paying for those who do not have health insurance. That is why the bill the leader is bringing forward, that will cover 98 percent of Americans, is going to help middle-income families by eliminating that hidden tax of $1,100 per family in Maryland and around the country.

Health care costs are growing three times faster than wages are growing in America. Inaction should not be an option.

For small businesses the situation is very dire. They are spending 20 percent more than a comparable company that does the same business that is larger. Just as stressful, they cannot predict what the annual premium increase is going to be. How can you run a business without knowing what your costs are going to be from 1 year to another? For the sake of small businesses we need to move forward with health care reform.

A lot of families in Maryland depend upon Medicare; a lot of middle-income families in Maryland depend upon Medicare. This bill will strengthen Medicare by dealing with the underlying costs of health care, by getting that under control. At the same time we protect Medicare for the future, we provide additional benefits for our seniors by starting to close the doughnut hole, getting prescription drug costs under control, and providing preventive care for our seniors. This legislation will help middle-income families by dealing with insurance reform and eliminating preexisting conditions. It will provide larger pools to offer more choice for middle-income families.

This legislation will help workers who work for small companies. It will help those people in our community who have preexisting conditions. It will help those people in our community who are changing jobs. It will help those in our community who depend upon Medicare. This is legislation that is critically important for middle-income families in America.

The status quo is unacceptable. We need to act, and we are going to have a chance to do that when we vote Saturday on proceeding with health care reform. I urge my colleagues to move forward on this vital legislation for America.

I yield the floor.

The PRESIDING OFFICER . The distinguished Senator from Utah is recognized.

Mr. BENNETT. Mr. President, I enjoyed listening to my colleague from Maryland. He says to us repeatedly the status quo is not acceptable. I agree with that. I would point out to him that the bill that has been presented to us by the majority leader guarantees the status will remain ''quo'' until 2014. This bill delays implementation until 2014. For 4 years the status will remain ''quo'' on key provisions.

Mr. CARDIN. Will my colleague yield on that point?

Mr. BENNETT. I am happy to yield.

Mr. CARDIN. Let me point out that much of the insurance reform takes effect immediately. The preexisting conditions are dealt with immediately. The larger pools for those who can't find health coverage, that is done and implemented immediately.

Mr. BENNETT. I understand, but the key provisions of the bill that cost significant money are postponed until 2014. Why? Because unless you make that postponement you cannot get the score down to the point where it is in the majority leader's bill.

The challenge is that the real cost of health care is substantially more than this bill demonstrates as it comes out of the Congressional Budget Office. Why? Because the Congressional Budget Office is required by law to give costs over a 10-year period. If this whole thing started at the time the bill was passed and ran for the whole 10 years, the cost would be so high that it could not be offset with the programs that have been put in the bill. So the easy way to save costs and bring it down below the level that is acceptable is to delay the implementation until 2014.

We saw that in the Finance Committee. The Baucus bill moved the date of implementation from January 1, 2013, to July 1, 2013, to save money. Now the Reid bill moves it from July 1, 2013, to January 1, 2014, an entire year of additional ''savings.''

These are not savings at all. These are simply a delay in the implementation and therefore a delay in the expenditures.

I want to move to the point the Senator from Mississippi was making with respect to the impact of this on the national debt and the national deficit. The last time we had a budget from President Bush, the last Bush budget said the total expenditures would be $3.1 trillion.

President Obama's budget called for expenditures of $3.6 trillion or ½ trillion more.

OK, ½ trillion more, you would assume, therefore, that the deficit that would occur would be roughly ½ trillion more than the Bush deficit. But the last deficit of the Bush administration, before the financial crisis hit us, was $116 billion. That is .1 trillion of the $3.1 trillion. And the first deficit of the Obama administration is $1.4 trillion.

You say: Wait a minute. Those numbers do not add up. The reason they do not add up is, we can control how much we spend, but we cannot control how much we take in. How much we take in is a function of the economy.

Let's go back to the budget that was submitted and passed by the Obama administration and passed on the floor of the Senate by the Democratic majority. It projected $2.2 trillion in revenue, and it projected $2.2 trillion in entitlement spending, mandatory spending. That meant that everything else in government had to be borrowed. Money for the Defense Department had to be borrowed, the State Department, all of our embassies overseas, all of that money had to be borrowed. The money for transportation, for the Federal Aviation Administration had to be borrowed. The money for national parks had to be borrowed. The money for education had to be borrowed.

It wasn't that the expenditures went up an extra $1½ trillion to get a $1.4 trillion deficit. It was that the revenues went down. Yes, the expenditures did go up. The expenditures under the Obama budget went up roughly $½ trillion from the expenditures under the Bush budget. But the big problem was, the revenues went down at the same time.

The cautionary tale that comes out of this is, again, we can control how much we spend, but we cannot control how much we get in. That is a function of the economy. Money does not come from the budget; money comes from the economy. When the economy is weak, as it is now, we are going to have deficits, no matter how big an effort we make to try to avoid them, because the money simply doesn't come in.

The reason I make that point is because, back again to the numbers that we realized when we were debating the budget, the money coming in was $2.2 trillion and the money already committed in entitlement benefits that the Congress did not deal with in the appropriations process was $2.2 trillion. What we will do, if we pass the bill the majority leader has introduced or will introduce, is to increase the amount of mandatory spending, increase the commitment of the Federal Government to make expenditures in the health care area that will be beyond the reach of the Appropriations Committee, that will be going out whether or not we have the money coming in to pay for them.

I know the score out of CBO says this will save money for the Federal Government, but let's get into the details of what the CBO had to say to see how much it would save and see why it would save.

The CBO says, about the longer term calculations with respect to this bill:

> These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation.

I think that is one of the understatements of the year. Major legislation does not often go unchanged for two decades. Congress will add goodies. Congress will delay some of the tax provisions. We see that every year with respect to the legislation known around here as the doc fix. It is in the law right now that every year we cut reimbursements to doctors under Medicare, and every year the Congress comes in and says: We won't do it this year. The doc fix comes in and says: We will change this earlier situation. That means any score that depends on our not passing a doc fix is going to be wrong. CBO says that. Again:

> These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation.

We keep hearing how the costs are going to come down. What does CBO have to say about that? This is the quote that has to do with what I was talking about with respect to expanding the Federal commitment for entitlement spending in health care. Quoting again from CBO:

> Under the legislation, federal outlays for health care would increase during the 2010–2019 period, as would the federal budgetary commitment to health care.

The Federal budgetary commitment to health care will increase. So how do we get a score that says we will save money? You get the score because you have projected revenues that will increase. You have tax provisions in there that say we will get the money from this tax, we will get the money from that tax. Then it will be a saving to the Federal Government. It is not a saving to the Federal Government; it is a raising of Federal revenues above the commitment to spend. But as I pointed out in the beginning, the raising of Federal revenues is not an automatic thing upon which we can depend. It is dependent upon the economy. What happens if we make the commitment to the spending and then the economy is not good and the revenues do not come in at the level CBO is projecting? These are all assumptions CBO is making, feeding into the computers. The computer cannot and does not project any kind of economic downturn, any kind of recession, any kind of problem. It just says: If, if, and if, you will get this number. And then they plug that number in, and that number says it will be big enough to pay for all of this. But make no mistake, what CBO says on the side where we can control it, the spending side, it says it would increase the Federal budgetary commitment to health care.

So once again we have entitlement spending. We have the demand for money going out going up on the hope that the revenues coming in will somehow be greater than the amount going up, and therefore we can project that this will save the government money.

How accurate has CBO been in the past with respect to the spending side? Well, we can go back to Lyndon Johnson and Joe Califano, who created Medicare, and take their original projections as to how much Medicare would cost. I have given that speech on the floor before. The answer is, Medicare costs 20 times more than was projected at the time it was put in place. We could do the same thing with Medicaid. It is not quite that big, not quite 20 times. SCHIP, whatever it is. With the exception of Medicare Part D, which was a Republican initiative, every single time the Federal Government has put in a Federal program for medical activity and medical expenditures, the actual expenditures have exceeded projections, sometimes 20 times exceeding it, going back to Medicare. That is the spending side.

We cannot produce that kind of money on the revenue side because we cannot really control the amount of revenue that comes in. The amount of revenue that comes in is a function of the economy.

Once again, where are we this year? Mr. President, $2.2 trillion in revenue, substantially below the amount of revenue that came in in the Bush administration. It is not Bush's fault that there was more or less. It was the economy that made a downturn. And if we think in this body we can repeal the business cycle and see there will be no more downturns in the future, we are really kidding ourselves. There will be downturns, and there we will be, with the commitment in place, the increase in the Federal budgetary commitment to health care, without the revenue to pay for it.

This is CBO again:

> The long-term budgetary impact could be quite different if key provisions of the bill were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress.

In other words: We will make no attempt to guess what is going to happen in the future, but we can tell you that any kind of tinkering with this in the future is going to make all of our predictions wrong. That is the logical thing for them to say, it is the prudent thing for them to say, and it is the accurate thing for them to say.

There are many things about this bill that I don't like. I am convinced it will increase premiums for those who currently have health insurance. There is no way it can produce the kinds of results my friend from Maryland talked about of covering 30 million more people and cutting costs for everybody in Middle America without costing a lot more money someplace else. One of those places is going to be either in your tax responsibilities or in increased premiums or in the States.

We all know how the Governors feel about this proposal. The Governors have said this proposal will bankrupt us by the rolling of Medicaid costs onto the States—not Republican Governors, it is Democratic Governors who have come forward and said: We can't handle this. So there are lots of things about this bill I don't like.

But I believe the score that has been put together is not an honest one. I am not accusing CBO of doing anything wrong. I am accusing those who wrote the bill of putting in provisions so that we will delay this implementation there, we will call for this tax here and the score that goes there and so on. And it ends up that when we feed all of that information into the computer and then say: O mighty computer, none of this will change, what is the number, the computer gives you a number, but it is a number based on assumptions that are based on smoke and mirrors.

There is an old saying: Where there is smoke, there is fire. This bill has a lot of smoke in it, and, in my opinion, it is the American people who are going to get burned.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Pennsylvania.

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

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Mr. SPECTER. Mr. President, I have sought recognition to comment briefly on the Patient Protection and Affordable Care Act, which was disclosed late yesterday by our distinguished majority leader, Senator REID, to whom we all owe a debt of gratitude for the extraordinary work in putting together this very complex legislative proposal. Also, compliments are due to Senator BAUCUS, who chairs the Finance Committee, and Senator DODD, who carried on the work of Senator Kennedy on the Health, Education, Labor, and Pensions bill. The bill provides for gross spending of $979 billion over a 10-year period, under the $1 trillion dollar mark. The coverage allocation is $848 billion. There are gross savings of $1,109 billion, and the deficit impact is to have a reduction of some $130 billion over the 10-year period. In the second 10-year period, the projection for savings is substantially greater. There will be millions of Americans covered who do not now have health coverage, so over 94 percent of all legal residents of all ages will be covered.

We are now digesting this very complex piece of legislation. The majority leader has scheduled a cloture vote for Saturday at 8 p.m. It is my hope and, candidly, my expectation that we will have the 60 votes to proceed for the consideration of this bill.

It is my view that inaction is not an option; that there are too many people not covered by health insurance or who are underinsured. The cost of health coverage is escalating at such a tremendous rate. It is having a great impact especially on small businesses. A recent prominent publication noted that rates for small business were being dramatically increased. Senator HARKIN scheduled a hearing in the Health, Education, Labor, and Pensions Committee. One of my constituents from Lancaster came in to testify that his premiums were rising by 128 percent. So I believe that inaction is not an option.

We have had many declarations of positions, and in the Senate, where you need 60 votes to move ahead, every one of those votes is indispensable. Only one Republican, Senator SNOWE in the Finance Committee, supported the Finance Committee bill, so there was no margin for error. It would be my hope that my colleagues will not draw any lines in the sand, realizing that no legislative proposal is going to meet the expectations and the desires of every individual Senator. There are 100 of us. There are 435 Members of the House of Representatives. If there is an art to politics, it is an art of listening, of being flexible, and accommodation or compromise.

So we are undertaking a major historic event. Efforts have been made since the days of Theodore Roosevelt to have this kind of health coverage legislation. It is too important for us to fail.

(The remarks of Senator SPECTER pertaining to the introduction of S. 2805 are printed in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

FORECLOSURES

Mr. SPECTER. Mr. President, while I have the floor, I wish to briefly address one other subject. I know my colleague is on the floor waiting for an opportunity to speak. This relates to a plan which is being carried on in the city of Philadelphia to stop foreclosures. We have seen a tremendous problem across America with the housing bubble, with so many people being in houses they could not afford and so many foreclosures. The Philadelphia program received front-page attention in the New York Times just yesterday as a model program. I call the Philadelphia program to the attention of my colleagues and to anyone who may be watching C–SPAN2, a program which is a model and which ought to be followed in other jurisdictions.

In March of 2008, the Philadelphia City Council passed a resolution called the Residential Mortgage Foreclosure Diversion Pilot Program. Following the council resolution, Philadelphia's civil court adopted rules that no owner-occupied house could be foreclosed on or sold at sheriff's sale before a mandatory conciliation conference between the borrower and lender aimed at finding a workable compromise. This Philadelphia program has emerged as a model, enabling hundreds of troubled home buyers to retain their homes.

In October of last year, a little more than a year ago, Senator CASEY and I held field hearings in Philadelphia and Pittsburgh to explore ways to keep borrowers in their homes using the successful Philadelphia program model.

I ask unanimous consent that at the conclusion of these remarks, a copy of the New York Times article be printed in full in the RECORD which details the Philadelphia program and is a suggestion for other cities as to how to follow that.

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

[From the New York Times, Nov. 18, 2009]

PHILADELPHIA GIVES HOMEOWNERS A WAY TO STAY PUT

(By Peter S. Goodman)

PHILADELPHIA.—Christopher Hall stepped tentatively through the entranceway of City Hall Courtroom 676 and took his place among dozens of others confronting foreclosure purgatory. His hopes all but extinguished, he fully expected the morning to end with a final indignity: He would sign over the deed to his house—his grandfather's two-story row house; the only house in which he had ever lived; the house where he had raised three children.

"This is devastating," he said last month as he sat in the gallery awaiting his hearing. "This is my childhood home. I grew up there. My mother passed away there. My grandfather passed away there. All of my memories are there."

A union roofer, Mr. Hall, 42, had not worked since August 2008, when the contractor that employed him as a foreman went broke and laid off more than 40 people. He had not made a mortgage payment in more than a year, and his lender, Bank of America, was threatening to auction off his house through the sheriffs office.

In most American cities, that probably would have been the end of the story: another home turned into distressed bank inventory by the national foreclosure crisis. But in Philadelphia, under a program begun last year to try to keep people in their homes, Mr. Hall entered the courtroom with a reasonable chance of hanging on.

Under the rules adopted by Philadelphia's primary civil court, no owner-occupied house may be foreclosed on and sold by the sheriffs office before a "conciliation conference," a face-to-face meeting between the homeowner and the lender aimed at striking a workable compromise. Every homeowner facing a default filing is furnished with counseling, and sometimes legal representation.

So, as Mr. Hall stepped into the ornate courtroom just after 9 o'clock, he was swiftly provided with a volunteer lawyer, Kristine A. Phillips. She huddled briefly with a lawyer for Bank of America and returned with a useful promise. The bank would leave him alone for six more weeks while his housing counselor pursued further negotiations in an attempt to lower his payments permanently.

"You've got more time," Ms. Phillips told him. "We'll get this all worked out," she said.

"Thank you so much," Mr. Hall said softly, his body shaking with pent-up anxiety now tinged with relief. "It's a lot of weight off of my shoulders."

In a nation confronting a still-gathering crisis of foreclosure, Philadelphia's program has emerged as a model that has enabled hundreds of troubled borrowers to retain their homes. Other cities, from Pittsburgh to Chicago to Louisville, have examined the program and adopted similar efforts.

"It brings the mortgage holder and the lender to the table," said City Councilor John M. Tobin Jr. of Boston, who is planning to introduce legislation to enact a program in his city modeled on Philadelphia's. "When people are face to face, it can be pretty disarming."

When homeowners in Philadelphia receive legal default notices from their mortgage

companies, the court system schedules a conciliation hearing. Canvassers working for local nonprofit agencies visit foreclosed homeowners, distributing fliers that inform them of their rights to a conference, and urging them to call a hot line that can direct them to free housing counselors.

''You can feel a certain sense of relief from their just being able to speak to someone about the program,'' said Anna Hargrove, who works as a canvasser in West Philadelphia.

Every Thursday morning, the courtroom on the sixth floor of the regal City Hall here is given over to the conciliation conferences. It fills up with volunteer lawyers in jogging shoes, who are representing homeowners; gray-suited corporate lawyers working for mortgage companies; and all variety of delinquent borrowers—elderly citizens leaning on canes, construction workers in coveralls, parents with bored children in tow. The lawyers exchange preliminary settlement terms, while the homeowners fill out papers and wait.

In some cases, deals are struck that lower monthly payments for borrowers and allow them to retain their homes. When a homeowner cannot afford the home even at modified terms, the program helps to create a graceful exit, in which the borrower accepts cash for vacating the property or signs over the deed in lieu of further payment.

Those outcomes are similar to the ones produced by the Obama administration's $75 billion program aimed at stemming foreclosures, which gives cash subsidies to mortgage companies as an inducement to accept lower payments. But in Philadelphia there is one crucial difference: the mortgage companies have no choice but to participate. They have to attend the conferences and negotiate in good faith or they cannot proceed with a sheriffs sale.

Since the administration's program was begun in March, it has been plagued by complaints of bureaucratic confusion and the indifference of mortgage companies. Many homeowners who have applied for loan modifications complain that their documents have been lost repeatedly or that they have been rejected without explanation.

RIGHT TO MEDIATION

The Philadelphia program forces an outcome by bringing together all the principals in one room. If the mortgage company proves intractable, the homeowner has the right to request mediation in front of a volunteer lawyer serving as a provisional judge, who relays recommendations to the program's supervising judge. If the judge finds that the mortgage company is not acting in good faith, she can hold the house in limbo by denying permission for a sheriffs sale.

While data is scant, a legal aid group, Philadelphia Volunteers for the Indigent Program, has complete information on 61 of the 309 cases it has resolved since October 2008 through the anti-foreclosure program.

Only five resulted in sheriff's sales, while 35 ended with loan modifications that lowered payments, the group says. The remaining 21 cases were divided among bankruptcies, loan forbearance and repayment arrangements, graceful exits and straightforward sales.

Some suggest the city's program is plagued by the same basic defect as the Obama rescue plan: Nearly all the loans that have been modified have been altered on a trial basis, requiring homeowners to reapply for an extension of the terms after only a few months—a process that appears rife with obstacles, according to participants.

''There's no teeth to the conciliation program,'' said Matthew B. Weisberg, a Philadelphia lawyer who represents homeowners in cases involving alleged mortgage fraud. ''It's a largely ineffective stopgap prolonging what appears to be the inevitable, which is the loss of homes.''

Still, Mr. Weisberg grudgingly praised the plan.

''It's arbitrary and unpredictable,'' he said, ''but it's better than what anybody else is doing.''

SHERIFF DELAYS AUCTION

Philadelphia's Residential Mortgage Foreclosure Diversion Pilot Program began with a resolution passed by the City Council in March 2008, calling on Sheriff John D. Green to scrap the sheriff's sale scheduled for April. Low-income neighborhoods were already experiencing a surge of foreclosures involving subprime loans given to people with tainted credit. With unemployment growing, lost paychecks were now pushing people into delinquency, reaching into middle-class and even wealthy neighborhoods. In early 2008, nearly 200 homes a month were being auctioned by the sheriff's office, about one-third more than in 2006.

In West Philadelphia, Councilman Curtis Jones Jr., one of the sponsors of the resolution, watched his childhood neighborhood consumed by foreclosure, as the homes of working families—their porches once lined with flower pots—were boarded up with plywood.

''It becomes a blight on your entire community,'' Mr. Jones said. ''It creates an environment that fosters everything bad, from prostitution to drug dealing to wildlife, like raccoons taking over whole houses. One house becomes 10, and 10 becomes the whole block.''

In response to the resolution, Sheriff Green canceled the April sale. Meanwhile, Judge Annette M. Rizzo, who oversaw a local task force on stemming foreclosures, joined with the president judge of Philadelphia's Court of Common Pleas to develop the program.

For Judge Rizzo, a high-energy woman who has long taken an interest in housing policy, the moratorium presented both a crisis and an opportunity. The sheriff was effectively refusing to fulfill his mandated responsibilities, leaving his office vulnerable to legal challenge. But if the mortgage companies could be persuaded to participate in an alternative way of addressing foreclosures, more people could stay in their homes.

''I realized we're either going to go down in flames or we're going to be a national model,'' Judge Rizzo said. ''We're going to look at these cases and see what we can work out.''

Mr. Hall knew none of this. What he knew was that his life seemed to be unraveling.

HOME TO FOUR GENERATIONS

Ever since he was a teenager, he had earned a middle-class living with his hands. He had been raised by his grandfather in his three-bedroom house on Akron Street, in a predominantly Irish Catholic working-class neighborhood in Northeast Philadelphia.

He had attended St. Martin's, the Catholic school around the corner, married his childhood sweetheart and still remained in his grandfather's house, sending his own children—two boys (now in their 20s) and a 12-year-old girl—to the same school.

Mr. Hall, a soft-spoken yet intense man with a silver-tinged goatee, had worked seven days a week for much of this decade, bringing home weekly pay of about $1,000—enough to build a deck in his backyard; enough to obtain a fixed-rate mortgage and buy the house for $44,000 when his grandfather succumbed to Alzheimer's disease in the mid–1990s; enough for a motorcycle and a boat.

But three years ago, Mr. Hall committed the sort of mistake that has upended millions of households. At the recommendation of a for-profit credit counselor, he took out a new mortgage—a variable-rate loan from Countrywide Financial, which is now owned by Bank of America. He paid off some credit card debt, and he borrowed an extra $15,000 to renovate his home, expanding his mortgage balance to $63,000.

The loan began with manageable payments of about $500 a month. But Mr. Hall's interest rate soon soared—something he says was never explained to him—lifting his payments to $950 a month.

''When I got the mortgage, I didn't really understand it,'' he said. ''They told me this would improve my credit and that was it. It was just, 'sign here,' and 'initial here.' ''

NO MORE CONSTRUCTION WORK

He might still have managed had construction not come to a halt. By 2007, Mr. Hall's employer was cutting work hours. In August 2008, it shut down, turning his $1,000 weekly paycheck into an $800 monthly unemployment check.

Every day, he set the alarm clock and headed to the union hall at 5 a.m., waiting and hoping for work. Every day, he went home, still jobless and discouraged, now confronting the displeasure of his wife, who worked as a nurse, and who he said never came to terms with their diminished spending power. After months of bickering, she left him last December, taking their daughter.

''She was saying, 'How are we going to have Christmas? How are we going to go on vacation?' '' he recalled. ''She just seen it getting worse instead of better, and she got depressed.''

In January, his truck was repossessed, leaving him to walk through the winter dawn to the union hall for his daily ritual of defeat.

He watched the For Sale signs proliferating on his block, as mostly elderly neighbors found themselves unable to make their mortgage payments. He saw their belongings piled up on their front lawns as they abandoned their homes to foreclosure.

In September, the envelope finally landed with his default notice. A canvasser knocked on his door, proffering a flier urging him to call the city hot line. When he called, a housing counselor helped him assemble the paperwork for a loan modification and prepare for his conciliation conference.

When he arrived inside courtroom 676 in October, Mr. Hall carried a sheaf of wrinkled papers in a white plastic grocery bag. He occupied a solid wooden chair as an announcer called off cases for hearing. ''Number 27, Wachovia Mortgage versus . . ..'' A girl no older than 6, with flower-shaped plastic barrettes in her hair, fidgeted as her mother applied for legal representation.

Mr. Hall was struggling to come to terms with what he assumed was the end.

''I put my whole life into this house,'' he said. ''After I do all this work, they want to take it from me. You've got to regroup and move, but where? If I can't pay my mortgage, how am I going to pay rent? And I have a whole house full of furniture.''

When he got the news that he had a few weeks' reprieve, relief quickly gave way to the worry that had dominated his thoughts for months.

''It's postponing the inevitable,'' he said.

''I'm a man,'' he kept saying, trying to make sense of how a lifetime of working on other people's homes had put him here, staring at the potential loss of his own home; still hoping for relief.

''I don't want no handouts,'' he said. ''I just want a reasonable loan that I can afford to pay so I can get on with my life.''

Mr. SPECTER. I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota is recognized.

Mr. THUNE. Mr. President, I ask unanimous consent that at the conclusion of my remarks, the Senator from Michigan, Senator STABENOW, be recognized.

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

HEALTH CARE REFORM

Mr. THUNE. Mr. President, we now have a draft of the Senate majority's health care reform bill, after spending several weeks behind closed doors producing that bill. Some of the details are starting to emerge.

I think it is critical that all Members in the Senate have an opportunity to look very closely at what is in the bill. It should come as no surprise that it is a 2,000-plus page bill. Much was made of the bill in the House of Representatives being a 2,200-page bill when it was all said and done. This one is 2,074 pages. It hasn't been amended yet, so that will probably expand it as this bill comes to the floor.

I think we at least now have something we can look at and review. There was a lot made last night by the majority when they rolled this bill out—how fiscally responsible this bill is and how much of an improvement it is over recent drafts of this legislation. I wish to point out a couple things that I think, perhaps, put into perspective what this bill would do, what it entails, and how, with all the rhetoric about how it differs and improves upon previous drafts of the bill, it comes down to basically the same elements that have been in all the bills we have seen.

First is with respect to the costs. It is very clear the cost of this bill—which was stated last night as $849 billion—is dramatically understated relative to its true cost when fully implemented. There are several reasons. One, they push back the effective implementation date to 2014 for many of the provisions to take effect. So you will not see the actual spending in the bill start to kick in until January 1 of 2014.

However, many of the revenue components in the bill begin to kick in next year, on January 1, 2010. So the tax increases, which are multiple and hundreds of billions of dollars, would begin to take effect immediately, starting January 1, 2010, while much of the spending in the bill would be deferred until much later in the budget window—not taking effect until January 1, 2014.

That distorts the true picture of what this legislation would cost and distorts it substantially.

The other point I will make is that there are a couple other provisions in the bill that, by its absence in one case and its inclusion in the other, understate the cost of the bill. One is the absence of the sustainable growth rate formula, or the so-called physician fee fix, the reimbursement form, that is a $247 billion hole—$247 billion in additional spending that is not included in the bill. That, obviously, understates the overall cost.

There is also a $72 billion assumption in there for a program called the CLASS Act. I wish to read for you something that one of my colleagues on the Democratic side said about the CLASS Act. This was the Senator from North Dakota, chairman of the Budget Committee in the Senate. He called the CLASS Act ''a ponzi scheme of the first order, the kind of thing that Bernie Madoff would be proud of.'' That is how he refers to this CLASS Act included in the bill and the savings that are associated with it. In fact, the $72 billion it shows as revenue in the first 10 years turns into a deficit in the second 10 years. So when you back out the $72 billion that, it is assumed, would add to the revenues in the bill and you add to the cost of the bill the $247 billion that would be required to fund the physician fee formula over a 10-year period, the so-called surplus that this bill generates actually turns into a deficit. It goes from a surplus of $130 billion to a deficit of $189 billion.

Again, a lot of gimmicks are being used to understate the true cost of the bill to the American people. All that being said, if you look at the overall cost, when fully implemented over 10 years, you come up with this: Remember, when the HELP Committee passed its version of this bill out of committee, the 10-year, fully-implemented cost was $2.2 trillion.

When the Finance Committee passed its version of the health care reform bill out of the committee, the 10-year, fully-implemented cost of that bill was $1.8 trillion. So that is $1.8 trillion for the Finance Committee bill and $2.2 trillion for the Health, Education, Labor, and Pensions Committee bill. Guess what the pricetag is on the bill that was merged together and has now been unveiled for all the world to see. It is $2.5 trillion in overall cost—10-year, fully-implemented cost. That is a $2.5 trillion expansion of the Federal Government in Washington, DC, associated with the fully implemented cost of the bill.

The point I am trying to make is this: The cost of the bill is being dramatically understated by the authors of the bill to make it look like it comes in under $1 trillion, when, in fact, when you back out the two components I mentioned, it is over $1 trillion in the first 10 years, and that is because they delay implementation of many provisions until January 1, 2014—a budgetary gimmick designed to understate the true cost of the bill.

When you look at the fully implemented, 10-year cost of the legislation, without the gimmick of the delayed implementation date and the other gimmicks in here, it is $2.5 trillion in additional costs to the taxpayers of this country. Of course, that $2.5 trillion has to be paid for somehow. The way it is paid for isn't any different than in any of the other bills we have seen so far. It is paid for with higher taxes on small businesses and higher taxes on individuals. It is paid for with cuts to Medicare Programs that would impact senior citizens in this country, as well as medical providers, from hospitals to home health agencies, to hospice—you name it—and medical device manufacturers get hit hard in this legislation. Everybody gets hit when it comes to the reimbursement side to pay for this.

Of course, the American taxpayer gets hit hard when it comes to the tax increases included in there—$½ trillion in tax increases and $½ trillion in Medicare cuts to finance this $2.5 trillion expansion of the Federal Government to create a new entitlement program.

The other thing this bill does, which wasn't included in a previous version, it has an increase in the payroll tax on Medicare. The argument is, it only applies to people in the higher income categories. They tried to carve out people under $200,000 a year. Remember, the Medicare tax—and the payroll tax that every employee in this country pays, which is 1.45 percent on their income, matched by their employer, for a total of 2.9 percent—is increased. It gets increased to pay for not reforming or making Medicare more sustainable, a program we all know is destined to be bankrupt by 2017.

The increase in the Medicare tax will fund a whole new entitlement program unrelated to Medicare. The argument will be it is a health care program. But the fact is, the Medicare payroll tax was put into place to fund Medicare, a program people would pay into so that when they retire, they would have the security of health care coverage.

The payroll tax included in this bill, first off, will hit a lot of people. If you are a couple who both make a couple hundred—or $100,000 a year, you are already into the category where you are going to be hit by the tax. One of my main objections—and I am not for this tax increase—one of my main objections is the majority has chosen to use that tax increase not to make Medicare more sustainable but to create a whole new entitlement program with this bill.

The other thing I wish to point out, because it has come up in the last day or two, is there has been all this discussion about mammograms, this U.S. Preventive Services Task Force that came out with a recommendation that women under 40 should not go through mammogram screening; and, of course, a few years ago they made the opposite recommendation—back in 2002—when the U.S. Preventive Services Task Force made the recommendation that women 40 and older should undergo annual mammogram checks for breast cancer. That recommendation was completely reversed earlier this week. The 16-member task force ruled that patients under 50 or over 75, without special risk factors, no longer need annual screening. What is being said about that? They are backing away from that in a hurry. The HHS Secretary, Kathleen Sebelius, said: No, no, no, nothing will change. This is just a recommendation. It is not binding.

That may be true today. Here is the problem with government-run health care, the problem with the direction we are heading with this legislation: A greater level of government involvement and intervention and more requirements imposed on those who offer insurance products, particularly those who contract with the government. I think it is safe to assume that. There are many new creations in this legislation, and there is a new Medicare advisory board. They will have recommendations that are not just recommendations and advisory but, in fact, binding.

This is exactly the point many colleagues have been making about government-run health care. When you start down that path—and we have seen the model in Europe and Canada—where the government imposes cost control measures, that leads to rationing. Pretty soon, people are denied care, and care is delayed when people want to get a particular procedure. It has been concluded that this is not cost-effective, and some of these decisions that have traditionally been made between patients and doctors are made by the government.

I will read for you something that was in an editorial in the Wall Street Journal today. It gets at the very heart of what I am talking about. It says:

> More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers are required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.
>
> In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thral, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to ''accounting exercises subject to interpretations and underlying assumptions,'' and based on costs and large group averages, not individuals.

He goes on to say:

> I fear that we are entering an era of deliberate decisions where we choose to trade people's lives for money.

What is important about that observation is that he is pointing out what a lot of people will be very concerned about. If you are a woman in my home State of South Dakota, and let's say you are 42 years old, the recommendation made by this task force, which everybody is now dismissing and saying don't worry about it, it is not binding—under legislation such as this, where you create a board that actually does have statutory powers and is enabled to make many of these decisions based on what is cost-effective, you could have someone in a State such as mine, or any woman in any State in this country who is in their forties—because they said 50 should be the baseline now, the age at which you get mammograms or breast cancer screening done—that you could actually have women in this country who would be denied the opportunity to do that.

Of course, we all know and everybody can relate to people in this country who, by virtue of that screening process and that test, have been detected early and able to beat breast cancer, which is something that afflicts a great number of women across this country.

That is one example. I use that as an example of how this new type of government-run program might work. But there are countless other examples of the very same thing.

As we head into this debate, again I remind my colleagues this type of undertaking—reforming health care—ought to be about driving down costs, it ought to be about providing more access to Americans, it ought to be about maintaining that important relationship between a physician and their patient and not getting to where we have the government making those decisions, where we are actually bending the cost curve up rather than driving it down.

By the way, the CBO said in response to the majority's bill that was unveiled yesterday that it actually increases costs by $160 billion. To me, the fundamental goal of health care reform for most Americans, the key concern they have about health care today, is its costs. Everything we have seen so far, including this most recent version which we are going to have at some point on the floor of the Senate, probably sometime after the Thanksgiving holiday, increases costs, drives the cost curve up.

How can you be for something that cuts Medicare to providers and seniors across this country, that raises taxes on small businesses, the economic engine that creates jobs in this country, raises taxes on middle-income Americans and which also, ironically, raises the cost of health care, increases the cost of health care? I am not saying this is the CBO. That has been consistent through all the bills that have been produced. It is consistent with this one as well that the proposals and all the new provisions that will be included—again, $2.5 trillion, 10-year fully implemented costs paid for by Medicare cuts, $½ trillion in Medicare cuts, $½ trillion in tax increases, and obviously much more than that when you get into the fully implemented time period, all that—all that—to raise health care costs for people in this country. How can we label that reform?

I hope the American people, as they listen to this debate, will engage, will take a hard look at this 2,074-page bill. It is going to be a lot of legislative, arcane language. We are all going to do our best to make sense out of it. But it is a massive bill, just in terms of its volume. It also includes a massive expansion of the Federal Government in Washington, DC, at tremendous cost to the taxpayers, to Medicare beneficiaries and, in the end, doesn't do anything to drive down the cost of health care. It simply increases it and puts at risk, I would argue, many of the types of things I talked about with regard to breast cancer screening. When government is making decisions rather than patients and doctors, that is a world in which I don't think I want to enter, and certainly I think most Americans don't either.

Mr. President, I ask unanimous consent to have printed in the RECORD a Wall Street Journal editorial.

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

A BREAST CANCER PREVIEW

A government panel's decision to toss out long-time guidelines for breast cancer screening is causing an uproar, and well it should. This episode is an all-too-instructive preview of the coming political decisions about cost-control and medical treatment that are at the heart of ObamaCare.

As recently as 2002, the U.S. Preventative Services Task Force affirmed its recommendation that women 40 and older undergo annual mammograms to check for breast cancer. Since regular mammography became standard practice in the early 1990s, mortality from breast cancer—the second leading cause of cancer death among American women—has dropped by about 30%, after remaining constant for the prior half-century. But this week the 16-member task force ruled that patients under 50 or over 75 without special risk factors no longer need screening.

So what changed? Nothing substantial in the clinical evidence. But the panel—which includes no oncologists and radiologists, who best know the medical literature—did decide to re-analyze the data with health-care spending as a core concern.

The task force concedes that the benefits of early detection are the same for all women. But according to its review, because there are fewer cases of breast cancer in

younger women, it takes 1,904 screenings of women in their 40s to save one life and only 1,339 screenings to do the same among women in their 50s. It therefore concludes that the tests for the first group aren't valuable, while also noting that screening younger women results in more false positives that lead to unnecessary (but only in retrospect) follow-up tests or biopsies.

Of course, this calculation doesn't consider that at least 40% of the patient years of life saved by screening are among women under 50. That's a lot of women, even by the terms of the panel's own statistical abstractions. To put it another way, 665 additional mammograms are more expensive in the aggregate. But at the individual level they are immeasurably valuable, especially if you happen to be the woman whose life is saved.

The recommendation to cut off all screening in women over 75 is equally as myopic. The committee notes that the benefits of screening ''occur only several years after the actual screening test, whereas the percentage of women who survive long enough to benefit decreases with age.'' It adds that ''women of this age are at much greater risk for dying of other conditions that would not be affected by breast cancer screening.'' In other words, grandma is probably going to die anyway, so why waste the money to reduce the chances that she dies of a leading cause of death among elderly women?

The effects of this new breast cancer cost-consciousness are likely to be large. Medicare generally adopts the panel's recommendations when it makes coverage decisions for seniors, and the panel's judgments also play a large role in the private insurance markets. Yes, people could pay for mammography out of pocket. This is fine with us, but it is also emphatically not the world of first-dollar insurance coverage we live in, in which reimbursement decisions deeply influence the practice of medicine.

More important for the future, every Democratic version of ObamaCare makes this task force an arbiter of the benefits that private insurers will be required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides where finite tax dollars are allowed to go.

In a rational system, the responsibility for health care ought to reside with patients and their doctors. James Thrall, a Harvard medical professor and chairman of the American College of Radiology, tells us that the breast cancer decision shows the dangers of medicine being reduced to ''accounting exercises subject to interpretations and underlying assumptions,'' and based on costs and large group averages, not individuals.

''I fear that we are entering an era of deliberate decisions where we choose to trade people's lives for money.'' Dr. Thrall continued. He's not overstating the case, as the 12% of women who will develop breast cancer during their lifetimes may now better appreciate.

More spending on ''prevention'' has long been the cry of health reformers, and President Obama has been especially forceful. In his health speech to Congress in September, the President made a point of emphasizing ''routine checkups and preventative care, like mammograms and colonoscopies—because there's no reason we shouldn't be catching diseases like breast cancer and colon cancer before they get worse.''

It turns out that there is, in fact, a reason: Screening for breast cancer will cost the government too much money, even if it saves lives.

Mr. THUNE. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent to speak for up to 20 minutes in morning business.

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

HEALTH CARE REFORM

Ms. STABENOW. Mr. President, first, it is a good thing our health care reform doesn't do the kinds of things the Senator is talking about. I wouldn't support it either. I don't think the Chair would either. It is a good thing that is not what we are doing. With respect to my friend from South Dakota, we have a different view of this bill.

Let me first start by saying, as the Chair knows and has said, this bill saves lives and saves money, and particularly protects Medicare and stops insurance abuses. That is what we are about.

Before going through the specifics of the bill, I wish to read from a very interesting column today in the New York Times. We can have competing newspapers, dueling newspapers on the floor. Nicholas Kristof did a column called ''The Wrong Side of History.'' I quote:

> Critics storm that health care reform is ''a cruel hoax and delusion.'' Ads in 100 newspapers thunder that reform would mean ''the beginning of socialized medicine.''
>
> The Wall Street Journal's editorial page predicts that the legislation will lead to ''deteriorating service.'' Business groups warn that Washington bureaucrats will invade ''the privacy of the examination room,'' that we are on the road to rationed care and that patients will lose the ''freedom to choose their own doctor.''
>
> All dire—but also wrong. Those forecasts date not from this year, but from the battle over Medicare in the early 1960s. The heirs of those who opposed Medicare, [who protected the insurance industry at that time] are conjuring the same bogymen [today].
>
> Indeed, these same arguments we hear today against health reform were used even earlier, to attack President Franklin Roosevelt's call for Social Security.

I appreciate the concerns that have been raised, but this is a replay of a time in the sixties when there was a debate about whether seniors who couldn't find affordable insurance in America should have access to the health care they need and the insurance they need.

Thank goodness, Democrats at that time, the President, and the Democratic majorities in the House and the Senate, chose to stand up for seniors and to override the objections coming from the insurance companies and the insurance lobby and those making money off the system at that time.

Let me talk a little bit about what is at stake if we do nothing, because that is the first question. Why should we be doing something? Every single day—in fact, today—14,000 Americans got up with health insurance and by the time they go to bed tonight they will not have it because they have lost their job, because their business had to drop them because the costs went up too much, because they couldn't afford the explosion in premiums and copays.

Insurance rates will almost double by 2016 for families, up to $24,000 for a family of four. Businesses will see their costs double in the next 10 years. What is extremely concerning to me as a Senator of the great State of Michigan, where we have a lot of employer-based care, employers doing the right thing, working hard to try to continue to provide health care coverage, those increased costs, doubling the costs over the next 10 years will, in fact, cost us 3.5 million jobs. Health care reform is about saving jobs.

Family incomes will be reduced by $10,000. Every single day—right now—5,000 homes are foreclosed. About half the homes that are foreclosed every day are foreclosed because of a medical crisis, and most of those families had insurance but it did not cover the cost of their medical expense. And we know that 62 percent of the bankruptcies today are because of a health care crisis and health care bills.

The status quo is not acceptable. Doing nothing means costs will go up, the insurance industry will still stand between you and your doctor deciding the kind of care you should get and the doctors you should see. In many cases, most plans require a certain set of doctors, a certain set of parameters.

We will lose jobs if we do not act. We cannot afford to lose more jobs. We are committed to turning the economy around and putting people back to work.

What do we hear from our Republican colleagues? Wait, wait, wait. We heard that in committee. Wait, slow down, we are going to have a lot of efforts on the floor to slow things down, take hours and hours and hours, don't act. Wait, wait, wait. And while we wait, those who make a lot of money off the current system will continue to make a lot of money off the current system while people see their health care costs go up and too many families struggle every day to figure out how they are going to provide health care for their children and themselves.

Business as usual from insurance companies—that is what we hear from the other side. Let the insurance companies do it. Let the insurance companies make the decisions about when you will be covered, how you will be covered, what you are going to pay, whether your doctor is in network or out of network, and whether you will be able to see the specialist you want to see. Business as usual is OK. Higher costs for middle-class families and small businesses are OK.

We believe these things are not OK, that doing nothing is only going to explode the deficit, hurt businesses, hurt families. We are prepared to act.

What does this mean in saving lives and saving money? First, it strengthens and protects Medicare. I will talk a little bit more about that. Lowering costs for small businesses and families. We know right now the majority of those who are uninsured are working. They are working in a small business or they are working out of their home as a single entrepreneur. They are in their garage, frequently working on that next invention, or they are out as a realtor in the community.

For years we have been saying we should pool small businesses and entrepreneurs into a larger group so they could get a better rate, such as a big business. That is what this is about. Amazingly, this big government takeover we hear so much about is for less than 20 percent of the people in the country right now. Eighty percent of the people in the country get their insurance through their employer—about 60 percent. The rest through a public program of some kind—Medicare, VA for veterans, our military, Medicaid. We are talking about filling in the gaps for small businesses and individuals, providing them tax cuts so that health insurance is more affordable and pooling them together. That is what this is about.

We are going to stop the insurance company bad practices as I talked about before. We are going to focus on prevention and quality which saves us money over time. In fact, one of the biggest ways we will save money is by focusing on keeping people healthy, focusing on ways that we change a system so we are not paying for individual procedures, but paying for those things the doctor needs to do and wants to do in total to help you recover from an operation or have the treatment you need.

We are going to, importantly, reduce long-term costs, lower the deficit and reduce long-term spending. If we do nothing, costs will continue to go up and up and, unfortunately, because of family costs and business costs, we are likely to see care go down and down as they struggle to keep their heads above water.

Let me talk a little bit more about Medicare. This is so important, as we know. We are going to strengthen Medicare. We know, again, if we do nothing, it is predicted the Medicare trust fund will be insolvent in 2017. We have to act.

We are doing a number of things both to bring down costs by focusing on prevention, saying to seniors and people with disabilities that if you go in for that annual checkup, if you go in for preventive work and, yes, mammograms, or the dread colonoscopy, that you will be able to do that without costs. There will be no deductible and no copay.

We are going to lower the gap in the prescription drug program under Medicare. Right now we know there is a gap in coverage, and we are going to begin to close that and hopefully close that all the way over time.

We are going to prevent payment cuts to doctors. This is something about which I care very deeply. We are going to make sure the cut for next year of 21 percent does not take place for doctors. But we need to solve long term the formula problems that are putting at risk doctors' and patients' ability to see their doctor. We are committed to doing that, to working with physicians.

It is incredibly important that seniors right now who can, in fact, see the doctor they want—because under Medicare you can choose your own doctor—we want to make sure they can continue to do that.

We are going to reduce the deficit and protect Medicare for the future. This is very important. In fact, the payroll tax that was talked about by the Senator from South Dakota would go into the Medicare trust fund to help make sure we are doing that.

It is important we recognize that the AARP, which has endorsed the House bill and supports health care reform moving forward—they have not specifically at this point endorsed what Senator REID has brought before us today, but we are hopeful they will. We know they are supporting health care reform.

There is no question that AARP, a champion for seniors in this country, would not be supporting moving forward on health care reform, they wouldn't be supporting what the House did if, in fact, it did what our colleagues are saying on the other side of the aisle. They would not.

Unfortunately, we have had too many seniors who have been scared. I, frankly, think that is shameful, the kind of misinformation that is being given out to seniors. I know my mom, at 83, was initially concerned about what she was hearing until I walked through what we are doing. By the way, I think you would have to wrestle my mother to the ground to take away her Medicare card.

The reality is, this is a great American success story, and we want to keep it that way.

The reality is also that the AARP Web site talks about the myth that health care reform will hurt Medicare. This is from them, from their Web site. I welcome anyone to check it out. The myth is that we would be hurting Medicare.

> Fact: None of the health care reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services.

None of them would cut Medicare benefits or increase your out-of-pocket costs.

> Fact: Health care reform will lower prescription drug costs for people in the Medicare part D coverage gap or ''donut hole'' so they can better afford the drugs they need.
>
> Fact: Rather than weaken Medicare, health care reform will strengthen the financial status of the Medicare program.

This is from AARP, not from the Senate, not from Democrats. This is from a group whose job, whose mission it is to analyze what we are doing here and call it as they see it on behalf of those who receive Medicare benefits.

It would be terrific if that stopped being a talking point.

Let me talk a little more about insurance reform.

Whether you have insurance now or whether you are in the less than 20 percent who are without insurance today, affordable insurance, who will be going into this new pool we have, the insurance exchange—we see broad changes that will benefit patients. We really are talking about patients, consumers, families benefiting from insurance reform.

We are going to end discrimination for preexisting conditions, whether your child has leukemia and you are worried about whether at some point they are going to be able to find insurance on their own as they get older, a child with disabilities, or someone with juvenile diabetes. Unfortunately, we have also seen this used to discriminate against women. We have seen insurance companies say pregnancy is a preexisting condition and use it not only against women but against men who are expectant fathers. We want to make it very clear that you cannot be discriminated against if you have either a temporary or a permanent health condition.

We are going to stop the practice of dropping you if you become seriously ill. I don't know how many times I have heard from people in Michigan who said: You know, I am doing fine, I am paying my insurance premiums, I have insurance coverage, I am doing fine. But they have never really had to use the insurance. They have been fortunate that no one in their family has gotten seriously ill. Then something happens—a cancer, serious car accident, some other diagnosis that is very serious—and then in too many cases we have seen the insurance company come back and look for a technicality in order to be able to drop them because they are now having to pay out money for health care. That is wrong. This process of rescissions needs to stop, and under health reform it will.

We also, again, are saying that as a matter of policy under insurance, preventive care should be free. You are paying a premium but no copays and deductibles. We want people to be able to go to the doctor to get the annual visit, to be able to get the screenings, to be able to get the other preventive services they need. We want to save lives. This saves lives and saves money. We want to make sure that happens.

Then we are eliminating the annual and lifetime caps, to be able to address the caps as well.

Also, I am very pleased about two other provisions I think are so important for families. One is to allow young people to be able to stay on their parents' insurance through age 26. I wish that had been in place a couple of years ago, actually. I know from experience that the first job a young person may get out of college may not have health insurance or they may come out of college and work one or two or three part-time jobs in order to put things together while looking for work. This is very important for young people, to give them the opportunity to stay on their parents' insurance until age 26. This is one of the provisions that will start immediately when the bill is enacted. I believe it is very important.

Another provision that will happen immediately that is particularly important for many people in my wonderful State is a provision that will help hold down costs for early retirees. I was proud to be the author, with Senator KERRY, of this provision. We have many people who are retiring at age 55. It may not be voluntary. To many people, it is not voluntary. If the company continues the insurance, it is expensive. A person is not eligible for Medicare yet, and when they are retired early, someone 55 to 64 is usually using more medical care, more health care services. So it tends to be higher cost.

We also now have situations such as the United Auto Workers have decided, in order to help their industry and their companies, that they would assume the costs of retiree insurance, and early retirees are finding it extremely difficult, as they put together the numbers, to pay for care. Going forward, when this bill passes we will be a partner with those businesses or entities providing early retiree insurance by providing coverage for catastrophic care. It is called reinsurance, but basically above a certain amount we will cover it as the Federal Government. Above a $15,000 amount of a particular health care cost or treatment, the company will know that the Federal Government will reinsure or cover that. That means the exposure for the company is capped, which means their costs will not go up. In fact, they should go down significantly for early retirees. It also means other entities as well should be able to more accurately plan based on this partnership between businesses, employer-based care, and the Federal Government. This is very significant.

Again, as I close, it is very important to stress what this is all about. There are many pieces to this. I invite anyone from Michigan, as we have done all year, to go to my Web site. We have the entire bill posted. We have done this at every step of the way. We will continue to do that as the debate moves forward, with amendments and so on. We welcome people to get engaged.

I have a Health Care People's Lobby that folks can sign up for e-mail, and we will keep you posted on what is happening, and you can share your thoughts, your feelings, and your stories about what health care reform would mean to you or what has happened to you as someone needing health care or not getting the health care help from your insurance company that you believe you should as someone who has been paying for health care.

We are in a position now, we are poised to do something that I believe should have been done years ago. Many have tried to do it.

I commend this President for making health care, health insurance reform, a top priority; for understanding that we are losing jobs overseas because we are not competitive internationally with other countries, that health insurance reform is about jobs. It is about saving jobs. It is about the cost of losing your insurance. It is about businesses seeing their costs go up. It is also about a moral imperative that says, if you loose your job, you should not loose your health insurance in the greatest country in the world.

This is about saving lives at every level. It is about saving money at every level—for families, individuals, small businesses, larger businesses, States, the Federal Government. This is about tackling what has become a huge cost to our economy and beginning to turn that. It will take time, but we have to begin to turn this ship so we can get these costs under control. Saving lives, saving money, protecting Medicare for the future, and stopping the insurance abuses that occur every day for too many families—that is what health insurance reform is all about.

I am so pleased and proud of our leader, Senator REID, and grateful for his leadership and amazing skill in bringing us to this point. I am so grateful for the leadership of Senator BAUCUS in Finance and Senator DODD and Senator HARKIN on the HELP Committee and everyone who has been involved in this effort.

It is worth the time, whatever it takes, to do this and get it right. Saving lives and saving money for American families and businesses, protecting Medicare, stopping insurance abuses—this is worth fighting for. I am very proud to be part of a group of people who have placed this as a top priority.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

INAUGURATION OF THE PRESIDENT OF AFGHANISTAN

Mr. KAUFMAN. Mr. President, today, I rise to recognize the inauguration of President Karzai, as he begins his second term as President of Afghanistan. This milestone presents a unique opportunity to begin a new chapter in Afghanistan's history, which I hope will be characterized by transparency, effective governance, accountability, and an even stronger partnership with America.

Our two governments share common interests in the success of Afghanistan and the stability of the region.

When I met with President Karzai during my September visit to Kabul, we discussed counterinsurgency strategy and the importance of stronger governance at all levels—national, provincial, and district. Counter-insurgency strategy has proven effective throughout the course of history, and good governance is essential for its success.

President Karzai knows that he must garner greater support among the Afghan people for his government because, ultimately, this is a battle for legitimacy between the Afghan government and the insurgents. We will continue to partner with the Afghans to defeat the Taliban, but counter-insurgency cannot succeed if the Afghan people believe their government is plagued by corruption.

I welcome President Karzai's recognition of corruption as a "dangerous enemy of the state" in his inaugural address earlier today.

His intention to create an anti-corruption unit is an important step to this end, but words are not enough. He must match this rhetoric with action, and immediately take steps to effectively address the problem.

No government official is above the law, and all should be held accountable for their actions. Numerous criminal cases involving government officials—such as recent allegations that the Afghan Minister of Mining accepted a $30 million bribe as part of an illicit deal with a Chinese mining firm—must be thoroughly investigated.

As President Karzai said today, government officials should register their earnings. Those who engage in corrupt behavior should face the full weight of the law and be brought to justice.

Corruption must be addressed for two primary reasons: one, to build the confidence of Afghans in their government; and two, to ensure that the government functions more effectively in providing essential services.

In order to fulfill these two goals, I urge President Karzai to appoint competent governors and cabinet members who respect the rule of law and human rights, and are unequivocally committed to the people of Afghanistan. The stakes are too high to revert to cronyism. Now is the time for President Karzai to appoint and support capable, effective, and law-abiding public servants.

The essential defense against the Taliban is an effective Afghan government. As such, I urge President Karzai

to work with the United States and other international partners to produce specific and measurable guidelines for combating corruption, improving government transparency and accountability, providing essential services, strengthening rule of law tackling the drug trade, and improving the economic infrastructure.

Clear benchmarks must be set, and progress must be monitored to ensure compliance.

This plan cannot be limited to Kabul. It is critical that government officials in the provinces and districts are well qualified and empowered with the necessary authorities and budgets to improve the lives of all Afghans. We must work together to undermine the Taliban's foothold and role as the de facto provider of rule of law and basic services, especially in southern Afghanistan.

In addition to good governance and essential services a third element of success in counterinsurgency is the training and deployment of effective national security forces.

I welcome President Karzai's stated intention to assume complete Afghan control over security within 5 years. I also echo his calls for NATO partners to take more effective steps to accelerate the training of the Afghan National Army—ANA and Police—ANP.

Currently there are not enough Afghan and international forces on the ground to ''clear and hold'' against the Taliban. In fact, the number of trained Afghan security forces is less than one-third that of Iraq—a geographically smaller country with nearly the same-sized population.

The training of the ANA and ANP must be expedited to build a stronger force of needed counterinsurgents, with the near-term goal of transferring responsibility to the Afghans.

During my two trips to Afghanistan this year, it was clear that the Afghan people identified security as a key concern, and wanted a swift transition from international to Afghan forces. Americans also hope for a swift transition, so we can eventually end our military presence and bring our brave troops home to their families.

I fundamentally disagree with accusations by some in Afghanistan—including President Karzai—that the U.S. presence in Afghanistan is purely self-serving. We are committed to working with President Karzai to secure our shared objectives. It has been said that nations have no permanent allies, only permanent interests. As we stand on the cusp of history together, the United States and Afghanistan are allies with shared goals and coinciding interests.

As President Obama outlined in March, it is America's goal to disrupt terrorist networks in Afghanistan, to defeat al-Qaida, and to help to promote a more capable and effective Afghan government. The way to do this is to partner with the Afghan people to defend them against a resurgent Taliban. As Secretary Clinton said, these are mutually reinforcing missions.

There is an underlying urgency to this joint venture, and we cannot succeed without a true partner in the Afghan government.

In his inaugural address, President Karzai said the right things. Now is the time for implementation.

During my visits to Afghanistan, I was impressed by the resolve and vision of the brave people of Afghanistan. In the face of enormous challenges, the majority of Afghans have rejected the Taliban's oppression, and chosen to seek a better life for future generations.

Today represents an opportunity for President Karzai to fulfill the hopes and dreams of his people, and bring greater peace and prosperity to Afghanistan through good governance.

As he begins his second term, President Karzai must forge a path that will lead to a brighter future, free from corruption. We need leadership, resolve, and determination, if we are to be successful in Afghanistan.

AMERICAN EDUCATION WEEK

Mr. FEINGOLD. Mr. President, this week I join my colleagues and the Nation in observing the 88th annual American Education Week.

The United States of America has a rich history of providing a free public education to its children, and the education that millions of students receive every year opens countless doors of opportunity to these students. Teachers, administrators, and support staff in our Nation's communities plant the seeds of knowledge in our students, who are the future of the American economy, American innovation, and American society. And sometimes I do not feel like enough is said of these individuals who have dedicated their lives to the cause of public education and who have touched the lives of millions of children. So this week, let us reflect on the positive impact teachers and schools have on this country.

While enormous strides have been made in expanding access to public education since our Nation's founding, the United States still has a long way to go before we can say that every child in our Nation has access to a high-quality public education. There is still a persistent achievement gap in many of our Nation's schools with respect to low-income and minority students. The nationwide high school graduation rate hovers around 70 percent and is even lower for students of color and low-income students. This is unacceptable and is a matter of fairness and equality that must be addressed. We can do better. We must do better. The future of our country rests on our efforts. Federal, State and local governments must work together to continue to support our educators and help ensure that every child has access to good teachers and high-quality schools.

That is why I am looking forward to working with educators as Congress undertakes the reauthorization of the Elementary and Secondary Education Act, also known as No Child Left Behind. We now have the opportunity to rethink the proper role for the Federal Government in education reform and how we can best support States and school districts as they continue to work to educate all our Nation's children and close the persistent achievement gap that still exists in too many of our Nation's schools. We need to work together to solve problems, strengthen our public school system, and make certain that all our students receive the education they deserve.

As Chief Justice Warren wrote when he delivered the opinion of the Supreme Court in the landmark Brown v. Board of Education decision:

> Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such an opportunity, where the state has undertaken to provide it, is a right which must be made available to all on equal terms.

More than 50 years later, these words still ring true, and as we celebrate American Education Week, let us honor the outstanding work that our Nation's educators do every day and recommit ourselves to working with these educators to address the continued inequities in American education so that all children, regardless of their background, can receive a high-quality public education.

COMBATING HUNGER

Mr. CARDIN. Mr. President, as we prepare to depart for the Thanksgiving break, I wish to thank those who work to combat hunger in this country and to commend the administration for its goal of eliminating child hunger by 2015. I encourage the administration to work with Congress to find solutions to achieve this goal and end hunger in America.

We must commit ourselves to solving this crisis. The U.S. Department of Agriculture has just released findings that 14.6 percent of Americans were ''food insecure,'' up from 11.1 percent in

2007. Food insecurity is measured by the number of persons who experience hunger at some point during the year because they could not afford enough food.

The Agriculture Department also found that one-third of these households had what the researchers called "very low food security," which mans that they were forced to skip meals or cut portions. The other two-thirds of households got by only through reliance on food stamps, soup kitchens, and food pantries.

The nearly 4 percent increase in food insecurity between 2007 and 2008 is the largest since USDA began reporting hunger statistics in 1995. Even more disturbing, USDA reports that nearly 17 million children live in households where food was scarce at some point during the last year. This figure amounts to more than one out of every five children in the United States.

An astonishing 1.1 million children went to sleep hungry at some point in 2008—a 36-percent increase from 2007. In my State of Maryland, more than 135,000 children currently live in food insecure households. Sixty-three thousand of these children are under the age of 5.

No child should ever know what it means to be hungry. Childhood hunger hinders development in the long term, and children who are hungry have difficulty learning and are at much higher risk to be in poverty as adults. Hunger negatively affects children's behavior, school performance, and cognitive development.

As we celebrate this holiday season, it is important to reflect on how each of us can support our communities. In my home State, the employees and volunteers at the Maryland Food Bank provide 14 million pounds of food annually to those in need. Working with more than 1,000 partner organizations, including soup kitchens, senior centers, daycare centers and afterschool programs, the food bank works to fill unmet needs of Maryland families. In these difficult economic times, the services of the Maryland Food Bank are more important than ever.

During the past year, the staff at the food bank's facilities in Baltimore and Salisbury saw demand increase by 50 percent. Middle-class families who a year ago made donations to the food bank are now turning to the organization to put food on their own tables.

Americans with full-time jobs are the fastest growing cohort of those in need. As unemployment continues to rise, families are being forced to spend their savings and are too quickly moving from middle to low income. America's working poor are most at risk. They live from paycheck to paycheck and have no safety net if their company downsizes or their hours are cut. When money is short, Americans are forced to make excruciating choices.

It is estimated that one-third of Marylanders relying on food assistance must choose between buying food and paying utility bills. Fifty-three percent of those who receive food assistance have unpaid medical bills. The number of working poor families in Maryland is 70 percent higher than it was two decades ago.

In addition to the food bank, I also want to highlight the work of employees at the many social service agencies across our State. These dedicated workers devote their time and energy to helping their community and work side-by-side with the Maryland Food Bank and other organizations to provide meals and services to those in need.

For example, the Maryland Department of Education works closely with the Maryland Food Bank on several projects that provide students with nutritious meals. More than 303,000 Maryland children rely on free or reduced-price meals in schools. Through the Backpack Program, the food bank provides schools such as Baltimore Highlands Elementary with backpacks filled with food. Children receive the backpacks on Friday afternoons to ensure they are not hungry over the weekend.

Kids Cafe is an innovative partnership between the food bank, the Maryland Department of Education, and local afterschool programs that provides nutritious meals and teaches children how to make healthful food choices.

Our seniors are also at risk of food insecurity at much higher levels than the general population. I applaud efforts such as the SNAP Outreach Program in Maryland, which is a partnership between the USDA and local organizations to help register seniors for food assistance programs.

Despite these efforts, we need to do more. In my State alone, it would take 82 million pounds of food to support the more than 350,000 Marylanders in need every year.

We must recommit ourselves to serving our communities and work together to support those in need during these difficult times.

So as Senators and staff leave Washington for their home States and prepare to give thanks and enjoy the company of family and friends, I encourage us all to show our support for those who work daily to make mealtime possible for millions of Americans in need.

225TH BIRTHDAY OF FORMER PRESIDENT ZACHARY TAYLOR

Mr. WARNER. Mr. President, today I wish to recognize the 225th anniversary of the birth of MG Zachary Taylor, a Virginia native son and the 12th President of the United States of America.

Best remembered as a distinguished military hero, Zachary Taylor was known as a resourceful, steadfast, modest and compassionate commander who fought many successful battles, earning from his soldiers and countrymen the affectionate nickname "Old Rough and Ready."

Zachary Taylor's personal popularity increased as his national prominence spread. General Taylor defeated Henry Clay, Winfield Scott and Daniel Webster for the Whig Party Presidential nomination. Although he had not sought office, Zachary Taylor was elected the 12th President of the United States.

Slavery was the driving issue of the campaign and the primary challenge of Zachary Taylor's brief Presidency. In his inaugural address, Zachary Taylor promised that the preservation of the Union would be his first obligation. He was determined to find a solution to end slavery even though he was a southerner and a slave holder. Zachary Taylor urged settlers in New Mexico and California to bypass the territorial stage and draft constitutions for statehood. As Southern Democrats called for a secession convention, Zachary Taylor reacted with a bristling statement that he would hang anyone who tried to disrupt the Union by force or by conspiracy, setting the stage for the Compromise of 1850.

During his 15 months in office, Zachary Taylor also created the Department of the Interior and signed a treaty with Great Britain guaranteeing a neutral canal connecting North and South America.

After laying the cornerstone of the Washington Monument on July 4, 1850, Zachary Taylor fell ill and passed away. An unprecedented 100,000 people lined the funeral route to see the hero laid at rest.

On November 24, 2009, representatives of local, State and Federal Government will gather to honor one of Orange County's most famous native sons. First Day Issue Zachary Taylor Dollar coins will be given to county schoolchildren. Please join me in commemorating the life of Zachary Taylor and the courage and efforts during his term of office to bring a peaceful end to slavery in the United States.

ADDITIONAL STATEMENTS

TRIBUTE TO PETER S. LEVI

• Mr. BOND. Mr. President, today I wish to honor a fine Missourian, Peter S. Levi, for his distinguished career as well as his lifelong commitment to community and economic development.

Mr. Levi has worked tirelessly in developing and fostering economic development throughout the Kansas City area for over 30 years. He first became involved in the region as executive director of the Mid-America Regional

Council. After 13 years as the executive director, he moved on to become president of the Greater Kansas City Chamber of Commerce.

Mr. Levi's lifelong dedication to the city of Kansas City and surrounding area is evident through his championing of Kansas City and its economic potential. His 19 years as one of the chamber's most effective presidents has seen the chamber grow to represent about 9,000 area businesses while expanding the chamber's annual budget to over $6 million.

Along with Mr. Levi's work with the Chamber of Commerce he has been an active member of several boards including the Kansas City Symphony, University of Missouri-Kansas City, Midwest Research Institute, University of Kansas Medical Center, and the Jewish Federation of Greater Kansas City.

Mr. Levi is a graduate of Northwestern University, B.A, and the University of Missouri-Kansas City, J.D., masters of law in urban legal affairs. He is married to Enid Levi and they have two sons Josh and Jeff.

Mr. Levi will retire from the Greater Kansas City Chamber of Commerce on December 31 of this year. From his honorable service to the community to his impeccable leadership within the Chamber of Commerce, Peter S. Levi has always worked to inspire those around him with his vigor, sense of duty, and pride in his community.

With his many Kansas City friends, I thank Pete for his service to the city of Kansas City, and I wish him all the best in his future endeavors.●

REMEMBERING LEWIS MILLETT

● Mrs. BOXER. Mr. President, I am honored to remember Lewis Millett—a recipient of the Congressional Medal of Honor, a retired Army colonel and a proud American who passed away on November 14, 2009.

Colonel Millett retired from the U.S. Army after a 31-year career that spanned three wars. He was awarded the Medal of Honor for leading a bayonet charge up a heavily defended hill during the Korean war. In his 31-year career in the Army, that included service in World War II, Korea and Vietnam, Colonel Millett received numerous awards, including the Distinguished Service Cross, the Silver Star, two Legions of Merit, three Bronze Stars, four Purple Hearts, and three Air Medals.

Born December 15, 1920, in Mechanic Falls, ME, Millett grew up in Massachusetts, where he joined the State National Guard. In 1940, with the war in Europe underway, he enlisted in the Army Air Corps. But after President Franklin D. Roosevelt said that no Americans would fight on foreign soil, he deserted the Army and joined the Canadian Army. When he arrived in Europe in 1942, the United States was in the war and he was allowed to transfer back to the U.S. Army.

As a member of the 27th Armored Field Artillery of the 1st Armored Division, Colonel Millett participated in the Allied invasion of North Africa, where he earned a Silver Star after driving a burning halftrack loaded with ammunition away from U.S. troops and jumping out before it exploded. After a year in combat, the Army reviewed his military record and convicted him of desertion. He was fined $52 and sentenced to 3 days hard labor. He was not required to do the hard time, and 2 weeks later he was made a second lieutenant.

After World War II, he returned to civilian status and joined the Maine National Guard. When the Army called for volunteers in 1949, he returned to Active Duty.

He later served in Korea as a company commander and in Vietnam as a military adviser with the intelligence program called Phoenix. Colonel Millett retired from the US Army in 1973.

He is survived by his sons, Lee and Tim, and daughter Elizabeth; a brother, Albert; three sisters, Ellen Larabee, Jean Pepin, and Marion Finnity; and four grandchildren. I extend my heartfelt condolences to them.

The military community, the State of California, and our Nation have lost a proud American and a great warrior.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Pate, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting nominations which were referred to the Committee on Foreign Relations.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 11:16 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1839. An act to amend the Small Business Act to improve SCORE, and for other purposes.

H.R. 1842. An act to amend the Small Business Act to improve the Small Business Administration's entrepreneurial development programs, and for other purposes.

H.R. 3014. An act to amend the Small Business Act to provide loan guarantees for the acquisition of health information technology by eligible professionals in solo and small group practices, and for other purposes.

H.R. 3738. An act to amend the Small Business Investment Act of 1958 to establish a program for the Small Business Administration to provide financing to support early-stage small businesses in targeted industries, and for other purposes.

H.R. 3791. An act to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1839. An act to amend the Small Business Act to improve SCORE, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 1842. An act to amend the Small Business Act to improve the Small Business Administration's entrepreneurial development programs, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 3014. An act to amend the Small Business Act to provide loan guarantees for the acquisition of health information technology by eligible professionals in solo and small group practices, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 3738. An act to amend the Small Business Investment Act of 1958 to establish a program for the Small Business Administration to provide financing to support early-stage small businesses in targeted industries, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 3791. An act to amend sections 33 and 34 of the Federal Fire Prevention and Control Act of 1974, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, November 19, 2009, she had presented to the President of the United States the following enrolled bills:

S. 748. An act to redesignate the facility of the United States Postal Service located at 2777 Logan Avenue in San Diego, California, as the ''Cesar E. Chavez Post Office''.

S. 1211. An act to designate the facility of the United States Postal Service located at 60 School Street, Orchard Park, New York, as the ''Jack F. Kemp Post Office Building''.

S. 1314. An act to designate the facility of the United States Postal Service located at 630 Northeast Killingsworth Avenue in Portland, Oregon, as the ''Dr. Martin Luther King, Jr. Post Office''.

S. 1825. An act to extend the authority for relocation expenses test programs for Federal employees, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3724. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule

entitled ''Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model ERJ 170 and ERJ 190 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0687)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3725. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model EMB–500 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–1039)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3726. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Saab AB, Saab Aerosystems Model SAAB 2000 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0909)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3727. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; International Aero Engines AG (IAE) V2500–A1, V2527E–A5, V2530–A5, and V2528–D5 Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0294)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3728. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Turbomeca S.A. ARRIUS 1A Turboshaft Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0348)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3729. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Rolls–Royce plc RB211 Trent 800 Series Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–1369)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3730. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; 328 Support Services GmbH Dornier Model 328–100 and –300 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0616)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3731. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A340–200 and –300 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0907)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3732. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Hamilton Sundstrand Power Systems T–62T–46C12 Auxiliary Power Units'' ((RIN2120–AA64)(Docket No. FAA–2009–0247)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3733. A communication from the Acting Farm Bill Coordinator, Commodity Credit Corporation, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Farm and Ranch Lands Protection Program'' (RIN0578–AA46) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3734. A communication from the Secretary of Defense, transmitting a report on the approved retirement of General Arthur J. Lichte, United States Air Force, and his advancement to the grade of general on the retired list; to the Committee on Armed Services.

EC–3735. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' ((44 CFR Part 67)(74 FR 57923)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3736. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Final Flood Elevation Determinations'' ((44 CFR Part 65)(74 FR 57921)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3737. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' ((44 CFR Part 67)(74 FR 57944)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3738. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' ((44 CFR Part 67)(74 FR 57928)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3739. A communication from the Deputy to the Chairman for External Affairs, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of the Debt Guarantee Program to Provide for the Establishment of a Limited Six-Month Emergency Guarantee Facility'' (RIN 3064–AD37) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3740. A communication from the Secretary, Division of Investment Management, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Regulation S–P (17 CFR Part 248, Subpart A)'' (RIN3235–AJ06) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3741. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Indiana'' (FRL No. 8980–4) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3742. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Maryland, Ohio and West Virginia; Determinations of Attainment for the 1997 Fine Particulate Matter Standard'' (FRL No. 8982–6) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3743. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Virginia; Transportation Conformity Regulations'' (FRL No. 8983–1) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3744. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval of the Clean Air Act, Section 112(I), Authority for Hazardous Air Pollutants: Perchloroethylene Air Emission Standards for Dry Cleaning Facilities: Commonwealth of Massachusetts Department of Environmental Protection'' (FRL No. 8974–5) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3745. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Fuel Economy Regulations for Automobiles: Technical Amendments and Corrections'' (FRL No. 8982–1) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3746. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Emission Standards for Hazardous Air Pollutants for Area Sources: Asphalt Processing and Asphalt Roofing Manufacturing'' (FRL No. 8983–6) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3747. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation,

Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Emission Standards for Hazardous Air Pollutants: Area Source Standards for Paints and Allied Products Manufacturing'' (FRL No. 8983–5) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC–3748. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Information Reporting Requirements Under Internal Revenue Code Section 6039'' (RIN1545–BH69) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Finance.

EC–3749. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Employee Stock Purchase Plans Under Internal Revenue Code Section 423'' (RIN1545–BH68) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Finance.

EC–3750. A communication from the Inspector General, Department of Health and Human Services, transmitting, pursuant to law, a report entitled ''Review of Medicare Contractor Information Security Program Evaluations for Fiscal Year 2006''; to the Committee on Finance.

EC–3751. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to Hong Kong relative to the design, manufacture, and delivery of the AsiaSat 5C Commercial Communication Satellite in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3752. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad relative to the modification CH–47SD Chinook Helicopters to the CH–47F configuration for end-use by Singapore in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3753. A communication from the Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, U.S. Agency for International Development, transmitting, pursuant to law, the Agency's response to the GAO report entitled ''Information Technology: Federal Agencies Need to Strengthen Investment Board Oversight of Poorly Planned and Performing Projects''; to the Committee on Foreign Relations.

EC–3754. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Listing of Color Additives Exempt From Certification; Astaxanthin Dimethyldisuccinate'' (Docket No. FDA–2007–C–0044) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3755. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, a report relative to a petition to add workers from Baker-Perkins Company in Saginaw, Michigan, to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. DODD, from the Committee on Banking, Housing, and Urban Affairs, without amendment:

S. 2799. An original bill to expand the Iran Sanctions Act of 1996, to provide for the divestment of assets in Iran by State and local governments and other entities, to identify locations of concern with respect to transshipment, reexportation, or diversion of certain sensitive items to Iran, and for other purposes (Rept. No. 111–99).

By Mr. LEAHY, from the Committee on the Judiciary, with an amendment in the nature of a substitute:

S. 1147. A bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, with an amendment in the nature of a substitute:

S. 1261. A bill to repeal title II of the REAL ID Act of 2005 and amend title II of the Homeland Security Act of 2002 to better protect the security, confidentiality, and integrity of personally identifiable information collected by States when issuing driver's licenses and identification documents, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. LIEBERMAN for the Committee on Homeland Security and Governmental Affairs.

*Erroll G. Southers, of California, to be an Assistant Secretary of Homeland Security.

*Daniel I. Gordon, of the District of Columbia, to be Administrator for Federal Procurement Policy.

By Mr. LEAHY for the Committee on the Judiciary.

Jane Branstetter Stranch, of Tennessee, to be United States Circuit Judge for the Sixth Circuit.

Christina Reiss, of Vermont, to be United States District Judge for the District of Vermont.

Abdul K. Kallon, of Alabama, to be United States District Judge for the Northern District of Alabama.

Victoria Angelica Espinel, of the District of Columbia, to be Intellectual Property Enforcement Coordinator, Executive Office of the President.

Benjamin B. Tucker, of New York, to be Deputy Director for State, Local, and Tribal Affairs, Office of National Drug Control Policy.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. DODD:

S. 2799. An original bill to expand the Iran Sanctions Act of 1996, to provide for the divestment of assets in Iran by State and local governments and other entities, to identify locations of concern with respect to transshipment, reexportation, or diversion of certain sensitive items to Iran, and for other purposes; from the Committee on Banking, Housing, and Urban Affairs; placed on the calendar.

By Mrs. MURRAY (for herself and Mr. FRANKEN):

S. 2800. A bill to amend subtitle B of title VII of the McKinney-Vento Homeless Assistance Act to provide education for homeless children and youths, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. FRANKEN (for himself and Mrs. MURRAY):

S. 2801. A bill to provide children in foster care with school stability and equal access to educational opportunities; to the Committee on Health, Education, Labor, and Pensions.

By Mr. CRAPO (for himself and Mr. RISCH):

S. 2802. A bill to settle land claims within the Fort Hall Reservation; to the Committee on Indian Affairs.

By Mr. CASEY:

S. 2803. A bill to direct the Secretary of Health and Human Services to encourage research and carry out an educational campaign with respect to pulmonary hypertension, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SANDERS (for himself and Mr. GRASSLEY):

S. 2804. A bill to require employers to certify that they have not and will not lay off a large number of employees before they are allowed to employ foreign workers in the United States, and for other purposes; to the Committee on the Judiciary.

By Mr. SPECTER:

S. 2805. A bill to amend the Food and Nutrition Act of 2008 to increase the amount made available to purchase commodities for the emergency food assistance program in fiscal year 2010; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. ENSIGN (for himself and Mr. CARPER):

S. 2806. A bill to codify and enhance existing regulations designed to encourage individuals to adopt healthy behaviors through voluntary participation in programs of health promotion and disease prevention; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LEVIN (for himself, Mr. MCCAIN, Mr. CASEY, Mr. GRAHAM, Mr. LIEBERMAN, Mr. CORKER, and Mr. NELSON of Florida):

S. Res. 355. A resolution expressing the sense of the Senate that the Government of

the Islamic Republic of Iran has systematically violated its obligations to uphold human rights provided for under its constitution and international law; considered and agreed to.

By Mr. CARDIN (for himself, Mr. BROWNBACK, Mr. REID, Mrs. SHAHEEN, Ms. SNOWE, and Mr. MENENDEZ):

S. Res. 356. A resolution calling upon the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay; to the Committee on Foreign Relations.

By Mr. INOUYE (for himself and Mr. REID):

S. Res. 357. A resolution urging the people of the United States to observe Global Family Day and One Day of Peace and Sharing; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 148

At the request of Mr. KOHL, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 148, a bill to restore the rule that agreements between manufacturers and retailers, distributors, or wholesalers to set the minimum price below which the manufacturer's product or service cannot be sold violates the Sherman Act.

S. 182

At the request of Mr. DODD, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 182, a bill to amend the Fair Labor Standards Act of 1938 to provide more effective remedies to victims of discrimination in the payment of wages on the basis of sex, and for other purposes.

S. 332

At the request of Mrs. FEINSTEIN, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 332, a bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

S. 455

At the request of Mr. ROBERTS, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 455, a bill to require the Secretary of the Treasury to mint coins in recognition of 5 United States Army Five—Star Generals, George Marshall, Douglas MacArthur, Dwight Eisenhower, Henry ''Hap'' Arnold, and Omar Bradley, alumni of the United States Army Command and General Staff College, Fort Leavenworth, Kansas, to coincide with the celebration of the 132nd Anniversary of the founding of the United States Army Command and General Staff College.

S. 850

At the request of Mr. KERRY, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 850, a bill to amend the High Seas Driftnet Fishing Moratorium Protection Act and the Magnuson—Stevens Fishery Conservation and Management Act to improve the conservation of sharks.

S. 883

At the request of Mr. KERRY, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 883, a bill to require the Secretary of the Treasury to mint coins in recognition and celebration of the establishment of the Medal of Honor in 1861, America's highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Services of the United States, to honor the American military men and women who have been recipients of the Medal of Honor, and to promote awareness of what the Medal of Honor represents and how ordinary Americans, through courage, sacrifice, selfless service and patriotism, can challenge fate and change the course of history.

S. 1067

At the request of Mr. FEINGOLD, the names of the Senator from Idaho (Mr. RISCH), the Senator from Mississippi (Mr. WICKER) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1076

At the request of Mr. MENENDEZ, the names of the Senator from Hawaii (Mr. AKAKA) and the Senator from Maryland (Mr. CARDIN) were added as cosponsors of S. 1076, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 1147

At the request of Mr. KOHL, the names of the Senator from Alabama (Mr. SESSIONS), the Senator from Texas (Mr. CORNYN) and the Senator from Utah (Mr. HATCH) were added as cosponsors of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1536

At the request of Mr. SCHUMER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1536, a bill to amend title 23, United States Code, to reduce the amount of Federal highway funding available to States that do not enact a law prohibiting an individual from writing, sending, or reading text messages while operating a motor vehicle.

S. 1559

At the request of Mr. KERRY, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1559, a bill to consolidate democracy and security in the Western Balkans by supporting the Governments and people of Bosnia and Herzegovina and Montenegro in reaching their goal of eventual NATO membership, and to welcome further NATO partnership with the Republic of Serbia, and for other purposes.

S. 1705

At the request of Mr. BARRASSO, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1705, a bill to suspend temporarily the duty on certain acrylic fiber tow containing a minimum of 92 percent acrylonitrile.

S. 1709

At the request of Mr. THUNE, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1709, a bill to amend the National Agricultural Research, Extension, and Teaching Policy Act of 1977 to establish a grant program to promote efforts to develop, implement, and sustain veterinary services, and for other purposes.

S. 1780

At the request of Mrs. LINCOLN, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1780, a bill to amend title 38, United States Code, to deem certain service in the reserve components as active service for purposes of laws administered by the Secretary of Veterans Affairs.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1963

At the request of Mr. AKAKA, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

S. 2128

At the request of Mr. LEMIEUX, the names of the Senator from Idaho (Mr. RISCH) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2727

At the request of Mr. LUGAR, the names of the Senator from Arizona (Mr. KYL), the Senator from Tennessee (Mr. CORKER), the Senator from Massachusetts (Mr. KERRY) and the Senator from Delaware (Mr. KAUFMAN) were added as cosponsors of S. 2727, a bill to provide for continued application of arrangements under the Protocol on Inspections and Continuous Monitoring

Activities Relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol's termination on December 5, 2009.

S. 2730

At the request of Mr. BROWN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2743

At the request of Ms. SNOWE, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2743, a bill to amend title 10, United States Code, to provide for the award of a military service medal to members of the Armed Forces who served honorably during the Cold War, and for other purposes.

S. 2787

At the request of Mr. THUNE, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 2787, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

S. RES. 316

At the request of Mr. MENENDEZ, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. Res. 316, a resolution calling upon the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide, and for other purposes.

S. RES. 337

At the request of Mr. ROCKEFELLER, the names of the Senator from Wyoming (Mr. ENZI), the Senator from North Dakota (Mr. DORGAN) and the Senator from Pennsylvania (Mr. CASEY) were added as cosponsors of S. Res. 337, a resolution designating December 6, 2009, as ''National Miners Day''.

AMENDMENT NO. 2785

At the request of Mr. COBURN, the names of the Senator from Oklahoma (Mr. INHOFE) and the Senator from North Carolina (Mr. BURR) were added as cosponsors of amendment No. 2785 proposed to S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. MURRAY (for herself and Mr. FRANKEN):

S. 2800. A bill to amend subtitle B of title VII of the McKinney-Vento Homeless Assistance Act to provide education for homeless children and youths, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mrs. MURRAY. Mr. President, I rise today to talk about legislation that I introduced with Senator FRANKEN today that is essential to the academic success of millions of vulnerable children and youth.

The Educational Success for Children and Youth Without Homes Act responds to the growing crisis of homelessness in our Nation. The legislation will help homeless children and youth thrive in school, despite the constant moves, trauma, and loss associated with homelessness.

This legislation is needed now more than ever. The economic downturn and foreclosure crisis have had a significant impact on homelessness. Public schools reported a 17-percent increase in the number of homeless students in 2007. In Washington State, the number of homeless students has increased dramatically. For example, the number of homeless students enrolled in Whatcom County schools increased by 66 percent over the past 2 years; in Evergreen Public Schools, there has been a 56-percent increase over the past 2 years. This Fall, many schools face a veritable tidal wave of homelessness. Over one million children and youth are now homeless in our Nation.

The recession has contributed to homelessness among two groups of students: children who are homeless with their families, and youth who are homeless on their own. This reality was brought starkly to light in the recent New York Times series about runaway and homeless youth. The series found a 40-percent increase in the number of homeless youth living on their own last year, more than double the number in 2003. It concluded that ''Foreclosures, layoffs, rising food and fuel prices and inadequate supplies of low-cost housing have stretched families to the extreme, and those pressures have trickled down to teenagers and preteens.''

School offers homeless children and youth structure, normalcy, support, and hope—it is a place where they can obtain the skills that they will need to avoid poverty and homelessness as adults. Yet these students face great educational challenges. High mobility, precarious living conditions, and severe poverty combine to create major barriers to school enrollment and regular attendance. Many homeless children and youth lack basic supplies and a reasonable environment where they can do homework. As a result of their circumstances, homeless students often perform below their peers in math and reading and are more likely to be held back.

We must do more to assist these students so they do not continue to be left behind. The Educational Success for Children and Youth Without Homes Act of 2009 would do just that. The bill amends the McKinney-Vento Act's Education for Homeless Children and Youth program. It makes a strong law even stronger by reinforcing and expanding the law's key provisions: school stability, enrollment, and support for academic achievement.

This legislation will enhance the right of homeless children to stay in the same school, so that children who have lost their homes do not also lose their schools. It will assist schools in meeting the challenges of transporting homeless students by increasing the authorized funding level and allowing other Federal funds for educating low-income students to be used for homeless transportation. When staying in the same school is not possible, or not in a child's best interest, the legislation will help the student make a seamless transition to a new school.

This bill will help students like Kyle, a 4th-grade student in Spokane. Due to the instability of homelessness, Kyle moved around with his family most of his life. In fact, he moved eleven times. There were large gaps where he had not gone to school at all, because of his family's frequent moves. Yet although Kyle moved eleven times, the homeless education program in Spokane was able to keep him stable in one school. Because he had the opportunity to attend one school consistently, the school district was able to determine that his academic and behavioral struggles were caused by more than just homelessness: a special education evaluation revealed that he was nearly deaf in both ears. He now has hearing aids in both ears and told his teacher: ''I can hear now, and I am being good. I want to be a crossing guard.''

Yet many more children like Kyle are not receiving the assistance they need due to lack of funding. In fact, only 9 percent of school districts are able to receive funding through the McKinney-Vento program currently. This legislation would increase the authorized funding level, so that more school districts can participate in the homeless education program and reach more children and youth experiencing homelessness.

One of the most successful features of the McKinney-Vento program is the requirement for every school district to designate a liaison for homeless children and youth. Liaisons identify homeless students, ensure their enrollment and attendance, and connect them to community resources. Liaisons are the backbone of this program, the unsung heroes who have become a lifeline for children and youth in crisis. Yet most liaisons do not have the capacity to carry out their required duties; they wear many hats and struggle to meet the growing demands of this population. As a result, too many

homeless children and youth are falling through the cracks and missing out on school. The Educational Success for Children and Youth Without Homes Act will strengthen the critical position of homeless liaison by ensuring that liaisons have the time, resources, and training to fulfill their mandated duties.

The Educational Success for Children and Youth Without Homes Act also recognizes the unique needs of certain groups of homeless children: preschool-aged homeless children, and unaccompanied homeless youth.

Young children who are homeless have higher rates of developmental delays and other problems that set them back as they start out life, yet they face numerous barriers to participating in early childhood programs. They miss out on services that can mitigate the harmful effect of homelessness on their development. This legislation will increase homeless children's participation in preschool programs by requiring public preschool programs to identify and prioritize homeless children for enrollment, and to develop the capacity to serve all identified homeless children.

Unaccompanied homeless youth struggle to go to school without the basic necessities of life or a parent to guide them. We must assist unaccompanied homeless youth to overcome the unique educational challenges related to being without a home and without a parent or guardian. This legislation will help ensure that unaccompanied homeless youth have the supports necessary to stay in school, graduate with their peers, and move on to a brighter future.

The history of litigation under the McKinney-Vento Act makes clear that we must do a better job helping educators learn about homelessness and support them in implementing the law. To this end, the legislation provides funding for technical assistance and training, and requires participation in professional development activities.

I am pleased to be joined by Senator FRANKEN in cosponsoring this legislation to assist homeless students, and I am honored to cosponsor Senator FRANKEN's legislation, the Fostering Success in Education Act, to assist students who are in foster care. These bills recognize the similarities, and the differences, between students who are homeless and those who are in foster care. It is our intention to work with our Senate colleagues to ensure that children and youth who are currently served through the McKinney-Vento Act under the category of ''awaiting foster care placement'' will be transitioned to the Fostering Success in Education program, so that their unique needs may be best met.

As we look forward to the reauthorization of the Elementary and Secondary Education Act, we must recognize that children who do not know where they will sleep at night, or where their next meal will come from, face far greater challenges than simply remembering to do their homework. We must acknowledge that children who bounce between schools with each change of residence have little hope of taking advantage of even the best school programs. The most qualified teacher, or the most exceptional math or reading program, will not benefit children who are not enrolled in school, not attending regularly, and not assisted to overcome the barriers caused by homelessness. The Educational Success for Children and Youth Without Homes Act builds upon the proven successes of the McKinney-Vento Act's Education of Homeless Children and Youth program, while addressing remaining challenges. It is critical legislation that will help ensure that the homeless children of today do not become the homeless adults of tomorrow.

Mr. FRANKEN (for himself and Mrs. MURRAY):

S. 2801. A bill to provide children in foster Care with school stability and equal access to educational opportunities; to the Committee on Health, Education, Labor, and Pensions.

Mr. FRANKEN. Mr. President, a quality education can serve as a positive counterweight to the abuse, neglect, and instability that children in foster care have experienced. That is why Senator MURRAY and I are introducing the Fostering Success in Education Act. The act builds on previous Federal efforts to increase the school stability and success of foster children.

The very placement of children in foster care has deprived many children of their opportunity to obtain a decent education. The primary reason is that children in foster care frequently move between foster homes, and often change schools when they move. Research shows that students lose 4 to 6 months of educational progress each time they change schools. It therefore becomes nearly impossible for foster children—who change schools multiple times—to make significant educational progress.

Moreover, foster children often change schools in the middle of the school year. When this happens, it is hard for them to catch up with their classmates, since they didn't learn the material their classmates studied earlier in the year.

Because different schools offer different courses, it is also difficult for foster children to transfer their course credits from prior schools after they move. Many foster children therefore end up repeating courses and even grades.

But what is even more disturbing is that foster children are often segregated from other students, and inappropriately placed in separate schools at group foster homes and residential treatment facilities. At these separate schools, foster children typically receive a subpar education, making it difficult for them to transition smoothly to regular public schools later on.

As a result of all these challenges, many foster children fall behind their peers in school, lose hope, and ultimately drop out. Consider, for example, the school experience of Carrie, a 19 year-old young woman in Minnesota, who was placed in foster care in eighth grade. When Carrie moved to her first foster home, she had to transfer to a new school. Being uprooted from her family was difficult enough, but she also had to cope with the transition to her new school—just when she most needed the support of her friends and teachers at her old school. Moreover, because she changed schools in the middle of the school year, she found it difficult to keep up with her classmates in her new school.

There was no need to add further instability to Carrie's life by making her change schools. Her old school—the school that she had attended since kindergarten—was just 20 minutes away from her foster home. It would have been perfectly reasonable to transport Carrie back to that school.

Over her next 5 years in foster care, Carrie ended up 7 moving between 7 different foster care placements and schools. The schools where she spent most of her time in high school separated her from other children in her community, and offered her a low-quality education. For example, in ninth grade, Carrie attended a school at a residential treatment facility, where her education consisted of sitting in a classroom with children as young as ten, and filling out simple workbooks with little help from an instructor. Given the multiple educational disruptions Carrie experienced, it is not surprising that she believes she left high school with only a ninth grade education.

Unfortunately, Carrie's school experience is not unique. Many foster children in Minnesota, and across the country, have experienced a similar pattern of moving between multiple schools, wasting time in segregated schools, and leaving school without much to show for all their years of education.

Last year, Congress decided that it was time to do something about this situation. Congress enacted the Fostering Connections to Success Act, a child welfare law that, among other things, requires child welfare agencies to collaborate with local education agencies to improve the school stability of foster children.

Child welfare agencies, however, can't go it alone. To fulfill the vision of the Fostering Connections Act, they need the full cooperation of State and local education agencies.

That is why Senator MURRAY and I have decided to place requirements on State and local education agencies that mirror those placed on child welfare agencies in the Fostering Connections Act. For example, our bill requires State and local education agencies to collaborate with child welfare agencies to provide foster children who move to new school districts with the right to attend their schools of origin—or, in other words, the right to attend their former schools or the schools they attended before they were placed in foster care.

If Carrie had this right when she was placed in foster care, she would have been able to remain in the school she had attended since kindergarten. When it's not in the best interest of particular foster children to remain in their schools of origin, our bill requires State and local education agencies to work with child welfare agencies to enroll foster children immediately in new schools. This is an important element of our bill because foster children often spend weeks out of school as a result of enrollment delays.

In addition, our bill provides funding to help school districts and child welfare agencies address the educational needs of foster children, such as funding to provide foster children with transportation back to schools in their former school districts.

Finally, our bill clarifies that foster children have a right to the same educational opportunities as other children in their community. This means, for example, that foster children cannot be placed in separate schools merely based on the misguided belief that foster children cannot fit in at a regular public school.

In addition to working with Senator MURRAY on the Fostering Success in Education Act, we have collaborated on a related bill—the Educational Success for Children and Youth Without Homes Act, which Senator MURRAY introduced earlier today. The Educational Success for Children and Youth Without Homes Act will improve the educational stability of homeless children, who, like foster children, face significant educational challenges because they often move between school districts. While there are many similarities between the protections provided to homeless and foster children in our bills, our bills also address the unique circumstances of each group.

I am grateful to Carrie, and the many other foster and homeless youth who have bravely spoken out about their difficult school experiences. Their efforts will help prevent other children entering foster care or experiencing homelessness in the future from suffering similar ordeals.

I believe it is time that we listen to these youth and take steps to ensure that we don't deprive homeless and foster children of their right to an equal education. Senator MURRAY and I therefore plan on working hard in the coming months to achieve the reforms we lay out in the bills we're introducing today, and I would urge my colleagues to support both of these important bills.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2801

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Fostering Success in Education Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is the following:

Sec. 1. Short title; table of contents.
Sec. 2. Findings; sense of Congress.
Sec. 3. Purpose.
Sec. 4. Definitions.
Sec. 5. Regulations.
Sec. 6. Effective date.

TITLE I—EDUCATIONAL RIGHTS FOR CHILDREN IN FOSTER CARE

Subtitle A—Required Educational Rights, Protections, and Services for Children in Foster Care

Sec. 101. Required educational rights, protections, and services for children in foster care.
Sec. 102. Remedies; rule of construction.
Sec. 103. Conforming amendments.

Subtitle B—State Foster Care and Education Plan Grants

Sec. 111. State foster care and education plan requirements and grants.
Sec. 112. Subgrants.
Sec. 113. Responsibilities of the Secretary.
Sec. 114. Authorization of appropriations.

TITLE II—SOCIAL SECURITY ACT AMENDMENTS

Sec. 201. Social Security Act amendments.

SEC. 2. FINDINGS; SENSE OF CONGRESS.

(a) FINDINGS.—Congress makes the following findings:

(1) Educational success is vital to every young person's well being, successful transition to adulthood, and economic stability.

(2) At the end of fiscal year 2007, approximately 500,000 children were in foster care in the United States, with nearly 800,000 children having spent at least some time in foster care in the United States during the year.

(3) Numerous studies have demonstrated that children in foster care fall behind the general student population with respect to test scores, graduation rates, and successful transitions to postsecondary education.

(4) Only one-third of high school students in foster care graduate on time and only 3 percent of such students graduate from college.

(5) On average, children in foster care move to new foster care placements 2 times per year, and often change schools when they move.

(6) Studies indicate that with each school move, children, on average, fall 4 to 6 months behind their classmates. Because foster children often change schools multiple times, it is difficult for them to make significant educational progress.

(7) Children in foster care are frequently denied the ability to remain in the same school as a result of changes in their living situations.

(8) In addition, children in foster care who are required to change schools are frequently denied immediate enrollment in a new school, which results in detrimental disruptions to their education.

(9) Moreover, the enrolling school frequently does not have access to the child's complete and accurate education records, which often results in the child's placement in inappropriate classes and educational settings.

(10) When foster children change schools, they often have difficulties transferring credits from previous schools and meeting the new set of graduation requirements in their new school.

(11) In 2008, Congress enacted the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–351), which requires, among other things, child welfare agencies to ensure that a child in foster care remains in the same school after moving to a new placement or, when remaining in the same school is not in the child's best interest, is enrolled in a new school immediately, and that the child's education records are transferred promptly. While the Fostering Connections to Success and Increasing Adoptions Act of 2008 requires child welfare agencies to coordinate with local educational agencies, the local educational agencies must play a critical role in the process. Otherwise, the education provisions of the Act cannot be fully implemented.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) in order to successfully meet the needs of the 500,000 children in foster care in the United States, State educational agencies, local educational agencies, State child welfare agencies, and local child welfare agencies must work together at the Federal, State, and local level to—

(A) address the unique needs of this population; and

(B) ensure school stability, immediate enrollment, and access to appropriate services; and

(2) such efforts will significantly increase the secondary school graduation rates and improve educational outcomes for children in foster care.

SEC. 3. PURPOSE.

The purpose of this Act is to ensure that the educational needs of children in foster care are addressed in a seamless and complete manner by—

(1) requiring the State educational agency of a recipient State to work together with the State child welfare agency to ensure that the educational needs of each child in foster care in the State are being met;

(2) requiring local child welfare agencies and local educational agencies of a recipient State to work together to ensure that the educational needs of each child in foster care in the State are being met;

(3) ensuring that issues related to stability in education, school attendance, and the proper handling of information, including education records and health records, are coordinated between schools and child welfare agencies; and

(4) ensuring that a coordinated process is utilized to address the best interest and needs of the child with regard to school placements, school attendance, access to appropriate education services, and required supports, including the provision of transportation services to ensure school stability.

SEC. 4. DEFINITIONS.

In this Act:

(1) CHILD IN FOSTER CARE.—The term ''child in foster care'' means a child whose care and placement is the responsibility of the State or Tribal agency that administers a State plan under part B or E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.), without regard to whether foster care maintenance payments are made under section 472 of the Social Security Act (42 U.S.C. 672) on behalf of the child.

(2) COURT REPRESENTATIVE.—The term ''court representative'' means an individual appointed by a court to represent a child in a juvenile court dependency proceeding.

(3) EDUCATION DECISIONMAKER.—The term ''education decisionmaker'' means—

(A) a parent of a child in foster care; or

(B) a person identified by the dependency court to make education decisions for a child in foster care who is someone other than the child's parent.

(4) EDUCATION RECORDS.—The term ''education records'' means documents and other materials relating to a child's enrollment and education, including transcripts, reports, plans, evaluations, and assessments maintained by a local educational agency.

(5) ELEMENTARY SCHOOL.—The term ''elementary school'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(6) ENROLLMENT.—The term ''enrollment'' means attending classes in a public preschool program, an elementary school, or secondary school and participating fully in the activities of such school or program.

(7) LOCAL CHILD WELFARE AGENCY.—The term ''local child welfare agency'' means, with respect to a child in foster care, the public agency in the local political subdivision where the child resides, or the Indian tribe or tribal organization, that is responsible for the placement and care of the child.

(8) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(9) PARENT.—The term ''parent'' means a biological or adoptive parent or a legal guardian of a child, as determined under applicable State law.

(10) PLACEMENT.—The term ''placement'' means the current or proposed living situation for a child in foster care, which can include a group home or other congregate care setting.

(11) PUBLIC AGENCY.—The term ''public agency'' means any State or local government entity.

(12) PUBLIC PRESCHOOL PROGRAM.—The term ''public preschool program'' means a preschool program funded, administered, or overseen by a State educational agency, local educational agency, or other State agency.

(13) RECIPIENT STATE.—The term ''recipient State'' means a State that receives funds under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.).

(14) SCHOOL OF ORIGIN.—The term ''school of origin'' means, with respect to a child in foster care, any of the following:

(A) The school in which the child was enrolled prior to entry into foster care.

(B) The school in which the child is enrolled when a change in foster care placement occurs or is proposed.

(C) The school the child attended when last permanently housed, as such term is used in section 722(g)(3)(G) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11432(g)(3)(G)).

(15) SCHOOL ATTENDANCE AREA.—The term ''school attendance area'' has the meaning given the term in section 1113(a)(2)(A) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a)(2)(A)).

(16) SCHOOL SELECTION DECISION.—The term ''school selection decision'' means a school selection decision as described in section 101(b)(4).

(17) SECONDARY SCHOOL.—The term ''secondary school'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801 et seq.).

(18) SECRETARY.—The term ''Secretary'' means the Secretary of Education.

(19) SPECIAL EDUCATION AND RELATED SERVICES.—The terms ''special education'' and ''related services'' have the meaning given such terms in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401).

(20) STATE.—The term ''State'' means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

(21) STATE CHILD WELFARE AGENCY.—The term ''State child welfare agency'' means the State agency responsible for administering the programs authorized under subpart 1 of part B and part E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.).

(22) STATE EDUCATIONAL AGENCY.—The term ''State educational agency'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

SEC. 5. REGULATIONS.

Not later than 60 days after the date of enactment of this Act, the Secretary shall develop, issue, and publish in the Federal Register a notice of proposed rulemaking to implement the provisions of this title. The issuance, amendment, and repeal of any regulations promulgated under this title shall comply with section 553 of title 5, United States Code.

SEC. 6. EFFECTIVE DATE.

Except as otherwise provided, this Act and the amendments made by this Act shall take effect on the date of enactment of this Act, except that subtitle A, and the amendments made by such subtitle, shall apply with respect to recipient States that receive funds under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.) on or after the date of enactment of this Act.

TITLE I—EDUCATIONAL RIGHTS FOR CHILDREN IN FOSTER CARE

Subtitle A—Required Educational Rights, Protections, and Services for Children in Foster Care

SEC. 101. REQUIRED EDUCATIONAL RIGHTS, PROTECTIONS, AND SERVICES FOR CHILDREN IN FOSTER CARE.

(a) RIGHTS OF CHILDREN IN FOSTER CARE.—Each recipient State shall ensure that each child in foster care in the State has the following rights:

(1) SCHOOL ATTENDANCE.—

(A) SCHOOL OF ORIGIN.—A child in foster care shall have the right to enroll in, or continue to enroll in, any of the child's schools of origin when the child is placed in foster care and during all subsequent changes in placement (including when the child returns home, as required under subparagraph (B)), unless it is determined through the school selection decision process that it is in the child's best interest to be immediately enrolled in a different school.

(B) SCHOOL UPON PERMANENT PLACEMENT.—In the case of a child in foster care for whom the child welfare case is closed as a result of the child returning home or achieving another permanency outcome during a school year—

(i) the child shall be entitled to complete the school year in the school that the child is attending unless the entity making the school selection decision determines that a change in schools is in the child's best interest; and

(ii) necessary transportation to the current school shall be arranged and funded by the local educational agency in which the current school is located.

(2) TREATMENT AS RESIDENT.—A child in foster care who remains in a school of origin shall be treated by the local educational agency serving such school as if the child resides in the school district and is entitled to all school privileges.

(3) IMMEDIATE ENROLLMENT.—If it is determined through the school selection process that it is not in the best interest of a child in foster care to attend a school of origin, or if a school selection decision is not sought for the child, the child shall have the right to be immediately enrolled in a new school in the child's school attendance area, regardless of the status of records normally required for enrollment such as previous academic records, medical or immunization records, proof of residency, or other documentation or requirements.

(4) RECORDS.—

(A) IN GENERAL.—The education records of a child in foster care shall be—

(i) maintained so that the records are available, in a timely fashion, when a child enters a new school or school district;

(ii) immediately sent to the enrolling school as complete as possible, even if the student owes fees or fines or was not withdrawn from the previous school in conformance with local withdrawal procedures; and

(iii) maintained in a manner consistent with section 444 of the General Education Provisions Act (commonly referred to as the ''Family''(20 U.S.C. 1232g).

(B) RECORDS FOR ACADEMIC DECISIONS.—The education records needed for academic placement decisions and decisions regarding the transfer of school course credits for a child in foster care shall be released immediately to an enrolling school by facsimile or other available electronic means.

(5) EQUAL ACCESS.—Each child in foster care shall have equal access to the same education and opportunities as other students attending the school or school district, including—

(A) having the same opportunities, access, and services needed to meet the challenging State student academic achievement standards under section 1111(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(1)) that are provided to other students;

(B) receiving educational services and transportation services that are comparable to the services offered other children in the child's school;

(C) having—

(i) equal access to the full range of educational offerings, including—

(I) services under title I of such Act (20 U.S.C. 6311 et seq.);

(II) publicly funded early childhood programs and public preschool programs;

(III) Early Head Start or Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.);

(IV) public charter and magnet schools;

(V) Advanced Placement courses and dual enrollment higher education courses;

(VI) career and technical education programs;

(VII) summer school; and

(VIII) extracurricular activities; and

(ii) as appropriate, prioritization in the educational offerings described in clause (i) in accordance with Federal and State law;

(D) being integrated with other students in all schools or programs within a school that are operated, licensed, or funded by a public entity;

(E) attending the elementary school or secondary school that serves the child's school attendance area unless—

(i) the student has an individualized education program under section 614 of the Individuals with Disabilities Education Act (20 U.S.C. 1414) requiring placement in an alternative setting, in another public school in the same or another local educational agency, or in a private school;

(ii) it is in the child's best interest to enroll in a school of origin that is not the school that serves the child's school attendance area, based on the school selection decision for the child; or

(iii) the education decisionmaker consents to another appropriate school placement.

(6) TRANSPORTATION.—

(A) IN GENERAL.—A child in foster care shall be provided with free transportation to and from the child's school of origin or other school in which the child is enrolled, in accordance with this subsection, paragraphs (4)(H) and (5)(D) of subsection (b), and section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)).

(B) CHILDREN WITH DISABILITIES.—In the case of a child in foster care that receives services under part A or C of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq., 1431 et seq.), nothing in this Act or section 475(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)) shall relieve a local educational agency of the agency's responsibility to provide the child with transportation as part of such services.

(b) REQUIREMENTS OF EDUCATION SYSTEM FOR CHILDREN IN FOSTER CARE.—In order to provide each child in foster care with the rights described in subsection (a), each recipient State shall meet the following requirements:

(1) POLICY REVIEW AND REVISION.—

(A) IN GENERAL.—Not more than 120 days after the effective date of this Act, any State or local educational agency in the State that has a school attendance law or other law, regulation, practice, or policy that may prohibit enrollment in, or attendance at, a school of origin for a child in foster care or that may prohibit implementation of any other requirement of this title, shall undertake steps to revise such law, regulation, practice, or policy to ensure that children in foster care—

(i) are afforded the same free, appropriate public education as is provided to other children; and

(ii) receive the protections of this subtitle.

(B) NO DELAY.—Nothing in this subsection shall be construed to permit a State or local educational agency to delay implementation of this Act until such review and revision is completed.

(2) COORDINATOR.—

(A) IN GENERAL.—The State shall designate a coordinator within the State educational agency to be the lead staff member to implement this title.

(B) COLLABORATION.—The coordinator shall collaborate with representatives from the State child welfare agency, the State's program supported under subtitle B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.), when appropriate, and with all other State and local agencies necessary to implement the requirements of this title and the provisions of parts B and E of title IV of the Social Security Act (42 U.S.C. 621 et seq., 42 U.S.C. 670 et seq.) relating to the educational needs of children in foster care.

(C) SPECIAL RULE.—In the case of a State that receives a grant under section 111 in an amount that is more than the minimum allotment described in section 111(b)(1)(B), the coordinator under this paragraph for the State shall not be the same individual who is assigned the role of State Coordinator for purposes of the State's program supported under subtitle B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11432 et seq.).

(D) RESPONSIBILITIES.—The responsibilities of a coordinator described in subparagraph (A) shall include, at minimum—

(i) ensuring that the requirements of this title and clauses (ii)(II), (iii), and (iv) of section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)) are carried out;

(ii) gathering and making public information on the problems children in foster care have in gaining access to public preschool programs and schools;

(iii) monitoring the progress of the State and local educational agencies in addressing any problems or difficulties in meeting the requirements of this title;

(iv) ensuring the success of the programs under this title;

(v) providing technical assistance to local educational agencies and local child welfare agencies on how to comply with this title;

(vi) collecting data related to the implementation of this title and the educational outcomes of children in foster care and reporting such information to the appropriate State officials and to the Secretary; and

(vii) ensuring effective implementation of a dispute resolution procedure, as described in paragraph (5), and a complaint management system, as described in paragraph (6).

(3) FOSTER CARE LIAISON.—

(A) IN GENERAL.—The State educational agency shall ensure that each local educational agency in the State designates a foster care liaison with sufficient capacity, resources, and time to fulfill the requirements of this title effectively.

(B) RESPONSIBILITIES.—The foster care liaison shall ensure, at minimum, that—

(i) each child in foster care served by the local educational agency is—

(I) identified for purposes of this title;

(II) enrolled in the appropriate public preschool program or elementary or secondary school, in accordance with any school selection decision made for the child; and

(III) has a full and equal opportunity to succeed in the child's school program and receive educational services for which the child is eligible, including—

(aa) special education and related services and protections under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.);

(bb) programs under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.);

(cc) English as a Second Language programs, including programs under title III of such Act (20 U.S.C. 6801 et seq.); and

(dd) early childhood and preschool programs;

(ii) the parents and education decisionmaker of the child in foster care, and the child welfare agency representative, are informed of the opportunities available to the child under this title;

(iii) school personnel are adequately prepared to implement this title; and

(iv) the local educational agency serving the child works collaboratively with individuals designated by the local child welfare agency to ensure—

(I) that child welfare agency personnel are informed of the rights of children in foster care and responsibilities of the State and local agencies under this title;

(II) that a child in foster care in a school served by the local educational agency has school stability and is promptly enrolled in a school in accordance with any school selection decision made for the child;

(III) that the child is provided with special education evaluations and services, as needed, and if the child is a child with a disability, as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401), the arrangement for, and provision of, the transportation, records transfers, and special education and related services as required under such Act, including—

(aa) the timely conduct of evaluations as required by section 614(a) of such Act (20 U.S.C. 1414(a));

(bb) the prompt transmittal of records under section 614(d)(2)(C)(ii) of such Act (20 U.S.C. 1414(d)(2)(C)(ii)); and

(cc) when appropriate, the appointment of a surrogate parent for a child required under section 615(b)(2) or 639(a)(5) of such Act (20 U.S.C. 1415(b)(2), 1439(a)(5)); and

(IV) the appointment by the appropriate court of an education decisionmaker for the child for purposes of this title, as needed.

(4) SCHOOL SELECTION DECISION.—

(A) IN GENERAL.—Upon a request made in accordance with subparagraph (C), the appropriate entity described in subparagraph (B) shall make an individualized school selection decision on an expedited basis for a child in foster care regarding whether it is in the child's best interest to attend a school of origin or to be immediately enrolled in the appropriate school where the child resides.

(B) ENTITIES MAKING SCHOOL SELECTION DECISIONS.—The school selection decision shall be made by the local educational agency that serves the school of origin in which enrollment is sought for a child in foster care, unless the State determines the school selection decision shall be made solely by—

(i) the dependency court;

(ii) the State child welfare agency; or

(iii) the local child welfare agency.

(C) INITIATING A SCHOOL SELECTION DECISION.—

(i) IN GENERAL.—The local child welfare agency responsible for a child in foster care shall, after consultation with the child and with the education decisionmaker and parent of the child, initiate the school selection decision process under this paragraph if the agency believes that a child should remain or enroll in a school of origin.

(ii) TIMING.—A school selection decision may be requested for a child in foster care each time the child's placement is changed or a placement change for the child is proposed.

(iii) NOTIFICATION OF FOSTER CARE LIAISON.—The local child welfare agency shall notify the foster care liaison described in paragraph (3) for the local educational agency serving the school in which the agency wants the child to remain or enroll to initiate the school selection decision process.

(iv) EXCEPTION.—If the local child welfare agency has not initiated the school selection

process, the child's education decisionmaker may do so by contacting the appropriate foster care liaison described in clause (iii).

(D) DEPENDENCY COURT DECISION.—Notwithstanding any other provision of this subsection, if the court with dependency jurisdiction over a child in foster care initiates or makes a school selection decision for such child, or appoints another person to initiate or make a school selection decision, the court's determination shall be binding on all parties, the State educational agency, and the appropriate local educational agency.

(E) SOURCES OF INFORMATION; FACTORS.—

(i) SOURCES OF INFORMATION.—The entity making the school selection decision for a child in foster care shall consider information and factors provided by—

(I) the State child welfare agency, local child welfare agency, State educational agency, local educational agency, or other public agency; and

(II) individuals who have knowledge about the child's education, including the child and the parent, educational decisionmaker, foster parent, court representative, and teachers of the child.

(ii) INFORMATION AND FACTORS.—The information and factors described in clause (i) shall include—

(I) the harmful impact of school mobility on the child's academic progress, achievement, and social and emotional well-being;

(II) the age of the child;

(III) the impact the commute to school may have on the child's education or well-being;

(IV) personal safety issues, including safety as it relates to family violence;

(V) the child's need for special instruction, including special education and related services, and where those needs can best be met;

(VI) the length of stay in foster care, placement type, and permanency plan for the child;

(VII) the time remaining in the school year;

(VIII) the school placement of family members;

(IX) the number of previous school changes;

(X) the child's connection to the school of origin under consideration;

(XI) the extent to which the educational program of the school of origin is appropriate, meets the child's needs and interests, and nurtures the child's talents; and

(XII) the availability of special programs, academically rigorous courses, and extra-curricular activities that are appropriate for the child.

(F) CONSIDERATIONS.—An entity making a school selection decision under this paragraph shall consider the wishes of the child.

(G) EXCLUDED FACTORS.—The cost of transportation to or from a school shall not be a consideration when making a school selection decision.

(H) TRANSPORTATION.—

(i) IN GENERAL.—The local educational agency serving the school of origin in which a child in foster care shall remain or enroll, based on the school selection decision for the child, shall collaborate with the local child welfare agency to ensure that the child is provided transportation to the school of origin in a cost effective manner and in accordance with section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)).

(ii) COST OF TRANSPORTATION.—In carrying out clause (i), a local educational agency shall provide the transportation described in such clause for a child in foster care if—

(I) the local child welfare agency reimburses the local educational agency for the cost of such transportation, in accordance with section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II));

(II) the local educational agency agrees to pay for the cost of such transportation; or

(III) the local educational agency and the local child welfare agency agree to share the cost of such transportation.

(5) SCHOOL SELECTION DECISION DISPUTE RESOLUTION.—

(A) IN GENERAL.—The State educational agency, or another State agency designated by the State, shall develop and oversee a fair and impartial dispute resolution procedure to promptly resolve school selection decision disputes, except that such procedure shall not be applied to disputes regarding school selection decisions made by a court.

(B) COMPONENTS OF DISPUTE RESOLUTION.—The dispute resolution procedure described in subparagraph (A) shall include, at a minimum—

(i) a procedural safeguard system to resolve disputes and render prompt school selection decisions;

(ii) written notice of the school selection decision and basis for the decision to the—

(I) parent, education decisionmaker, and court representative of the child; and

(II) local child welfare agency serving the child;

(iii) a right to appeal a school selection decision, an impartial and prompt review of such decision, and a written determination of the administrative appeal; and

(iv) a right to initiate a dispute under this paragraph that is provided to—

(I) the parent, education decisionmaker, and court representative of the child; and

(II) a representative from the local child welfare agency or local educational agency serving the child.

(C) SCHOOL PLACEMENT DURING DISPUTE.—If a dispute arises over the school selection decision, the child shall remain in the child's current school until full resolution of the dispute, unless—

(i) the dependency court determines otherwise and selects a different school for the child; or

(ii) the State child welfare agency or local child welfare agency with responsibility for the child determines that the child's health or safety would be at risk if the child remained in such school prior to a determination made under subparagraph (A) and selects a different school for the child.

(D) TRANSPORTATION.—In the case of a dispute under this paragraph regarding a child in foster care, the local educational agency where the child is attending school pending the resolution of the dispute, as determined under subparagraph (C), shall collaborate with the local child welfare agency to ensure transportation is provided, as required under section 101(a)(6), for the child to such school, until the full resolution of the dispute in accordance with this paragraph.

(6) COMPLAINT MANAGEMENT SYSTEM.—Each State shall maintain a complaint management system by which individuals and organizations acting on behalf of a child in foster care can request that the State investigate and correct violations of this subtitle in a timely manner on behalf of a child in foster care or a group of children in foster care.

(7) SCHOOL READINESS FOR CHILDREN IN FOSTER CARE.—

(A) STATE AND LOCAL EDUCATIONAL AGENCIES.—Each State educational agency and local educational agency shall ensure that public preschool programs funded, administered, or overseen by such agency—

(i) provide preschool-aged children in foster care with the rights described in subsection (a), and comply with the requirements of this subsection with respect to such children, except that such programs shall not be required to enroll a child in foster care immediately in a public preschool program that is operating at full capacity when enrollment for the child is sought, unless otherwise required by State law;

(ii) identify and prioritize preschool-aged children in foster care for enrollment and increase such children's enrollment and attendance in the public preschool program, through activities such as—

(I) reserving spaces in public preschool programs for children in foster care;

(II) conducting targeted outreach to local child welfare agencies and foster care providers;

(III) waiving application deadlines;

(IV) providing ongoing professional development for staff regarding the needs of children in foster care and their families and strategies to serve such children and families; and

(V) developing capacity to serve all children in foster care in the area served by such agency; and

(iii) review the educational and related needs of children in foster care and their families in such agencies' service areas, in coordination with the State child welfare agency, the local child welfare agency, and the foster care liaison designated under paragraph (3), and develop policies and practices to meet identified needs.

(B) OTHER STATE AGENCIES.—In the case of public preschool programs that are not funded, administered, or overseen by the State educational agency or a local educational agency, the State agency that funds such public preschool programs shall—

(i) develop, review, and revise its policies and practices to remove barriers to the enrollment, attendance, retention, and success of children in foster care in public preschool programs funded, administered, or overseen by the agency;

(ii) provide preschool-aged children in foster care with the rights described in subsection (a), and comply with the requirements of this subsection with respect to such children, except that such programs—

(I) shall not be required to enroll a child in foster care immediately in a public preschool program that is operating at full capacity when enrollment is sought for the child, unless otherwise required by State law;

(II) shall not be subject to the dispute resolution procedures of the State educational agency or local educational agencies, but shall—

(aa) ensure that all of the dispute resolution procedures available through such programs and the State agency that funds, administers, or oversees such programs are accessible to the education decisionmaker, court representative of a child in foster care, and a representative from the local child welfare agency; and

(bb) provide such individuals with a written explanation of their dispute and appeal rights; and

(III) shall not be subject to the transportation requirements of paragraph (5)(D) and subsection (a)(6), but shall remove barriers to existing transportation services for children in foster care and shall, to the maximum extent practicable, arrange or provide transportation for children in foster care to attend public preschool programs, including the children's school of origin;

(iii) identify and prioritize children in foster care for enrollment and increase such children's enrollment and attendance in public preschool programs, including through

activities described in subclauses (I) through (V) of subparagraph (A)(ii); and

(iv) review the educational and related needs of children in foster care and the children's families in the State, in coordination with the coordinator described in paragraph (2), and develop policies and practices to meet identified needs.

(C) SCHOOL OF ORIGIN.—For the purposes of applying this paragraph, a reference to a school shall be deemed to include a public preschool program.

(8) SHARING INFORMATION.—

(A) IN GENERAL.—The State educational agency and local educational agency shall review and eliminate any barriers to information-sharing with State child welfare agencies and local child welfare agencies, while continuing to protect the privacy interests of children and families, as required by Federal or State law.

(B) IMMEDIATE AVAILABILITY.—To ensure a child in foster care's immediate enrollment in a new school (including a preschool program), all education records of the child shall be made available in accordance with subsection (a)(4). A school sending education records shall ensure that the records are as complete and accurate as possible.

(C) COMPLIANCE WITH FERPA.—Education records of a child in foster care shall be—

(i) maintained and provided to other schools in a manner consistent with section 444 of the General Education Provisions Act (commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'') (20 U.S.C. 1232g); and

(ii) provided to the child welfare agency or other child welfare system advocates in a manner that complies with such section.

(D) EXPEDITED TRANSFER.—Each foster care liaison described in paragraph (3) and coordinator described in paragraph (2) within a State shall work to expedite the transfer of education records of children in foster care.

(9) TRANSFER OF CREDITS; DIPLOMA.—

(A) TRANSFER OF CREDITS.—The State shall have a system for ensuring that—

(i) a child in foster care who is changing schools can transfer school credits and receive partial credits for coursework satisfactorily completed while attending a prior school or educational program; and

(ii) a child in foster care is afforded opportunities to recover school credits lost due to placement instability while in foster care.

(B) ELIMINATING BARRIERS.—The State shall undertake steps to eliminate barriers to allowing a child in foster care who has experienced multiple school placements to receive a secondary school diploma either from one of the school districts in which the student was enrolled or through a State-issued secondary school diploma system.

(10) EQUAL ACCESS.—

(A) IN GENERAL.—The State and each local educational agency of the State shall take steps to eliminate barriers to access for children in foster care to academic, nonacademic, or extracurricular programs that are created by application or entrance deadlines and other admissions requirements that children in foster care cannot meet because of frequent school changes.

(B) NO FORCED PRIVATE PLACEMENT.—The State shall ensure that each group home or placement facility in the State in which a child in foster care may be placed does not explicitly or implicitly condition such placement on attendance at a private school owned or operated by an agency associated with the facility.

(C) NO SCHOOL SEGREGATION.—The State shall ensure that a child in foster care, including a child residing in a group home or placement facility—

(i) shall not be educated in a segregated setting due to the child's status as a child in foster care; and

(ii) shall have access to—

(I) a public elementary school or secondary school; or

(II) in the case of a child with an individualized education program under section 614 of the Individuals with Disabilities Education Act (20 U.S.C. 1414), an alternative setting, if required under such plan.

(11) COLLABORATION IN DEVELOPING CHILD-SPECIFIC CASE PLANS.—

(A) IN GENERAL.—Each local educational agency of the State shall collaborate, at the local child welfare agency's request, with the local child welfare agency with respect to the following to ensure that educational issues for children in foster care are appropriately identified and addressed:

(i) The development of the following components of the case plan required for children in foster care:

(I) The written description of the programs and services which will help the child prepare for the transition from foster care to independent living required under subparagraph (D) of section 475(1) of the Social Security Act (42 U.S.C. 675(1)).

(II) The plan for ensuring the educational stability of the child while in foster care required under subparagraph (G) of section 475(1) of the Social Security Act (42 U.S.C. 675(1)).

(ii) The requirement under subparagraph (H) of section 475(5) of the Social Security Act (42 U.S.C. 675(5)) to provide a child in foster care with assistance and support in developing a transition plan for aging out of foster care to independent living.

(iii) The programs and activities, including vouchers for education and training, including postsecondary training and education, for youths who have aged out of foster care, carried out under the John H. Chafee Foster Care Independence Program established under section 477 of the Social Security Act (42 U.S.C. 677).

(iv) All other child welfare agency-based planning that relate to educational issues for a child in foster care or a child transitioning out of foster care to independent living.

(B) CONTENTS.—The local child welfare agency shall specify in the case plan required for children in foster care under parts B and E of title IV of the Social Security Act the local educational agency's role in providing guidance, information, and support to implement the education-related provisions of the plan.

(C) LOCAL EDUCATIONAL AGENCY ROLE.—Each local educational agency of the State shall—

(i) cooperate with the implementation of programs, activities, services, and vouchers described in subparagraph (A); and

(ii) ensure that such programs, activities, services, and vouchers are coordinated with any education plans developed by the local educational agency, including, when appropriate, any plan for transition services for a child in foster care that is included in the child's individualized education program, as required under section 614(d) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)).

(12) COLLECTING INFORMATION.—

(A) IN GENERAL.—The State shall collect valid and reliable information as needed to report annually to the Secretary on the State's progress in meeting the requirements of this title. Such report shall include, at a minimum—

(i) the number of children in foster care enrolled in school and in public preschool programs;

(ii) the number of such children who remained in the child's school of origin;

(iii) the number of such children who experienced enrollment delays;

(iv) State assessment scores disaggregated for children in foster care;

(v) secondary school graduation rates, including on-time graduation rates, for such children;

(vi) the number of such children who repeated grades; and

(vii) the number of such children who—

(I) are eligible for special education and related services; or

(II) receive services under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.).

(B) INFORMATION SHARING.—The State educational agency and local educational agencies shall collaborate with the State child welfare agency and local child welfare agencies to collect and share necessary information in order to generate such reports.

(c) COLLABORATION.—To carry out this section, each State educational agency and the local educational agencies of a recipient State shall collaborate with the State child welfare agency and local child welfare agencies of such State.

SEC. 102. REMEDIES; RULE OF CONSTRUCTION.

(a) JUDICIAL REMEDIES.—

(1) IN GENERAL.—Any party aggrieved by a finding or decision made under paragraph (5) or (6) of section 101(b), or who otherwise claims that a right provided under this Act has been violated, may bring a civil action in an appropriate district court of the United States.

(2) JURISDICTION.—The district courts of the United States shall have jurisdiction of actions brought under this title without regard to the amount in controversy.

(3) ATTORNEY'S FEES.—In any action or proceeding brought under paragraph (1), the court, in its discretion, may award reasonable attorney's fees and expert witness fees as part of costs to a prevailing party who is acting on behalf of a child in foster care.

(4) STATE SOVEREIGN IMMUNITY.—

(A) IN GENERAL.—A recipient State's receipt or use of funds under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) shall constitute a waiver of sovereign immunity, under the 11th amendment to the Constitution or otherwise, to a civil action brought under paragraph (1).

(B) EFFECTIVE DATE.—This paragraph shall apply with respect to violations that occur in whole or in part after the effective date of this Act.

(C) REMEDIES.—In a civil action against a State for a violation of this paragraph, remedies (including remedies both at law and in equity) are available for such a violation to the same extent as those remedies are available for such a violation in the civil action against any public entity other than a State.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to restrict or limit the rights, procedures, and remedies available under—

(1) the Constitution;

(2) the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11461 et seq.);

(3) the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–315), or the amendments made by such Act;

(4) section 444 of the General Education Provisions Act (commonly referred to as the

''Family Educational Rights and Privacy Act of 1974'') (20 U.S.C. 1232g);

(5) the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.); or

(6) any other Federal or State law protecting the rights of children in foster care.

SEC. 103. CONFORMING AMENDMENTS.

The Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) is amended—

(1) in section 1111 (20 U.S.C. 6311)—

(A) in subsection (b)(2), by adding after subparagraph (K) the following:

''(L) ACCOUNTABILITY FOR CHILDREN IN FOSTER CARE.—The accountability provisions under this Act shall ensure that children in foster care, as defined in section 4 of the Fostering Success in Education Act, are included in academic assessment, reporting, and accountability systems, in accordance with paragraph (3)(C)(xi).''; and

(B) in subsection (c)—

(i) in paragraph (13), by striking ''and'' at the end;

(ii) in paragraph (14), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(15) The State and State educational agency will ensure that the requirements of section 101 of the Fostering Success in Education Act will be satisfied.''; and

(2) in section 1112(c)(1) (20 U.S.C. 6312(c)(1))—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(P) comply with the requirements of section 101 of the Fostering Success in Education Act that relate to the local educational agency.''.

Subtitle B—State Foster Care and Education Plan Grants

SEC. 111. STATE FOSTER CARE AND EDUCATION PLAN REQUIREMENTS AND GRANTS.

(a) GENERAL AUTHORITY.—From amounts appropriated to carry out this subtitle and not reserved under subsection (b)(2), the Secretary shall make grants to States, from allotments under subsection (b)(1), to enable the States to carry out activities, and award subgrants, in accordance with subsection (d).

(b) ALLOTMENTS AND RESERVATION.—

(1) ALLOTMENTS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary is authorized to make an allotment to each State with an approved State foster care and education plan under subsection (c) for a fiscal year in an amount that bears the same relation to the total amount available under this paragraph for a fiscal year as the number of children in foster care who reside in the State bears to the total number of children in foster care who reside in all States with approved State foster care and education plans.

(B) MINIMUM ALLOTMENTS.—The amount of a State's allotment under this paragraph for a fiscal year shall not be less than $300,000.

(C) RATABLE REDUCTIONS.—In the case of a fiscal year for which the amounts available to carry out this subtitle are not sufficient to award grants to States in the amounts described in subparagraphs (A) and (B), the Secretary shall ratably reduce the amount of all such grants.

(2) RESERVATIONS.—

(A) RESERVATION FOR TECHNICAL ASSISTANCE AND EVALUATION.—Of the funds made available to carry out this section, the Secretary shall reserve 1 percent of such funds to provide—

(i) technical assistance to States that receive grants under this subtitle; and

(ii) rigorous evaluation of the activities funded with grants under this subtitle in accordance with section 113.

(B) STUDENTS IN TERRITORIES.—Of the funds made available to carry out this section, the Secretary shall reserve 0.10 percent of such funds to be allocated among the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands, according to their respective need for assistance under this subtitle, as determined by the Secretary.

(C) INDIAN STUDENTS.—Of the funds made available to carry out this section, the Secretary shall reserve 1.0 percent to provide assistance to the Secretary of the Interior for programs that are for Indian children in foster care who are served by schools funded by the Department of Interior and that are consistent with the purposes of the activities described in this subtitle.

(c) STATE FOSTER CARE AND EDUCATION PLAN.—

(1) ELIGIBILITY REQUIREMENT.—No State shall receive a grant under this subtitle unless the State educational agency has submitted to the Secretary, and the Secretary has approved under section 113(a)(1), a State foster care and education plan (referred to in this section as the ''plan'') that—

(A) includes the information described in paragraph (3); and

(B) describes the specific responsibilities and procedures undertaken by each applicable agency of the State to meet the requirements of subsections (e) and (f) and subtitle A.

(2) APPROVAL, REVIEW, AND RESUBMISSION.—

(A) DEVELOPMENT AND APPROVAL.—The plan for a State shall be—

(i) developed by the State educational agency, in collaboration with the State child welfare agency; and

(ii) approved by the chief executive officer of the State before submission to the Secretary.

(B) ANNUAL REVIEW.—Each State receiving a grant under this subtitle shall review the plan annually, in collaboration with the State child welfare agency and the State educational agency, to determine the State's compliance with the plan, including a review of the—

(i) information collected under section 101(b)(12); and

(ii) the State's progress in eliminating barriers identified under paragraph (3)(B).

(C) RESUBMISSION.—Each State receiving a grant under this subtitle shall resubmit the plan, with amendments as necessary, after collaboration with the State child welfare agency and approval by the chief State official in charge of the State's child welfare system, every 3 years for review and approval by the Secretary.

(3) PLAN CONTENTS.—The plan shall address how each right and requirement under section 101 will be achieved, including—

(A) the method by which the State will monitor local educational agencies and other local agencies with responsibility under this title to ensure compliance with this title;

(B) an analysis of the State and local barriers to meeting the requirements of this title, including the barriers described in paragraphs (8), (9)(B), and (10) of section 101(b), and specific steps taken to eliminate those barriers;

(C) a description of, and protocol for, how State foster care coordinators described in section 101(b)(2) and foster care liaisons described in section 101(b)(3) will work collaboratively with State child welfare agencies and local child welfare agencies to implement the provisions of this title;

(D) detailed procedures for making the school selection decisions for children in foster care in the State in accordance with section 101(b)(4);

(E) clear procedures regarding how transportation to maintain each child in foster care in the appropriate school will be provided, arranged, and funded;

(F) an explanation of how the State will—

(i) ensure transfers of school credits and partial credits for children in foster care who experience multiple school moves; and

(ii) eliminate barriers to allowing such children to obtain secondary school diplomas as required under section 101(b)(4);

(G) an explanation of how the State will put in place a procedural safeguard system that meets the requirements of section 101(b) and protects the rights of children in foster care, as described in section 101(a), and how such system will—

(i) operate;

(ii) resolve disputes about school stability, immediate enrollment, and eligibility for services under the title;

(iii) provide notice to children in foster care, and the parents, educational decision makers, and court representatives, of the rights of children under section 101(a) and the processes for obtaining a school selection decision for the child and for resolving disputes under section 101(b); and

(iv) protect the child's rights under section 101(a) during the resolution of any disputes;

(H) a description of how the State has involved, and will continue to involve, individuals representing all critical stakeholders involved with children in foster care, including children in foster care, parents, education decisionmakers, foster parents and other caretakers, caseworkers, court representatives, and judges, in the development of the plan and when making decisions about policies and procedures to implement this title;

(I) a description of how training needs relating to children in foster care will be identified and addressed for—

(i) critical stakeholders in the State educational agency, local educational agencies, the State child welfare agency, and local child welfare agencies; and

(ii) other necessary parties involved with children in foster care;

(J) a description of how local educational agencies in the State, in collaboration with local child welfare agencies, will meet the requirements of subsection (f), section 101(b)(1), and other provisions in this title relating to local educational agencies;

(K) a description of services or policies needed for children in foster care to meet the same challenging student academic achievement standards under section 1111(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(1)) to which other children are held, and a description of the steps that will be taken to create and implement those services or policies;

(L) a description of all efforts to promote efficient record maintenance and sharing to further the purposes of this title while protecting confidentiality rights under section 444 of the General Education Provisions Act (commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'') (20 U.S.C. 1232g) and other laws;

(M) a description of how immediate enrollment for children in foster care, as required

under section 101(a)(3), will be achieved, including how any record requirements in effect as of the date of the plan will be addressed so as to not delay enrollment;

(N) a description of the system that will ensure the timely transfer of education and health records of children in foster care and an explanation of how any delay in such transfer will not interfere with immediate enrollment; and

(O) procedures for periodically monitoring local educational agency compliance with the requirements of this title and for maintaining a complaint management system as required under section 101(b)(12).

(d) USE OF FUNDS.—A State receiving an allotment under this subtitle shall use—

(1) not more than 25 percent of the State's allotment to carry out the State plan under subsection (c), meet the requirements under subsections (e) and (f), and carry out activities, directly or through grants or contracts, to further the purposes of this title; and

(2) not less than 75 percent of the State's allotment to award subgrants under section 112.

(e) STATE REQUIREMENTS.—

(1) STATE EDUCATIONAL AGENCY ROLE.—

(A) IN GENERAL.—The State educational agency of a State receiving a grant under this subtitle shall be responsible for—

(i) the general administration and supervision of programs and activities receiving funds under this subtitle, including the activities described in paragraph (2) and subgrants awarded under section 112;

(ii) monitoring programs and activities used by the State to carry out this title, whether or not such programs or activities are receiving assistance under this subtitle; and

(iii) ensuring that the State is in compliance with the requirements under this title.

(B) COLLABORATION.—A State educational agency shall collaborate with the State child welfare agency in carrying out the responsibilities under this paragraph.

(2) ACTIVITIES.—Each State receiving a grant under this subtitle shall carry out the following activities:

(A) STAKEHOLDER COUNCIL.—

(i) IN GENERAL.—The State educational agency shall establish a Stakeholder Council (referred to in this paragraph as the ''Council'') that meets publicly on not less than a semiannual basis.

(ii) MEMBERSHIP.—The members of the Council shall include, at a minimum—

(I) a designee from the State educational agency;

(II) a designee from the State child welfare agency; and

(III) individuals representing local educational agencies, local child welfare agencies, juvenile courts, court representatives, court appointed special advocates, children in foster care, foster parents, and parents.

(iii) DUTIES.—The Council shall—

(I) review the State's policies, practices, data, and other information regarding the implementation of this title;

(II) review and advise the State on the plan before the plan's submission or resubmission;

(III) make recommendations regarding procedures and policies for implementing this title;

(IV) assess progress towards eliminating identified barriers to compliance that are described in subsection (c)(3)(B);

(V) prepare and submit an annual report to the State educational agency, the State child welfare agency, any other applicable State agency, and the Secretary on the status of implementation efforts, including an analysis of data collected; and

(VI) make recommendations regarding the next steps the State should take regarding implementation and submit such recommendations to the Secretary with each plan resubmission under subsection (c)(2)(C).

(B) MONITORING.—The State educational agency, in collaboration with the State child welfare agency, shall periodically monitor local educational agencies and other local agencies with responsibilities under this title to ensure compliance.

(f) LOCAL EDUCATIONAL AGENCY REQUIREMENTS.—Each local educational agency in a State receiving a grant under this subtitle shall meet the following requirements:

(1) IN GENERAL.—The local educational agency shall ensure, in coordination with the corresponding local child welfare agency, that children in foster care in the school district served by the local educational agency receive all of the rights described in section 101(a) by carrying out, at a minimum, all of the following:

(A) Ensuring that each child in foster care in the school district served by the local educational agency remains in a school of origin or is immediately enrolled in a new school, in accordance with the child's best interest as required under section 101(a).

(B) Documenting that written notice has been provided to the parent, education decisionmaker, and court representative of the child and the local child welfare agency representative responsible for the child with regard to any decisions made by the local educational agency regarding the rights under this title of a child in foster care, including—

(i) an explanation of the basis for the decision;

(ii) the right to appeal the decision; and

(iii) the right of the child to remain in the child's current school while a dispute is pending.

(C) Ensuring compliance with this title by all schools served by the local educational agency.

(D) Identifying and removing any barriers that exist in schools served by the local educational agency, including—

(i) barriers identified in the plan under subsection (b)(3)(B);

(ii) barriers to remaining or enrolling in a school of origin, or to enrolling promptly in a new school for a child in foster care if such enrollment is in the child's best interest; or

(iii) other barriers impeding the rights of a child in foster care under this title.

(E) Ensuring that the schools served by the local educational agency promptly transfer the school credits and partial school credits of children in foster care, and provide children in foster care with access to credit recovery programs or services.

SEC. 112. SUBGRANTS.

(a) IN GENERAL.—The State educational agency shall, in accordance with section 111(b)(2), award subgrants, on a competitive basis, to public agencies, including local educational agencies and local child welfare agencies, or partnerships comprised of public agencies, to carry out the requirements of this title or clause (ii)(II), (iii), or (iv) of section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)).

(b) APPLICATION.—A public agency, or a partnership of public agencies, desiring a subgrant under this section shall submit an application to the State educational agency at such time, in such manner, and containing such information as the State educational agency may require.

(c) AWARD BASIS.—

(1) IN GENERAL.—The State educational agency shall award subgrants under this section based on—

(A) the established need for attention to the education of children in foster care in the area served by the public agency or partnership of public agencies; and

(B) the quality of activities proposed to address such need by the agency or partnership in the application described in subsection (b).

(2) PRIORITY.—In awarding subgrants under this section, the State educational agency shall give priority to the following applicants:

(A) Local child welfare agencies that have entered into agreements with local educational agencies to share responsibilities for providing, arranging, and paying for the transportation of children in foster care to the children's school of origin in a cost-effective manner.

(B) Local educational agencies that have entered into such agreements with local child welfare agencies.

(C) Partnerships that—

(i) include not less than 1 local child welfare agency and not less than 1 local educational agency; and

(ii) have entered into such agreements.

(d) USE OF FUNDS.—A public agency, or a partnership of public agencies, receiving a subgrant under this section shall use subgrant funds to assist the State educational agency providing the subgrant in meeting the State's responsibilities under this title or clause (ii)(II), (iii), or (iv) of section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)), which assistance may include—

(1) funding of foster care liaison positions, as described in section 101(b)(3), at the local educational agency;

(2) coordinating activities that support the purposes of this title between local educational agencies, local child welfare agencies, and other relevant agencies;

(3) expenditures for transportation costs;

(4) tutoring or other educational support services specifically targeted to children in foster care;

(5) expediting special education evaluations for children in foster care;

(6) pupil activities and services needed to promote school and preschool success for children in foster care;

(7) training for the staff of the State educational agency, the local educational agencies, the State child welfare agency, and the local child welfare agencies, and for children in foster care, such children's families, and others involved with children in foster care, about—

(A) the unique educational needs of children in foster care;

(B) the benefits afforded under this title; and

(C) other issues that further the purposes of this title; and

(8) assisting in funding State-level education coordinators in the State child welfare agency and local education liaisons within the local child welfare agency to be specific points of contact on education issues.

SEC. 113. RESPONSIBILITIES OF THE SECRETARY.

(a) REVIEW OF STATE PLANS.—

(1) IN GENERAL.—The Secretary of Education, in collaboration with the Secretary of Health and Human Services, shall review the plan submitted or resubmitted by a State under section 111(c). If the plan meets the requirements of section 111 and is reasonably calculated to ensure that all children in foster care in the State receive all rights, benefits, and protections required by this title, the Secretary shall approve the plan.

(2) DISAPPROVAL.—

(A) IN GENERAL.—If a plan does not meet the requirements described in paragraph (1), the Secretary shall disapprove the plan and provide the State educational agency with specific findings as to what needs to be corrected for approval.

(B) REVIEW PROCESS.—The Secretary shall promulgate regulations establishing a system by which States whose plans are disapproved can appeal such disapproval.

(b) TECHNICAL ASSISTANCE.—The Secretary shall provide—

(1) training, support, and technical assistance to a State educational agency receiving a grant to assist the State educational agency in carrying out its responsibilities under this title; and

(2) training, support, and technical assistance to a State that has had the State's plan described in section 111 disapproved.

(c) SUBMISSION AND DISTRIBUTION.—The Secretary shall—

(1) require applications for grants under this subtitle to be submitted to the Secretary not later than the expiration of the 60-day period beginning on the date that funds are available for purposes of making such grants; and

(2) award such grants not later than the expiration of the 120-day period beginning on such date.

(d) DETERMINATION BY SECRETARY.—The Secretary, based on the information received from the States and information gathered by the Secretary under this subtitle and under section 101(b)(11), shall determine the extent to which State educational agencies are ensuring that each child in foster care has access to a free, appropriate public education.

(e) INFORMATION.—

(1) COORDINATION; ENFORCEMENT.—The Secretary shall coordinate and enforce the information collection requirements under this subtitle and section 101(b)(12).

(2) DATA COLLECTION AND DISSEMINATION.—The Secretary shall—

(A) directly or through grants, contracts, or cooperative agreements, periodically collect and disseminate data and information regarding the education of children in foster care; and

(B) require each State receiving a grant under this subtitle to annually provide—

(i) the information described in section 101(b)(12)(A); and

(ii) such other data and information as the Secretary determines to be necessary and relevant to carry out this subtitle.

(f) EVALUATION AND DISSEMINATION.—The Secretary shall conduct evaluation and dissemination activities regarding programs designed to meet the educational needs of elementary and secondary school students who are children in foster care.

(g) REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary shall prepare and submit to the Committee on Education and Labor and the Committee on Ways and Means of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate a report on the status of the education of children in foster care, which shall include information on—

(1) the educational outcomes of children in foster care; and

(2) the actions of the Secretary and the effectiveness of the programs supported under this title.

SEC. 114. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out the subtitle, $150,000,000 for each of the fiscal years 2011 through 2015.

TITLE II—SOCIAL SECURITY ACT AMENDMENTS

SEC. 201. SOCIAL SECURITY ACT AMENDMENTS.

(a) EDUCATIONAL STABILITY FOR FOSTER CARE CHILDREN.—Section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)) is amended—

(1) in clause (ii)—

(A) by striking ''or'' at the end of subclause (I) and inserting ''and''; and

(B) by striking subclause (II), and inserting the following:

''(II) assurances that the State agency has coordinated with the appropriate local educational agency to ensure that the child remains in the school in which the child is enrolled at the time of placement including, when necessary, the State agency arranging for, providing, or paying the cost of the transportation necessary to enable the child to remain in the school;''; and

(2) by adding at the end the following:

''(iii) assurances by the State agency and the local educational agencies, if remaining in such school is not in the best interests of the child, to provide immediate and appropriate enrollment in a new school, with all of the educational records provided to the school; and

''(iv) assurances by the State agency and local child welfare agencies that steps have been undertaken to collaborate with the State and local educational agencies to eliminate barriers to the educational stability, school enrollment, and educational success of the child.''.

(b) STATE PLAN REQUIREMENT.—Section 471 of the Social Security Act (42 U.S.C. 671(a)) is amended—

(1) in paragraph (32), by striking ''and'' after the semicolon;

(2) in paragraph (33), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(34) provides that the State agency and local child welfare agencies will collaborate with the State and local educational agencies to collect the data and other information necessary to monitor implementation of the requirements of clauses (ii)(II), (iii), and (iv) of subparagraph (G) of section 475(1) and the provisions of section 101 of the Fostering Success in Education Act; and

''(35) provides that the State agency and local child welfare agencies have identified staff within the agencies to be the point people with the State and local educational agencies related to educational issues, including the implementation of the requirements of clauses (ii)(II), (iii), and (iv) of subparagraph (G) of section 475(1), as well as to coordinate with educational agency liaisons and coordinators to implement the provisions of section 101 of the Fostering Success in Education Act.''.

By Mr. SPECTER:

S. 2805. A bill to amend the Food and Nutrition Act of 2008 to increase the amount made available to purchase commodities for the emergency food assistance program in fiscal year 2010; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. SPECTER. Mr. President, I seek recognition to introduce legislation to deal with the pressing problem of hunger in the United States. The report of the Economic Research Service of the Department of Agriculture on Monday, November 16—3 days ago—disclosed some startling facts about hunger in America. The report showed there are 49 million Americans who experienced hunger last year. Among that number, 17 million were children, and 500,000 of those children were under the age of 6, which is a critical stage in childhood development.

The hunger problem hit disproportionately higher for Hispanics at 27 percent higher and African Americans at 26 percent higher. It is hard to find a sufficiently tough word to describe it—scandalous, outrageous, criminal, repugnant—that in this land of plenty, we should find Americans who are hungry. It is unacceptable to have people hungry anywhere in the world, but right here in our own backyard for this situation to exist is beyond the pale.

Having read the article on the 16th, I contacted the Secretary of Agriculture, Tom Vilsack, discussed the issue with him, and I am now introducing legislation which will add $250 million to the food banks to try to deal with this issue on an emergency basis. It would be my hope that this is the kind of legislation which could be passed very promptly—hopefully, before Christmas of this year during our current session—to take some immediate action to replenish the food banks so people in America are not hungry.

Mr. President, I ask unanimous consent that my full statement be printed in the RECORD.

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

SENATOR ARLEN SPECTER—STATEMENT ON THE INTRODUCTION OF LEGISLATION PROVIDING FOR EMERGENCY FOOD RELIEF

Mr. SPECTER. Mr. President, I have sought recognition to introduce legislation addressing our nation's hunger crisis. The United States Department of Agriculture just released its annual report on Household Food Security in the United States. This report finds that 49 million Americans, 17 million of whom are children, experienced food insecurity and hunger in 2008. Poverty is the underlying cause of this problem. While job creation policies to lift these Americans out of poverty are being implemented, Congress must provide immediate relief so that they have access to the nutrition necessary to live a healthful and productive life.

The USDA report contains alarming data on the struggles faced by too many American families. In 2008, 17 million households reported being food insecure, that is to say they lacked access to enough food for an active and healthy life. This is an increase from 13 million households in 2007. In my state of Pennsylvania, 11.2 percent of our 4,970,000 households reported being food insecure, and 4.2 percent reported very low food security, meaning they were unable to eat at various times over the year.

Of these 49 million Americans who reported hunger, 12 million adults and 5.2 million children reported periods of extreme hunger, possibly going days without eating. The data shows that black and Hispanic households experienced food insecurity at rates far higher than the national average at 26 percent and 27 percent respectively.

Among the 17 million children, nearly half a million under the age of 6 were hungry.

This is a critical stage of childhood development that is being undermined by a lack of access to proper nutrition, which is necessary for learning and academic achievement.

Fortunately, Congress has taken steps to address this important issue, appropriating for fiscal year 2010 $9.2 billion for the School Lunch Program and $171 million for the Commodity Supplemental Food Program which provides nutrition assistance to mothers, children and the elderly. The economic stimulus package contained more than $20 billion for nutrition assistance. Yet, this USDA study shows us that more is needed.

That is why I am introducing legislation to double spending on The Emergency Food Assistance Program, or TEFAP, from $250 to $500 million annually. Through TEFAP, the USDA makes commodity and food purchases and then distributes nutrition assistance to states based on need. The numbers show us there is great need.

According to Feeding America, which operates 205 food banks nationwide and 10 in the Commonwealth of Pennsylvania, 99 percent of their food banks experienced an increase in demand during the month of September 2009 and 91 percent of food banks reported unemployment as a critical factor driving the increase in emergency food assistance. Unfortunately 51 percent of these food banks had to turn someone away in the last year. By doubling TEFAP spending, Congress would significantly increase the amount of food being delivered to local food banks, ensuring that less Americans go hungry.

According to the Department of Agriculture, nearly 27 percent of the 356 billion pounds of available food in America is wasted each year. That is nearly 100 billion pounds of waste, when according the charity Feeding America only 5 billion pounds of food is needed to eliminate hunger. In a country with such a food abundance, it is criminal that children to go to bed hungry. Our country has a developed network of food assistance providers in place. Government agencies, community food banks, food pantries, soup kitchens, shelters and churches all stand ready to address the challenge of combating hunger. Let us provide them the resources they need. The legislation I am introducing today will do that and will stem the tide of hunger.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2805

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

SECTION 1. FINDINGS.

Congress finds that—

(1) more than 1 in 7 households in the United States struggled to find enough to eat during 2008;

(2) poverty is the primary cause of food insecurity and hunger in the United States;

(3) the annual report of the Economic Research Service of the Department of Agriculture on household food security in the United States found that in 2008, 17,000,000 households were food insecure, an increase from 13,000,000 households in 2007;

(4) the term ''low food security'' means people being unable to consistently get enough to eat and the term ''very low food security'' means people being hungry at various times over the year and being unable to eat because of lack of money to purchase food;

(5) the 17,000,000 food insecure households in the United States are home to 49,000,000 Americans, of whom—

(A) 17,000,000 are children, among whom nearly 500,000 in the developmentally critical years under the age of 6 are going hungry; and

(B) 12,000,000 adults and 5,200,000 children reported experiencing severe hunger, possibly going days without eating;

(6) good nutrition is necessary for learning and academic achievement; and

(7) Black and Hispanic households experienced food insecurity at far higher rates (25.7 percent in the case of Black households and 26.9 percent in the case of Hispanic households) than the national average.

SEC. 2. AVAILABILITY OF COMMODITIES FOR THE EMERGENCY FOOD ASSISTANCE PROGRAM.

Section 27(a)(2) of the Food and Nutrition Act of 2009 (7 U.S.C. 2036(a)(2)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end;

(2) by redesignating subparagraph (C) as subparagraph (E);

(3) in subparagraph (E) (as so redesignated)—

(A) by striking ''each of fiscal years 2010 through 2012'' and inserting ''fiscal year 2012''; and

(B) by striking ''subparagraph (B)'' and inserting ''subparagraph (D)''; and

(4) by inserting after subparagraph (B) the following:

''(C) for fiscal year 2010, $500,000,000;

''(D) for fiscal year 2011, $250,000,000, as adjusted in accordance with subparagraph (E); and''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 355—EXPRESSING THE SENSE OF THE SENATE THAT THE GOVERNMENT OF THE ISLAMIC REPUBLIC OF IRAN HAS SYSTEMATICALLY VIOLATED ITS OBLIGATIONS TO UPHOLD HUMAN RIGHTS PROVIDED FOR UNDER ITS CONSTITUTION AND INTERNATIONAL LAW

Mr. LEVIN (for himself, Mr. MCCAIN, Mr. CASEY, Mr. GRAHAM, Mr. LIEBERMAN, Mr. CORKER, and Mr. NELSON of Florida) submitted the following resolution; which was considered and agreed to:

S. RES. 355

Whereas the 1979 Constitution of the Islamic Republic of Iran supposedly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1968), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which its ratified on June 24, 1975);

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including flogging, and amputations;

(2) high incidence and increase in the rate of executions carried out in the absence of internationally recognized safeguards, including public executions and executions of juvenile offenders;

(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning;

(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidation against women's rights defenders, and continuing discrimination against women and girls;

(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities;

(6) ongoing, systematic, and serious restrictions of freedom of peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship of expression in online forums such as blogs and websites; and

(7) severe limitations and restrictions on freedom of religion and belief, including arbitrary arrest, indefinite detention, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that sets out a mandatory death sentence for apostasy, the abandoning of one's faith;

Whereas, since March 9, 2007, Robert Levinson, a United States citizen, has been missing in the Islamic Republic of Iran, and the Government of Iran has provided little information on his whereabouts or assistance in ensuring his safe return to the United States;

Whereas Ja'far Kiani was publicly stoned to death in July 2007 in the Islamic Republic of Iran in contravention of an order from the Head of the Judiciary granting a temporary stay of execution;

Whereas, since May 2008, Reza Taghavi, a 71-year old Iranian-American, has been imprisoned without a trial or formal charges;

Whereas, on October 15, 2008, authorities in the Islamic Republic of Iran jailed Esha Momeni, a graduate student at California State University, Northridge, for her peaceful activities in connection with the women's rights movement in the Islamic Republic of Iran, and refused to grant her permission to leave Iran for 10 months following her release from prison in November 2008;

Whereas Iranian-American journalist Roxana Saberi was jailed in January 2009 and sentenced in a closed-door, one-hour trial to eight years in prison for charges of espionage before her release in May 2009;

Whereas, on June 19, 2009, the United Nations High Commissioner for Human Rights expressed concerns about the increasing number of illegal arrests not in conformity with the law and the illegal use of excessive force in responding to protests following the June 12, 2009, elections, resulting in at least dozens of deaths and hundreds of injuries;

Whereas the Government of Iran closed the Center for Defenders of Human Rights, headed by Nobel Peace prize winner Shirin Ebadi, in December 2008, and the Association of Iranian Journalists in August 2009, the country's largest independent association for journalists;

Whereas, on August 1, 2009, authorities in the Islamic Republic of Iran began a mass trial of over 100 individuals in connection with election protests, most of whom were held incommunicado for weeks, in solitary confinement, with little or no access to their lawyers and families, many of whom showed signs of torture and drugging;

Whereas, in early October 2009, the judiciary of the Islamic Republic of Iran sentenced four individuals to death after the disputed presidential election, without providing the individuals adequate access to legal representation during their trials;

Whereas the Supreme Leader of Iran, Ali Khamenei, issued a statement on October 28, 2009, effectively criminalizing dissent regarding the national election in the Islamic Republic of Iran this past June, further restricting the right to freedom of expression;

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all persons;

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used brutal force to disperse thousands of protesters, resulting in a number of injuries and arrests, in violation of international standards regarding the proportionate use of force against peaceful demonstrations;

Whereas the Government of Iran expelled students from universities, particularly over the past two years, in reprisal for their being critical of the government;

Whereas the Government of Iran has imposed restrictions on the travel of individuals, including artists and filmmakers since the recent elections, in reprisal for their political views or their criticism of the government, such as those presently imposed on human rights lawyer Abdolfattah Soltani, human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and

Whereas, according to Amnesty International, at least 346 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning: Now, therefore, be it

Resolved, That the Senate—

(1) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly;

(2) condemns the Government of Iran's human rights violations and calls on the Government of Iran to hold those responsible accountable for their actions;

(3) reminds the Government of Iran of its constitutional obligations under its 1979 Constitution and four international covenants to which it is a signatory;

(4) calls for the immediate release from detention of opposition figures, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association;

(5) urges the Government of Iran to ensure that anyone placed on trial for committing acts of violence or other clearly criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by independent counsel, and guarantees that no statements shall be admitted into evidence that were shown to have been obtained through torture, inhumane, or degrading treatment;

(6) calls for the Government of Iran to ensure those currently in detention are treated humanely, to provide detainees immediate prompt access to their families, lawyers, and any medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and

(7) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the ''freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, or in print, in the form of art, or through any other media of his choice''.

SENATE RESOLUTION 356—CALLING UPON THE GOVERNMENT OF TURKEY TO FACILITATE THE REOPENING OF THE ECUMENICAL PATRIARCHATE'S THEOLOGICAL SCHOOL OF HALKI WITHOUT CONDITION OR FURTHER DELAY

Mr. CARDIN (for himself, Mr. BROWNBACK, Mr. REID, Mrs. SHAHEEN, Ms. SNOWE, and Mr. MENENDEZ) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 356

Whereas the Ecumenical Patriarchate is an institution with a history spanning 17 centuries, serving as the center of the Orthodox Christian Church throughout the world;

Whereas the Ecumenical Patriarchate sits at the crossroads of East and West, offering a unique perspective on the religions and cultures of the world;

Whereas the title of Ecumenical Patriarch was formally accorded to the Archbishop of Constantinople by a synod convened in Constantinople during the sixth century;

Whereas since November 1991, His All Holiness, Bartholomew I, has served as Archbishop of Constantinople, New Rome and Ecumenical Patriarch;

Whereas Ecumenical Patriarch Bartholomew I was awarded the Congressional Gold Medal in 1997, in recognition of his outstanding and enduring contributions toward religious understanding and peace;

Whereas during the 110th Congress, 75 Senators and the overwhelming majority of members of the Committee on Foreign Affairs of the House of Representatives wrote to President George W. Bush and the Prime Minister of Turkey to express congressional concern, which continues today, regarding the absence of religious freedom for Ecumenical Patriarch Bartholomew I in the areas of church-controlled Patriarchal succession, the confiscation of the vast majority of Patriarchal properties, recognition of the international Ecumenicity of the Patriarchate, and the reopening of the Theological School of Halki;

Whereas the Theological School of Halki, founded in 1844 and located outside Istanbul, Turkey, served as the principal seminary for the Ecumenical Patriarchate until its forcible closure by the Turkish authorities in 1971;

Whereas the alumni of this preeminent educational institution include numerous prominent Orthodox scholars, theologians, priests, bishops, and patriarchs, including Bartholomew I;

Whereas the Republic of Turkey has been a participating state of the Organization for Security and Cooperation in Europe (OSCE) since signing the Helsinki Final Act in 1975;

Whereas in 1989, the OSCE participating states adopted the Vienna Concluding Document, committing to respect the right of religious communities to provide ''training of religious personnel in appropriate institutions'';

Whereas the continued closure of the Ecumenical Patriarchate's Theological School of Halki has been an ongoing issue of concern for the American people and the United States Congress and has been repeatedly raised by members of the Commission on Security and Cooperation in Europe and by United States delegations to the OSCE's annual Human Dimension Implementation Meeting;

Whereas in his address to the Grand National Assembly of Turkey on April 6, 2009, President Barack Obama said, ''Freedom of religion and expression lead to a strong and vibrant civil society that only strengthens the state, which is why steps like reopening Halki Seminary will send such an important signal inside Turkey and beyond.'';

Whereas in a welcomed development, the Prime Minister of Turkey, Recep Tayyip Erdoğan, met with the Ecumenical Patriarch on August 15, 2009, and, in an address to a wider gathering of minority religious leaders that day, concluded by stating, ''We should not be of those who gather, talk, and disperse. A result should come out of this.'';

Whereas during his visit to the United States in November 2009, Ecumenical Patriarch Bartholomew I raised the issue of the continued closure of the Theological School of Halki with President Obama, congressional leaders, and others; and

Whereas Prime Minister Erdoğan is scheduled to make an official visit to Washington, D.C., in early December 2009: Now, therefore, be it

Resolved, That the Senate—

(1) welcomes the historic meeting between Prime Minister Recep Tayyip Erdoğan and Ecumenical Patriarch Bartholomew I;

(2) urges the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay; and

(3) urges the Government of Turkey to address other longstanding concerns relating to the Ecumenical Patriarchate.

Mr. CARDIN. Mr. President, I was pleased to meet with the Ecumenical Patriarch, Bartholomew I, again last week during his visit to Washington. Together with the congressional leadership, we heard his impassioned call for support for the reopening of the Theological School of Halki, an institution that has come to symbolize many of the difficulties faced by the Patriarch, the remnant of the Greek community in Turkey and other religious and ethnic minorities in that country.

I had the pleasure to meet Bartholomew I during an official visit to modern-day Istanbul in 1998. He impressed me as a man of good will, anchored in his deep personal faith, seeking to promote understanding, justice and respect for the human rights and dignity of each individual, the very qualities that prompted the Congress a year earlier to award him the Congressional Gold Medal. Indeed, his leadership extends well beyond the borders of Turkey to the Orthodox community around the world.

The Ecumenical Patriarch repeatedly returned to the issue of the Halki Seminary in various meetings during his U.S. visit, including at this oval office meeting with President Obama. Earlier this year, several of my colleagues from the Commission on Security and Cooperation in Europe, which I chair, joined me in a letter to the President underscoring our longstanding concern over the continued closure of this unique institution.

Founded in 1844, the Theological School of Halki, located outside modern-day Istanbul, served as the principal seminary for the Ecumenical Patriarchate until its forcible closure by the Turkish authorities in 1971. Counted among alumni of this preeminent educational institution are numerous prominent Orthodox scholars, theologians, priests, and bishops as well as patriarchs, including Bartholomew I. Many of these scholars and theologians have served as faculty at other institutions serving Orthodox communities around the world.

While over the years there have been occasional indications by the Turkish authorities of pending action to reopen the seminary, to date all have failed to materialize. In a potentially promising development, Turkey's Prime Minister, Recep Tayyip Erdogan, met with the Ecumenical Patriarch in August. In an address to a wider gathering of minority religious leaders that day, Erdogan concluded by stating, "We should not be of those who gather, talk and disperse. A result should come out of this."

I urge Prime Minister Erdoğan to follow through on the sentiment of those remarks by actions that will facilitate the reopening of the Halki Seminary without condition or further delay. As Chairman of the Helsinki Commission, I am particularly mindful of the fact that the continued closure of the Theological School of Halki stands in clear violation of Turkey's obligations under the 1989 OSCE Vienna Concluding Document, which affirmed the right of religious communities to provide "training of religious personnel in appropriate institutions."

At a time when Turkey is seeking to chart a new course, the resolution of this longstanding issue would not only be a demonstration of Ankara's good will, but, as President Obama mentioned in his address to the Turkish Grand National Assembly in April, will send such an important signal inside Turkey and beyond. I remain hopeful and encourage Prime Minister Erdoğan to act decisively and without condition on this matter before his upcoming visit to Washington in early December.

To underscore the importance attached to the reopening of the Theological School of Halki and our solidarity with the Ecumenical Patriarch, I am pleased to submit a resolution on this issue together with Mr. BROWNBACK, Mr. REID, Mrs. SHAHEEN, Ms. SNOWE, and Mr. MENENDEZ.

SENATE RESOLUTION 357—URGING THE PEOPLE OF THE UNITED STATES TO OBSERVE GLOBAL FAMILY DAY AND ONE DAY OF PEACE AND SHARING

Mr. INOUYE (for himself and Mr. REID) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 357

Whereas in 2009, the people of the world suffered many calamitous events, including devastation from tsunamis, terror attacks, wars, famines, genocides, hurricanes, earthquakes, political and religious conflicts, diseases, poverty, and rioting, all necessitating global cooperation, compassion, and unity previously unprecedented among diverse cultures, faiths, and economic classes;

Whereas grave global challenges in 2010 may require cooperation and innovative problem-solving among citizens and nations on an even greater scale;

Whereas on December 15, 2000, Congress adopted Senate Concurrent Resolution 138, expressing the sense of Congress that the President of the United States should issue a proclamation each year calling upon the people of the United States and interested organizations to observe an international day of peace and sharing at the beginning of each year;

Whereas in 2001, the United Nations General Assembly adopted Resolution 56/2, which invited "Member States, intergovernmental and non-governmental organizations and all the peoples of the world to celebrate One Day in Peace, 1 January 2002, and every year thereafter";

Whereas many foreign heads of State have recognized the importance of establishing Global Family Day, a special day of international unity, peace, and sharing, on the first day of each year; and

Whereas family is the basic structure of humanity, thus, we must all look to the stability and love within our individual families to create stability in the global community: Now, therefore, be it

Resolved, That the Senate urgently requests—

(1) the people of the United States to observe Global Family Day and One Day of Peace and Sharing with appropriate activities stressing the need—

(A) to eradicate violence, hunger, poverty, and suffering; and

(B) to establish greater trust and fellowship among peace-loving countries and families everywhere; and

(2) American businesses, labor organizations, and faith and civic leaders to join in promoting appropriate activities for Americans and in extending appropriate greetings from the families of the United States to families in the rest of the world.

Mr. INOUYE. Mr. President, today, I am submitting a Senate resolution to observe Global Family Day, One Day of Peace and Sharing, and am pleased to be joined in this endeavor by Senator REID.

We are a global society, interconnected by highly efficient modes of communication and transportation. With continued advancements in technology, nations will become even more interdependent upon each other. For this reason, I will continue to support and advocate for world peace. This is not a lofty pursuit. I have great confidence that if nations use everything at their disposal, they can promote peaceful, diplomatic options instead of war.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

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

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS

"SUBPART II—IMPROVING COVERAGE

"Sec. 2711. No lifetime or annual limits.
"Sec. 2712. Prohibition on rescissions.
"Sec. 2713. Coverage of preventive health services.
"Sec. 2714. Extension of dependent coverage.
"Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.
"Sec. 2716. Prohibition of discrimination based on salary.
"Sec. 2717. Ensuring the quality of care.
"Sec. 2718. Bringing down the cost of health care coverage.
"Sec. 2719. Appeals process.

Sec. 1002. Health insurance consumer information.
Sec. 1003. Ensuring that consumers get value for their dollars.
Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a preexisting condition.

Sec. 1102. Reinsurance for early retirees.
Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.
Sec. 1104. Administrative simplification.
Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

Sec. 1201. Amendment to the Public Health Service Act.

''SUBPART I—GENERAL REFORM

''Sec. 2701. Fair health insurance premiums.
''Sec. 2702. Guaranteed availability of coverage.
''Sec. 2703. Guaranteed renewability of coverage.
''Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.
''Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.
''Sec. 2706. Non-discrimination in health care.
''Sec. 2707. Comprehensive health insurance coverage.
''Sec. 2708. Prohibition on excessive waiting periods.

PART II—OTHER PROVISIONS

Sec. 1251. Preservation of right to maintain existing coverage.
Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.
Sec. 1253. Effective dates.

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Sec. 1301. Qualified health plan defined.
Sec. 1302. Essential health benefits requirements.
Sec. 1303. Special rules.
Sec. 1304. Related definitions.

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

Sec. 1311. Affordable choices of health benefit plans.
Sec. 1312. Consumer choice.
Sec. 1313. Financial integrity.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.
Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.
Sec. 1323. Community health insurance option.
Sec. 1324. Level playing field.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.
Sec. 1332. Waiver for State innovation.
Sec. 1333. Provisions relating to offering of plans in more than one State.

PART V—REINSURANCE AND RISK ADJUSTMENT

Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.
Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.
Sec. 1343. Risk adjustment.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

SUBPART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan.
Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans.

SUBPART B—ELIGIBILITY DETERMINATIONS

Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing , and individual responsibility exemptions.
Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.
Sec. 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.
Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.
Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.

PART II—SMALL BUSINESS TAX CREDIT

Sec. 1421. Credit for employee health insurance expenses of small businesses.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

Sec. 1501. Requirement to maintain minimum essential coverage.
Sec. 1502. Reporting of health insurance coverage.

PART II—EMPLOYER RESPONSIBILITIES

Sec. 1511. Automatic enrollment for employees of large employers.
Sec. 1512. Employer requirement to inform employees of coverage options.
Sec. 1513. Shared responsibility for employers.
Sec. 1514. Reporting of employer health insurance coverage.
Sec. 1515. Offering of Exchange-participating qualified health plans through cafeteria plans.

Subtitle G—Miscellaneous Provisions

Sec. 1551. Definitions.
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TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) by striking the part heading and inserting the following:

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS";

(2) by redesignating sections 2704 through 2707 as sections 2725 through 2728, respectively;

(3) by redesignating sections 2711 through 2713 as sections 2731 through 2733, respectively;

(4) by redesignating sections 2721 through 2723 as sections 2735 through 2737, respectively; and

(5) by inserting after section 2702, the following:

"Subpart II—Improving Coverage

"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

''(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

''(2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.

''(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.

"SEC. 2712. PROHIBITION ON RESCISSIONS.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

"SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements for—

''(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

''(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

''(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

''(b) INTERVAL.—

''(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

''(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.

''(c) VALUE-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

"SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

''(b) REGULATIONS.—The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

''(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the definition of 'dependent' as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

"SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

''(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the 'NAIC'), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

''(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

''(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

''(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

''(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes—

''(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

''(B) a description of the coverage, including cost sharing for—

''(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

''(ii) other benefits, as identified by the Secretary;

''(C) the exceptions, reductions, and limitations on coverage;

''(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

''(E) the renewability and continuation of coverage provisions;

''(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

''(G) a statement of whether the plan or coverage—

''(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

''(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

''(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

''(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

''(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

''(d) REQUIREMENT TO PROVIDE.—

''(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

''(A) an applicant at the time of application;

''(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

''(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

''(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

''(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

''(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

''(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

''(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

''(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

''(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

''(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

''(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

''(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

''(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

''SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

''(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

''(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

''SEC. 2717. ENSURING THE QUALITY OF CARE.

''(a) QUALITY REPORTING.—

''(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

''(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

''(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

''(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

''(D) implement wellness and health promotion activities.

''(2) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

''(B) TIMING OF REPORTS.—A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

''(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website

''(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

''(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

''(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

''(1) Smoking cessation.

''(2) Weight management.

''(3) Stress management.

''(4) Physical fitness.

''(5) Nutrition.

''(6) Heart disease prevention.

''(7) Healthy lifestyle support.

''(8) Diabetes prevention.

''(c) REGULATIONS.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

''(d) STUDY AND REPORT.—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

''SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

''(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends—

''(1) on reimbursement for clinical services provided to enrollees under such coverage;

''(2) for activities that improve health care quality; and

''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

''(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—

''(A) with respect to a health insurance issuer offering coverage in the group market, 20 percent, or such lower percentage as a State may by regulation determine; or

''(B) with respect to a health insurance issuer offering coverage in the individual market, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State.

''(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

''(3) TERMINATION.—The provisions of this subsection shall have no force or effect after December 31, 2013.

''(c) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

''(d) DEFINITIONS.—The Secretary, in consultation with the National Association of Insurance Commissions, shall establish uniform definitions for the activities reported under subsection (a).

"SEC. 2719. APPEALS PROCESS.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

''(1) have in effect an internal claims appeal process;

''(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes;

''(3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and

''(4) provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans.''.

SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

"SEC. 2793. HEALTH INSURANCE CONSUMER INFORMATION.

''(a) IN GENERAL.—The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

''(1) offices of health insurance consumer assistance; or

''(2) health insurance ombudsman programs.

''(b) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

''(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

''(c) DUTIES.—The office of health insurance consumer assistance or health insurance ombudsman shall—

''(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

''(2) collect, track, and quantify problems and inquiries encountered by consumers;

''(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

''(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

''(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

''(d) DATA COLLECTION.—As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

''(e) FUNDING.—

''(1) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

''(2) AUTHORIZATION FOR SUBSEQUENT YEARS.—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.''.

SEC. 1003. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

"SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

''(a) INITIAL PREMIUM REVIEW PROCESS.—

''(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

''(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

''(b) CONTINUING PREMIUM REVIEW PROCESS.—

''(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

''(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

''(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

''(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

''(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

''(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

''(c) GRANTS IN SUPPORT OF PROCESS.—

''(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

''(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and

''(B) in providing information and recommendations to the Secretary under subsection (b)(1).

''(2) FUNDING.—

''(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

''(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

''(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

''(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

''(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.''.

SEC. 1004. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.

(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) ADMINISTRATION.—

(1) IN GENERAL.—The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) ELIGIBLE ENTITIES.—To be eligible for a contract under paragraph (1), an entity shall—

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) QUALIFIED HIGH RISK POOL.—

(1) IN GENERAL.—Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) REQUIREMENTS.—A qualified high risk pool meets the requirements of this paragraph if such pool—

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage—

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall—

(i) except as provided in clause (ii), vary only as provided for under section 2701 of the Public Health Service Act (as amended by this Act and notwithstanding the date on which such amendments take effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) ELIGIBLE INDIVIDUAL.—An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411);

(2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) PROTECTION AGAINST DUMPING RISK BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) SANCTIONS.—An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan—

(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)—

(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or

(II) the prior coverage is a policy for which duration of coverage form issue or health status are factors that can be considered in determining premiums at renewal.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) OVERSIGHT.—The Secretary shall establish—

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

(g) FUNDING; TERMINATION OF AUTHORITY.—

(1) IN GENERAL.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

(2) INSUFFICIENT FUNDS.—If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.

(3) TERMINATION OF AUTHORITY.—

(A) IN GENERAL.—Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(B) TRANSITION TO EXCHANGE.—The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) LIMITATIONS.—The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

SEC. 1102. REINSURANCE FOR EARLY RETIREES.

(a) ADMINISTRATION.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014.

(2) REFERENCE.—In this section:

(A) HEALTH BENEFITS.—The term ''health benefits'' means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-funded, or delivered through the purchase of insurance or otherwise.

(B) EMPLOYMENT-BASED PLAN.—The term ''employment-based plan'' means a group health benefits plan that—

(i) is—

(I) maintained by one or more current or former employers (including without limitation any State or local government or political subdivision thereof), employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and

(ii) provides health benefits to early retirees.

(C) EARLY RETIREES.—The term ''early retirees'' means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act, and who are not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.

(b) PARTICIPATION.—

(1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—A participating employment-based plan is an employment-based plan that—

(A) meets the requirements of paragraph (2) with respect to health benefits provided under the plan; and

(B) submits to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(2) EMPLOYMENT-BASED HEALTH BENEFITS.—An employment-based plan meets the requirements of this paragraph if the plan—

(A) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;

(B) provides documentation of the actual cost of medical claims involved; and

(C) is certified by the Secretary.

(c) PAYMENTS.—

(1) SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—A participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

(B) BASIS FOR CLAIMS.—Claims submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating

employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceed $15,000, subject to the limits contained in paragraph (3).

(3) LIMIT.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved.

(4) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such entities.

(5) PAYMENTS NOT TREATED AS INCOME.—Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

(6) APPEALS.—The Secretary shall establish—

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under the program.

(d) AUDITS.—The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that such plans are in compliance with the requirements of this section.

(e) FUNDING.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to carry out the program under this section. Such funds shall be available without fiscal year limitation.

(f) LIMITATION.—The Secretary has the authority to stop taking applications for participation in the program based on the availability of funding under subsection (e).

SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.

(a) INTERNET PORTAL TO AFFORDABLE COVERAGE OPTIONS.—

(1) IMMEDIATE ESTABLISHMENT.—Not later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State.

(2) CONNECTING TO AFFORDABLE COVERAGE.—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

(i) a single disease or condition; or

(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary);

(B) Medicaid coverage under title XIX of the Social Security Act.

(C) Coverage under title XXI of the Social Security Act.

(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

(E) Coverage under a high risk pool under section 1101.

(b) ENHANCING COMPARATIVE PURCHASING OPTIONS.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.

(2) USE OF FORMAT.—The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).

(c) AUTHORITY TO CONTRACT.—The Secretary may carry out this section through contracts entered into with qualified entities.

SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.

(a) PURPOSE OF ADMINISTRATIVE SIMPLIFICATION.—Section 261 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d note) is amended—

(1) by inserting ''uniform'' before ''standards''; and

(2) by inserting ''and to reduce the clerical burden on patients, health care providers, and health plans'' before the period at the end.

(b) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

''(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.''.

(2) TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

''(J) Electronic funds transfers.'';

(B) in subsection (a), by adding at the end the following new paragraph:

''(4) REQUIREMENTS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

''(A) IN GENERAL.—The standards and associated operating rules adopted by the Secretary shall—

''(i) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care;

''(ii) be comprehensive, requiring minimal augmentation by paper or other communications;

''(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

''(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

''(B) REDUCTION OF CLERICAL BURDEN.—In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.''; and

(C) by adding at the end the following new subsections:

''(g) OPERATING RULES.—

''(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

''(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:

''(A) The entity focuses its mission on administrative simplification.

''(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

''(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

''(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

''(E) The entity allows for public review and updates of the operating rules.

''(3) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—

''(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);

''(B) review the operating rules developed and recommended by such nonprofit entity;

''(C) determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

''(D) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and

''(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

''(4) IMPLEMENTATION.—

''(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.

''(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—

''(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

''(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall—

''(I) allow for automated reconciliation of the electronic payment with the remittance advice; and

''(II) be adopted not later than July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.

''(iii) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions shall be adopted not later than July 1, 2014, in a manner ensuring that such operating rules are effective not later than January 1, 2016.

''(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

''(h) COMPLIANCE.—

''(1) HEALTH PLAN CERTIFICATION.—

''(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and associated operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

''(B) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIMS ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

''(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

''(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

''(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

''(3) SERVICE CONTRACTS.—A health plan shall be required to ensure that any entities that provide services pursuant to a contract with such health plan shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection.

''(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may designate independent, outside entities to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.

''(5) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—

''(A) IN GENERAL.—A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that—

''(i) amends any standard or operating rule described under paragraph (1) of this subsection; or

''(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

''(B) DATE OF COMPLIANCE.—A health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule.

''(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (i)(5).

''(i) REVIEW AND AMENDMENT OF STANDARDS AND OPERATING RULES.—

''(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

''(2) EVALUATIONS AND REPORTS.—

''(A) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the adopted standards and operating rules established under this section.

''(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and operating rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

''(3) INTERIM FINAL RULEMAKING.—

''(A) IN GENERAL.—Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

''(B) PUBLIC COMMENT.—

''(i) PUBLIC COMMENT PERIOD.—The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

''(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

''(4) REVIEW COMMITTEE.—

''(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee chartered by or within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

''(i) the National Committee on Vital and Health Statistics; or

''(ii) any appropriate committee as determined by the Secretary.

''(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

''(5) OPERATING RULES FOR OTHER STANDARDS ADOPTED BY THE SECRETARY.—The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).

''(j) PENALTIES.—

''(1) PENALTY FEE.—

''(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health

plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with—

''(i) the standards and associated operating rules described under paragraph (1) of such subsection; and

''(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

''(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

''(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

''(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

''(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

''(i) an amount equal to $20 per covered life under such plan; or

''(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

''(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

''(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

''(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

''(4) COLLECTION OF PENALTY FEE.—

''(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

''(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

''(C) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

''(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

''(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6621 of the Internal Revenue Code of 1986; and

''(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

''(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.''.

(c) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(3) HEALTH CLAIMS ATTACHMENTS.—The Secretary shall promulgate a final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d-2(a)(2)(B))) that is consistent with the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016.

(d) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking the ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.''.

SEC. 1105. EFFECTIVE DATE.

This subtitle shall take effect on the date of enactment of this Act.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

''Subpart I—General Reform'';

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

''SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.''; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg–1)—

(i) by striking the section heading and all that follows through subsection (a);

(ii) in subsection (b)—

(I) by striking ''health insurance issuer offering health insurance coverage in connection with a group health plan'' each place that such appears and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(II) in paragraph (2)(A)—

(aa) by inserting ''or individual'' after ''employer''; and

(bb) by inserting ''or individual health coverage, as the case may be'' before the semicolon; and

(iii) in subsection (e)—

(I) by striking ''(a)(1)(F)'' and inserting ''(a)(6)'';

(II) by striking ''2701'' and inserting ''2704''; and

(III) by striking ''2721(a)'' and inserting ''2735(a)''; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

''SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

''(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

''(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

''(A) such rate shall vary with respect to the particular plan or coverage involved only by—

''(i) whether such plan or coverage covers an individual or family;

''(ii) rating area, as established in accordance with paragraph (2);

''(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

''(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

''(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

''(2) RATING AREA.—

''(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State

for purposes of applying the requirements of this title.

''(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

''(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

''(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

''(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market in the State.

''SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

''(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

''(b) ENROLLMENT.—

''(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

''(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

''(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

''SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

''(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

''SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

''(1) Health status.

''(2) Medical condition (including both physical and mental illnesses).

''(3) Claims experience.

''(4) Receipt of health care.

''(5) Medical history.

''(6) Genetic information.

''(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

''(8) Disability.

''(9) Any other health status-related factor determined appropriate by the Secretary.

''(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

''(1) GENERAL PROVISIONS.—

''(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

''(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

''(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

''(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

''(A) A program that reimburses all or part of the cost for memberships in a fitness center.

''(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

''(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

''(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

''(E) A program that provides a reward to individuals for attending a periodic health education seminar.

''(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

''(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

''(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

''(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

''(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

''(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

''(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

''(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

''(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

''(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise

applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

''(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

''(l) WELLNESS PROGRAM DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

''(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

''(3) REQUIREMENTS.—

''(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

''(i) will not result in any decrease in coverage; and

''(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

''(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

''(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

''(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

''(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

''(I) do not create undue burdens for individuals insured in the individual market;

''(II) do not lead to cost shifting; and

''(III) are not a subterfuge for discrimination;

''(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note); and

''(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

''(m) REPORT.—

''(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

''(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

''(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

''(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

''(D) the effectiveness of different types of rewards.

''(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

''(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

''SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

''(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

''(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

''SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

''(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

''(b) COST-SHARING UNDER GROUP HEALTH PLANS.—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

''(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

''(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

''SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.''.

PART II—OTHER PROVISIONS

SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.

(a) NO CHANGES TO EXISTING COVERAGE.—

(1) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) CONTINUATION OF COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) DEFINITION.—In this title, the term ''grandfathered health plan'' means any group health plan or health insurance coverage to which this section applies.

SEC. 1252. RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such

amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d).

SEC. 1253. EFFECTIVE DATES.

This subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after January 1, 2014.

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

(a) QUALIFIED HEALTH PLAN.—In this title:

(1) IN GENERAL.—The term ''qualified health plan'' means a health plan that—

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322 or a community health insurance option under section 1323, unless specifically provided for otherwise.

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term ''health plan'' means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term ''health plan'' shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms ''health insurance coverage'' and ''health insurance issuer'' have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term ''essential health benefits package'' means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an

amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.—

(A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

(i) $2,000 in the case of a plan covering a single individual; and

(ii) $4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) INDEXING OF LIMITS.—In the case of any plan year beginning in a calendar year after 2014—

(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(C) ACTUARIAL VALUE.—The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) COORDINATION WITH PREVENTIVE LIMITS.—Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.

(3) COST-SHARING.—In this title—

(A) IN GENERAL.—The term ''cost-sharing'' includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—

(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) EMPLOYER CONTRIBUTIONS.—The Secretary may issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

SEC. 1303. SPECIAL RULES.

(a) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—

(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagraphs (C) and (D)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

(B) ABORTION SERVICES.—

(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(C) PROHIBITION ON FEDERAL FUNDS FOR ABORTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.—

(i) DETERMINATION BY SECRETARY.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—

(I) assures compliance with the requirements of paragraph (2);

(II) assures, in accordance with applicable provisions of generally accepted accounting

requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and

(III) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option's coverage of services described in subparagraph (B)(i).

(ii) STATE REQUIREMENT.—If a State requires, in addition to the essential health benefits required under section 1323(b)(3) (A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State, the State shall assure that no funds flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing coverage of services described in subparagraph (B)(i). The United States shall not bear the insurance risk for a State's required coverage of services described in subparagraph (B)(i).

(iii) EXCEPTIONS.—Nothing in this subparagraph shall apply to coverage of services described in subparagraph (B)(ii) by the community health insurance option. Services described in subparagraph (B)(ii) shall be covered to the same extent as such services are covered under title XIX of the Social Security Act.

(D) ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH EXCHANGES.—

(i) IN GENERAL.—The Secretary shall assure that with respect to qualified health plans offered in any Exchange established pursuant to this title—

(I) there is at least one such plan that provides coverage of services described in clauses (i) and (ii) of subparagraph (B); and

(II) there is at least one such plan that does not provide coverage of services described in subparagraph (B)(i).

(ii) SPECIAL RULES.—For purposes of clause (i)—

(I) a plan shall be treated as described in clause (i)(II) if the plan does not provide coverage of services described in either subparagraph (B)(i) or (B)(ii); and

(II) if a State has one Exchange covering more than 1 insurance market, the Secretary shall meet the requirements of clause (i) separately with respect to each such market.

(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(ii) Any cost-sharing reduction under section 1402 of thePatient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

(B) SEGREGATION OF FUNDS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall, out of amounts not described in subparagraph (A), segregate an amount equal to the actuarial amounts determined under subparagraph (C) for all enrollees from the amounts described in subparagraph (A).

(C) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

(i) IN GENERAL.—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).

(ii) CONSIDERATIONS.—In making such estimate, the Secretary—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than $1 per enrollee, per month.

(3) PROVIDER CONSCIENCE PROTECTIONS.—No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions.

(b) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

(1) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

(A) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(c) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ''EMTALA'').

SEC. 1304. RELATED DEFINITIONS.

(a) DEFINITIONS RELATING TO MARKETS.—In this title:

(1) GROUP MARKET.—The term ''group market'' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) INDIVIDUAL MARKET.—The term ''individual market'' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) LARGE AND SMALL GROUP MARKETS.—The terms ''large group market'' and ''small group market'' mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) EMPLOYERS.—In this title:

(1) LARGE EMPLOYER.—The term ''large employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) SMALL EMPLOYER.—The term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting ''51 employees'' for ''101 employees'' in paragraph (1) and by substituting ''50 employees'' for ''100 employees'' in paragraph (2).

(4) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) CONTINUATION OF PARTICIPATION FOR GROWING SMALL EMPLOYERS.—If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subtitle for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) SECRETARY.—In this title, the term ''Secretary'' means the Secretary of Health and Human Services.

(d) STATE.—In this title, the term ''State'' means each of the 50 States and the District of Columbia.

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not

later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) RENEWABILITY OF GRANT.—

(A) IN GENERAL.—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) LIMITATION.—No grant shall be awarded under this subsection after January 1, 2015.

(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) IN GENERAL.—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an ''Exchange'') for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a ''SHOP Exchange'') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES.—A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) RESPONSIBILITIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) INTERNET PORTALS.—The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.

(5) ENROLLMENT PERIODS.—The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

(d) REQUIREMENTS.—

(1) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) OFFERING OF COVERAGE.—

(A) IN GENERAL.—An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) LIMITATION.—

(i) IN GENERAL.—An Exchange may not make available any health plan that is not a qualified health plan.

(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).

(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—

(i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).

(ii) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).

(4) FUNCTIONS.—An Exchange shall, at a minimum—

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because—

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury—

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) FUNDING LIMITATIONS.—

(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) PROHIBITING WASTEFUL USE OF FUNDS.—In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) CONSULTATION.—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

(A) health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) PUBLICATION OF COSTS.—An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) CERTIFICATION.—

(1) IN GENERAL.—An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) PREMIUM CONSIDERATIONS.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(f) FLEXIBILITY.—

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) SUBSIDIARY EXCHANGES.—A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT.—

(A) IN GENERAL.—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) ELIGIBLE ENTITY.—In this paragraph, the term ''eligible entity'' means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act.

(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—

(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) the implementation of wellness and health promotion activities.

(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) QUALITY IMPROVEMENT.—

(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2015, a qualified health plan may contract with—

(A) a hospital with greater than 50 beds only if such hospital—

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive

program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) EXCEPTIONS.—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) ADJUSTMENT.—The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) NAVIGATORS.—

(1) IN GENERAL.—An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) ELIGIBILITY.—

(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) TYPES.—Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that—

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) DUTIES.—An entity that serves as a navigator under a grant under this subsection shall—

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) FUNDING.—Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) APPLICABILITY OF MENTAL HEALTH PARITY.—Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) CONFLICT.—An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

SEC. 1312. CONSUMER CHOICE.

(a) CHOICE.—

(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.

(2) QUALIFIED EMPLOYERS.—

(A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) SINGLE RISK POOL.—

(1) INDIVIDUAL MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) SMALL GROUP MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) MERGER OF MARKETS.—A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) STATE LAW.—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) EMPOWERING CONSUMER CHOICE.—

(1) CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.—Nothing in this title shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) VOLUNTARY NATURE OF AN EXCHANGE.—

(A) CHOICE TO ENROLL OR NOT TO ENROLL.—Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) PROHIBITION AGAINST COMPELLED ENROLLMENT.—Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) MEMBERS OF CONGRESS IN THE EXCHANGE.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) DEFINITIONS.—In this section:

(I) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.

(II) CONGRESSIONAL STAFF.—The term ''congressional staff'' means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) ENROLLMENT THROUGH AGENTS OR BROKERS.—The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

(f) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—

(1) QUALIFIED INDIVIDUALS.—In this title:

(A) IN GENERAL.—The term ''qualified individual'' means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) QUALIFIED EMPLOYER.—In this title:

(A) IN GENERAL.—The term ''qualified employer'' means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) EXTENSION TO LARGE GROUPS.—

(i) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) LARGE EMPLOYERS ELIGIBLE.—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term ''qualified employer'' shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—

(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) AUDITS.—An Exchange shall be subject to annual audits by the Secretary.

(4) PATTERN OF ABUSE.—If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

(B) the Secretary has authority to implement under this title or any other Act.

(6) APPLICATION OF THE FALSE CLAIMS ACT.—

(A) IN GENERAL.—Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

(B) DAMAGES.—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(b) GAO OVERSIGHT.—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—

(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;

(2) any significant observations regarding the utilization and adoption of Exchanges;

(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges; and

(4) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part V; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) CONSULTATION.—In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) STATE ACTION.—Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—

(1) IN GENERAL.—If—

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) ENFORCEMENT AUTHORITY.—The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—

(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) PURPOSE.—It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) LOANS AND GRANTS UNDER THE CO-OP PROGRAM.—

(1) IN GENERAL.—The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) REQUIREMENTS FOR AWARDING LOANS AND GRANTS.—

(A) IN GENERAL.—In awarding loans and grants under the CO-OP program, the Secretary shall—

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) STATES WITHOUT ISSUERS IN PROGRAM.—If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) AGREEMENT.—

(i) IN GENERAL.—The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—

(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) RESTRICTIONS ON USE OF FEDERAL FUNDS.—The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.

(D) TIME FOR AWARDING LOANS AND GRANTS.—The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) ADVISORY BOARD.—

(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) RULES RELATING TO APPOINTMENTS.—

(i) STANDARDS.—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) ORIGINAL APPOINTMENTS.—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.

(C) VACANCY.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) PAY AND REIMBURSEMENT.—

(i) NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.—Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) TERMINATION.—The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(c) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—

(1) IN GENERAL.—The term ''qualified nonprofit health insurance issuer'' means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation;

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) CERTAIN ORGANIZATIONS PROHIBITED.—An organization shall not be treated as a qualified nonprofit health insurance issuer if—

(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

(3) GOVERNANCE REQUIREMENTS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless—

(A) the governance of the organization is subject to a majority vote of its members;

(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(4) PROFITS INURE TO BENEFIT OF MEMBERS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

(5) COMPLIANCE WITH STATE INSURANCE LAWS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b).

(6) COORDINATION WITH STATE INSURANCE REFORMS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).

(d) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—

(1) IN GENERAL.—Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) COUNCIL MAY NOT SET PAYMENT RATES.—The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) CONTINUED APPLICATION OF ANTITRUST LAWS.—

(A) IN GENERAL.—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) ANTITRUST LAWS.—For purposes of this subparagraph, the term ''antitrust laws'' has

the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(e) LIMITATION ON PARTICIPATION.—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) LIMITATIONS ON SECRETARY.—

(1) IN GENERAL.—The Secretary shall not—

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) COMPETITION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) APPROPRIATIONS.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.

(h) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—

(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

''(29) CO-OP HEALTH INSURANCE ISSUERS.—

''(A) IN GENERAL.—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

''(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—

''(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

''(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

''(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

''(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.''.

(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

''(m) ADDITIONAL INFORMATION REQUIRED FROM CO-OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

''(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

''(2) The amount of reserves on hand.''.

(3) APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking ''paragraph (3) or (4)'' and inserting ''paragraph (3), (4), or (29)''.

(i) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.

(a) VOLUNTARY NATURE.—

(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non-participation.

(2) NO REQUIREMENT FOR INDIVIDUALS TO JOIN.—Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non-participation.

(3) STATE OPT OUT.—

(A) IN GENERAL.—A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title (other than Exchanges in States that elect to opt out as provided for in subsection (a)(3)), health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.

(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term ''community health insurance option'' means health insurance coverage that—

(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;

(B) provides high value for the premium charged;

(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

(D) promotes high quality clinical care;

(E) provides high quality customer service to beneficiaries;

(F) offers a sufficient choice of providers; and

(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).

(3) ESSENTIAL HEALTH BENEFITS.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).

(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.

(C) CREDITS.—

(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner as an individual who is enrolled in a qualified health plan.

(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).

(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.

(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

(4) COST SHARING.—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).

(5) PREMIUMS.—

(A) PREMIUMS SUFFICIENT TO COVER COSTS.—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.

(B) APPLICABLE RULES.—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) NATIONAL POOLING.—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the

Secretary shall include an appropriate amount for a contingency margin.

(6) REIMBURSEMENT RATES.—

(A) NEGOTIATED RATES.—The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option.

(B) LIMITATION.—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Exchange.

(C) INNOVATION.—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (d) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.

(7) SOLVENCY AND CONSUMER PROTECTION.—

(A) SOLVENCY.—The Secretary shall establish a Federal solvency standard to be applied with respect to a community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.

(B) MINIMUM REQUIRED.—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.

(C) CONSUMER PROTECTIONS.—The consumer protection laws of a State shall apply to a community health insurance option.

(8) REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS.—

(A) IN GENERAL.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the ''NAIC''), may promulgate regulations to establish additional requirements for a community health insurance option.

(B) APPLICABILITY.—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.

(c) START-UP FUND.—

(1) ESTABLISHMENT OF FUND.—

(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the ''Health Benefit Plan Start-Up Fund'' (referred to in this section as the ''Start-Up Fund''), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.

(B) FUNDING.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—

(i) pay the start-up costs associated with the initial operations of a community health insurance option; and

(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered.

(2) USE OF START-UP FUND.—The Secretary shall use amounts contained in the Start-Up Fund to make payments (subject to the repayment requirements in paragraph (4)) for the purposes described in paragraph (1)(B).

(3) PASS THROUGH OF REBATES.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

(4) REPAYMENT.—

(A) IN GENERAL.—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 9 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repayments at rates that do not exceed the market interest rate (as determined by the Secretary).

(B) SANCTIONS IN CASE OF FOR-PROFIT CONVERSION.—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health insurance option and such entity is determined to be a for-profit entity by the Secretary, such entity shall be—

(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and

(ii) permanently ineligible to offer a qualified health plan.

(d) STATE ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—A State (other than a State that elects to opt out as provided for in subsection (a)(3)) shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:

(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and

(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.

(3) APPLICABILITY OF RECOMMENDATIONS.—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.

(e) AUTHORITY TO CONTRACT; TERMS OF CONTRACT.—

(1) AUTHORITY.—

(A) IN GENERAL.—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to a community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.

(B) REQUIREMENTS APPLY.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—

(i) shall meet the criteria established under paragraph (2); and

(ii) shall receive an administrative fee under paragraph (7).

(C) LIMITATION.—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.

(D) REFERENCE.—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a ''contracting administrator''.

(2) QUALIFIED ENTITY.—To be qualified to be selected by the Secretary to offer a community health insurance option, an entity shall—

(A) meet the criteria established under section 1874A(a)(2) of the Social Security Act;

(B) be a nonprofit entity for purposes of offering such option;

(C) meet the solvency standards applicable under subsection (b)(7);

(D) be eligible to offer health insurance or health benefits coverage;

(E) meet quality standards specified by the Secretary;

(F) have in place effective procedures to control fraud, abuse, and waste; and

(G) meet such other requirements as the Secretary may impose.

Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.

(3) TERM.—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph.

(4) LIMITATION.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).

(5) AUDITS.—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) REVOCATION.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.

(7) FEE FOR ADMINISTRATION.—

(A) IN GENERAL.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.—The Secretary may increase the fee described in subparagraph (A) by not

more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) NON-RENEWAL.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.

(8) LIMITATION.—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subsection (b)(6).

(f) REPORT BY HHS AND INSOLVENCY WARNINGS.—

(1) IN GENERAL.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(2) RESULT.—If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.

(3) SUBMISSION OF PLAN AND PROCEDURE.—

(A) IN GENERAL.—If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.

(B) PROCEDURE.—In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a medicare funding warning.

(g) MARKETING PARITY.—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

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

SEC. 1324. LEVEL PLAYING FIELD.

(a) IN GENERAL.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(b) LAWS DESCRIBED.—The Federal and State laws described in this subsection are those Federal and State laws relating to—

(1) guaranteed renewal;

(2) rating;

(3) preexisting conditions;

(4) non-discrimination;

(5) quality improvement and reporting;

(6) fraud and abuse;

(7) solvency and financial requirements;

(8) market conduct;

(9) prompt payment;

(10) appeals and grievances;

(11) privacy and confidentiality;

(12) licensure; and

(13) benefit plan material or information.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.

(b) STANDARD HEALTH PLAN.—In this section, the term ''standard heath plan'' means a health benefits plan that the State contracts with under this section—

(1) under which the only individuals eligible to enroll are eligible individuals;

(2) that provides at least the essential health benefits described in section 1302(b); and

(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(c) CONTRACTING PROCESS.—

(1) IN GENERAL.—A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).

(2) SPECIFIC ITEMS TO BE CONSIDERED.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) INNOVATION.—Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—

(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

(ii) incentives for use of preventive services; and

(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.

(B) HEALTH AND RESOURCE DIFFERENCES.—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.

(C) MANAGED CARE.—Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

(D) PERFORMANCE MEASURES.—Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

(3) ENHANCED AVAILABILITY.—

(A) MULTIPLE PLANS.—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(4) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

(d) TRANSFER OF FUNDS TO STATES.—

(1) IN GENERAL.—If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard

health plans are operating within the State the amount determined under paragraph (3).

(2) USE OF FUNDS.—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

(3) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle.

(ii) SPECIFIC REQUIREMENTS.—The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.

(iii) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(B) CORRECTIONS.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

(4) APPLICATION OF SPECIAL RULES.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) ELIGIBLE INDIVIDUAL.—

(1) IN GENERAL.—In this section, the term ''eligible individual'' means, with respect to any State, an individual—

(A) who a resident of the State who is not eligible to enroll in the State's medicaid program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such Code); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.—An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

(f) SECRETARIAL OVERSIGHT.—The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

(1) eligibility verification requirements for participation in the program;

(2) the requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

(g) STANDARD HEALTH PLAN OFFERORS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.

(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term ''Secretary'' means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) GRANTING OF WAIVERS.—

(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—

(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—

(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

(a) HEALTH CARE CHOICE COMPACTS.—

(1) IN GENERAL.—Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(2) STATE AUTHORITY.—A State may not enter into an agreement under this subsection unless the State enacts a law after the date of the enactment of this title that specifically authorizes the State to enter into such agreements.

(3) APPROVAL OF COMPACTS.—The Secretary may approve interstate health care choice compacts under paragraph (1) only if the Secretary determines that such health care choice compact—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;

(D) will not increase the Federal deficit; and

(E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.

(4) EFFECTIVE DATE.—A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.

(b) AUTHORITY FOR NATIONWIDE PLANS.—

(1) IN GENERAL.—Except as provided in paragraph (2), if an issuer (including a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark) of a qualified health plan in the individual or small group market meets the requirements of this subsection (in this subsection a ''nationwide qualified health plan'')—

(A) the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than 1 State; and

(B) with respect to State laws mandating benefit coverage by a health plan, only the State laws of the State in which such plan is written or issued shall apply to the nationwide qualified health plan.

(2) STATE OPT-OUT.—A State may, by specific reference in a law enacted after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.

(3) PLAN REQUIREMENTS.—An issuer meets the requirements of this subsection with respect to a nationwide qualified health plan if, in the determination of the Secretary—

(A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraphs (4) through (6);

(B) the issuer is licensed in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to, the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;

(C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver and gold levels of the plan in each Exchange in the State for the market in which the plan is offered;

(D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;

(E) the issuer offers the nationwide qualified health plan in at least 60 percent of the participating States in the first year in which the plan is offered, 65 percent of such States in the second year, 70 percent of such States in the third year, 75 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;

(F) the issuer shall offer the plan in participating States across the country, in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act; and

(G) the issuer clearly notifies consumers that the policy may not contain some benefits otherwise mandated for plans in the State in which the purchaser resides and provides a detailed statement of the benefits offered and the benefit differences in that State, in accordance with rules promulgated by the Secretary.

(4) FORM REVIEW FOR NATIONWIDE PLANS.—Notwithstanding any contrary provision of State law, at least 3 months before any nationwide qualified health plan is offered, the issuer shall file all nationwide qualified health plan forms with the regulator in each participating State in which the plan will be offered. An issuer may appeal the disapproval of a nationwide qualified health plan form to the Secretary.

(5) APPLICABLE RULES.—The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue rules for the offering of nationwide qualified health plans under this subsection. Nationwide qualified health plans may be offered only after such rules have taken effect.

(6) COVERAGE.—The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include at least the essential benefits package described in section 1302.

(7) STATE LAW MANDATING BENEFIT COVERAGE BY A HEALTH BENEFITS PLAN.—For the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific health services or specific diseases. A law that mandates health insurance coverage or reimbursement for services

provided by certain classes of providers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

PART V—REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.

(a) IN GENERAL.—Each State shall, not later than January 1, 2014—

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) MODEL REGULATION.—

(1) IN GENERAL.—In establishing the Federal standards under section 1321(a), the Secretary, in consultation with the National Association of Insurance Commissioners (the ''NAIC''), shall include provisions that enable States to establish and maintain a program under which—

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3); and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

(2) HIGH-RISK INDIVIDUAL; PAYMENT AMOUNTS.—The Secretary shall include the following in the provisions under paragraph (1):

(A) DETERMINATION OF HIGH-RISK INDIVIDUALS.—The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) PAYMENT AMOUNT.—The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(A) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed—

(i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or

(ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

(3) DETERMINATION OF REQUIRED CONTRIBUTIONS.—

(A) IN GENERAL.—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) SPECIFIC REQUIREMENTS.—The method under this paragraph shall be designed so that—

(i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;

(iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning 2015, and $4,000,000,000 for plan years beginning in 2016; and

(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional $2,000,000,000 for 2014, an additional $2,000,000,000 for 2015, and an additional $1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis.

(4) EXPENDITURE OF FUNDS.—The provisions under paragraph (1) shall provide that—

(A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

(B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

(c) APPLICABLE REINSURANCE ENTITY.—For purposes of this section—

(1) IN GENERAL.—The term ''applicable reinsurance entity'' means a not-for-profit organization—

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) STATE DISCRETION.—A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) ENTITIES ARE TAX-EXEMPT.—An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (relating to tax on unrelated business taxable income of an exempt organization).

(d) COORDINATION WITH STATE HIGH-RISK POOLS.—The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) DEFINITIONS.—In this section:

(1) ALLOWABLE COSTS.—

(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs

shall reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.

(2) TARGET AMOUNT.—The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

SEC. 1343. RISK ADJUSTMENT.

(a) IN GENERAL.—

(1) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(2) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) CRITERIA AND METHODS.—The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 1321.

(c) SCOPE.—A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost-sharing Reductions

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

"SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

''(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

''(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

''(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

''(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

''(B) the excess (if any) of—

''(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

''(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

''(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

''(A) APPLICABLE PERCENTAGE.—

''(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to 2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as—

''(I) the taxpayer's household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, bears to

''(II) an amount equal to 200 percent of the poverty line for a family of the size involved.

''(ii) SPECIAL RULE FOR TAXPAYERS UNDER 133 PERCENT OF POVERTY LINE.—If a taxpayer's household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer's applicable percentage shall be 2 percent.

''(iii) INDEXING.—In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

''(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

''(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

''(ii) provides—

''(I) self-only coverage in the case of an applicable taxpayer—

''(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

''(bb) who is not described in item (aa) but who purchases only self-only coverage, and

''(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

''(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

''(D) ADDITIONAL BENEFITS.—If—

''(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

''(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

''(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

''(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

''(1) APPLICABLE TAXPAYER.—

''(A) IN GENERAL.—The term 'applicable taxpayer' means, with respect to any taxable year, a taxpayer whose household income for the taxable year exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

''(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

''(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

''(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX

of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

''(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

''(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(2) COVERAGE MONTH.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'coverage month' means, with respect to an applicable taxpayer, any month if—

''(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

''(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

''(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

''(i) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

''(ii) MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' has the meaning given such term by section 5000A(f).

''(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

''(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

''(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

''(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.8 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

''(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

''(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

''(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.8 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

''(3) DEFINITIONS AND OTHER RULES.—

''(A) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

''(B) GRANDFATHERED HEALTH PLAN.—The term 'grandfathered health plan' has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

''(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

''(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

''(2) HOUSEHOLD INCOME.—

''(A) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—

''(i) the modified gross income of the taxpayer, plus

''(ii) the aggregate modified gross incomes of all other individuals who—

''(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

''(II) were required to file a return of tax imposed by section 1 for the taxable year.

''(B) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

''(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

''(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

''(iii) determined without regard to sections 911, 931, and 933.

''(3) POVERTY LINE.—

''(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

''(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

''(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

''(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

''(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

''(i) A method under which—

''(I) the taxpayer's family size is determined by not taking such individuals into account, and

''(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

''(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

''(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

''(ii) A comparable method reaching the same result as the method under clause (i).

''(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

''(3) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

''(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

''(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

''(2) EXCESS ADVANCE PAYMENTS.—

''(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

''(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—

''(i) IN GENERAL.—In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed $400 ($250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

''(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

''(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

''(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.''.

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.''.

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term ''appropriate committees of Congress'' means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''36B,'' after ''36A,''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

''Sec. 36B. Refundable credit for coverage under a qualified health plan.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—

(1) the Secretary shall notify the issuer of the plan of such eligibility; and

(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

(b) ELIGIBLE INSURED.—In this section, the term ''eligible insured'' means an individual—

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) DETERMINATION OF REDUCTION IN COST-SHARING.—

(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

(A) IN GENERAL.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit under section 1302(c)(1) in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—

(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

(I) 90 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and

(III) 70 percent in the case of an eligible insured described in clause (ii) or (iii) of subparagraph (A).

(ii) ADJUSTMENT.—The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSUREDS.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.

(3) METHODS FOR REDUCING COST-SHARING.—

(A) IN GENERAL.—An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) CAPITATED PAYMENTS.—The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) ADDITIONAL BENEFITS.—If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(d) SPECIAL RULES FOR INDIANS.—

(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If an individual who is an eligible insured is not lawfully present—

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a

taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) SECRETARIAL AUTHORITY.—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) DEFINITIONS AND SPECIAL RULES.—In this section:

(1) IN GENERAL.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

(2) LIMITATIONS ON REDUCTION.—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.

(3) DATA USED FOR ELIGIBILITY.—Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

Subpart B—Eligibility Determinations

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING , AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an ''enrollee''); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:

(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) CITIZENSHIP OR IMMIGRATION STATUS.—

(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) INFORMATION.—The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) METHODS.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) SPECIFIC ACTIONS NOT INVOLVING CITIZENSHIP OR LAWFUL PRESENCE.—

(i) IN GENERAL.—Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) ELIGIBILITY OR AMOUNT OF CREDIT OR REDUCTION.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) EMPLOYER AFFORDABILITY.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of such Code.

(iv) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(C) APPEALS PROCESS.—The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) APPEALS AND REDETERMINATIONS.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) EMPLOYER LIABILITY.—

(A) IN GENERAL.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) CONFIDENTIALITY.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—

(1) IN GENERAL.—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) RECEIPT OF INFORMATION.—Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) PENALTIES.—

(1) FALSE OR FRAUDULENT INFORMATION.—

(A) CIVIL PENALTY.—

(i) IN GENERAL.—If—

(I) any person fails to provides correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms ''negligence'' and ''disregard'' shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) KNOWING AND WILLFUL VIOLATIONS.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $250,000.

(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(3) LIMITATIONS ON LIENS AND LEVIES.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) REPORT.—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

(1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;

(2) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the name and employer identification number of each employer with respect to whom 1 or more employee of the employer were determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because—

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.

(b) ADVANCE DETERMINATIONS.—

(1) IN GENERAL.—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—

(A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and

(B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.

(2) CHANGES IN CIRCUMSTANCES.—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) PREMIUM TAX CREDIT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) ISSUER RESPONSIBILITIES.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) COST-SHARING REDUCTIONS.—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) STATE FLEXIBILITY.—Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a

determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State medicaid plan under title XIX, or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act, the individual is enrolled for assistance under such plan or program.

(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who—

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.

(3) DETERMINATION OF ELIGIBILITY.—

(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement.

(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) ADMINISTRATIVE AUTHORITY.—

(1) AGREEMENTS.—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term ''applicable State health subsidy program'' means—

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State medicaid program under title XIX of the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.—

(1) TAXPAYER RETURN INFORMATION.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

''(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),

''(iv) the modified gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year,

''(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and

''(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

''(B) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services may disclose to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).

''(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in—

''(i) establishing eligibility for participation in the Exchange, and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

''(ii) determining eligibility for participation in the State programs described in subparagraph (A).''.

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

''(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection

and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.''.

(b) CONFIDENTIALITY AND DISCLOSURE.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting '', or any entity described in subsection (l)(21),'' after ''or (20)'' in the matter preceding subparagraph (A),

(2) by inserting ''or any entity described in subsection (l)(21),'' after ''or (o)(1)(A)'' in subparagraph (F)(ii), and

(3) by inserting ''or any entity described in subsection (l)(21),'' after ''or (20)'' both places it appears in the matter after subparagraph (F).

(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTION PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

PART II—SMALL BUSINESS TAX CREDIT

SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

''SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

''(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

''(b) HEALTH INSURANCE CREDIT AMOUNT.—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

''(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans offered by the employer to its employees through an Exchange, or

''(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

''(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:

''(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

''(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.

''(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible small employer' means, with respect to any taxable year, an employer—

''(A) which has no more than 25 full-time equivalent employees for the taxable year,

''(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and

''(C) which has in effect an arrangement described in paragraph (4).

''(2) FULL-TIME EQUIVALENT EMPLOYEES.—

''(A) IN GENERAL.—The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing—

''(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

''(ii) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

''(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

''(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

''(3) AVERAGE ANNUAL WAGES.—

''(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—

''(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

''(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

''(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—

''(i) 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $20,000.

''(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

''(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

''(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

''(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

''(B) DEFINITION OF SEASONAL WORKER.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

''(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

''(1) EMPLOYEE.—

''(A) CERTAIN EMPLOYEES EXCLUDED.—The term 'employee' shall not include—

''(i) an employee within the meaning of section 401(c)(1),

''(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

''(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

''(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

''(B) LEASED EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

''(2) CREDIT PERIOD.—The term 'credit period' means, with respect to any eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

''(3) NONELECTIVE CONTRIBUTION.—The term 'nonelective contribution' means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

''(4) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

''(5) AGGREGATION AND OTHER RULES MADE APPLICABLE.—

''(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

''(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.

''(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

''(1) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subpart C (and not allowable under this subpart) the lesser of—

''(A) the amount of the credit determined under this section with respect to such employer, or

''(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

''(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—For purposes of this section, the term 'tax-exempt eligible small employer' means an eligible small employer which is any organization described in section 501(c) which is exempt from taxation under section 501(a).

''(3) PAYROLL TAXES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'payroll taxes' means—

''(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer under section 3401(a),

''(ii) amounts required to be withheld from such employees under section 3101(b), and

''(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

''(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

''(g) APPLICATION OF SECTION FOR CALENDAR YEARS 2011, 2012, AND 2013.—In the case of any taxable year beginning in 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

''(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2013, no credit period shall be treated as beginning with a taxable year beginning before 2014.

''(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—

''(A) by substituting '35 percent (25 percent in the case of a tax-exempt eligible small employer)' for '50 percent (35 percent in the case of a tax-exempt eligible small employer)',

''(B) by reference to an eligible small employer's nonelective contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)) of an employee, and

''(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).

''(3) CONTRIBUTION ARRANGEMENT.—An arrangement shall not fail to meet the requirements of subsection (d)(4) solely because it provides for the offering of insurance outside of an Exchange.

''(h) INSURANCE DEFINITIONS.—Any term used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.

''(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under subsection (c) through the use of multiple entities.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'', and by inserting after paragraph (35) the following:

''(36) the small employer health insurance credit determined under section 45R.''.

(c) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue Code of 1986 (defining specified credits) is amended by redesignating clauses (vi), (vii), and (viii) as clauses (vii), (viii), and (ix), respectively, and by inserting after clause (v) the following new clause:

''(vi) the credit determined under section 45R,''.

(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—

(1) IN GENERAL.—Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed), as amended by section 1401(b), is amended by adding at the end the following new subsection:

''(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.—No deduction shall be allowed for that portion of the premiums for qualified health plans (as defined in section 1301(a) of the Patient Protection and Affordable Care Act), or for health insurance coverage in the case of taxable years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit determined under section 45R(a) with respect to the premiums.''.

(2) DEDUCTION FOR EXPIRING CREDITS.—Section 196(c) of such Code is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', and'', and by adding at the end the following new paragraph:

''(14) the small employer health insurance credit determined under section 45R(a).''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 45R. Employee health insurance expenses of small employers.''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.

(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the ''requirement'') is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.

(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(H) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential

to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

''Sec. 5000A. Requirement to maintain minimum essential coverage.

"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

''(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

''(b) SHARED RESPONSIBILITY PAYMENT.—

''(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

''(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

''(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

''(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

''(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

''(c) AMOUNT OF PENALTY.—

''(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to 1⁄12 of the applicable dollar amount for the calendar year.

''(2) DOLLAR LIMITATION.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

''(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $750.

''(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

''(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

''(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

''(i) $750, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

''(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

''(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

''(i) the modified gross income of the taxpayer, plus

''(ii) the aggregate modified gross incomes of all other individuals who—

''(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

''(II) were required to file a return of tax imposed by section 1 for the taxable year.

''(C) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

''(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

''(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

''(iii) determined without regard to sections 911, 931, and 933.

''(D) POVERTY LINE.—

''(i) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

''(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

''(2) RELIGIOUS EXEMPTIONS.—

''(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

''(B) HEALTH CARE SHARING MINISTRY.—

''(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

''(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

''(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

''(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

''(III) members of which retain membership even after they develop a medical condition,

''(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

''(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

''(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

''(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

''(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

''(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

''(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

''(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

''(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

''(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

''(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall

be made by reference to the affordability of the coverage to the employee.

''(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

''(2) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

''(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

''(4) MONTHS DURING SHORT COVERAGE GAPS.—

''(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

''(B) SPECIAL RULES.—For purposes of applying this paragraph—

''(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

''(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

''(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

''(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

''(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

''(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

''(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

''(i) the Medicare program under part A of title XVIII of the Social Security Act,

''(ii) the Medicaid program under title XIX of the Social Security Act,

''(iii) the CHIP program under title XXI of the Social Security Act,

''(iv) the TRICARE for Life program,

''(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

''(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

''(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

''(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

''(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

''(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

''(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

''(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

''(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

''(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

''(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

''(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

''(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

''(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

''(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

''(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

''(g) ADMINISTRATION AND PROCEDURE.—

''(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

''(2) SPECIAL RULES.—Notwithstanding any other provision of law—

''(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

''(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

''(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

''(ii) levy on any such property with respect to such failure.''.

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

''CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:

"Subpart D—Information Regarding Health Insurance Coverage

''Sec. 6055. Reporting of health insurance coverage.

"SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

''(b) FORM AND MANNER OF RETURN.—

''(1) IN GENERAL.—A return is described in this subsection if such return—

''(A) is in such form as the Secretary may prescribe, and

''(B) contains—

''(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy,

''(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,

''(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—

''(I) whether or not the coverage is a qualified health plan offered through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act, and

''(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

''(iv) such other information as the Secretary may require.

''(2) INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

''(A) the name, address, and employer identification number of the employer maintaining the plan,

''(B) the portion of the premium (if any) required to be paid by the employer, and

''(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

''(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(B) the information required to be shown on the return with respect to such individual.

''(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

''(e) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section, the term 'minimum essential coverage' has the meaning given such term by section 5000A(f).''.

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking ''or'' at the end of clause (xxii), by striking ''and'' at the end of clause (xxiii) and inserting ''or'', and by inserting after clause (xxiii) the following new clause:

''(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and''.

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting '', or'' and by inserting after subparagraph (FF) the following new subparagraph:

''(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).''.

(c) NOTIFICATION OF NONENROLLMENT.—Not later than June 30 of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A of the Internal Revenue Code of 1986). Such notification shall contain information on the services available through the Exchange operating in the State in which such individual resides.

(d) CONFORMING AMENDMENT.—The table of subparts for part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to subpart C the following new item:

''SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after 2013.

PART II—EMPLOYER RESPONSIBILITIES

SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18 (29 U.S.C. 218) the following:

''SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

''In accordance with regulations promulgated by the Secretary, an employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in. Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section.''.

SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOYEES OF COVERAGE OPTIONS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18A (as added by section 1513) the following:

''SEC. 18B. NOTICE TO EMPLOYEES.

''(a) IN GENERAL.—In accordance with regulations promulgated by the Secretary, an employer to which this Act applies, shall provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice—

''(1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;

''(2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and

''(3) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

''(b) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013.''.

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

''(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—If—

''(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

''(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

''(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 30 DAYS.—

''(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment, in the amount specified in paragraph (2), for each full-time employee of the employer to whom the extended waiting period applies.

''(2) AMOUNT.—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—

''(A) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, $400, and

''(B) in the case of an extended waiting period which exceeds 60 days, $600.

''(3) EXTENDED WAITING PERIOD.—The term 'extended waiting period' means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 30 days.

''(c) LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—

''(1) IN GENERAL.—If—

''(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

''(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

''(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) APPLICABLE PAYMENT AMOUNT.—The term 'applicable payment amount' means, with respect to any month, 1⁄12 of $750.

''(2) APPLICABLE LARGE EMPLOYER.—

''(A) IN GENERAL.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

''(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

''(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

''(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

''(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

''(ii) DEFINITION OF SEASONAL WORKERS.—The term 'seasonal worker' means a worker

who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

''(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

''(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(iii) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

''(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term 'applicable premium tax credit and cost-sharing reduction' means—

''(A) any premium tax credit allowed under section 36B,

''(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

''(C) any advance payment of such credit or reduction under section 1412 of such Act.

''(4) FULL-TIME EMPLOYEE.—

''(A) IN GENERAL.—The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

''(B) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

''(5) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b)(2) and (d)(1) shall be increased by an amount equal to the product of—

''(i) such dollar amount, and

''(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

''(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

''(6) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

''(7) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

''(e) ADMINISTRATION AND PROCEDURE.—

''(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

''(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

''(3) COORDINATION WITH CREDITS, ETC..—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980H. Shared responsibility for employers regarding health coverage.''.

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1502, is amended by inserting after section 6055 the following new section:

''SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

''(b) FORM AND MANNER OF RETURN.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, date, and employer identification number of the employer,

''(B) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)),

''(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

''(i) the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage,

''(ii) the months during the calendar year for which coverage under the plan was available,

''(iii) the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and

''(iv) the applicable large employer's share of the total allowed costs of benefits provided under the plan,

''(D) the number of full-time employees for each month during the calendar year,

''(E) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and

''(F) such other information as the Secretary may require.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

''(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing—

''(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(B) the information required to be shown on the return with respect to such individual.

''(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—

''(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

''(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under this section with the return and statement required to be provided by the issuer under section 6055.

''(e) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

''(f) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.''.

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), as amended by section 1502, is amended by striking ''or'' at the end of clause (xxiii), by striking ''and'' at the end of clause (xxiv) and inserting ''or'', and by inserting after clause (xxiv) the following new clause:

''(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and''.

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking ''or'' at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting '', or'' and by inserting after subparagraph (GG) the following new subparagraph:

''(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).''.

(c) CONFORMING AMENDMENT.—The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:

''Sec. 6056. Large employers required to report on health insurance coverage.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2013.

SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—

''(A) IN GENERAL.—The term 'qualified benefit' shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.

''(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee's employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.''.

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking ''For purposes of this section, the term'' and inserting ''For purposes of this section—

''(1) IN GENERAL.—The term'', and

(2) by striking ''Such term shall not include'' and inserting the following:

''(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term 'qualified benefit' shall not include''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

Subtitle G—Miscellaneous Provisions

SEC. 1551. DEFINITIONS.

Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91) shall apply with respect to this title.

SEC. 1552. TRANSPARENCY IN GOVERNMENT.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the authorities provided to the Secretary under this Act (and the amendments made by this Act).

SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.

(a) IN GENERAL.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(b) DEFINITION.—In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.—Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to—

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(d) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.

SEC. 1554. ACCESS TO THERAPIES.

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;

(2) impedes timely access to health care services;

(3) interferes with communications regarding a full range of treatment options between the patient and the provider;

(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professionals; or

(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

SEC. 1556. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.

(a) REBUTTABLE PRESUMPTION.—Section 411(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.

(b) CONTINUATION OF BENEFITS.—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 932(l)) is amended by striking '', except with respect to a claim filed under this part on or after the effective date of the Black Lung Benefits Amendments of 1981''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to claims filed under part B or part C of the Black Lung Benefits Act (30 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005, that are pending on or after the date of enactment of this Act.

SEC. 1557. NONDISCRIMINATION.

(a) IN GENERAL.—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) REGULATIONS.—The Secretary may promulgate regulations to implement this section.

SEC. 1558. PROTECTIONS FOR EMPLOYEES.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18B (as added by section 1512) the following:

''SEC. 18C. PROTECTIONS FOR EMPLOYEES.

''(a) PROHIBITION.—No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has—

''(1) received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;

''(2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

''(3) testified or is about to testify in a proceeding concerning such violation;

''(4) assisted or participated, or is about to assist or participate, in such a proceeding; or

''(5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this title (or amendment), or any order, rule, regulation, standard, or ban under this title (or amendment).

''(b) COMPLAINT PROCEDURE.—

''(1) IN GENERAL.—An employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

''(2) NO LIMITATION ON RIGHTS.—Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or

under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.''.

SEC. 1559. OVERSIGHT.

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

SEC. 1560. RULES OF CONSTRUCTION.

(a) NO EFFECT ON ANTITRUST LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term ''antitrust laws'' has the meaning given such term in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

(b) RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.—Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).

(c) STUDENT HEALTH INSURANCE PLANS.—Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

(d) NO EFFECT ON EXISTING REQUIREMENTS.—Nothing in this title (or an amendment made by this title, unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 1413.

SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:

''Subtitle C—Other Provisions

''SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

''(a) IN GENERAL.—

''(1) STANDARDS AND PROTOCOLS.—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

''(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.

''(b) CONTENT.—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

''(1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

''(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

''(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

''(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

''(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

''(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

''(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

''(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under subsection (a) that has been approved by the HIT Policy Committee and the HIT Standards Committee, the Secretary—

''(1) shall notify States of such standards or protocols; and

''(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.

''(d) GRANTS FOR IMPLEMENTATION OF APPROPRIATE ENROLLMENT HIT.—

''(1) IN GENERAL.—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as 'appropriate HIT technology').

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant under this subsection, an entity shall—

''(A) be a State, political subdivision of a State, or a local governmental entity; and

''(B) submit to the Secretary an application at such time, in such manner, and containing—

''(i) a plan to adopt and implement appropriate enrollment technology that includes—

''(I) proposed reduction in maintenance costs of technology systems;

''(II) elimination or updating of legacy systems; and

''(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

''(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

''(iii) such other information as the Secretary may require.

''(3) SHARING.—

''(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

''(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.''.

SEC. 1562. CONFORMING AMENDMENTS.

(a) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg-21), as so redesignated by section 1001(4), is amended—

(1) by striking subsection (a);

(2) in subsection (b)—

(A) in paragraph (1), by striking ''1 through 3'' and inserting ''1 and 2''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''subparagraph (D)'' and inserting ''subparagraph (D) or (E)'';

(ii) by striking ''1 through 3'' and inserting ''1 and 2''; and

(iii) by adding at the end the following:

''(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subpart 1.'';

(3) in subsection (c), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group''; and

(4) in subsection (d)—

(A) in paragraph (1), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group'';

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group''; and

(ii) in subparagraph (C), by inserting ''or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer''; and

(C) in paragraph (3), by striking ''any group'' and inserting ''any individual coverage or any group''.

(b) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg-91(d)) is amended by adding at the end the following:

''(20) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

''(21) EXCHANGE.—The term 'Exchange' means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.''.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in section 2704 (42 U.S.C. 300gg), as so redesignated by section 1201(2)—

(A) in subsection (c)—

(i) in paragraph (2), by striking ''group health plan'' each place that such term appears and inserting ''group or individual health plan''; and

(ii) in paragraph (3)—

(I) by striking ''group health insurance'' each place that such term appears and inserting ''group or individual health insurance''; and

(II) in subparagraph (D), by striking ''small or large'' and inserting ''individual or group'';

(B) in subsection (d), by striking ''group health insurance'' each place that such term appears and inserting ''group or individual health insurance''; and

(C) in subsection (e)(1)(A), by striking ''group health insurance'' and inserting ''group or individual health insurance'';

(2) by striking the second heading for subpart 2 of part A (relating to other requirements);

(3) in section 2725 (42 U.S.C. 300gg-4), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance issuer offering group or individual health insurance coverage'';

(B) in subsection (b)—

(i) by striking ''health insurance issuer offering group health insurance coverage in connection with a group health plan'' in the matter preceding paragraph (1) and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (1), by striking ''plan'' and inserting ''plan or coverage'';

(C) in subsection (c)—

(i) in paragraph (2), by striking ''group health insurance coverage offered by a health insurance issuer'' and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (3), by striking ''issuer'' and inserting ''health insurance issuer''; and

(D) in subsection (e), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance issuer offering group or individual health insurance coverage'';

(4) in section 2726 (42 U.S.C. 300gg-5), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

(B) in subsection (b), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage''; and

(C) in subsection (c)—

(i) in paragraph (1), by striking ''(and group health insurance coverage offered in connection with a group health plan)'' and inserting ''and a health insurance issuer offering group or individual health insurance coverage'';

(ii) in paragraph (2), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such term appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

(5) in section 2727 (42 U.S.C. 300gg-6), as so redesignated by section 1001(2), by striking ''health insurance issuers providing health insurance coverage in connection with group health plans'' and inserting ''and health insurance issuers offering group or individual health insurance coverage'';

(6) in section 2728 (42 U.S.C. 300gg-7), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking ''health insurance coverage offered in connection with such plan'' and inserting ''individual health insurance coverage'';

(B) in subsection (b)—

(i) in paragraph (1), by striking ''or a health insurance issuer that provides health insurance coverage in connection with a group health plan'' and inserting ''or a health insurance issuer that offers group or individual health insurance coverage'';

(ii) in paragraph (2), by striking ''health insurance coverage offered in connection with the plan'' and inserting ''individual health insurance coverage''; and

(iii) in paragraph (3), by striking ''health insurance coverage offered by an issuer in connection with such plan'' and inserting ''individual health insurance coverage'';

(C) in subsection (c), by striking ''health insurance issuer providing health insurance coverage in connection with a group health plan'' and inserting ''health insurance issuer that offers group or individual health insurance coverage''; and

(D) in subsection (e)(1), by striking ''health insurance coverage offered in connection with such a plan'' and inserting ''individual health insurance coverage'';

(7) by striking the heading for subpart 3;

(8) in section 2731 (42 U.S.C. 300gg-11), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (b);

(B) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small group'' and inserting ''group and individual''; and

(II) in subparagraph (B)—

(aa) in the matter preceding clause (i), by inserting ''and individuals'' after ''employers'';

(bb) in clause (i), by inserting ''or any additional individuals'' after ''additional groups''; and

(cc) in clause (ii), by striking ''without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such'' and inserting ''and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals''; and

(ii) in paragraph (2), by striking ''small group'' and inserting ''group or individual'';

(C) in subsection (d)—

(i) by striking ''small group'' each place that such appears and inserting ''group or individual''; and

(ii) in paragraph (1)(B)—

(I) by striking ''all employers'' and inserting ''all employers and individuals'';

(II) by striking ''those employers'' and inserting ''those individuals, employers''; and

(III) by striking ''such employees'' and inserting ''such individuals, employees'';

(D) by striking subsection (e);

(E) by striking subsection (f); and

(F) by transferring such section (as amended by this paragraph) to appear at the end of section 2702 (as added by section 1001(4));

(9) in section 2732 (42 U.S.C. 300gg-12), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (a);

(B) in subsection (b)—

(i) in the matter preceding paragraph (1), by striking ''group health plan in the small or large group market'' and inserting ''health insurance coverage offered in the group or individual market'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''plan sponsor'';

(iii) in paragraph (2), by inserting '', or individual, as applicable,'' after ''plan sponsor''; and

(iv) by striking paragraph (3) and inserting the following:

''(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.'';

(C) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''group health insurance coverage offered in the small or large group market'' and inserting ''group or individual health insurance coverage'';

(II) in subparagraph (A), by inserting ''or individual, as applicable,'' after ''plan sponsor'';

(III) in subparagraph (B)—

(aa) by inserting ''or individual, as applicable,'' after ''plan sponsor''; and

(bb) by inserting ''or individual health insurance coverage''; and

(IV) in subparagraph (C), by inserting ''or individuals, as applicable,'' after ''those sponsors''; and

(ii) in paragraph (2)(A)—

(I) in the matter preceding clause (i), by striking ''small group market or the large group market, or both markets,'' and inserting ''individual or group market, or all markets,''; and

(II) in clause (i), by inserting ''or individual, as applicable,'' after ''plan sponsor''; and

(D) by transferring such section (as amended by this paragraph) to appear at the end of section 2703 (as added by section 1001(4));

(10) in section 2733 (42 U.S.C. 300gg-13), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in the matter preceding paragraph (1), by striking ''small employer'' and inserting ''small employer or an individual'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''employer'' each place that such appears; and

(iii) in paragraph (2), by striking ''small employer'' and inserting ''employer, or individual, as applicable,'';

(B) in subsection (b)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small employer'' and inserting ''employer, or individual, as applicable,'';

(II) in subparagraph (A), by adding ''and'' at the end;

(III) by striking subparagraphs (B) and (C); and

(IV) in subparagraph (D)—

(aa) by inserting '', or individual, as applicable,'' after ''employer''; and

(bb) by redesignating such subparagraph as subparagraph (B);

(ii) in paragraph (2)—

(I) by striking ''small employers'' each place that such term appears and inserting ''employers, or individuals, as applicable,''; and

(II) by striking ''small employer'' and inserting ''employer, or individual, as applicable,''; and

(C) by redesignating such section (as amended by this paragraph) as section 2709 and transferring such section to appear after section 2708 (as added by section 1001(5));

(11) by redesignating subpart 4 as subpart 2;

(12) in section 2735 (42 U.S.C. 300gg-21), as so redesignated by section 1001(4)—

(A) by striking subsection (a);

(B) by striking ''subparts 1 through 3'' each place that such appears and inserting ''subpart 1'';

(C) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively; and

(D) by redesignating such section (as amended by this paragraph) as section 2722;

(13) in section 2736 (42 U.S.C. 300gg-22), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in paragraph (1), by striking ''small or large group markets'' and inserting ''individual or group market''; and

(ii) in paragraph (2), by inserting ''or individual health insurance coverage'' after ''group health plans'';

(B) in subsection (b)(1)(B), by inserting ''individual health insurance coverage or'' after ''respect to''; and

(C) by redesignating such section (as amended by this paragraph) as section 2723;

(14) in section 2737(a)(1) (42 U.S.C. 300gg-23), as so redesignated by section 1001(4)—

(A) by inserting ''individual or'' before ''group health insurance''; and

(B) by redesignating such section(as amended by this paragraph) as section 2724;

(15) in section 2762 (42 U.S.C. 300gg-62)—

(A) in the section heading by inserting ''and application'' before the period; and

(B) by adding at the end the following:

''(c) APPLICATION OF PART A PROVISIONS.—

''(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.

''(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply.''; and

(16) in section 2791(e) (42 U.S.C. 300gg-91(e))—

(A) in paragraph (2), by striking ''51'' and inserting ''101''; and

(B) in paragraph (4)—

(i) by striking ''at least 2'' each place that such appears and inserting ''at least 1''; and

(ii) by striking ''50'' and inserting ''100''.

(d) APPLICATION.—Notwithstanding any other provision of the Patient Protection and Affordable Care Act, nothing in such Act (or an amendment made by such Act) shall be construed to—

(1) prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act; or

(2) restrict the application of the amendments made by this subtitle.

(e) TECHNICAL AMENDMENT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart B of part 7 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et. seq.) is amended, by adding at the end the following:

''SEC. 715. ADDITIONAL MARKET REFORMS.

''(a) GENERAL RULE.—Except as provided in subsection (b)—

''(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

''(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

''(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.''.

(f) TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''SEC. 9815. ADDITIONAL MARKET REFORMS.

''(a) GENERAL RULE.—Except as provided in subsection (b)—

''(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and

''(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

''(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.''.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

''(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);''.

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

''(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.''.

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking ''or'' at the end;

(ii) in paragraph (25), by striking the period and inserting ''; or''; and

(iii) by adding at the end the following:

''(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).''.

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting ''subsection (y) and'' before ''section 1933(d)''; and

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

''(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

''(1) AMOUNT OF INCREASE.—

''(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

''(B) 2017 AND 2018.—

''(i) IN GENERAL.—During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

''(ii) APPLICABLE PERCENTAGE POINT INCREASE.—

''(I) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

"For any fiscal year quarter occurring in the calendar year:	If the State is an expansion State, the applicable percentage point increase is:	If the State is not an expansion State, the applicable percentage point increase is:
2017	30.3	34.3
2018	31.3	33.3

"(II) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

"(C) 2019 AND SUCCEEDING YEARS.—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

"(D) LIMITATION.—The Federal medical assistance percentage determined for a State under subparagraph (B) or (C) shall in no case be more than 95 percent.

"(2) DEFINITIONS.—In this subsection:

"(A) NEWLY ELIGIBLE.—The term 'newly eligible' means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

"(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).".

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

"(2) Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

"(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.".

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking "and (XIV)" and inserting "(XIV)" and by inserting "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)" before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking "100" and inserting "133".

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xii);

(ii) by inserting "or" at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

"(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),".

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(i)(VIII)," after "1902(a)(10)(A)(i)(VII),".

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u–7(a)(1)(B)) is amended by inserting "subclause (VIII) of section 1902(a)(10)(A)(i) or under" after "eligible under".

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking "and" at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting "; and"; and

(C) by inserting after paragraph (73) the following new paragraph:

"(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg)."; and

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

"(gg) MAINTENANCE OF EFFORT.—

"(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

"(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

"(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is

made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

''(4) DETERMINATION OF COMPLIANCE.—

''(A) STATES SHALL APPLY MODIFIED GROSS INCOME.—A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

''(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).''.

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6),'' before ''each'';

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6)'' after ''subsection (a)(1),'';

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

''(iv) Coverage of prescription drugs.

''(v) Mental health services.''; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

''(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

''(6) MENTAL HEALTH SERVICES PARITY.—

''(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

''(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).''.

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking ''and'' at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting ''; and''; and

(C) by inserting after paragraph (74) the following new paragraph:

''(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

''(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

''(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

''(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.''.

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking ''or'' at the end;

(ii) in subclause (XIX), by adding ''or'' at the end; and

(iii) by adding at the end the following new subclause:

''(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);'' and

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

''(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

''(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xiii);

(ii) by inserting ''or'' at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

''(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),''.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

(C) Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by subsection (a)(4)(B), is amended by inserting ''or clause (ii)(XX)'' after ''clause (i)(VIII)''.

SEC. 2002. INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(14) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

''(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State

shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

''(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

''(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

''(D) EXCEPTIONS.—

''(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

''(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

''(II) Individuals who have attained age 65.

''(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

''(IV) Individuals described in subsection (a)(10)(C).

''(V) Individuals described in any clause of subsection (a)(10)(E).

''(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

''(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

''(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

''(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

''(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

''(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

''(G) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms 'modified gross income' and 'household income' have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

''(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

''(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

''(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting ''(e)(14),'' before ''(l)(3)''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2003. REQUIREMENT TO OFFER PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE.

(a) IN GENERAL.—Section 1906A of such Act (42 U.S.C. 1396e–1) is amended—

(1) in subsection (a)—

(A) by striking ''may elect to'' and inserting ''shall'';

(B) by striking ''under age 19''; and

(C) by inserting '', in the case of an individual under age 19,'' after ''(and'';

(2) in subsection (c), in the first sentence, by striking ''under age 19''; and

(3) in subsection (d)—

(A) in paragraph (2)—

(i) in the first sentence, by striking ''under age 19''; and

(ii) by striking the third sentence and inserting ''A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.''; and

(B) in paragraph (3), by striking ''the parent of an individual under age 19'' and inserting ''an individual (or the parent of an individual)''; and

(4) in subsection (e), by striking ''under age 19'' each place it appears.

(b) CONFORMING AMENDMENT.—The heading for section 1906A of such Act (42 U.S.C. 1396e–1) is amended by striking ''OPTION FOR CHILDREN''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014.

SEC. 2004. MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended—

(1) by striking ''or'' at the end of subclause (VII);

(2) by adding ''or'' at the end of subclause (VIII); and

(3) by inserting after subclause (VIII) the following:

''(IX) who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are

no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age;''.

(b) OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.—Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by section 2001(a)(4)(B) and amended by section 2001(e)(2)(C), is amended by inserting '', clause (i)(IX),'' after ''clause (i)(VIII)''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(a)(5)(D), is amended by inserting ''1902(a)(10)(A)(i)(IX),'' after ''1902(a)(10)(A)(i)(VIII),''.

(2) Section 1937(a)(2)(B)(viii) of such Act (42 U.S.C. 1396u–7(a)(2)(B)(viii)) is amended by inserting '', or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX)'' before the period.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2019.

SEC. 2005. PAYMENTS TO TERRITORIES.

(a) INCREASE IN LIMIT ON PAYMENTS.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking ''paragraph (3)'' and inserting ''paragraphs (3) and (5)'';

(2) in paragraph (4), by striking ''and (3)'' and inserting ''(3), and (4)''; and

(3) by adding at the end the following paragraph:

''(5) FISCAL YEAR 2011 AND THEREAFTER.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent.''.

(b) DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.—Section 1108(g)(4) of such Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking ''to fiscal years beginning'' and inserting ''to—

''(A) fiscal years beginning'';

(2) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible (as defined in section 1905(y)(2)) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under title XIX or under a waiver on the date of enactment of the Patient Protection and Affordable Care Act, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.''.

(c) INCREASED FMAP.—

(1) IN GENERAL.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ''shall be 50 per centum'' and inserting ''shall be 55 percent''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.

SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3) and 2001(b)(2), is amended—

(1) in subsection (b), in the first sentence, by striking ''subsection (y)'' and inserting ''subsections (y) and (aa)''; and

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

''(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

''(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5.

''(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

''(2) In this subsection, the term 'disaster-recovery FMAP adjustment State' means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

''(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

''(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

''(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.''.

SEC. 2007. MEDICAID IMPROVEMENT FUND RESCISSION.

(a) RESCISSION.—Any amounts available to the Medicaid Improvement Fund established under section 1941 of the Social Security Act (42 U.S.C. 1396w–1) for any of fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not so obligated as of the date of the enactment of this Act are rescinded.

(b) CONFORMING AMENDMENTS.—Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended—

(1) in subparagraph (A), by striking ''$100,000,000'' and inserting ''$0''; and

(2) in subparagraph (B), by striking ''$150,000,000'' and inserting ''$0''.

Subtitle B—Enhanced Support for the Children's Health Insurance Program

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended by adding at the end the following: ''Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).''.

(b) MAINTENANCE OF EFFORT.—

(1) IN GENERAL.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

''(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—

''(A) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from—

''(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

''(ii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

''(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.''.

(2) CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding before the period '', except as required under section 1902(e)(14)''.

(c) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(iii)) is amended by inserting ''or any children enrolled on or after October 1, 2013'' before the period.

(d) INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.—

(1) STATE PLAN REQUIREMENT.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (iii), by striking ''and'' after the semicolon;

(B) in clause (iv), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14).''.

(2) CONFORMING AMENDMENT.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

(B) by inserting after subparagraph (D), the following:

''(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income).''.

(e) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

''(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency).''.

(f) CHIP ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of an income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 2110(b) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as ''CHIPRA''):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been claimed at the enhanced FMAP rate rather than the Federal medical assistance percentage matching rate for such population.''.

(2) Section 605 of CHIPRA is amended by striking ''legal residents'' and insert ''lawfully residing in the United States''.

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by section 104 of CHIPRA, are each amended by striking '', respectively''.

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking subclause (IV).

(5) Section 2105(c)(9)(B) of the Social Security Act (42 U.S.C. 1397e(c)(9)(B)), as added by section 211(c)(1) of CHIPRA, is amended by striking ''section 1903(a)(3)(F)'' and inserting ''section 1903(a)(3)(G)''.

(6) Section 2109(b)(2)(B) of the Social Security Act (42 U.S.C. 1397ii(b)(2)(B)), as added by section 602 of CHIPRA, is amended by striking ''the child population growth factor under section 2104(m)(5)(B)'' and inserting ''a high-performing State under section 2111(b)(3)(B)''.

(7) Section 2110(c)(9)(B)(v) of the Social Security Act (42 U.S.C. 1397jj(c)(9)(B)(v)), as added by section 505(b) of CHIPRA, is amended by striking ''school or school system'' and inserting ''local educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965''.

(8) Section 211(a)(1)(B) of CHIPRA is amended—

(A) by striking ''is amended'' and all that follows through ''adding'' and inserting ''is amended by adding''; and

(B) by redesignating the new subparagraph to be added by such section to section 1903(a)(3) of the Social Security Act as a new subparagraph (H).

(b) ARRA.—Effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the second sentence of section 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking ''or (i)'' and inserting '', (i), or (j)''.

Subtitle C—Medicaid and CHIP Enrollment Simplification

SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

''(a) CONDITION FOR PARTICIPATION IN MEDICAID.—As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is met.

''(b) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES AND CHIP.—

''(1) IN GENERAL.—A State shall establish procedures for—

''(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

''(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act as being eligible for—

''(i) medical assistance under the State plan or under a waiver of the plan; or

''(ii) child health assistance under the State child health plan under title XXI;

''(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under title XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

''(D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the 'State Medicaid agency'), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the 'State CHIP agency') and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment

in the State plan under this title, title XXI, or a qualified health plan, as appropriate;

''(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

''(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

''(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

''(3) STREAMLINED ENROLLMENT SYSTEM.—The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1413 of the Patient Protection and Affordable Care Act (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

''(4) ENROLLMENT WEBSITE REQUIREMENTS.—The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

''(5) CONTINUED NEED FOR ASSESSMENT FOR HOME AND COMMUNITY-BASED SERVICES.—Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).''.

SEC. 2202. PERMITTING HOSPITALS TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID ELIGIBLE POPULATIONS.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) by striking ''at the option of the State, provide'' and inserting ''provide—

''(A) at the option of the State,'';

(2) by inserting ''and'' after the semicolon; and

(3) by adding at the end the following:

''(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, or 1920B (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;''.

(b) CONFORMING AMENDMENT.—Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(1) by striking ''or for'' and inserting ''for''; and

(2) by inserting before the period at the end the following: '', or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014, and apply to services furnished on or after that date.

Subtitle D—Improvements to Medicaid Services

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and''; and

(2) in subsection (l), by adding at the end the following new paragraph:

''(3)(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

''(B) The term 'freestanding birth center' means a health facility—

''(i) that is not a hospital;

''(ii) where childbirth is planned to occur away from the pregnant woman's residence;

''(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

''(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

''(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term 'birth attendant' means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the matter preceding clause (i) by striking ''and (21)'' and inserting '', (21), and (28)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

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

''(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title

for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.''.

(b) APPLICATION TO CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by inserting ''(concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made'' after ''hospice care''.

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

(A) in subclause (XIX), by striking ''or'' at the end;

(B) in subclause (XX), by adding ''or'' at the end; and

(C) by adding at the end the following new subclause:

''(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 2001(d), is amended by adding at the end the following new subsection:

''(ii)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

''(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking ''and (XV)'' and inserting ''(XV)''; and

(B) by inserting '', and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting'' before the semicolon.

(4) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)—

(i) in clause (xiv), by striking ''or'' at the end;

(ii) in clause (xv), by adding ''or'' at the end; and

(iii) by inserting after clause (xv) the following:

''(xvi) individuals described in section 1902(ii),''.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(e)(2)(B), is amended by inserting ''1902(a)(10)(A)(ii)(XXI),'' after ''1902(a)(10)(A)(ii)(XX),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period; and

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 2202(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section''; and

(ii) in subparagraph (B), by striking ''or 1920B'' and inserting ''1920B, or 1920C''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by section 2202(b), is amended by inserting ''or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section,'' after ''1920B during a presumptive eligibility period under such section,''.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)), as amended by section 2001(c), is amended by adding at the end the following:

''(7) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''or the care and services themselves, or both'' before ''(if provided in or after''.

Subtitle E—New Options for States to Provide Long-Term Services and Supports

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

''(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

''(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

''(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

''(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

''(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

''(iv) the furnishing of which—

''(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

''(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

''(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

''(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

''(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

''(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

''(iii) voluntary training on how to select, manage, and dismiss attendants.

''(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

''(i) room and board costs for the individual;

''(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

''(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

''(iv) medical supplies and equipment; or

''(v) home modifications.

''(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

''(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

''(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

''(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

''(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

''(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

''(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

''(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

''(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community- based attendant services and supports that—

''(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

''(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

''(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

''(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

''(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

''(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

''(A) withholding and payment of Federal and State income and payroll taxes;

''(B) the provision of unemployment and workers compensation insurance;

''(C) maintenance of general liability insurance; and

''(D) occupational health and safety.

''(5) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS.—

''(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

''(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

''(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

''(ii) The number of individuals that received such services and supports during the preceding fiscal year.

''(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

''(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

''(C) REPORTS.—Not later than—

''(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

''(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

''(6) DEFINITIONS.—In this subsection:

''(A) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

''(B) CONSUMER CONTROLLED.—The term 'consumer controlled' means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

''(C) DELIVERY MODELS.—

''(i) AGENCY-PROVIDER MODEL.—The term 'agency-provider model' means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

''(ii) OTHER MODELS.—The term 'other models' means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

''(D) HEALTH-RELATED TASKS.—The term 'health-related tasks' means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

''(E) INDIVIDUAL'S REPRESENTATIVE.—The term 'individual's representative' means a parent, family member, guardian, advocate, or other authorized representative of an individual.

''(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.''.

SEC. 2402. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES.

(a) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure—

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

''(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

''(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

''(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

''(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

''(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

''(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

''(B) 5-YEAR TERM.—

''(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

''(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

''(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

''(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

''(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.''.

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking ''or such other services requested by the State as the Secretary may approve''.

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2304(a)(1), is amended—

(A) in subclause (XX), by striking ''or'' at the end;

(B) in subclause (XXI), by adding ''or'' at the end; and

(C) by inserting after subclause (XXI), the following new subclause:

''(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A), by inserting ''1902(a)(10)(A)(ii)(XXII),'' after ''1902(a)(10)(A)(ii)(XXI),''.

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as so amended, is amended in the matter preceding paragraph (1)—

(i) in clause (xv), by striking ''or'' at the end;

(ii) in clause (xvi), by adding ''or'' at the end; and

(iii) by inserting after clause (xvi) the following new clause:

''(xvii) individuals who are eligible for home and community-based services under

needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,''.

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

''(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.''; and

(2) in subclause (II) of subparagraph (D)(ii), by striking ''to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services'' and inserting ''to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria''.

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking ''1902(a)(1) (relating to statewideness)'' and inserting ''1902(a)(10)(B) (relating to comparability)''.

(g) EFFECTIVE DATE.—The amendments made by subsections (b) through (f) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) EXTENSION OF DEMONSTRATION.—

(1) IN GENERAL.—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in paragraph (1)(E), by striking ''fiscal year 2011'' and inserting ''each of fiscal years 2011 through 2016''; and

(B) in paragraph (2), by striking ''2011'' and inserting ''2016''.

(2) EVALUATION.—Paragraphs (2) and (3) of section 6071(g) of such Act is amended are each amended by striking ''2011'' and inserting ''2016''.

(b) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

(1) IN GENERAL.—Section 6071(b)(2) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in subparagraph (A)(i), by striking '', for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State'' and inserting ''for a period of not less than 90 consecutive days''; and

(B) by adding at the end the following:

''Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though ''is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)'' were substituted in such section for ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)''.

SEC. 2405. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, $10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 3012).

SEC. 2406. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) FINDINGS.—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also know as the ''Pepper Commission'', released its ''Call for Action'' blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our Nation's elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while ½ of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) long term services and supports should be made available in the community in addition to in institutions.

Subtitle F—Medicaid Prescription Drug Coverage

SEC. 2501. PRESCRIPTION DRUG REBATES.

(a) INCREASE IN MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

(A) in clause (i)—

(i) in subclause (IV), by striking ''and'' at the end;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2010'' after ''December 31, 1995,''; and

(II) by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subclause:

''(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent.''; and

(B) by adding at the end the following new clause:

''(iii) MINIMUM REBATE PERCENTAGE FOR CERTAIN DRUGS.—

''(I) IN GENERAL.—In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

''(II) DRUG DESCRIBED.—For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

''(aa) A clotting factor for which a separate furnishing payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

''(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications.''.

(2) RECAPTURE OF TOTAL SAVINGS DUE TO INCREASE.—Section 1927(b)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

''(i) IN GENERAL.—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

''(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

''(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

''(ii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under

clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under section 1116(d).''.

(b) INCREASE IN REBATE FOR OTHER DRUGS.—Section 1927(c)(3)(B) of such Act (42 U.S.C. 1396r–8(c)(3)(B)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by inserting ''and before January 1, 2010,'' after ''December 31, 1993,''; and

(B) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(iii) after December 31, 2009, is 13 percent.''.

(c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) of such Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking ''and'' at the end;

(B) in clause (xii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.''.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (b)—

(i) in paragraph (1)(A), in the first sentence, by inserting '', including such drugs dispensed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs'' before the period; and

(ii) in paragraph (2)(A), by inserting ''including such information reported by each medicaid managed care organization,'' after ''for which payment was made under the plan during the period,''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(d) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) TREATMENT OF NEW FORMULATIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of—

''(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

''(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

''(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

''(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs that are paid for by a State after December 31, 2009.

(e) MAXIMUM REBATE AMOUNT.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

''(D) MAXIMUM REBATE AMOUNT.—In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.''.

(f) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(A) in subsection (a)(2)(B)(i), by striking ''1927(c)(4)'' and inserting ''1927(c)(3)''; and

(B) by striking subsection (c); and

(C) redesignating subsection (d) as subsection (c).

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

SEC. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–8(d)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

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

''(7) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

''(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

''(B) Barbiturates.

''(C) Benzodiazepines.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) in paragraph (4), by striking ''(or, effective January 1, 2007, two or more)''; and

(B) by striking paragraph (5) and inserting the following:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1847A.''.

(2) DEFINITION OF AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in subparagraph (A), by striking ''by'' and all that follows through the period and inserting ''by—

''(i) wholesalers for drugs distributed to retail community pharmacies; and

''(ii) retail community pharmacies that purchase drugs directly from the manufacturer.''; and

(B) by striking subparagraph (B) and inserting the following:

''(B) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS AND OTHER PAYMENTS.—

''(i) IN GENERAL.—The average manufacturer price for a covered outpatient drug shall exclude—

''(I) customary prompt pay discounts extended to wholesalers;

''(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

''(III) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction; and

''(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies,

long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

''(ii) INCLUSION OF OTHER DISCOUNTS AND PAYMENTS.—Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug.''; and

(C) in subparagraph (C), by striking ''the retail pharmacy class of trade'' and inserting ''retail community pharmacies''.

(3) DEFINITION OF MULTIPLE SOURCE DRUG.—Section 1927(k)(7) of such Act (42 U.S.C. 1396r–8(k)(7)) is amended—

(A) in subparagraph (A)(i)(III), by striking ''the State'' and inserting ''the United States''; and

(B) in subparagraph (C)—

(i) in clause (i), by inserting ''and'' after the semicolon;

(ii) in clause (ii), by striking ''; and'' and inserting a period; and

(iii) by striking clause (iii).

(4) DEFINITIONS OF RETAIL COMMUNITY PHARMACY; WHOLESALER.—Section 1927(k) of such Act (42 U.S.C. 1396r–8(k)) is amended by adding at the end the following new paragraphs:

''(10) RETAIL COMMUNITY PHARMACY.—The term 'retail community pharmacy' means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

''(11) WHOLESALER.—The term 'wholesaler' means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) manufacturers, repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer's and distributor's warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.''.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in the first sentence, by inserting after clause (iii) the following:

''(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug;''; and

(B) in the second sentence, by inserting ''(relating to the weighted average of the most recently reported monthly average manufacturer prices)'' after ''(D)(v)''; and

(2) in subparagraph (D)(v), by striking ''average manufacturer prices'' and inserting ''the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)''.

(c) CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)(i), by inserting ''with respect to a retail community pharmacy,'' before ''the determination''; and

(2) in subparagraph (C)(ii), by striking ''retail pharmacies'' and inserting ''retail community pharmacies''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (1), by striking ''and (3)'' and inserting '', (3), and (7)'';

(2) in paragraph (3)(A), by striking ''paragraph (6)'' and inserting ''paragraphs (6) and (7)'';

(3) by redesignating paragraph (7) as paragraph (8); and

(4) by inserting after paragraph (6) the following new paragraph:

''(7) REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

''(A) IN GENERAL.—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—

''(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i); and

''(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined under this paragraph for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(ii).

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:

''(i) UNINSURED REDUCTION THRESHOLD FISCAL YEAR.—In the case of the first fiscal year described in subparagraph (C) with respect to the State—

''(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

''(II) if the State is any other State, the applicable percentage is 50 percent.

''(ii) SUBSEQUENT FISCAL YEARS IN WHICH THE PERCENTAGE OF UNINSURED DECREASES.—In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage of such individuals determined for the State for the preceding fiscal year—

''(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

''(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.

''(C) FISCAL YEAR DESCRIBED.—For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is at least 45 percent less than the percentage of such individuals determined for the State for fiscal year 2009.

''(D) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State for a fiscal year, the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State's diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

''(E) MINIMUM ALLOTMENT.—In no event shall the DSH allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

''(F) UNCOVERED INDIVIDUALS.—In this paragraph, the term 'uncovered individuals' means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2011.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

SEC. 2601. 5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting ''(1)'' after ''(h)'';

(2) by inserting '', or a waiver described in paragraph (2)'' after ''(e)''; and

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

''(2)(A) Notwithstanding subsections (c)(3) and (d) (3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

''(B) In this paragraph, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1915 of such Act (42 U.S.C. 1396n) is amended—

(A) in subsection (b), by adding at the end the following new sentence: ''Subsection (h)(2) shall apply to a waiver under this subsection.'';

(B) in subsection (c)(3), in the second sentence, by inserting ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection'';

(C) in subsection (d)(3), in the second sentence, by inserting ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection''.

(2) Section 1115 of such Act (42 U.S.C. 1315) is amended—

(A) in subsection (e)(2), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''; and

(B) in subsection (f)(6), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''.

SEC. 2602. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.

(a) ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.—

(1) IN GENERAL.—Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Federal Coordinated Health Care Office.

(2) ESTABLISHMENT AND REPORTING TO CMS ADMINISTRATOR.—The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) PURPOSE.—The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) GOALS.—The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) SPECIFIC RESPONSIBILITIES.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6)), as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(e) REPORT.—The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) DUAL ELIGIBLE DEFINED.—In this section, the term ''dual eligible individual'' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

Subtitle I—Improving the Quality of Medicaid for Patients and Providers

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended by inserting after section 1139A the following new section:

''SEC. 1139B. ADULT HEALTH QUALITY MEASURES.

''(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

''(b) DEADLINES.—

''(1) RECOMMENDED MEASURES.—Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

''(2) DISSEMINATION.—Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

''(3) STANDARDIZED REPORTING.—Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

''(4) REPORTS TO CONGRESS.—Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

''(5) ESTABLISHMENT OF MEDICAID QUALITY MEASUREMENT PROGRAM.—

''(A) IN GENERAL.—Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1)), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A).

''(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

''(d) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID.—

''(1) ANNUAL STATE REPORTS.—Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of the annual report required

under section 1139A(c)), to the Secretary on the—

''(A) State-specific adult health quality measures applied by the State under the such plan, including measures described in subsection (a)(5); and

''(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

''(2) PUBLICATION.—Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

''(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, $60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.''.

SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) HEALTH CARE-ACQUIRED CONDITION.—In this section. the term ''health care-acquired condition'' means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) MEDICARE PROVISIONS.—In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

''SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

''(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

''(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

''(c) PAYMENTS.—

''(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

''(2) METHODOLOGY.—

''(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

''(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

''(ii) shall be established consistent with section 1902(a)(30)(A).

''(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

''(3) PLANNING GRANTS.—

''(A) IN GENERAL.—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

''(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

''(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

''(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

''(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

''(f) MONITORING.—A State shall include in the State plan amendment—

''(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

''(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

''(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

''(h) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'eligible individual with chronic conditions' means an individual who—

''(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

''(ii) has at least—

''(I) 2 chronic conditions;

''(II) 1 chronic condition and is at risk of having a second chronic condition; or

''(III) 1 serious and persistent mental health condition.

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

''(2) CHRONIC CONDITION.—The term 'chronic condition' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

''(A) A mental health condition.

''(B) Substance use disorder.

''(C) Asthma.

''(D) Diabetes.

''(E) Heart disease.

''(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

''(3) HEALTH HOME.—The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

''(4) HEALTH HOME SERVICES.—

''(A) IN GENERAL.—The term 'health home services' means comprehensive and timely

high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

''(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

''(i) comprehensive care management;

''(ii) care coordination and health promotion;

''(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

''(iv) patient and family support (including authorized representatives);

''(v) referral to community and social support services, if relevant; and

''(vi) use of health information technology to link services, as feasible and appropriate.

''(5) DESIGNATED PROVIDER.—The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

''(A) has the systems and infrastructure in place to provide health home services; and

''(B) satisfies the qualification standards established by the Secretary under subsection (b).

''(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term 'team of health care professionals' means a team of health professionals (as described in the State plan amendment) that may—

''(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

''(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

''(7) HEALTH TEAM.—The term 'health team' has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.''.

(b) EVALUATION.—

(1) INDEPENDENT EVALUATION.—

(A) IN GENERAL.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(B) EVALUATION REPORT.—Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

(2) SURVEY AND INTERIM REPORT.—

(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

(i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation;

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.

(a) AUTHORITY TO CONDUCT PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

(A) with respect to an episode of care that includes a hospitalization; and

(B) for concurrent physicians services provided during a hospitalization.

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than if their care had not been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

(c) WAIVER OF PROVISIONS.—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

(d) EVALUATION AND REPORT.—

(1) DATA.—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

(2) REPORT.—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project.

SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act, as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

(c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.—For purposes of this section, the term ''eligible safety net hospital system or network'' means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

(d) EVALUATION.—

(1) TESTING.—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as so added) shall not be applicable.

(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

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

SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—

(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

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

SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

(1) have attained age 21, but have not attained age 65;

(2) are eligible for medical assistance under such plan; and

(3) require such medical assistance to stabilize an emergency medical condition.

(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)) . This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) IN GENERAL.—An eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

(3) SELECTION.—A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 5-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

(3) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2015.

(4) FUNDS ALLOCATED TO STATES.—Funds shall be allocated to eligible States on the basis of criteria, including a State's application and the availability of funds, as determined by the Secretary.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

(f) EVALUATION AND REPORT TO CONGRESS.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.

(B) An assessment of discharge planning by participating hospitals.

(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(2) REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term ''Federal medical assistance percentage'' has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) INSTITUTION FOR MENTAL DISEASES.—The term ''institution for mental diseases'' has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) MEDICAL ASSISTANCE.—The term ''medical assistance'' has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(5) STABILIZED.—The term ''stabilized'' means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

SEC. 2801. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) IN GENERAL.—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the paragraph heading, by inserting ''FOR ALL STATES'' before ''AND ANNUAL''; and

(ii) in subparagraph (A), by striking ''children's'';

(iii) in subparagraph (B), by inserting '', the Secretary, and States'' after ''Congress'';

(iv) in subparagraph (C), by striking ''March 1'' and inserting ''March 15''; and

(v) in subparagraph (D), by striking ''June 1'' and inserting ''June 15'';

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) in clause (i)—

(aa) by inserting ''the efficient provision of'' after ''expenditures for''; and

(bb) by striking ''hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees'' and inserting ''payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services''; and

(II) in clause (iii), by inserting ''(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations)'' after ''beneficiaries'';

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (F) and (H), respectively;

(iii) by inserting after subparagraph (A), the following:

''(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

''(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

''(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

''(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.'';

(iv) by inserting after subparagraph (F) (as redesignated by clause (ii) of this subparagraph), the following:

''(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.'' and

(v) in subparagraph (H) (as so redesignated), by inserting ''and preventive, acute, and long-term services and supports'' after ''barriers'';

(C) by redesignating paragraphs (3) through (9) as paragraphs (4) through (10), respectively;

(D) by inserting after paragraph (2), the following new paragraph:

''(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

''(A) review national and State-specific Medicaid and CHIP data; and

''(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.'';

(E) in paragraph (4), as redesignated by subparagraph (C), by striking ''or any other problems'' and all that follows through the period and inserting '', as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.'';

(F) in paragraph (5), as so redesignated,—

(i) in the paragraph heading, by inserting ''AND REGULATIONS'' after ''REPORTS''; and

(ii) by striking ''If'' and inserting the following:

''(A) CERTAIN SECRETARIAL REPORTS.—If''; and

(iii) in the second sentence, by inserting ''and the Secretary'' after ''appropriate committees of Congress''; and

(iv) by adding at the end the following:

''(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.'';

(G) in paragraph (10), as so redesignated, by inserting '', and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations'' before the period; and

(H) by adding at the end the following:

''(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

''(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

''(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

''(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

''(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

''(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.'';

(2) in subsection (c)(2)—

(A) by striking subparagraphs (A) and (B) and inserting the following:

''(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

''(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.''.

(3) in subsection (d)(2), by inserting ''and State'' after ''Federal'';

(4) in subsection (e)(1), in the first sentence, by inserting ''and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP,'' after ''United States''; and

(5) in subsection (f)—

(A) in the subsection heading, by striking ''AUTHORIZATION OF APPROPRIATIONS'' and inserting ''FUNDING'';

(B) in paragraph (1), by inserting ''(other than for fiscal year 2010)'' before ''in the same manner''; and

(C) by adding at the end the following:

''(3) FUNDING FOR FISCAL YEAR 2010.—

''(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

''(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

''(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.''.

(b) CONFORMING MEDPAC AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)), is amended—

(1) in paragraph (1)(C), by striking ''March 1 of each year (beginning with 1998)'' and inserting ''March 15'';

(2) in paragraph (1)(D), by inserting '', and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible'' before the period; and

(3) by adding at the end the following:

''(9) REVIEW AND ANNUAL REPORT ON MEDICAID AND COMMERCIAL TRENDS.—The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 (in this section referred to as 'MACPAC').

''(10) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

''(11) INTERACTION OF MEDICAID AND MEDICARE.—The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.''.

Subtitle K—Protections for American Indians and Alaska Natives

SEC. 2901. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.—For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.

(b) PAYER OF LAST RESORT.—Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

(c) FACILITATING ENROLLMENT OF INDIANS UNDER THE EXPRESS LANE OPTION.—Section 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(ii)) is amended—

(1) in the clause heading, by inserting ''AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS'' after ''AGENCIES''; and

(2) by adding at the end the following:

''(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).''.

(d) TECHNICAL CORRECTIONS.—Section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)) is amended by striking ''In this section'' and inserting ''For purposes of this section, title XIX, and title XXI''.

SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking ''during the 5-year period beginning on'' and inserting ''on or after''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

Subtitle L—Maternal and Child Health Services

SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

''SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

''(a) PURPOSES.—The purposes of this section are—

''(1) to strengthen and improve the programs and activities carried out under this title;

''(2) to improve coordination of services for at risk communities; and

''(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

''(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

''(A) communities with concentrations of—

''(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

''(ii) poverty;

''(iii) crime;

''(iv) domestic violence;

''(v) high rates of high-school drop-outs;

''(vi) substance abuse;

''(vii) unemployment; or

''(viii) child maltreatment;

''(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

''(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

''(ii) the gaps in early childhood home visitation in the State; and

''(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

''(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

''(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

''(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

''(A) the results of the statewide needs assessment required under paragraph (1); and

''(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

''(c) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—

''(1) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

''(2) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds

made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

''(3) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

''(4) TECHNICAL ASSISTANCE.—The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds.

''(d) REQUIREMENTS.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

''(1) QUANTIFIABLE, MEASURABLE IMPROVEMENT IN BENCHMARK AREAS.—

''(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in each of the following areas:

''(i) Improved maternal and newborn health.

''(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.

''(iii) Improvement in school readiness and achievement.

''(iv) Reduction in crime or domestic violence.

''(v) Improvements in family economic self-sufficiency.

''(vi) Improvements in the coordination and referrals for other community resources and supports.

''(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

''(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

''(ii) CORRECTIVE ACTION PLAN.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

''(iii) TECHNICAL ASSISTANCE.—

''(I) IN GENERAL.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

''(II) ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

''(iv) NO IMPROVEMENT OR FAILURE TO SUBMIT REPORT.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

''(C) FINAL REPORT.—Not later than December 31, 2015, the eligible entity shall submit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

''(2) IMPROVEMENTS IN OUTCOMES FOR INDIVIDUAL FAMILIES.—

''(A) IN GENERAL.—The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

''(B) PARTICIPANT OUTCOMES.—The participant outcomes described in this subparagraph are the following:

''(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes.

''(ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators.

''(iii) Improvements in parenting skills.

''(iv) Improvements in school readiness and child academic achievement.

''(v) Reductions in crime or domestic violence.

''(vi) Improvements in family economic self-sufficiency.

''(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

''(3) CORE COMPONENTS.—The program includes the following core components:

''(A) SERVICE DELIVERY MODEL OR MODELS.—

''(i) IN GENERAL.—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

''(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

''(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

''(bb) quasi-experimental research designs.

''(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

''(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.—An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

''(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.—The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

''(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

''(iii) The program maintains high quality supervision to establish home visitor competencies.

''(iv) The program demonstrates strong organizational capacity to implement the activities involved.

''(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

''(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

''(4) PRIORITY FOR SERVING HIGH-RISK POPULATIONS.—The eligible entity gives priority to providing services under the program to the following:

''(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

''(B) Low-income eligible families.

''(C) Eligible families who are pregnant women who have not attained age 21.

''(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

''(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

''(F) Eligible families that have users of tobacco products in the home.

''(G) Eligible families that are or have children with low student achievement.

''(H) Eligible families with children with developmental delays or disabilities.

''(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

''(e) APPLICATION REQUIREMENTS.—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

''(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve

high risk populations described in subsection (d)(4).

''(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

''(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

''(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

''(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

''(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

''(7) Assurances that the entity will establish procedures to ensure that—

''(A) the participation of each eligible family in the program is voluntary; and

''(B) services are provided to an eligible family in accordance with the individual assessment for that family.

''(8) Assurances that the entity will—

''(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

''(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

''(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

''(10) Other information as required by the Secretary.

''(f) MAINTENANCE OF EFFORT.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

''(g) EVALUATION.—

''(1) INDEPENDENT, EXPERT ADVISORY PANEL.—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development—

''(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

''(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

''(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

''(2) AUTHORITY TO CONDUCT EVALUATION.—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

''(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

''(B) an assessment of—

''(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

''(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

''(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

''(3) REPORT.—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

''(h) OTHER PROVISIONS.—

''(1) INTRA-AGENCY COLLABORATION.—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

''(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

''(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

''(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—

''(A) INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

''(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

''(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

''(B) NONPROFIT ORGANIZATIONS.—If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (j) that are available for expenditure under paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

''(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

''(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

''(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

''(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

''(B) REQUIREMENTS.—The Secretary shall ensure that—

''(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

''(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

''(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

''(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

''(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

''(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

''(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

''(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

''(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

''(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

''(C) Section 504(d) (relating to a limitation on administrative expenditures).

''(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(E) Section 507 (relating to penalties for false statements).

''(F) Section 508 (relating to nondiscrimination).

''(G) Section 509(a) (relating to the administration of the grant program).

''(j) APPROPRIATIONS.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

''(A) $100,000,000 for fiscal year 2010;

''(B) $250,000,000 for fiscal year 2011;

''(C) $350,000,000 for fiscal year 2012;

''(D) $400,000,000 for fiscal year 2013; and

''(E) $400,000,000 for fiscal year 2014.

''(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

''(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

''(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

''(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

''(k) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—

''(A) IN GENERAL.—The term 'eligible entity' means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

''(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.

''(2) ELIGIBLE FAMILY.—The term 'eligible family' means—

''(A) a woman who is pregnant, and the father of the child if the father is available; or

''(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

''(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian Tribe' and 'Tribal Organization', and 'Urban Indian Organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.''.

SEC. 2952. SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.

(a) RESEARCH ON POSTPARTUM CONDITIONS.—

(1) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—The Secretary of Health and Human Services (in this subsection and subsection (c) referred to as the ''Secretary'') is encouraged to continue activities on postpartum depression or postpartum psychosis (in this subsection and subsection (c) referred to as ''postpartum conditions''), including research to expand the understanding of the causes of, and treatments for, postpartum conditions. Activities under this paragraph shall include conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and knowledge of postpartum conditions. Activities under such a national campaign may—

(i) include public service announcements through television, radio, and other means; and

(ii) focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(2) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

(A) SENSE OF CONGRESS.—It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(B) REPORT.—Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enactment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(b) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 2951, is amended by adding at the end the following new section:

''SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

''(a) IN GENERAL.—In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

''(b) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

''(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services.

''(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

''(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance).

''(4) Providing education about postpartum conditions to promote earlier diagnosis and treatment. Such education may include—

''(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

''(B) in the case of a grantee that is a State, hospital, or birthing facility—

''(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

''(ii) ensuring that training programs regarding such education are carried out at the health facility.

''(c) INTEGRATION WITH OTHER PROGRAMS.—To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

''(d) REQUIREMENTS.—The Secretary shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for each grant period, a report to the Secretary that describes how grant funds were used during such period.

''(e) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

''(f) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

''(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

''(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

''(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

''(C) Section 504(d) (relating to a limitation on administrative expenditures).

''(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(E) Section 507 (relating to penalties for false statements).

''(F) Section 508 (relating to nondiscrimination).

''(G) Section 509(a) (relating to the administration of the grant program).

''(g) DEFINITIONS.—In this section:

''(1) The term 'eligible entity'—

''(A) means a public or nonprofit private entity; and

''(B) includes a State or local government, public-private partnership, recipient of a grant under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

''(2) The term 'postpartum condition' means postpartum depression or postpartum psychosis.''.

(c) GENERAL PROVISIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section and the amendment made by subsection (b), there are authorized to be appropriated, in addition to such other sums as may be available for such purpose—

(A) $3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) REPORT BY THE SECRETARY.—

(A) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by subparagraph (A) and submit a report to the Congress on the results of such study.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION.

Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended by adding at the end the following:

"SEC. 513. PERSONAL RESPONSIBILITY EDUCATION.

''(a) ALLOTMENTS TO STATES.—

''(1) AMOUNT.—

''(A) IN GENERAL.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

''(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

''(ii) the State youth population percentage determined under paragraph (2).

''(B) MINIMUM ALLOTMENT.—

''(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

''(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

''(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

''(i) IN GENERAL.—A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

''(ii) REQUIREMENTS.—The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

''(I) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for the State for youth ages 10 to 14 and youth ages 15 to 19 for which data are available, the most recent birth rates for such youth populations in the State for which data are available, and trends in those rates for the most recently preceding 5-year period for which such data are available.

''(II) State-established goals for reducing the pregnancy rates and birth rates for such youth populations.

''(III) A description of the State's plan for using the State allotments provided under this section to achieve such goals, especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

''(2) STATE YOUTH POPULATION PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

''(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

''(ii) the number of such individuals in all States.

''(B) DETERMINATION OF NUMBER OF YOUTH.—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

''(3) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

''(A) GRANTS FROM UNEXPENDED ALLOTMENTS.—If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

''(B) 3-YEAR GRANTS.—

''(i) IN GENERAL.—The Secretary shall solicit applications to award 3-year grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct, consistent with subsection (b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

''(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia.

''(C) EVALUATION.—An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

''(5) MAINTENANCE OF EFFORT.—No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

''(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

''(b) PURPOSE.—

''(1) IN GENERAL.—The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants made under subsection (a)(4)(B), to enable a local organization or entity) to carry out personal responsibility education programs consistent with this subsection.

''(2) PERSONAL RESPONSIBILITY EDUCATION PROGRAMS.—

''(A) IN GENERAL.—In this section, the term 'personal responsibility education program' means a program that is designed to educate adolescents on—

''(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

''(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

''(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

''(i) The program replicates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

''(ii) The program is medically-accurate and complete.

''(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

''(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

''(v) The program provides age-appropriate information and activities.

''(vi) The information and activities carried out under the program are provided in

the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

''(C) ADULTHOOD PREPARATION SUBJECTS.—The adulthood preparation subjects described in this subparagraph are the following:

''(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

''(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

''(iii) Financial literacy.

''(iv) Parent-child communication.

''(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

''(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

''(c) RESERVATIONS OF FUNDS.—

''(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

''(2) OTHER RESERVATIONS.—From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

''(A) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

''(B) SECRETARIAL RESPONSIBILITIES.—

''(i) RESERVATION OF FUNDS.—The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the activities described in clauses (ii) and (iii).

''(ii) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, research, training and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other State, tribal, and community organizations working to reduce teen pregnancy. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

''(iii) EVALUATION.—The Secretary shall evaluate the programs and activities carried out with funds made available through allotments or grants under this section.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary shall administer this section through the Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services.

''(2) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the other provisions of this title shall not apply to allotments or grants made under this section.

''(B) EXCEPTIONS.—The following provisions of this title shall apply to allotments and grants made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

''(i) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

''(ii) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

''(iii) Section 504(d) (relating to a limitation on administrative expenditures).

''(iv) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(v) Section 507 (relating to penalties for false statements).

''(vi) Section 508 (relating to nondiscrimination).

''(e) DEFINITIONS.—In this section:

''(1) AGE-APPROPRIATE.—The term 'age-appropriate', with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

''(2) MEDICALLY ACCURATE AND COMPLETE.—The term 'medically accurate and complete' means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

''(A) published in peer-reviewed journals, where applicable; or

''(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

''(3) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The terms 'Indian tribe' and 'Tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

''(4) YOUTH.—The term 'youth' means an individual who has attained age 10 but has not attained age 20.

''(f) APPROPRIATION.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this subsection shall remain available until expended.''.

SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), by striking ''fiscal year 1998 and each subsequent fiscal year'' and inserting ''each of fiscal years 2010 through 2014''; and

(2) in subsection (d)—

(A) in the first sentence, by striking ''1998 through 2003'' and inserting ''2010 through 2014''; and

(B) in the second sentence, by inserting ''(except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)'' before the period.

SEC. 2955. INCLUSION OF INFORMATION ABOUT THE IMPORTANCE OF HAVING A HEALTH CARE POWER OF ATTORNEY IN TRANSITION PLANNING FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.

(a) TRANSITION PLANNING.—Section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)) is amended by inserting ''includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,'' after ''employment services,''.

(b) INDEPENDENT LIVING EDUCATION.—Section 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

''(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.''.

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (v), by striking ''and'' at the end; and

(2) by adding at the end the following:

''(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended

by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

''(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the 'Program') under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

''(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

''(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term 'hospital' means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

''(ii) EXCLUSIONS.—The term 'hospital' shall not include, with respect to a fiscal year, a hospital—

''(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

''(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

''(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

''(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

''(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

''(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

''(2) MEASURES.—

''(A) IN GENERAL.—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

''(B) REQUIREMENTS.—

''(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

''(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

''(aa) Acute myocardial infarction (AMI).

''(bb) Heart failure.

''(cc) Pneumonia.

''(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as 'Surgical Infection Prevention' for discharges occurring before July 2006).

''(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

''(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

''(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of 'Medicare spending per beneficiary'. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

''(C) LIMITATIONS.—

''(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

''(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

''(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

''(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

''(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

''(D) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

''(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

''(ii) historical performance standards;

''(iii) improvement rates; and

''(iv) the opportunity for continued improvement.

''(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

''(5) HOSPITAL PERFORMANCE SCORE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the 'hospital performance score') for each hospital for each performance period.

''(B) APPLICATION.—

''(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

''(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

''(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

''(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

''(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

''(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

''(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

''(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

''(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

''(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

''(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

''(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

''(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

''(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

''(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

''(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

''(B) ADJUSTMENT TO PAYMENTS.—

''(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

''(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

''(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term 'applicable percent' means—

''(i) with respect to fiscal year 2013, 1.0 percent;

''(ii) with respect to fiscal year 2014, 1.25 percent;

''(iii) with respect to fiscal year 2015, 1.5 percent;

''(iv) with respect to fiscal year 2016, 1.75 percent; and

''(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

''(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

''(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

''(I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

''(II) any portion of such payment amount that is attributable to—

''(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

''(bb) such other payments under subsection (d) determined appropriate by the Secretary.

''(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

''(I) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

''(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

''(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

''(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

''(10) PUBLIC REPORTING.—

''(A) HOSPITAL SPECIFIC INFORMATION.—

''(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

''(I) the performance of the hospital with respect to each measure that applies to the hospital;

''(II) the performance of the hospital with respect to each condition or procedure; and

''(III) the hospital performance score assessing the total performance of the hospital.

''(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

''(iii) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

''(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

''(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

''(11) IMPLEMENTATION.—

''(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

''(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

''(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

''(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

''(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

''(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

''(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

''(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

''(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).''.

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

(A) in subclause (II), by adding at the end the following sentence: ''The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).'';

(B) in subclause (V), by striking ''beginning with fiscal year 2008'' and inserting ''for fiscal years 2008 through 2012'';

(C) in subclause (VII), in the first sentence, by striking ''data submitted'' and inserting ''information regarding measures submitted''; and

(D) by adding at the end the following new subclauses:

''(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

''(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

''(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

''(aa) physicians under section 1848(k); and

''(bb) other providers of services and suppliers under this title.

''(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.''.

(3) WEBSITE IMPROVEMENTS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 4102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

''(x)(I) The Secretary shall develop standard Internet website reports tailored to meet

the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

''(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.''.

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as diverse in terms of race, ethnicity, and socioeconomic status);

(ii) expenditures under the Medicare program, including any reduced expenditures under Part A of title XVIII of such Act that are attributable to the improvement in the delivery of inpatient hospital services by reason of such hospital value-based purchasing program;

(iii) the quality performance among safety net hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program; and

(iv) the quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program.

(B) REPORTS.—

(i) INTERIM REPORT.—Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) FINAL REPORT.—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS.—

(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term ''applicable hospital'' means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) EXTENSION.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''2010'' and inserting ''2014''; and

(B) in subparagraph (B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new clauses:

''(iii) for 2011, 1.0 percent; and

''(iv) for 2012, 2013, and 2014, 0.5 percent.'';

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting ''(or, for purposes of subsection (a)(8), for the quality reporting period for the year)'' after ''reporting period''; and

(B) in subparagraph (C)(i), by inserting '', or, for purposes of subsection (a)(8), for a quality reporting period for the year'' after ''(a)(5), for a reporting period for a year'';

(3) in paragraph (5)(E)(iv), by striking ''subsection (a)(5)(A)'' and inserting ''paragraphs (5)(A) and (8)(A) of subsection (a)''; and

(4) in paragraph (6)(C)—

(A) in clause (i)(II), by striking '', 2009, 2010, and 2011'' and inserting ''and subsequent years''; and

(B) in clause (iii)—

(i) by inserting ''(a)(8)'' after ''(a)(5)''; and

(ii) by striking ''under subparagraph (D)(iii) of such subsection'' and inserting

''under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively''.

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

''(8) INCENTIVES FOR QUALITY REPORTING.—

''(A) ADJUSTMENT.—

''(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2015, 98.5 percent; and

''(II) for 2016 and each subsequent year, 98 percent.

''(B) APPLICATION.—

''(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

''(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

''(C) DEFINITIONS.—For purposes of this paragraph:

''(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms 'eligible professional' and 'covered professional services' have the meanings given such terms in subsection (k)(3).

''(ii) PHYSICIAN REPORTING SYSTEM.—The term 'physician reporting system' means the system established under subsection (k).

''(iii) QUALITY REPORTING PERIOD.—The term 'quality reporting period' means, with respect to a year, a period specified by the Secretary.''.

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by inserting ''or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry'' after ''Database)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

''(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

''(A) The selection of measures, the reporting of which would both demonstrate—

''(i) meaningful use of an electronic health record for purposes of subsection (o); and

''(ii) quality of care furnished to an individual.

''(B) Such other activities as specified by the Secretary.''.

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

''(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.''.

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking ''There shall'' and inserting ''Except as provided in subparagraph (I), there shall''; and

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

''(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.''.

SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) IN GENERAL.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking ''GENERAL.—The Secretary'' and inserting ''GENERAL.—

''(i) ESTABLISHMENT.—The Secretary'';

(ii) in clause (i), as added by clause (i), by striking ''the 'Program')'' and all that follows through the period at the end of the second sentence and inserting ''the 'Program').''; and

(iii) by adding at the end the following new clauses:

''(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

''(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.''; and

(B) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''subparagraph (A)(ii)'';

(2) in paragraph (4)—

(A) in the heading, by inserting ''INITIAL'' after ''FOCUS''; and

(B) in the matter preceding subparagraph (A), by inserting ''initial'' after ''focus the'';

(3) in paragraph (6), by adding at the end the following new sentence: ''For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.''; and

(4) by adding at the end the following new paragraphs:

''(9) REPORTS ON UTILIZATION.—

''(A) DEVELOPMENT OF EPISODE GROUPER.—

''(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

''(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

''(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

''(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

''(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

''(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

''(i) attribute episodes of care, in whole or in part, to physicians;

''(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

''(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

''(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

''(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

''(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

''(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

''(i) the methodologies established under subparagraph (C);

''(ii) information regarding any adjustments made to data under subparagraph (D); and

''(iii) aggregate reports with respect to physicians.

''(F) DEFINITION OF PHYSICIAN.—In this paragraph:

''(i) IN GENERAL.—The term 'physician' has the meaning given that term in section 1861(r)(1).

''(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

''(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

''(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.''.

(b) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following new paragraph:

''(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPER UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.''.

SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

''(5) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

''(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''.

(b) INPATIENT REHABILITATION HOSPITALS.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(1) by redesignating paragraph (7) as paragraph (8); and

(2) by inserting after paragraph (6) the following new paragraph:

''(7) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

''(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.''.

(c) HOSPICE PROGRAMS.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

''(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

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

(1) in subsection (a)(1)—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k).''; and

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

''(k) QUALITY REPORTING BY CANCER HOSPITALS.—

''(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

''(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(3) QUALITY MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

''(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

''(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in skilled nursing facilities.

(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iii) must have been endorsed by the entity with a contract under section 1890(a).

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) HOME HEALTH AGENCIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(1), by inserting ''subject to subsection (p),'' after ''1998,''; and

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

''(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

''(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

''(2) QUALITY.—

''(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

''(B) MEASURES.—

''(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

''(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

''(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

''(4) IMPLEMENTATION.—

''(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

''(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

''(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

''(iii) The initial performance period (as specified under subparagraph (B)(ii)).

''(B) DEADLINES FOR IMPLEMENTATION.—

''(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

''(ii) INITIAL PERFORMANCE PERIOD.—

''(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

''(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

''(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

''(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

''(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

''(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

''(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

''(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

''(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term 'physician' has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) COSTS.—The term 'costs' means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

''(B) PERFORMANCE PERIOD.—The term 'performance period' means a period specified by the Secretary.

''(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

''(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the establishment of the value-based payment modifier under this subsection;

''(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

''(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

''(D) the dates for implementation of the value-based payment modifier;

''(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

''(F) the application of the value-based payment modifier under paragraph (7); and

''(G) the determination of costs under paragraph (8)(A).''.

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following new subsection:

''(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

''(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

''(2) APPLICABLE HOSPITALS.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'applicable hospital' means a subsection (d) hospital that meets the criteria described in subparagraph (B).

''(B) CRITERIA DESCRIBED.—

''(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

''(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

''(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

''(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term 'hospital acquired condition' means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

''(4) APPLICABLE PERIOD.—In this subsection, the term 'applicable period' means, with respect to a fiscal year, a period specified by the Secretary.

''(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

''(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

''(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

''(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

''(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) The criteria described in paragraph (2)(A).

''(B) The specification of hospital acquired conditions under paragraph (3).

''(C) The specification of the applicable period under paragraph (4).

''(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).''.

(b) STUDY AND REPORT ON EXPANSION OF HEALTHCARE ACQUIRED CONDITIONS POLICY TO OTHER PROVIDERS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on expanding the healthcare acquired conditions policy under subsection (d)(4)(D) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) to payments made to other facilities under the Medicare program under title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities, long-term care hospitals (as described in subsection(d)(1)(B)(iv) of such section), hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

(2) REPORT.—Not later than January 1, 2012, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART S—HEALTH CARE QUALITY PROGRAMS

''Subpart I—National Strategy for Quality Improvement in Health Care

''SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

''(a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

''(1) NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

''(2) IDENTIFICATION OF PRIORITIES.—

''(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

''(B) REQUIREMENTS.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

''(i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;

''(ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

''(iii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;

''(iv) improve Federal payment policy to emphasize quality and efficiency;

''(v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

''(vi) address the health care provided to patients with high-cost chronic diseases;

''(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;

''(viii) reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and

''(ix) address other areas as determined appropriate by the Secretary.

''(C) CONSIDERATIONS.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders.

''(D) COORDINATION WITH STATE AGENCIES.—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children's Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under subparagraph (A).

''(b) STRATEGIC PLAN.—

''(1) IN GENERAL.—The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

''(2) REQUIREMENTS.—The strategic plan shall include provisions for addressing, at a minimum, the following:

''(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

''(B) Agency-specific strategic plans to achieve national priorities.

''(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

''(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

''(E) Strategies to align public and private payers with regard to quality and patient safety efforts.

''(F) Incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

''(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

''(d) SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATES.—

''(1) DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

''(2) UPDATES.—

''(A) IN GENERAL.—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1).

''(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

''(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

''(ii) an analysis of the progress, or lack of progress, in meeting such goals and any barriers to such progress;

''(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

''(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

''(C) SATISFACTION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements under sections 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

''(e) HEALTH CARE QUALITY INTERNET WEBSITE.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

''(1) the national priorities for health care quality improvement established under subsection (a)(2);

''(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

''(3) other information, as the Secretary determines to be appropriate.''.

SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

(a) IN GENERAL.—The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the ''Working Group'').

(b) GOALS.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 399HH(a)(2) of the Public Health Service Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

(c) COMPOSITION.—

(1) IN GENERAL.—The Working Group shall be composed of senior level representatives of—

(A) the Department of Health and Human Services;

(B) the Centers for Medicare & Medicaid Services;

(C) the National Institutes of Health;

(D) the Centers for Disease Control and Prevention;

(E) the Food and Drug Administration;

(F) the Health Resources and Services Administration;

(G) the Agency for Healthcare Research and Quality;

(H) the Office of the National Coordinator for Health Information Technology;

(I) the Substance Abuse and Mental Health Services Administration;

(J) the Administration for Children and Families;

(K) the Department of Commerce;

(L) the Office of Management and Budget;

(M) the United States Coast Guard;

(N) the Federal Bureau of Prisons;

(O) the National Highway Traffic Safety Administration;

(P) the Federal Trade Commission;

(Q) the Social Security Administration;

(R) the Department of Labor;

(S) the United States Office of Personnel Management;

(T) the Department of Defense;

(U) the Department of Education;

(V) the Department of Veterans Affairs;

(W) the Veterans Health Administration; and

(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) CHAIR AND VICE-CHAIR.—

(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) VICE CHAIR.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) REPORT TO CONGRESS.—Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

SEC. 3013. QUALITY MEASURE DEVELOPMENT.

(a) PUBLIC HEALTH SERVICE ACT.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as so redesignated, by striking ''931'' and inserting ''941''; and

(4) by inserting after section 926 the following:

''PART D—HEALTH CARE QUALITY IMPROVEMENT

''Subpart I—Quality Measure Development

''SEC. 931. QUALITY MEASURE DEVELOPMENT.

''(a) QUALITY MEASURE.—In this subpart, the term 'quality measure' means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

''(b) IDENTIFICATION OF QUALITY MEASURES.—

''(1) IDENTIFICATION.—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality

measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 399HH, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

''(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

''(B) quality measures identified by the pediatric quality measures program under section 1139A of the Social Security Act; and

''(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

''(2) PUBLICATION.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

''(c) GRANTS OR CONTRACTS FOR QUALITY MEASURE DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

''(2) PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

''(A) health outcomes and functional status of patients;

''(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

''(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decisionmaking about treatment options, including the use of shared decisionmaking tools and preference sensitive care (as defined in section 936);

''(D) the meaningful use of health information technology;

''(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

''(F) the efficiency of care;

''(G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas;

''(H) patient experience and satisfaction;

''(I) the use of innovative strategies and methodologies identified under section 933; and

''(J) other areas determined appropriate by the Secretary.

''(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

''(B) have adopted procedures to include in the quality measure development process—

''(i) the views of those providers or payers whose performance will be assessed by the measure; and

''(ii) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

''(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

''(D) have transparent policies regarding governance and conflicts of interest; and

''(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

''(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

''(A) Such measures support measures required to be reported under the Social Security Act, where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

''(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

''(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

''(D) Each quality measure is free of charge to users of such measure.

''(E) Each quality measure is publicly available on an Internet website.

''(d) OTHER ACTIVITIES BY THE SECRETARY.—The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act or adopted by the Secretary.

''(e) COORDINATION OF GRANTS.—The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under sections 1139A(5) and 1139B(4)(A) of the Social Security Act.''.

(b) SOCIAL SECURITY ACT.—Section 1890A of the Social Security Act, as added by section 3014(b), is amended by adding at the end the following new subsection:

''(e) DEVELOPMENT OF QUALITY MEASURES.—The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality measures (as determined appropriate by the Administrator) for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.''.

(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, $75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be used pursuant to subsection (e) of section 1890A of the Social Security Act, as added by subsection (b), with respect to programs under such Act. Amounts appropriated under this subsection for a fiscal year shall remain available until expended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs:

''(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

''(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

''(i) the selection of quality measures described in subparagraph (B), from among—

''(I) such measures that have been endorsed by the entity; and

''(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

''(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

''(B) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), the quality measures described in this subparagraph are quality measures—

''(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(t)(17), 1848(k)(2)(C), 1866(k)(3), 1881(h)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D), 1886(o)(2), and 1895(b)(3)(B)(v);

''(II) for use in reporting performance information to the public; and

''(III) for use in health care programs other than for use under this Act.

''(ii) EXCLUSION.—Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this title shall not be quality measures described in this subparagraph.

''(C) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

''(i) IN GENERAL.—In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

''(ii) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

''(D) MULTI-STAKEHOLDER GROUP DEFINED.—In this paragraph, the term 'multi-stakeholder group' means, with respect to a quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

''(8) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).''.

(2) ANNUAL REPORT.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new clauses:

''(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality measures are unavailable or inadequate to identify or address such gaps;

''(v) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

''(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).''.

(b) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1890 the following:

''QUALITY MEASUREMENT

''SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality measures described in section 1890(b)(7)(B):

''(1) INPUT.—Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in subparagraph (B) of such paragraph.

''(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

''(3) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

''(4) CONSIDERATION OF MULTI-STAKEHOLDER INPUT.—The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

''(5) RATIONALE FOR USE OF QUALITY MEASURES.—The Secretary shall publish in the Federal Register the rationale for the use of any quality measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

''(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

''(A) conduct an assessment of the quality impact of the use of endorsed measures described in section 1890(b)(7)(B); and

''(B) make such assessment available to the public.

''(b) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the following:

''(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

''(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

''(2) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process established under paragraph (1).

''(c) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall—

''(A) periodically (but in no case less often than once every 3 years) review quality measures described in section 1890(b)(7)(B); and

''(B) with respect to each such measure, determine whether to—

''(i) maintain the use of such measure; or

''(ii) phase out such measure.

''(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

''(A) seek to avoid duplication of measures used; and

''(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using the quality measures identified under sections 1139A and 1139B.''.

(c) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3011, is further amended by adding at the end the following:

''SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

''(a) IN GENERAL.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

''(b) GRANTS OR CONTRACTS FOR DATA COLLECTION.—

''(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) be—

''(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

''(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

''(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

''(B) promote the use of the systems that provide data to improve and coordinate patient care;

''(C) support the provision of timely, consistent quality and resource use information to health care providers, and other groups and organizations as appropriate, with an opportunity for providers to correct inaccurate measures; and

''(D) agree to report, as determined by the Secretary, measures on quality and resource use to the public in accordance with the public reporting process established under section 399JJ.

''(c) CONSISTENT DATA AGGREGATION.—The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

''(d) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

''SEC. 399JJ. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

''(a) DEVELOPMENT OF PERFORMANCE WEBSITES.—The Secretary shall make available to the public, through standardized Internet websites, performance information summarizing data on quality measures. Such information shall be tailored to respond to the differing needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders, as the Secretary may specify.

''(b) INFORMATION ON CONDITIONS.—The performance information made publicly available on an Internet website, as described in subsection (a), shall include information regarding clinical conditions to the extent such information is available, and the information shall, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.

''(c) CONSULTATION.—

''(1) IN GENERAL.—In carrying out this section, the Secretary shall consult with the entity with a contract under section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting Internet websites.

''(2) CONSULTATION WITH STAKEHOLDERS.—The entity with a contract under section 1890(a) of the Social Security Act shall convene multi-stakeholder groups, as described in such section, to review the design and format of each Internet website made available

under subsection (a) and shall transmit to the Secretary the views of such multi-stakeholder groups with respect to each such design and format.

''(d) COORDINATION.—Where appropriate, the Secretary shall coordinate the manner in which data are presented through Internet websites described in subsection (a) and for public reporting of other quality measures by the Secretary, including such quality measures under title XVIII of the Social Security Act.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.''.

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

''CENTER FOR MEDICARE AND MEDICAID INNOVATION

''SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

''(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

''(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

''(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

''(4) DEFINITIONS.—In this section:

''(A) APPLICABLE INDIVIDUAL.—The term 'applicable individual' means—

''(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;

''(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

''(iii) an individual who meets the criteria of both clauses (i) and (ii).

''(B) APPLICABLE TITLE.—The term 'applicable title' means title XVIII, title XIX, or both.

''(b) TESTING OF MODELS (PHASE I).—

''(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

''(2) SELECTION OF MODELS TO BE TESTED.—

''(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subparagraph (B).

''(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

''(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

''(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

''(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

''(I) An inability to perform 2 or more activities of daily living.

''(II) Cognitive impairment, including dementia.

''(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

''(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

''(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

''(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

''(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

''(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

''(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

''(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

''(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

''(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

''(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

''(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

''(I) developing, documenting, and disseminating best practices and proven care methods;

''(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

''(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

''(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

''(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

''(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

''(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

''(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

''(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

''(iii) Whether the model provides for in-person contact with applicable individuals.

''(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

''(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-

based organizations, and other providers of services and suppliers.

''(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

''(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

''(3) BUDGET NEUTRALITY.—

''(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

''(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

''(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

''(ii) reduce spending under the applicable title without reducing the quality of care; or

''(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

''(4) EVALUATION.—

''(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

''(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

''(ii) the changes in spending under the applicable titles by reason of the model.

''(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

''(c) EXPANSION OF MODELS (PHASE II).—Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected to—

''(A) reduce spending under applicable title without reducing the quality of care; or

''(B) improve the quality of care and reduce spending; and

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

''(d) IMPLEMENTATION.—

''(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

''(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the selection of models for testing or expansion under this section;

''(B) the selection of organizations, sites, or participants to test those models selected;

''(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

''(D) determinations regarding budget neutrality under subsection (b)(3);

''(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

''(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

''(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

''(f) FUNDING.—

''(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

''(A) $5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

''(B) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

''(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

''(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

''(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.''.

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 8002(b), is amended—

(1) in paragraph (81), by striking ''and'' at the end;

(2) in paragraph (82), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (82) the following new paragraph:

''(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.''.

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking ''5-year'' each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SHARED SAVINGS PROGRAM

''SEC. 1899. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

''(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and

''(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

''(b) ELIGIBLE ACOS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

''(A) ACO professionals in group practice arrangements.

''(B) Networks of individual practices of ACO professionals.

''(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

''(D) Hospitals employing ACO professionals.

''(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

''(2) REQUIREMENTS.—An ACO shall meet the following requirements:

''(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

''(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the 'agreement period').

''(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

''(D) The ACO shall include primary care ACO professionals that are sufficient for the

number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

''(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

''(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

''(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

''(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

''(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

''(i) clinical processes and outcomes;

''(ii) patient and, where practicable, caregiver experience of care; and

''(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

''(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

''(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

''(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

''(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

''(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

''(B) The independence at home medical practice pilot program under section 1866E.

''(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOs.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

''(d) PAYMENTS AND TREATMENT OF SAVINGS.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

''(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

''(ii) the ACO meets the requirement under subparagraph (B)(i).

''(B) SAVINGS REQUIREMENT AND BENCHMARK.—

''(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

''(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

''(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

''(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

''(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

''(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

''(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

''(g) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(1) the specification of criteria under subsection (a)(1)(B);

''(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

''(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

''(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

''(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

''(6) the termination of an ACO under subsection (d)(4).

''(h) DEFINITIONS.—In this section:

''(1) ACO PROFESSIONAL.—The term 'ACO professional' means—

''(A) a physician (as defined in section 1861(r)(1)); and

''(B) a practitioner described in section 1842(b)(18)(C)(i).

''(2) HOSPITAL.—The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

''(3) MEDICARE FEE-FOR-SERVICE BENEFICIARY.—The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.''.

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1886C the following new section:

''NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

''SEC. 1866D. (a) IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

''(2) DEFINITIONS.—In this section:

''(A) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who—

''(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C or a PACE program under section 1894; and

''(ii) is admitted to a hospital for an applicable condition.

''(B) APPLICABLE CONDITION.—The term 'applicable condition' means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

''(i) Whether the conditions selected include a mix of chronic and acute conditions.

''(ii) Whether the conditions selected include a mix of surgical and medical conditions.

''(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

''(iv) Whether a condition has significant variation in—

''(I) the number of readmissions; and

''(II) the amount of expenditures for post-acute care spending under this title.

''(v) Whether a condition is high-volume and has high post-acute care expenditures under this title.

''(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

''(C) APPLICABLE SERVICES.—The term 'applicable services' means the following:

''(i) Acute care inpatient services.

''(ii) Physicians' services delivered in and outside of an acute care hospital setting.

''(iii) Outpatient hospital services, including emergency department services.

''(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

''(v) Other services the Secretary determines appropriate.

''(D) EPISODE OF CARE.—

''(i) IN GENERAL.—Subject to clause (ii), the term 'episode of care' means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

''(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

''(II) the length of stay of the applicable beneficiary in such hospital; and

''(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

''(ii) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

''(E) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given such term in section 1861(q).

''(F) PILOT PROGRAM.—The term 'pilot program' means the pilot program under this section.

''(G) PROVIDER OF SERVICES.—The term 'provider of services' has the meaning given such term in section 1861(u).

''(H) READMISSION.—The term 'readmission' has the meaning given such term in section 1886(q)(5)(E).

''(I) SUPPLIER.—The term 'supplier' has the meaning given such term in section 1861(d).

''(3) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program not later than January 1, 2013.

''(b) DEVELOPMENTAL PHASE.—

''(1) DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.—The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically appropriate site for the provision of post-acute care to the applicable beneficiary.

''(2) DEVELOPMENT OF QUALITY MEASURES FOR AN EPISODE OF CARE AND FOR POST-ACUTE CARE.—

''(A) IN GENERAL.—The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, shall develop quality measures for use in the pilot program—

''(i) for episodes of care; and

''(ii) for post-acute care.

''(B) SITE-NEUTRAL POST-ACUTE CARE QUALITY MEASURES.—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

''(C) COORDINATION WITH QUALITY MEASURE DEVELOPMENT AND ENDORSEMENT PROCEDURES.—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all post-acute care settings.

''(c) DETAILS.—

''(1) DURATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

''(B) EXTENSION.—The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this title.

''(2) PARTICIPATING PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

''(B) REQUIREMENTS.—The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

''(3) PAYMENT METHODOLOGY.—

''(A) IN GENERAL.—

''(i) ESTABLISHMENT OF PAYMENT METHODS.—The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

''(ii) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section for applicable items and services under this title (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

''(B) INCLUSION OF CERTAIN SERVICES.—A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

''(C) BUNDLED PAYMENTS.—

''(i) IN GENERAL.—A bundled payment under the pilot program shall—

''(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

''(II) be made to the entity which is participating in the pilot program.

''(ii) REQUIREMENT FOR PROVISION OF APPLICABLE SERVICES AND OTHER APPROPRIATE SERVICES.—Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

''(D) PAYMENT FOR POST-ACUTE CARE SERVICES AFTER THE EPISODE OF CARE.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

''(4) QUALITY MEASURES.—

''(A) IN GENERAL.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

''(i) Functional status improvement.

''(ii) Reducing rates of avoidable hospital readmissions.

''(iii) Rates of discharge to the community.

''(iv) Rates of admission to an emergency room after a hospitalization.

''(v) Incidence of health care acquired infections.

''(vi) Efficiency measures.

''(vii) Measures of patient-centeredness of care.

''(viii) Measures of patient perception of care.

''(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

''(B) REPORTING ON QUALITY MEASURES.—

''(i) IN GENERAL.—A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

''(ii) SUBMISSION OF DATA THROUGH ELECTRONIC HEALTH RECORD.—To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj–11(13)) in a manner specified by the Secretary.

''(d) WAIVER.—The Secretary may waive such provisions of this title and title XI as may be necessary to carry out the pilot program.

''(e) INDEPENDENT EVALUATION AND REPORTS ON PILOT PROGRAM.—

''(1) INDEPENDENT EVALUATION.—The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has—

''(A) improved quality measures established under subsection (c)(4)(A);

''(B) improved health outcomes;

''(C) improved applicable beneficiary access to care; and

''(D) reduced spending under this title.

''(2) REPORTS.—

''(A) INTERIM REPORT.—Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

''(B) FINAL REPORT.—Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

''(f) CONSULTATION.—The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1861(mm)(1)), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

''(g) IMPLEMENTATION PLAN.—

''(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

''(h) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.''.

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

''INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

''SEC. 1866D. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

''(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

''(A) reducing preventable hospitalizations;

''(B) preventing hospital readmissions;

''(C) reducing emergency room visits;

''(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

''(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

''(F) reducing the cost of health care services covered under this title; and

''(G) achieving beneficiary and family caregiver satisfaction.

''(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

''(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

''(A) IN GENERAL.—The term 'independence at home medical practice' means a legal entity that—

''(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

''(ii) is organized at least in part for the purpose of providing physicians' services;

''(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

''(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

''(v) has entered into an agreement with the Secretary;

''(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

''(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

''(B) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

''(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

''(A) all the requirements of this section are met;

''(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

''(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

''(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

''(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

''(c) PAYMENT METHODOLOGY.—

''(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

''(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

''(d) APPLICABLE BENEFICIARIES.—

''(1) DEFINITION.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

''(A) is entitled to benefits under part A and enrolled for benefits under part B;

''(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

''(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

''(D) within the past 12 months has had a nonelective hospital admission;

''(E) within the past 12 months has received acute or subacute rehabilitation services;

''(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

''(G) meets such other criteria as the Secretary determines appropriate.

''(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

''(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

''(e) IMPLEMENTATION.—

''(1) STARTING DATE.—The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

''(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

''(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

''(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

''(A) located in high-cost areas of the country;

''(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

''(C) use electronic medical records, health information technology, and individualized plans of care.

''(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

''(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

''(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

''(f) EVALUATION AND MONITORING.—

''(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

''(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

''(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

''(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

''(i) TERMINATION.—

''(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

''(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

''(B) such practice fails to meet quality standards during any year of the demonstration program.

''(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.''.

SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

''(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

''(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

''(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

''(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

''(2) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

''(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

''(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

''(B) SPECIAL RULES FOR CERTAIN HOSPITALS.—

''(i) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

''(ii) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

''(3) ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

''(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

''(ii) the floor adjustment factor specified in subparagraph (C).

''(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

''(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

''(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

''(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

''(i) fiscal year 2013 is 0.99;

''(ii) fiscal year 2014 is 0.98; or

''(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

''(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

''(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term 'aggregate payments for excess readmissions' means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

''(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

''(ii) the number of admissions for such condition for such hospital for such applicable period; and

''(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

''(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term 'aggregate payments for all discharges' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

''(C) EXCESS READMISSION RATIO.—

''(i) IN GENERAL.—Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

''(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

''(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

''(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

''(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

''(ii) measures of such readmissions—

''(I) have been endorsed by the entity with a contract under section 1890(a); and

''(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

''(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

''(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify.

''(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

''(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

''(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

''(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

''(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) The determination of base operating DRG payment amounts.

''(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

''(C) The measures of readmissions as described in paragraph (5)(A)(ii).

''(8) READMISSION RATES FOR ALL PATIENTS.—

''(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this title and posted on the CMS Hospital Compare website.

''(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

''(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.—

''(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

''(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

''(D) DEFINITIONS.—For purposes of this paragraph:

''(i) The term 'all patients' means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

''(ii) The term 'specified hospital' means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.''.

(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

''SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SEVERITY ADJUSTED READMISSION RATE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 921(4)).

''(2) ELIGIBLE HOSPITAL DEFINED.—In this subsection, the term 'eligible hospital' means a hospital that the Secretary determines has a high rate of risk adjusted readmissions for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.

''(3) RISK ADJUSTMENT.—The Secretary shall utilize appropriate risk adjustment measures to determine eligible hospitals.

''(b) REPORT TO THE SECRETARY.—As determined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates.''.

SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

(2) HIGH-RISK MEDICARE BENEFICIARY.—The term ''high-risk Medicare beneficiary'' means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(3) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual

who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(4) PROGRAM.—The term ''program'' means the program conducted under this section.

(5) READMISSION.—The term ''readmission'' has the meaning given such term in section 1886(q)(5)(E) of the Social Security Act, as added by section 3025.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(c) REQUIREMENTS.—

(1) DURATION.—

(A) IN GENERAL.—The program shall be conducted for a 5-year period, beginning January 1, 2011.

(B) EXPANSION.—The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies) that such expansion would reduce spending under this title without reducing quality.

(2) APPLICATION; PARTICIPATION.—

(A) IN GENERAL.—

(i) APPLICATION.—An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(ii) PARTNERSHIP.—If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

(B) INTERVENTION PROPOSAL.—Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

(C) LIMITATION.—A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

(B) provide services to medically underserved populations, small communities, and rural areas.

(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the program.

(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting ''(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)'' after ''December 31, 2009''.

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting ''and for fiscal year 2010, $1,600,000,'' after ''$6,000,000,''.

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking ''2010'' and inserting ''2014 or until expended''.

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking ''December 1, 2008'' and inserting ''March 31, 2011''.

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking ''May 1, 2010'' and inserting ''March 31, 2013''.

Subtitle B—Improving Medicare for Patients and Providers

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(10) UPDATE FOR 2010.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.''.

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) EXTENSION OF WORK GPCI FLOOR.—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before January 1, 2010'' and inserting ''before January 1, 2011''.

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''and (G)'' and inserting ''(G), and (H)''; and

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

''(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

''(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ¾ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

''(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

''(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

''(iv) ANALYSIS.—The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

''(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

''(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

''(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

''(v) REVISION FOR 2012 AND SUBSEQUENT YEARS.—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

''(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

''(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to

clauses (i) and (ii) and shall be made in a budget neutral manner.''.

SEC. 3103. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2010''.

SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''and 2009'' and inserting ''2009, and 2010''.

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i)—

(A) by striking ''2007, and for'' and inserting ''2007, for''; and

(B) by striking ''2010'' and inserting ''2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,''; and

(2) in each of clauses (i) and (ii), by inserting '', and on or after April 1, 2010, and before January 1, 2011'' after ''January 1, 2010'' each place it appears.

(b) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011''.

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking ''2010'' and inserting ''2010, and on or after April 1, 2010, and before January 1, 2011''.

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND OF MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) EXTENSION OF CERTAIN PAYMENT RULES.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111–5), is further amended by striking ''3-year period'' each place it appears and inserting ''4-year period''.

(b) EXTENSION OF MORATORIUM.—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking ''3-year period'' and inserting ''4-year period''.

SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2010''.

SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—

(1) IN GENERAL.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395f(a)(2)), in the matter preceding subparagraph (A), is amended by striking ''or clinical nurse specialist'' and inserting '', a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5))'' after ''nurse practitioner''.

(2) CONFORMING AMENDMENT.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended, in the second sentence, by striking ''or clinical nurse specialist'' and inserting ''clinical nurse specialist, or physician assistant'' after ''nurse practitioner,''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 3109. EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) IN GENERAL.—Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 100–275), is amended—

(1) in subparagraph (F)(i)—

(A) by inserting ''and subparagraph (G)'' after ''clause (ii)''; and

(B) by inserting '', except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011'' before the semicolon at the end; and

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

''(G) APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.—

''(i) IN GENERAL.—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

''(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

''(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

''(ii) PHARMACIES DESCRIBED.—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

''(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

''(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

''(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

''(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.''.

(b) ADMINISTRATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

(c) RULE OF CONSTRUCTION.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

''(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

''(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

''(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

''(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

''(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the

Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking ''section 1837(i)(4)'' and inserting ''subsection (i)(4) or (l) of section 1837''.

SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) PAYMENT.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (b)—

(i) in paragraph (4)(B), by inserting '', and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))'' before the period at the end; and

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

''(6) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

''(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

''(B) the conversion factor (established under subsection (d)) for 2006; and

''(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively.''; and

(B) in subsection (c)(2)(B)(iv)—

(i) in subclause (II), by striking ''and'' at the end;

(ii) in subclause (III), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subclause:

''(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010 or 2011.''.

(2) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) by program instruction or otherwise.

(b) STUDY AND REPORT BY THE INSTITUTE OF MEDICINE.—

(1) IN GENERAL.—The Secretary of Health and Human Services is authorized to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the ramifications of Medicare payment reductions for dual-energy x-ray absorptiometry (as described in section 1848(b)(6) of the Social Security Act, as added by subsection (a)(1)) during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

(2) REPORT.—An agreement entered into under paragraph (1) shall provide for the Institute of Medicine to submit to the Secretary and to Congress a report containing the results of the study conducted under such paragraph.

SEC. 3112. REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act (42 U.S.C. 1395iii) is amended by striking ''$22,290,000,000'' and inserting ''$0''.

SEC. 3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

(2) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—In this section, the term ''complex diagnostic laboratory test'' means a diagnostic laboratory test—

(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

(C) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

(D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and

(E) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)).

(3) SEPARATE PAYMENT DEFINED.—In this section, the term ''separate payment'' means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such Act (42 U.S.C. 1395y(a)(14); 42 U.S.C. 1395cc(a)(1)(H)(i)).

(b) DURATION.—Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

(c) PAYMENTS AND LIMITATION.—Payments under the demonstration project under this section shall—

(1) be made from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t); and

(2) may not exceed $100,000,000.

(d) REPORT.—Not later than 2 years after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include—

(1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act (including any savings under such title); and

(2) such recommendations as the Secretary determines appropriate.

(e) IMPLEMENTATION FUNDING.—For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting ''(or 100 percent for services furnished on or after January 1, 2011)'' after ''1992, 65 percent''.

PART II—RURAL PROTECTIONS

SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) IN GENERAL.—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking ''2010''and inserting ''2011''; and

(B) in the second sentence, by striking ''or 2009'' and inserting '', 2009, or 2010''; and

(2) in subclause (III), by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

(b) PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HOLD HARMLESS.—Section 1833(t)(7)(D)(i)(III) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at the end the following new sentence: ''In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.''.

SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note) and section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), is amended by inserting ''or during the 1-year period beginning on July 1, 2010'' before the period at the end.

SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ONE-YEAR EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

''(g) ONE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period (in this section referred to as the '1-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

''(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

''(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may

participate in the demonstration program under this section.

''(4) NO AFFECT ON HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary shall provide for the continued participation of such rural community hospital in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation.''.

(b) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by inserting ''(in this section referred to as the 'initial 5-year period') and, as provided in subsection (g), for the 1-year extension period'' after ''5-year period''.

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (b) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in paragraph (1)(B)(ii), by striking ''2)'' and inserting ''2))''; and

(B) in paragraph (2), by inserting ''cost'' before ''reporting period'' the first place such term appears in each of subparagraphs (A) and (B).

(2) Subsection (f)(1) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in subparagraph (A)(ii), by striking ''paragraph (2)'' and inserting ''subparagraph (B)''; and

(B) in subparagraph (B), by striking ''paragraph (1)(B)'' and inserting ''subparagraph (A)(ii)''.

SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2012''; and

(2) in clause (ii)(II), by striking ''October 1, 2011'' and inserting ''October 1, 2012''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2012''; and

(B) in clause (iv), by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2012''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2012''.

SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (A), by inserting ''or (D)'' after ''subparagraph (B)'';

(2) in subparagraph (B), in the matter preceding clause (i), by striking ''The Secretary'' and inserting ''For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary'';

(3) in subparagraph (C)(i)—

(A) by inserting ''(or, with respect to fiscal years 2011 and 2012, 15 road miles)'' after ''25 road miles''; and

(B) by inserting ''(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)'' after ''800 discharges''; and

(4) by adding at the end the following new subparagraph:

''(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year.''.

SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) REMOVAL OF LIMITATION ON NUMBER OF ELIGIBLE COUNTIES SELECTED.—Subsection (d)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395i–4 note) is amended by striking ''not more than 6''.

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIANS' SERVICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(i)(3), by striking subclause (III); and

(2) in subsection (j)—

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

''(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).'';

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

SEC. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8) of section 1834 of the Social Security Act (42 U.S.C. 1395m) are each amended by inserting ''101 percent of'' before ''the reasonable costs''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2266).

SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) AUTHORIZATION.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i–4(j)) is amended—

(1) by striking ''2010, and for'' and inserting ''2010, for''; and

(2) by inserting ''and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended'' before the period at the end.

(b) USE OF FUNDS.—Section 1820(g)(3) of the Social Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

(1) in subparagraph (A), by inserting ''and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end; and

(2) in subparagraph (E)—

(A) by striking '', and to offset'' and inserting '', to offset''; and

(B) by inserting ''and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—

(1) IN GENERAL.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(A) in clause (i)(III), by striking ''For periods'' and inserting ''Subject to clause (iii), for periods''; and

(B) by adding at the end the following new clause:

''(iii) ADJUSTMENT FOR 2013 AND SUBSEQUENT YEARS.—

''(I) IN GENERAL.—Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode,

the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

''(II) TRANSITION.—The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2016. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act.''.

(2) MEDPAC STUDY AND REPORT.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments on—

(i) access to care;

(ii) quality outcomes;

(iii) the number of home health agencies; and

(iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) REPORT.—Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) PROGRAM-SPECIFIC OUTLIER CAP.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended—

(1) in paragraph (3)(C), by striking ''the aggregate'' and all that follows through the period at the end and inserting ''5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.''; and

(2) in paragraph (5)—

(A) by striking ''OUTLIERS.—The Secretary'' and inserting the following: ''OUTLIERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary'';

(B) in subparagraph (A), as added by subparagraph (A), by striking ''5 percent'' and inserting ''2.5 percent''; and

(C) by adding at the end the following new subparagraph:

''(B) PROGRAM SPECIFIC OUTLIER CAP.—The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.''.

(c) APPLICATION OF THE MEDICARE RURAL HOME HEALTH ADD-ON POLICY.—Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46), is amended—

(1) in the section heading, by striking ''**ONE-YEAR**'' and inserting ''**TEMPORARY**''; and

(2) in subsection (a)—

(A) by striking '', and episodes'' and inserting '', episodes'';

(B) by inserting ''and episodes and visits ending on or after April 1, 2010, and before January 1, 2016,'' after ''January 1, 2007,''; and

(C) by inserting ''(or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2016, 3 percent)'' before the period at the end.

(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REFORMS IN ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing ongoing access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including—

(i) payment adjustments for services that may be under- or over-valued;

(ii) necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

(iii) ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and penalties in driving provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

(D) A timetable for implementation of any appropriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C).

(E) Other areas determined appropriate by the Secretary.

(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care, such as—

(A) population density and relative patient access to care;

(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

(C) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes;

(D) poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;

(E) the absence of caregivers;

(F) language barriers;

(G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) REPORT.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) CONSULTATIONS.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—

(A) stakeholders representing home health agencies;

(B) groups representing Medicare beneficiaries;

(C) the Medicare Payment Advisory Commission;

(D) the Inspector General of the Department of Health and Human Services; and

(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

(1) IN GENERAL.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)), as amended by section 3004(c), is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

''(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

''(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

''(i) charges and payments;

''(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and

''(iii) with respect to each type of service included in hospice care—

''(I) the number of days of hospice care attributable to the type of service;

''(II) the cost of the type of service; and

''(III) the amount of payment for the type of service;

''(iv) charitable contributions and other revenue of the hospice program;

''(v) the number of hospice visits;

''(vi) the type of practitioner providing the visit; and

''(vii) the length of the visit and other basic information with respect to the visit.

''(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

''(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include

adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

''(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this title for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.

''(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).''.

(2) CONFORMING AMENDMENTS.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)'' after ''subsequent fiscal year''; and

(ii) in subclause (VII), by inserting ''(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv),'' after ''subsequent fiscal year''; and

(B) by adding at the end the following new clause:

''(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.''.

(b) ADOPTION OF MEDPAC HOSPICE PROGRAM ELIGIBILITY RECERTIFICATION RECOMMENDATIONS.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end; and

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

''(D) on and after January 1, 2011—

''(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

''(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and''.

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking ''For'' and inserting ''Subject to subsection (r), for''; and

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

''(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

''(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2015 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

''(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

''(A) FACTOR ONE.—A factor equal to the difference between—

''(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

''(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

''(B) FACTOR TWO.—

''(i) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

''(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and

''(II) who are uninsured in the most recent period for which data is available (as so calculated).

''(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

''(I) who are uninsured in 2012 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

''(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

''(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

''(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

''(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

''(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

''(B) Any period selected by the Secretary for such purposes.''.

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraphs:

''(K) POTENTIALLY MISVALUED CODES.—

''(i) IN GENERAL.—The Secretary shall—

''(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

''(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

''(iii) REVIEW AND ADJUSTMENTS.—

''(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

''(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

''(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

''(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

''(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

''(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

''(L) VALIDATING RELATIVE VALUE UNITS.—

''(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

''(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

''(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

''(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

''(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).''.

(b) IMPLEMENTATION.—

(1) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)) is repealed.

SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

(B) by adding at the end the following new subparagraph:

''(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

''(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

''(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

''(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclauses:

''(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

''(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

''(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.''.

(b) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (a), is amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

''(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.''; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

''(VI) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).''.

(c) ANALYSIS BY THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Not later than January 1, 2013, the Chief Actuary of the Centers for Medicare & Medicaid Services shall make publicly available an analysis of whether, for the period of 2010 through 2019, the cumulative expenditure reductions under title XVIII of the Social Security Act that are attributable to the adjustments under the amendments made by this section are projected to exceed $3,000,000,000.

SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by inserting ''subclause (III) and'' after ''Subject to''; and

(B) by adding at the end the following new subclause:

''(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting '15 percent' and '6 percent' for '10 percent' and '7.5 percent', respectively.''; and

(2) in clause (iii)—

(A) in the heading, by inserting ''COMPLEX, REHABILITATIVE'' before ''POWER-DRIVEN''; and

(B) by inserting ''complex, rehabilitative'' before ''power-driven''.

(b) TECHNICAL AMENDMENT.—Section 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395m(a)(7)(C)(ii)(II)) is amended by striking ''(A)(ii) or''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''September 30, 2009'' and inserting ''September 30, 2010''.

(2) USE OF PARTICULAR WAGE INDEX IN FISCAL YEAR 2010.—For purposes of implementation of the amendment made by this subsection during fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled ''Report to Congress: Promoting Greater Efficiency in Medicare'', including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

(c) USE OF PARTICULAR CRITERIA FOR DETERMINING RECLASSIFICATIONS.—Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.

SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 13951(t)) is amended by adding at the end the following new paragraph:

''(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.''.

SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

(iii) by adding at the end the following new subparagraph:

''(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).''; and

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

''(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

''(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

''(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).''; and

(2) in subsection (c)(6), by adding at the end the following new subparagraph:

''(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

''(I) REFERENCE BIOLOGICAL PRODUCT.—The term 'reference biological product' means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

(b) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to medicare-dependent, small rural hospitals under subsection (d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) URBAN MEDICARE-DEPENDENT HOSPITAL DEFINED.—For purposes of this section, the term ''urban Medicare-dependent hospital'' means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act (42 U.S.C. 1395f(l)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted

under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Provisions Relating to Part C

SEC. 3201. MEDICARE ADVANTAGE PAYMENT.

(a) MA BENCHMARK BASED ON PLAN'S COMPETITIVE BIDS.—

(1) IN GENERAL.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–23(j)) is amended—

(A) by striking ''AMOUNTS.—For purposes'' and inserting ''AMOUNTS.—

''(1) IN GENERAL.—For purposes'';

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B)—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately; and

(ii) in clause (i), as redesignated by clause (i), by striking ''an amount equal to'' and all that follows through the end and inserting ''an amount equal to—

''(I) for years before 2007, 1⁄12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

''(II) for 2007 through 2011, 1⁄12 of the applicable amount determined under subsection (k)(1) for the area for the year;

''(III) for 2012, the sum of—

''(aa) 2⁄3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 1⁄3 of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

''(IV) for 2013, the sum of—

''(aa) 1⁄3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 2⁄3 of the MA competitive benchmark amount (as so determined) for the area for the month;

''(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

''(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or'';

(iii) in clause (ii), as redesignated by clause (i), by striking ''subparagraph (A)'' and inserting ''clause (i)'';

(D) by adding at the end the following new paragraphs:

''(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1858(f)(4), except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1853(j)(2)' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

''(B) WEIGHTING RULES.—

''(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

''(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

''(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year.''; and

(E) in subsection (k)(2)(B)(ii)(III), by striking ''(j)(1)(A)'' and inserting ''(j)(1)(A)(i)''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1853(k)(2) of the Social Security Act (42 U.S.C. 1395w–23(k)(2)) is amended—

(i) in subparagraph (A), by striking ''through 2010'' and inserting ''and subsequent years''; and

(ii) in subparagraph (C)—

(I) in clause (iii), by striking ''and'' at the end;

(II) in clause (iv), by striking the period at the end and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(v) for 2011 and subsequent years, 0.00.''.

(B) Section 1854(b) of the Social Security Act (42 U.S.C. 1395w–24(b)) is amended—

(i) in paragraph (3)(B)(i), by striking ''1853(j)(1)'' and inserting ''1853(j)(1)(A)''; and

(ii) in paragraph (4)(B)(i), by striking ''1853(j)(2)'' and inserting ''1853(j)(1)(B)''.

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w–27(f)) is amended—

(i) in paragraph (1), by striking ''1853(j)(2)'' and inserting ''1853(j)(1)(B)''; and

(ii) in paragraph (3)(A), by striking ''1853(j)(1)(A)'' and inserting ''1853(j)(1)(A)(i)''.

(D) Section 1860C–1(d)(1)(A) of the Social Security Act (42 U.S.C. 1395w–29(d)(1)(A)) is amended by striking ''1853(j)(1)(A)'' and inserting ''1853(j)(1)(A)(i)''.

(b) REDUCTION OF NATIONAL PER CAPITA GROWTH PERCENTAGE FOR 2011.—Section 1853(c)(6) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)) is amended—

(1) in clause (v), by striking ''and'' at the end;

(2) in clause (vi)—

(A) by striking ''for a year after 2002'' and inserting ''for 2003 through 2010''; and

(B) by striking the period at the end and inserting a comma; and

(C) by adding at the end the following new clauses:

''(vii) for 2011, 3 percentage points; and

''(viii) for a year after 2011, 0 percentage points.''.

(c) ENHANCEMENT OF BENEFICIARY REBATES.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by inserting ''(or 100 percent in the case of plan years beginning on or after January 1, 2014)'' after ''75 percent''.

(d) BIDDING RULES.—

(1) REQUIREMENTS FOR INFORMATION SUBMITTED.—Section 1854(a)(6)(A) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)) is amended, in the flush matter following clause (v), by adding at the end the following sentence: ''Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).''.

(2) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—Section 1854(a)(6)(B) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(A) in clause (i), by striking ''(iii) and (iv)'' and inserting ''(iii), (iv), and (v)''; and

(B) by adding at the end the following new clause:

''(v) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—

''(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish—

''(aa) actuarial guidelines for the submission of bid information under this paragraph; and

''(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

''(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

''(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to bid amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)) is amended—

(A) in the subsection heading, by striking ''MA REGION'' and inserting ''MA REGION; MA LOCAL PLAN SERVICE AREA'';

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

''(A) with respect to an MA local plan—

''(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

''(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and''; and

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

''(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

''(A) URBAN AREAS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

''(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

''(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

''(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

''(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of the date of enactment of the Patient Protection and Affordable Care Act)—

''(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

''(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.''.

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—

(i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w–21(b)(1)) is amended by striking subparagraph (C).

(ii) Section 1853(b)(1)(B)(i) of such Act (42 U.S.C. 1395w–23(b)(1)(B)(i))—

(I) in the matter preceding subclause (I), by striking ''MA payment area'' and inserting ''MA local area (as defined in subsection (d)(2))''; and

(II) in subclause (I), by striking ''MA payment area'' and inserting ''MA local area (as so defined)''.

(iii) Section 1853(b)(4) of such Act (42 U.S.C. 1395w–23(b)(4)) is amended by striking ''Medicare Advantage payment area'' and inserting ''MA local area (as so defined)''.

(iv) Section 1853(c)(1) of such Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(I) in the matter preceding subparagraph (A), by striking ''a Medicare Advantage payment area that is''; and

(II) in subparagraph (D)(i), by striking ''MA payment area'' and inserting ''MA local area (as defined in subsection (d)(2))''.

(v) Section 1854 of such Act (42 U.S.C. 1395w–24) is amended by striking subsection (h).

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect on January 1, 2012.

(f) PERFORMANCE BONUSES.—

(1) MA PLANS.—

(A) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(n) PERFORMANCE BONUSES.—

''(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

''(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

''(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

''(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

''(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

''(i) Care management programs that—

''(I) target individuals with 1 or more chronic conditions;

''(II) identify gaps in care; and

''(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

''(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

''(I) help manage chronic conditions;

''(II) reduce declines in health status; and

''(III) foster patient and provider collaboration.

''(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

''(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

''(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

''(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

''(vii) Medication therapy management programs that are more extensive than is required under section 1860D–4(c) (as determined by the Secretary).

''(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

''(ix) Such other care management and coordination programs as the Secretary determines appropriate.

''(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

''(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

''(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

''(2) QUALITY PERFORMANCE BONUSES.—

''(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

''(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating on such system, 4 percent of such national monthly per capita cost for the year.

''(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

''(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

''(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

''(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

''(D) DATA USED IN DETERMINING SCORE.—

''(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

''(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

''(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

''(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1854(a)(1)(A)

for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in section 1851(e), and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

''(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

''(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

''(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.''

(B) CONFORMING AMENDMENT.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended—

(i) in clause (i), by inserting ''and any performance bonus under subsection (n)'' before the period at the end; and

(ii) in clause (ii), by striking ''(G)'' and inserting ''(G), plus the amount (if any) of any performance bonus under subsection (n)''.

(2) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended—

(A) in subsection (f)(1), by striking ''subsection (e)'' and inserting ''subsections (e) and (i)''; and

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

''(i) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.''.

(g) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLEES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsection (f), is amended by adding at the end the following new subsection:

''(o) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—

''(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

''(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

''(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

''(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

''(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

''(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

''(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

''(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

''(i) for 2012 and 2013, the sum of—

''(I) the bid amount under section 1854(a) for the MA local plan; and

''(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

''(ii) for 2014 and subsequent years, the sum of—

''(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

''(II) the applicable amount (as so defined) for the MA local plan for the year.

''(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

''(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

''(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1854(c) shall not apply with respect to the MA local plan.

''(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

''(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

''(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (effective as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1).''.

(h) TRANSITIONAL EXTRA BENEFITS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsections (f) and (g), is amended by adding at the end the following new subsection:

''(p) TRANSITIONAL EXTRA BENEFITS.—

''(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

''(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

''(A) enrolls in an MA local plan in an applicable area; and

''(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1854(b)(1)(C) as a result of competitive bidding under this part (as determined by the Secretary).

''(3) APPLICABLE AREAS.—In this subsection, the term 'applicable area' means the following:

''(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

''(B) A county where—

''(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

''(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

''(iii) average bids submitted by an MA organization under section 1854(a) for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this

part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

''(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

''(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

''(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits under this subsection.''.

(i) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395eee) is amended—

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

''(h) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART C.—With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

''(1) Section 1853(j)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

''(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

''(3) Section 1853(n), relating to the payment of performance bonuses.

''(4) Section 1853(o), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

''(5) Section 1853(p), relating to transitional extra benefits.''.

(2) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)), as amended by subsection (e), is amended by adding at the end the following new paragraph:

''(6) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—For years beginning with 2012, in the case of a PACE program under section 1894, the MA payment area shall be the MA local area (as defined in paragraph (2)).''.

SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.

(a) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(A) in clause (i), by inserting '', subject to clause (iii),'' after ''and B or''; and

(B) by adding at the end the following new clauses:

''(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

''(iv) SERVICES DESCRIBED.—The following services are described in this clause:

''(I) Chemotherapy administration services.

''(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

''(III) Skilled nursing care.

''(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

''(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND PREMIUMS.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) is amended—

(A) in clause (ii), by striking ''REBATE.—A rebate'' and inserting ''REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate'';

(B) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

(C) by inserting after clause (ii) the following new clause:

''(iii) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

''(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

''(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

''(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).''.

(2) APPLICATION OF PERFORMANCE BONUSES.—Section 1853(n) of the Social Security Act, as added by section 3201(f), is amended by adding at the end the following new paragraph:

''(6) APPLICATION OF PERFORMANCE BONUSES.—For plan years beginning on or after January 1, 2014, any performance bonus paid to an MA plan under this subsection shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of section 1854(b)(1)(C)(iii).''.

(3) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(C)) is amended—

(A) by striking ''PREMIUM.—The term'' and inserting ''PREMIUM.—

''(i) IN GENERAL.—The term''; and

(B) by adding at the end the following new clause:

''(ii) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).''.

SEC. 3203. APPLICATION OF CODING INTENSITY ADJUSTMENT DURING MA PAYMENT TRANSITION.

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clause:

''(iii) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

''(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

''(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.''.

SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

(1) IN GENERAL.—Section 1851(e)(2)(C) of the Social Security Act (42 U.S.C. 1395w–1(e)(2)(C)) is amended to read as follows:

''(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D–1.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) TIMING OF THE ANNUAL, COORDINATED ELECTION PERIOD UNDER PARTS C AND D.—Section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w–1(e)(3)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv)—

(A) by striking ''and succeeding years'' and inserting '', 2008, 2009, and 2010''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.''.

SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF SNP AUTHORITY.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''2011'' and inserting ''2014''.

(b) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following new clause:

''(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

''(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

''(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.''.

(c) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended by adding at the end the following new paragraph:

''(6) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—

''(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

''(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

''(ii) the original medicare fee-for-service program under parts A and B.

''(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term 'applicable individual' means an individual who—

''(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

''(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

''(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

''(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.''.

(d) TEMPORARY EXTENSION OF AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SPECIAL NEEDS PLANS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

(e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsections (a) and (c), is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(C) If applicable, the plan meets the requirement described in paragraph (7).'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(E) If applicable, the plan meets the requirement described in paragraph (7).'';

(3) in paragraph (4), by adding at the end the following new subparagraph:

''(C) If applicable, the plan meets the requirement described in paragraph (7).''; and

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

''(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).''.

(f) RISK ADJUSTMENT.—Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395i–23(a)(1)(C)) is amended by adding at the end the following new clause:

''(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

''(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

''(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

''(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

''(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.''.

(g) TECHNICAL CORRECTION.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended, in the matter preceding subparagraph (A), by striking ''described in subsection (b)(6)(B)(i)''.

SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking ''January 1, 2010'' and inserting ''January 1, 2013''.

SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS.

For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject ''2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans'') to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as of October 1, 2009.

SEC. 3208. MAKING SENIOR HOUSING FACILITY DEMONSTRATION PERMANENT.

(a) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

''(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

''(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

''(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

''(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

''(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

''(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.

SEC. 3209. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

''(C) REJECTION OF BIDS.—

''(i) IN GENERAL.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

''(ii) AUTHORITY TO DENY BIDS THAT PROPOSE SIGNIFICANT INCREASES IN COST SHARING OR DECREASES IN BENEFITS.—The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.''.

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

''(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1854(a).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids submitted for contract years beginning on or after January 1, 2011.

SEC. 3210. DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.

(a) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(y) DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDICARE SUPPLEMENTAL POLICIES.—

''(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

''(2) BENEFIT PACKAGES DESCRIBED.—The benefit packages described in this paragraph are benefit packages classified as 'C' and 'F'.''.

(b) CONFORMING AMENDMENT.—Section 1882(o)(1) of the Social Security Act (42 U.S.C. 1395ss(o)(1)) is amended by striking '', and (w)'' and inserting ''(w), and (y)''.

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

SEC. 3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.

(a) CONDITION FOR COVERAGE OF DRUGS UNDER PART D.—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.), is amended by adding at the end the following new section:

''CONDITION FOR COVERAGE OF DRUGS UNDER THIS PART

''SEC. 1860D–43. (a) IN GENERAL.—In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D–2(e)) of a manufacturer, the manufacturer must—

''(1) participate in the Medicare coverage gap discount program under section 1860D–14A;

''(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

''(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

''(b) EFFECTIVE DATE.—Subsection (a) shall apply to covered part D drugs dispensed under this part on or after July 1, 2010.

''(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

''(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

''(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

''(d) DEFINITION OF MANUFACTURER.—In this section, the term 'manufacturer' has the meaning given such term in section 1860D–14A(g)(5).''.

(b) MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following new section:

''MEDICARE COVERAGE GAP DISCOUNT PROGRAM

''SEC. 1860D–14A. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the 'program') by not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than April 1, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

''(b) TERMS OF AGREEMENT.—

''(1) IN GENERAL.—

''(A) AGREEMENT.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

''(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

''(C) TIMING OF AGREEMENT.—

''(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than May 1, 2010.

''(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

''(2) PROVISION OF APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

''(3) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

''(4) LENGTH OF AGREEMENT.—

''(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

''(B) TERMINATION.—

''(i) BY THE SECRETARY.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

''(ii) BY A MANUFACTURER.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

''(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

''(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

''(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

''(iv) NOTICE TO THIRD PARTY.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

''(c) DUTIES DESCRIBED AND SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—

''(1) DUTIES DESCRIBED.—The duties described in this subsection are the following:

''(A) ADMINISTRATION OF PROGRAM.—Administering the program, including—

''(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

''(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

''(iii) in the case where, during the period beginning on July 1, 2010, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

''(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

''(I) the negotiated price of the applicable drug; and

''(II) the discounted price of the applicable drug;

''(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that

provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

''(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

''(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

''(B) MONITORING COMPLIANCE.—

''(i) IN GENERAL.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

''(ii) NOTIFICATION.—If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

''(C) COLLECTION OF DATA FROM PRESCRIPTION DRUG PLANS AND MA–PD PLANS.—The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

''(2) SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

''(2) LIMITATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

''(B) EXCEPTION.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

''(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

''(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

''(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

''(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

''(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

''(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

''(5) IMPLEMENTATION.—The Secretary may implement the program under this section by program instruction or otherwise.

''(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

''(e) ENFORCEMENT.—

''(1) AUDITS.—Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

''(2) CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

''(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

''(ii) 25 percent of such amount.

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

''(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

''(g) DEFINITIONS.—In this section:

''(1) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who, on the date of dispensing an applicable drug—

''(A) is enrolled in a prescription drug plan or an MA–PD plan;

''(B) is not enrolled in a qualified retiree prescription drug plan;

''(C) is not entitled to an income-related subsidy under section 1860D–14(a);

''(D) is not subject to a reduction in premium subsidy under section 1839(i); and

''(E) who—

''(i) has reached or exceeded the initial coverage limit under section 1860D–2(b)(3) during the year; and

''(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B).

''(2) APPLICABLE DRUG.—The term 'applicable drug' means, with respect to an applicable beneficiary, a covered part D drug—

''(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of such section 351); and

''(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in;

''(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

''(iii) is provided through an exception or appeal.

''(3) APPLICABLE NUMBER OF CALENDAR DAYS.—The term 'applicable number of calendar days' means—

''(A) with respect to claims for reimbursement submitted electronically, 14 days; and

''(B) with respect to claims for reimbursement submitted otherwise, 30 days.

''(4) DISCOUNTED PRICE.—

''(A) IN GENERAL.—The term 'discounted price' means 50 percent of the negotiated price of the applicable drug of a manufacturer.

''(B) CLARIFICATION.—Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

''(C) SPECIAL CASE FOR CERTAIN CLAIMS.—In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1860D–2(b)(3) and below the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

''(5) MANUFACTURER.—The term 'manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

''(6) NEGOTIATED PRICE.—The term 'negotiated price' has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

''(7) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' has the meaning given such term in section 1860D–22(a)(2).''.

(c) INCLUSION IN INCURRED COSTS.—

(1) IN GENERAL.—Section 1860D–2(b)(4) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)) is amended—

(A) in subparagraph (C), in the matter preceding clause (i), by striking ''In applying'' and inserting ''Except as provided in subparagraph (E), in applying''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF APPLICABLE DRUGS UNDER MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—In applying subparagraph

(A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D–14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A, regardless of whether part of such costs were paid by a manufacturer under such program.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to costs incurred on or after July 1, 2010.

(d) CONFORMING AMENDMENT PERMITTING PRESCRIPTION DRUG DISCOUNTS.—

(1) IN GENERAL.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

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

(D) by adding at the end the following new subparagraph:

''(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A(g)) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A.''.

(2) CONFORMING AMENDMENT TO DEFINITION OF BEST PRICE UNDER MEDICAID.—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(VI)) is amended by inserting '', or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D–14A'' before the period at the end.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs dispensed on or after July 1, 2010.

SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUM.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting '', determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)'' before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

SEC. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended by adding at the end the following new paragraph:

''(5) WAIVER OF DE MINIMIS PREMIUMS.—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.''.

(b) AUTHORIZING THE SECRETARY TO AUTO-ENROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT WAIVE DE MINIMIS PREMIUMS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—

(1) in subparagraph (C), by inserting ''except as provided in subparagraph (D),'' after ''shall include,''

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

''(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.''.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

''(vi) SPECIAL RULE FOR WIDOWS AND WIDOWERS.—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d) FACILITATION OF REASSIGNMENTS.—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

''(1) information on formulary differences between the individual's former plan and the plan to which the individual is reassigned with respect to the individual's drug regimens; and

''(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(f).''.

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

''(i) for fiscal year 2009, of $7,500,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $7,500,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $10,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $5,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such section 119 is amended by adding at the end the following new subsection:

''(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection to support the conduct of activities described in the preceding sentence.''.

SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

(a) IMPROVING FORMULARY REQUIREMENTS.—Section 1860D–4(b)(3)(G) of the Social Security Act is amended to read as follows:

''(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(i) FORMULARY REQUIREMENTS.—

''(I) IN GENERAL.—Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I).

''(II) EXCEPTIONS.—The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).

''(ii) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

''(I) IN GENERAL.—Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

''(II) CRITERIA.—The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

''(iii) IMPLEMENTATION.—The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

''(iv) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES UNTIL CRITERIA ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes of drugs shall be identified under clause (ii)(I):

''(I) Anticonvulsants.

''(II) Antidepressants.

''(III) Antineoplastics.

''(IV) Antipsychotics.

''(V) Antiretrovirals.

''(VI) Immunosuppressants for the treatment of transplant rejection.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) INCOME-RELATED INCREASE IN PART D PREMIUM.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

''(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

''(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

''(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

''(i) the quotient obtained by dividing—

''(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

''(II) 25.5 percent; and

''(ii) the base beneficiary premium (as computed under paragraph (2)).

''(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

''(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

''(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

''(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

''(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

''(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

''(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

''(III) The monthly adjustment amount specified in subparagraph (B).

''(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

''(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.''.

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(A) in paragraph (1), by striking ''(2) and (3)'' and inserting ''(2), (3), and (4)''; and

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

''(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

''(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

''(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

(A) by redesignating subparagraph (F) as subparagraph (G);

(B) in subparagraph (G), as redesignated by subparagraph (A), by striking ''(D) and (E)'' and inserting ''(D), (E), and (F)''; and

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

''(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).''.

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by inserting ''AND PART D BASE BENEFICIARY PREMIUM INCREASE'' after ''PART B PREMIUM SUBSIDY ADJUSTMENT'';

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting ''or increase under section 1860D–13(a)(7)'' after ''1839(i)''; and

(ii) in clause (vii), by inserting after ''subsection (i) of such section'' the following: ''or increase under section 1860D–13(a)(7) of such Act''; and

(C) in subparagraph (B)—

(i) by striking ''Return information'' and inserting the following:

''(i) IN GENERAL.—Return information'';

(ii) by inserting ''or increase under such section 1860D–13(a)(7)'' before the period at the end;

(iii) as amended by clause (i), by inserting ''or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment or increase'' before the period at the end; and

(iv) by adding at the end the following new clause:

''(ii) DISCLOSURE TO OTHER AGENCIES.—Officers, employees, and contractors of the Social Security Administration may disclose—

''(I) the taxpayer identity information and the amount of the premium subsidy adjustment or premium increase with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Centers for Medicare and Medicaid Services, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

''(II) the taxpayer identity information and the amount of the premium subsidy adjustment or the increased premium amount with respect to a taxpayer described in subparagraph (A) to officers and employees of the Office of Personnel Management and the Railroad Retirement Board, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

''(III) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Health and Human Services to the extent necessary to resolve administrative appeals of such premium subsidy adjustment or increased premium, and

''(IV) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Justice for use in judicial proceedings to the extent necessary to carry out the purposes described in clause (i).''.

SEC. 3309. ELIMINATION OF COST SHARING FOR CERTAIN DUAL ELIGIBLE INDIVIDUALS.

Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by inserting ''or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1903(m) or under section 1932'' after ''1902(q)(1)(B))''.

SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) IN GENERAL.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) MODEL ELECTRONIC COMPLAINT FORM.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) ANNUAL REPORTS BY THE SECRETARY.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) DEFINITIONS.—In this section:

(1) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(2) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

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

(4) SYSTEM.—The term ''system'' means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

''(H) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall—

''(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

''(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2012.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

(2) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title (as determined by the Inspector General based on volume and expenditures), of—

(I) the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

(II) the prices paid for covered outpatient drugs by a State plan under title XIX.

(ii) An assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal Government; and

(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan under title XIX.

(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r–8).

(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title XIX necessary to carry out the comparison under subparagraph (A).

(2) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

(3) DEFINITIONS.—In this section:

(A) COVERED PART D DRUG.—The term ''covered part D drug'' has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

(B) COVERED OUTPATIENT DRUG.—The term ''covered outpatient drug'' has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1396r(k)).

(C) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(D) MEDICARE ADVANTAGE ORGANIZATION.—The term ''Medicare Advantage organization'' has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28)(a)(1)).

(E) PDP SPONSOR.—The term ''PDP sponsor'' has the meaning given such term in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

(F) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

SEC. 3314. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (ii) the following new clause:

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

''(II) under a State Pharmaceutical Assistance Program;

''(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

''(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 3315. IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.

Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (7)''; and

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

''(7) INCREASE IN INITIAL COVERAGE LIMIT IN 2010.—

''(A) IN GENERAL.—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

''(B) APPLICATION.—In applying subparagraph (A)—

''(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

''(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

''(iii) the Secretary shall establish procedures, which may include a reconciliation process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

''(iv) the Secretary shall develop an estimate of the additional increased costs attributable to the application of this paragraph for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

''(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

''(C) NO EFFECT ON SUBSEQUENT YEARS.—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph (A) had never applied.''.

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 3001(a)(3), is further amended—

(1) in clause (i)(XX), by striking ''clause (viii)'' and inserting ''clauses (viii), (ix), (xi), and (xii)'';

(2) in the first sentence of clause (viii), by inserting ''of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))'' after ''one-quarter'';

(3) in the first sentence of clause (ix)(I), by inserting ''(determined without regard to clause (viii), (xi), or (xii))'' after ''clause (i)'' the second time it appears; and

(4) by adding at the end the following new clauses:

''(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

''(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

''(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

''(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

''(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point; and

''(II) subject to clause (xiii), for each of fiscal years 2012 through 2019, by 0.2 percentage point.

The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

''(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B)) is amended—

(1) by striking ''PERCENTAGE.—The term'' and inserting ''PERCENTAGE.—

''(i) IN GENERAL.—Subject to clause (ii), the term''; and

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

''(ii) ADJUSTMENT.—For fiscal year 2012 and each subsequent fiscal year, after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.''.

(c) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraphs:

''(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—

''(A) IN GENERAL.—In implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

''(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

''(B) SPECIAL RULE.—The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(4) OTHER ADJUSTMENT.—

''(A) IN GENERAL.—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

''(i) for each of rate years 2010 and 2011, 0.25 percentage point; and

''(ii) subject to subparagraph (B), for each of rate years 2012 through 2019, 0.2 percentage point.

''(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

''(i) the excess (if any) of—

''(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either

House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

''(ii) 5 percentage points.''.

(d) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3) of the Social Security Act (42 U.S.C. 1395ww(j)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking ''FACTOR.—For purposes'' and inserting ''FACTOR.—

''(i) IN GENERAL.—For purposes'';

(B) by inserting ''subject to clause (ii)'' before the period at the end of the first sentence of clause (i), as added by paragraph (1); and

(C) by adding at the end the following new clause:

''(ii) PRODUCTIVITY AND OTHER ADJUSTMENT.—After establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

''(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.''; and

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

''(D) OTHER ADJUSTMENT.—

''(i) IN GENERAL.—For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

''(I) for each of fiscal years 2010 and 2011, 0.25 percentage point; and

''(II) subject to clause (ii), for each of fiscal years 2012 through 2019, 0.2 percentage point.

''(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(e) HOME HEALTH AGENCIES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (ii)(V), by striking ''clause (v)'' and inserting ''clauses (v) and (vi)''; and

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

''(vi) ADJUSTMENTS.—After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

''(I) for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) for each of 2011 and 2012, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.''.

(f) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subsection:

''(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

''(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

''(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

''(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

''(B) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(3) OTHER ADJUSTMENT.—

''(A) IN GENERAL.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

''(i) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point; and

''(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

''(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such rate year—

''(i) the excess (if any) of—

''(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

''(ii) 5 percentage points.''.

(g) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3132, is amended by adding at the end the following new clauses:

''(iv) After determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal year 2013 and each subsequent fiscal year, the Secretary shall reduce such percentage—

''(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.5 percentage point.

The application of this clause may result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting '0.0 percentage points' for '0.5 percentage point', if for such fiscal year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(h) DIALYSIS.—Section 1881(b)(14)(F) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended—

(1) in clause (i)—

(A) by inserting ''(I)'' after ''(F)(i)''

(B) in subclause (I), as inserted by subparagraph (A)—

(i) by striking ''clause (ii)'' and inserting ''subclause (II) and clause (ii)''; and

(ii) by striking ''minus 1.0 percentage point''; and

(C) by adding at the end the following new subclause:

''(II) For 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.''; and

(2) in clause (ii)(II)—

(A) by striking ''The'' and inserting ''Subject to clause (i)(II), the''; and

(B) by striking ''clause (i) minus 1.0 percentage point'' and inserting ''clause (i)(I)''.

(i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of the Social Security Act (42 U.S.C. 1395l(t)(3)) is amended—

(1) in subparagraph (C)(iv), by inserting ''and subparagraph (F) of this paragraph'' after ''(17)''; and

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

''(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

''(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

''(G) OTHER ADJUSTMENT.—

''(i) ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

''(I) for each of 2010 and 2011, 0.25 percentage point; and

''(II) subject to clause (ii), for each of 2012 through 2019, 0.2 percentage point.

''(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of 2014 through 2019 by substituting '0.0 percentage points' for '0.2 percentage point', if for such year—

''(I) the excess (if any) of—

''(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

''(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

''(II) 5 percentage points.''.

(j) AMBULANCE SERVICES.—Section 1834(l)(3) of the Social Security Act (42 U.S.C. 1395m(l)(3)) is amended—

(1) in subparagraph (A), by striking ''and'' at the end;

(2) in subparagraph (B)—

(A) by inserting '', subject to subparagraph (C) and the succeeding sentence of this paragraph,'' after ''increased''; and

(B) by striking the period at the end and inserting ''; and'';

(3) by adding at the end the following new subparagraph:

''(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(4) by adding at the end the following flush sentence:

''The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.''.

(k) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

''(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.''.

(l) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i)—

(A) by inserting '', subject to clause (iv),'' after ''year) by''; and

(B) by striking ''through 2013'' and inserting ''and 2010''; and

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

''(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

''(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

''(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.''.

(m) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K)—

(A) by striking ''2011, 2012, and 2013,''; and

(B) by inserting ''and'' after the semicolon at the end;

(2) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:

''(L) for 2011 and each subsequent year—

''(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

''(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(3) by adding at the end the following flush sentence:

''The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.''.

(n) PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—Section 1834(h)(4) of the Social Security Act (42 U.S.C. 1395m(h)(4)) is amended—

(1) in subparagraph (A)—

(A) in clause (ix), by striking ''and'' at the end;

(B) in clause (x)—

(i) by striking ''a subsequent year'' and inserting ''for each of 2007 through 2010''; and

(ii) by inserting ''and'' after the semicolon at the end;

(C) by adding at the end the following new clause:

''(xi) for 2011 and each subsequent year—

''(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

''(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(D) by adding at the end the following flush sentence:

''The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.''.

(o) OTHER ITEMS.—Section 1842(s)(1) of the Social Security Act (42 U.S.C. 1395u(s)(1)) is amended—

(1) in the first sentence, by striking ''Subject to'' and inserting ''(A) Subject to'';

(2) by striking the second sentence and inserting the following new subparagraph:

''(B) Any fee schedule established under this paragraph for such item or service shall be updated—

''(i) for years before 2011—

''(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

''(II) for items and services described in paragraph (2)(D) for 2009, section 1834(a)(14)(J) shall apply under this paragraph instead of the percentage increase otherwise applicable; and

''(ii) for 2011 and subsequent years—

''(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

''(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).''; and

(3) by adding at the end the following flush sentence:

''The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.''.

(p) NO APPLICATION PRIOR TO APRIL 1, 2010.—Notwithstanding the preceding provisions of this section, the amendments made by subsections (a), (c), and (d) shall not apply to discharges occurring before April 1, 2010.

SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULATION OF PART B PREMIUMS.

Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting ''subject to paragraph (6),'' after ''subsection,'';

(2) in paragraph (3)(A)(i), by striking ''The applicable'' and inserting ''Subject to paragraph (6), the applicable'';

(3) by redesignating paragraph (6) as paragraph (7); and

(4) by inserting after paragraph (5) the following new paragraph:

''(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2019—

''(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

''(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.''.

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) BOARD.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

''INDEPENDENT MEDICARE ADVISORY BOARD

''SEC. 1899A. (a) ESTABLISHMENT.—There is established an independent board to be known as the 'Independent Medicare Advisory Board'.

''(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

''(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as 'a determination year') the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as 'an implementation year');

''(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as 'a proposal year') a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

''(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

''(c) BOARD PROPOSALS.—

''(1) DEVELOPMENT.—

''(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

''(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

''(2) PROPOSALS.—

''(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

''(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

''(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

''(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

''(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a).

''(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

''(vi) The proposal shall only include recommendations related to the Medicare program.

''(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

''(i) give priority to recommendations that extend Medicare solvency;

''(ii) include recommendations that—

''(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

''(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

''(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

''(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

''(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates; and

''(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX.

''(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

''(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

''(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary's review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

''(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

''(3) TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT.—

''(A) IN GENERAL.—

''(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall transmit a proposal under this section to the President on January 15 of each year (beginning with 2014).

''(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

''(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph;

''(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year; or

''(III) for proposal year 2019 and subsequent proposal years, a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in paragraph (8) exceeds the growth rate described in paragraph (6)(A)(i).

''(iii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

''(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

''(i) the recommendations described in paragraph (2)(A)(i);

''(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

''(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

''(iv) a legislative proposal that implements the recommendations; and

''(v) other information determined appropriate by the Board.

''(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Board under paragraph (3)(A)(i) or the Secretary under paragraph (5), the President shall immediately submit such proposal to Congress.

''(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, to but fails, to submit a proposal to the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

''(A) such proposal to the President; and

''(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

''(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

''(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

''(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

''(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

''(B) MEDICARE PER CAPITA GROWTH RATE.—

''(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

''(ii) REQUIREMENT.—The projection under clause (i) shall—

''(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

''(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

''(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in—

''(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

''(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

''(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

''(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

''(7) SAVINGS REQUIREMENT.—

''(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

''(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

''(i) the total amount of projected Medicare program spending for the proposal year; and

''(ii) the applicable percent for the implementation year.

''(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

''(i) in the case of—

''(I) implementation year 2015, 0.5 percent;

''(II) implementation year 2016, 1.0 percent;

''(III) implementation year 2017, 1.25 percent; and

''(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

''(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

''(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.

''(d) CONGRESSIONAL CONSIDERATION.—

''(1) INTRODUCTION.—

''(A) IN GENERAL.—On the day on which a proposal is submitted by the President to the House of Representatives and the Senate under subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

''(B) NOT IN SESSION.—If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

''(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

''(D) REFERRAL.—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

''(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

''(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is submitted by the President to Congress under this section, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

''(B) CALCULATIONS.—In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

''(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

''(D) DISCHARGE.—If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

''(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

''(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(C) LIMITATION ON CHANGES TO THIS SUBSECTION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

''(D) WAIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

''(E) APPEALS.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

''(4) EXPEDITED PROCEDURE.—

''(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

''(B) AMENDMENT.—

''(i) TIME LIMITATION.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

''(ii) GERMANE.—No amendment that is not germane to the provisions of such bill shall be received.

''(iii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

''(iv) AMENDMENT NOT IN ORDER.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

''(v) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

''(C) CONSIDERATION BY THE OTHER HOUSE.—

''(i) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

''(ii) BEFORE PASSAGE.—If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

''(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

''(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

''(iii) AFTER PASSAGE.—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

''(iv) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

''(v) LIMITATION.—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

''(I) is related only to the program under this title; and

''(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(D) SENATE LIMITS ON DEBATE.—

''(i) IN GENERAL.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

''(ii) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

''(iii) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

''(iv) FINAL DISPOSITION.—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

''(E) CONSIDERATION IN CONFERENCE.—

''(i) IN GENERAL.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

''(ii) TIME LIMITATION.—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

''(iii) FINAL DISPOSITION.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

''(iv) LIMITATION.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

''(I) is related only to the program under this title; and

''(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

''(F) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

''(5) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

''(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

''(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

''(e) IMPLEMENTATION OF PROPOSAL.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

''(2) APPLICATION.—

''(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

''(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

''(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

''(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

''(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

''(3) EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the President to Congress pursuant to this section if—

''(A) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: 'This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.'; and

''(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

''(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

''(f) JOINT RESOLUTION REQUIRED TO DISCONTINUE THE BOARD.—

''(1) IN GENERAL.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

''(A) that is introduced in 2017 by not later than February 1 of such year;

''(B) which does not have a preamble;

''(C) the title of which is as follows: 'Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of

the Independent Medicare Advisory Board under section 1899A of the Social Security Act'; and

''(D) the matter after the resolving clause of which is as follows: 'That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.'.

''(2) PROCEDURE.—

''(A) REFERRAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

''(C) CONSIDERATION.—

''(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

''(ii) DEBATE LIMITATION.—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

''(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

''(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

''(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

''(i) The joint resolution of the other House shall not be referred to a committee.

''(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

''(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

''(II) the vote on final passage shall be on the joint resolution of the other House.

''(E) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

''(F) MAJORITY REQUIRED FOR ADOPTION.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

''(3) TERMINATION.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

''(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

''(i) make any determinations under subsection (c)(6) after May 1, 2017; or

''(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

''(B) the Board shall not submit any proposals or advisory reports to Congress under this section after January 16, 2018; and

''(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

''(g) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

''(1) MEMBERSHIP.—

''(A) IN GENERAL.—The Board shall be composed of—

''(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

''(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

''(B) QUALIFICATIONS.—

''(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmacoeconomics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

''(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

''(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

''(i) the majority leader of the Senate concerning the appointment of 3 members;

''(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

''(iii) the minority leader of the Senate concerning the appointment of 3 members; and

''(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

''(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

''(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

''(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

''(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

''(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

''(3) CHAIRPERSON.—

''(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

''(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

''(i) the appointment and supervision of personnel employed by the Board;

''(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

''(iii) the use and expenditure of funds.

''(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

''(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

''(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

''(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

''(1) VACANCIES.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

''(2) QUORUM.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

''(3) SEAL.—The Board shall have an official seal, of which judicial notice shall be taken.

''(4) VICE CHAIRPERSON.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

''(5) VOTING ON PROPOSALS.—Any proposal of the Board must be approved by the majority of appointed members present.

''(i) POWERS OF THE BOARD.—

''(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

''(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

''(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

''(4) POSTAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(5) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

''(6) OFFICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

''(j) PERSONNEL MATTERS.—

''(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

''(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

''(3) STAFF.—

''(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

''(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

''(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

''(k) CONSUMER ADVISORY COUNCIL.—

''(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

''(2) MEMBERSHIP.—

''(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

''(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

''(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

''(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

''(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

''(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

''(l) DEFINITIONS.—In this section:

''(1) BOARD; CHAIRPERSON; MEMBER.—The terms 'Board', 'Chairperson', and 'Member' mean the Independent Medicare Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

''(2) MEDICARE.—The term 'Medicare' means the program established under this title, including parts A, B, C, and D.

''(3) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

''(4) MEDICARE PROGRAM SPENDING.—The term 'Medicare program spending' means program spending under parts A, B, and D net of premiums.

''(m) FUNDING.—

''(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

''(A) for fiscal year 2012, $15,000,000; and

''(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

''(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.''.

(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

''(3) MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—

''(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Medicare Advisory Board under section 1899A.

''(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.''.

(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

(1) INITIAL STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

(i) Medicare beneficiary access to providers and items and services;

(ii) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

(iii) the potential impact of changes on other government or private-sector purchasers and payers of care; and

(iv) quality of patient care, including patient experience, outcomes, and other measures of care.

(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payments policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(c) CONFORMING AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

(2) by inserting after paragraph (3) the following:

''(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.''.

Subtitle F—Health Care Quality Improvements

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

''Subpart II—Health Care Quality Improvement Programs

''SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

''(a) PURPOSE.—The purposes of this section are to—

''(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as 'best practices') in health care quality, safety, and value; and

''(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

''(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), or any other relevant agency or department designated by the Director, shall—

''(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

''(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

''(A) best practices for quality improvement practices in the delivery of health care services; and

''(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

''(3) identify health care providers, including health care systems, single institutions, and individual providers, that—

''(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and

''(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

''(4) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

''(5) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

''(6) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

''(7) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

''(8) provide for the development of best practices in the delivery of health care services that—

''(A) have a high likelihood of success, based on structured review of empirical evidence;

''(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

''(C) are designed to be readily adapted by health care providers in a variety of settings; and

''(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and in engaging patients and their families in improving the care and patient health outcomes;

''(9) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children's health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

''(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

''(c) RESEARCH FUNCTIONS OF CENTER.—

''(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

''(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

''(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

''(B) identify areas in which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1890(a) of the Social Security Act in the report required under section 399JJ;

''(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

''(D) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

''(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

''(F) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

''(i) the implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

''(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Entercoccus infections and other emerging infections; and

''(iii) practical methods for reducing preventable hospital admissions and readmissions;

''(G) expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

''(H) identify and mitigate hazards by—

''(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

''(ii) using the results of such analyses to develop scientific methods of response to such events;

''(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

''(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

''(d) DISSEMINATION OF RESEARCH FINDINGS.—

''(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

''(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the health information technology extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

''(e) PRIORITIZATION.—The Director shall identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account—

''(1) the cost to Federal health programs;

''(2) consumer assessment of health care experience;

''(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

''(4) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children;

''(5) the areas of insufficient evidence identified under subsection (c)(2)(B); and

''(6) the evolution of meaningful use of health information technology, as defined in section 3000.

''(f) COORDINATION.—The Center shall coordinate its activities with activities conducted by the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act.

''(g) FUNDING.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal years 2010 through 2014.

''SEC. 934. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

''(a) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), shall award—

''(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

''(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

''(b) ELIGIBLE ENTITIES.—

''(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

''(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(2) IMPLEMENTATION AWARD.—To be eligible to receive an implementation grant or contract under subsection (a)(2), an entity—

''(A) may be a hospital or other health care provider or consortium or providers, as determined by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(c) APPLICATION.—

''(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for a sustainable business model that may include a system of—

''(i) charging fees to institutions and providers that receive technical support from the entity; and

''(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations; and

''(B) such other information as the Director may require.

''(2) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

''(i) financial cost, staffing requirements, and timeline for implementation; and

''(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

''(B) such other information as the Director may require.

''(d) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) EVALUATION.—

''(1) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

''(A) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 933;

''(B) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

''(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

''(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

''(f) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.''.

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as ''health teams'') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants;

(5) agree to provide services to eligible individuals with chronic conditions, as described in section 1945 of the Social Security Act (as added by section 2703), in accordance with the payment methodology established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, report to the Secretary information on quality measures used under section 399JJ of the Public Health Service Act.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term ''primary care'' means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after section 934 the following:

''SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

''(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established in section 933 (referred to in this section as the 'Center'), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this section as 'MTM') services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

''(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

''(2) submit to the Secretary a plan for achieving long-term financial sustainability;

''(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3502 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W;

''(4) submit a plan for meeting the requirements under subsection (c); and

''(5) submit to the Secretary such other information as the Secretary may require.

''(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law including applicable collaborative pharmacy practice agreements, include—

''(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

''(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

''(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

''(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

''(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

''(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

''(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

''(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

''(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

''(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

''(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who—

''(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

''(2) take any 'high risk' medications;

''(3) have 2 or more chronic diseases, as identified by the Secretary; or

''(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

''(e) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

''(f) REPORTING TO THE SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures endorsed by the entity with a contract under section 1890 of the Social Security Act, as determined by the Secretary.

''(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall—

''(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

''(2) assess changes in overall health care resource use by targeted individuals;

''(3) assess patient and prescriber satisfaction with MTM services;

''(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

''(5) identify and evaluate other factors that may impact clinical and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

''(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

''(h) GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may, through the quality measure development program under section 931 of the Public Health Service Act, award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.''.

SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(A) in the section heading, by inserting ''**FOR TRAUMA SYSTEMS**'' after ''**GRANTS**''; and

(B) in subsection (a), by striking ''Administrator of the Health Resources and Services Administration'' and inserting ''Assistant Secretary for Preparedness and Response'';

(2) by inserting after section 1203 the following:

''SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

''(b) ELIGIBLE ENTITY; REGION.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a State or a partnership of 1 or more States and 1 or more local governments; or

''(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

''(2) REGION.—The term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

''(3) EMERGENCY SERVICES.—The term 'emergency services' includes acute, prehospital, and trauma care.

''(c) PILOT PROJECTS.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—

''(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;

''(2) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion;

''(3) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

''(4) includes a consistent region-wide prehospital, hospital, and interfacility data management system that—

''(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

''(B) reports data to appropriate Federal and State databanks and registries; and

''(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

''(d) APPLICATION.—

''(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

''(2) APPLICATION INFORMATION.—Each application shall include—

''(A) an assurance from the eligible entity that the proposed system—

''(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office);

''(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

''(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

''(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

''(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

''(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents; and

''(B) such other information as the Secretary may require.

''(e) REQUIREMENT OF MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

''(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

''(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

''(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

''(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

''(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

''(4) the State and local legislation necessary to implement and to maintain the system;

''(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

''(6) recommendations on the utilization of available funding for future regionalization efforts.

''(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).''; and

(3) in section 1232—

(A) in subsection (a), by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated $24,000,000 for each of fiscal years 2010 through 2014.''; and

(B) by inserting after subsection (c) the following:

''(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.''.

(b) SUPPORT FOR EMERGENCY MEDICINE RESEARCH.—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is

amended by inserting after the section 498C the following:

"SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.

''(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

''(1) the basic science of emergency medicine;

''(2) the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;

''(3) the translation of basic scientific research into improved practice; and

''(4) the development of timely and efficient delivery of health services.

''(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

''(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

''(2) the role of pediatric emergency services as an integrated component of the overall health system;

''(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

''(4) pediatric training in professional education; and

''(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

''(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, the implementation of coordinated emergency care systems.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 3505. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY.

(a) TRAUMA CARE CENTERS.—

(1) GRANTS FOR TRAUMA CARE CENTERS.—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsections (a) and (b) and inserting the following:

''(a) IN GENERAL.—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

''(1) to assist in defraying substantial uncompensated care costs;

''(2) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

''(3) to provide emergency relief to ensure the continued and future availability of trauma services.

''(b) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

''(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a) unless the trauma center is a participant in a trauma system that substantially complies with section 1213.

''(2) EXEMPTION.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

''(3) QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE COSTS.—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in 1 of the following 3 categories:

''(A) CATEGORY A.—The criteria for category A are as follows:

''(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

''(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

''(B) CATEGORY B.—The criteria for category B are as follows:

''(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

''(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

''(C) CATEGORY C.—The criteria for category C are as follows:

''(i) At least 20 percent of the visits in the emergency department were charity or self-pay patients.

''(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

''(4) TRAUMA CENTERS IN 1115 WAIVER STATES.—Notwithstanding paragraph (3), the Secretary may award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool or Safety Net Care Pool established through a waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

''(5) DESIGNATION.—The Secretary may not award a grant to a trauma center unless such trauma center is verified by the American College of Surgeons or designated by an equivalent State or local agency.

''(c) ADDITIONAL REQUIREMENTS.—The Secretary may not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

''(1) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

''(2) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.''.

(2) CONSIDERATIONS IN MAKING GRANTS.—Section 1242 of the Public Health Service Act (42 U.S.C. 300d–42) is amended by striking subsections (a) and (b) and inserting the following:

''(a) SUBSTANTIAL UNCOMPENSATED CARE AWARDS.—

''(1) IN GENERAL.—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

''(2) PERCENTAGES.—The applicable percentages are as follows:

''(A) With respect to a category A trauma center, 100 percent of the uncompensated care costs.

''(B) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

''(C) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.

''(b) CORE MISSION AWARDS.—

''(1) IN GENERAL.—In awarding grants under section 1241(a)(2), the Secretary shall—

''(A) reserve 25 percent of the amount allocated for core mission awards for Level III and Level IV trauma centers; and

''(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I and II trauma centers—

''(i) that have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand is exceeding supply;

''(ii) for which—

''(I) annual uncompensated care costs exceed $10,000,000; or

''(II) at least 20 percent of emergency department visits are charity or self-pay or Medicaid patients; and

''(iii) that are not eligible for substantial uncompensated care awards under section 1241(a)(1).

''(c) EMERGENCY AWARDS.—In awarding grants under section 1241(a)(3), the Secretary shall—

''(1) give preference to any application submitted by a trauma center that provides trauma care in a geographic area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downgrade service or growth in demand for trauma services exceeds capacity; and

''(2) reallocate any emergency awards funds not obligated due to insufficient, or a lack of qualified, applications to the significant uncompensated care award program.''.

(3) CERTAIN AGREEMENTS.—Section 1243 of the Public Health Service Act (42 U.S.C. 300d–43) is amended by striking subsections (a), (b), and (c) and inserting the following:

''(a) MAINTENANCE OF FINANCIAL SUPPORT.—The Secretary may require a trauma center receiving a grant under section 1241(a) to maintain access to trauma services at comparable levels to the prior year during the grant period.

''(b) TRAUMA CARE REGISTRY.—The Secretary may require the trauma center receiving a grant under section 1241(a) to provide data to a national and centralized registry of trauma cases, in accordance with guidelines developed by the American College of Surgeons, and as the Secretary may otherwise require.''.

(4) GENERAL PROVISIONS.—Section 1244 of the Public Health Service Act (42 U.S.C. 300d–44) is amended by striking subsections (a), (b), and (c) and inserting the following:

''(a) APPLICATION.—The Secretary may not award a grant to a trauma center under section 1241(a) unless such center submits an application for the grant to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the

Secretary determines to be necessary to carry out this part.

''(b) LIMITATION ON DURATION OF SUPPORT.—The period during which a trauma center receives payments under a grant under section 1241(a)(3) shall be for 3 fiscal years, except that the Secretary may waive such requirement for a center and authorize such center to receive such payments for 1 additional fiscal year.

''(c) LIMITATION ON AMOUNT OF GRANT.—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding $2,000,000 for each fiscal year.

''(d) ELIGIBILITY.—Except as provided in section 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant under section 1241(a) shall not preclude a trauma center from being eligible for other grants described in such section.

''(e) FUNDING DISTRIBUTION.—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for emergency awards under section 1241(a)(3).

''(f) MINIMUM ALLOWANCE.—Notwithstanding subsection (e), if the amount appropriated for a fiscal year under section 1245 is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a)(1).

''(g) SUBSTANTIAL UNCOMPENSATED CARE AWARD DISTRIBUTION AND PROPORTIONAL SHARE.—Notwithstanding section 1242(a), of the amount appropriated for substantial uncompensated care grants for a fiscal year, the Secretary shall—

''(1) make available—

''(A) 50 percent of such funds for category A trauma center grantees;

''(B) 35 percent of such funds for category B trauma center grantees; and

''(C) 15 percent of such funds for category C trauma center grantees; and

''(2) provide available funds within each category in a manner proportional to the award basis specified in section 1242(a)(2) to each eligible trauma center.

''(h) REPORT.—Beginning 2 years after the date of enactment of the Patient Protection and Affordable Care Act, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding the status of the grants made under section 1241 and on the overall financial stability of trauma centers.''.

(5) AUTHORIZATION OF APPROPRIATIONS.—Section 1245 of the Public Health Service Act (42 U.S.C. 300d–45) is amended to read as follows:

''SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2015. Such authorization of appropriations is in addition to any other authorization of appropriations or amounts that are available for such purpose.''.

(6) DEFINITION.—Part D of title XII of the Public Health Service Act (42 U.S.C. 300d–41 et seq.) is amended by adding at the end the following:

''SEC. 1246. DEFINITION.

''In this part, the term 'uncompensated care costs' means unreimbursed costs from serving self-pay, charity, or Medicaid patients, without regard to payment under section 1923 of the Social Security Act, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital.''.

(b) TRAUMA SERVICE AVAILABILITY.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following:

''PART H—TRAUMA SERVICE AVAILABILITY

''SEC. 1281. GRANTS TO STATES.

''(a) ESTABLISHMENT.—To promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties, the Secretary shall provide funding to States to enable such States to award grants to eligible entities for the purposes described in this section.

''(b) AWARDING OF GRANTS BY STATES.—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

''(c) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to receive a grant under subsection (b) an entity shall—

''(A) be—

''(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b);

''(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

''(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

''(B) submit to the State an application at such time, in such manner, and containing such information as the State may require.

''(2) LIMITATION.—A State shall use at least 40 percent of the amount available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

''(d) USE OF FUNDS.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b):

''(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

''(2) Providing for individual safety net trauma center fiscal stability and costs related to having service that is available 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

''(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

''(4) Establishing new trauma services in underserved areas as defined by the State.

''(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

''(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

''(7) Enhancing trauma surge capacity at specific trauma centers.

''(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

''(9) Enhancing interstate trauma center collaboration.

''(e) LIMITATION.—

''(1) IN GENERAL.—A State may use not more than 20 percent of the amount available to the State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

''(2) MAINTENANCE OF EFFORT.—The Secretary may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

''(f) DISTRIBUTION OF FUNDS.—The following shall apply with respect to grants provided in this part:

''(1) LESS THAN $10,000,000.—If the amount of appropriations for this part in a fiscal year is less than $10,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3)(A).

''(2) LESS THAN $20,000,000.—If the amount of appropriations in a fiscal year is less than $20,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under subparagraphs (A) and (B) of section 1241(b)(3).

''(3) LESS THAN $30,000,000.—If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).

''(4) $30,000,000 OR MORE.—If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

''SEC. 1282. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015.''.

SEC. 3506. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

Part D of title IX of the Public Health Service Act, as amended by section 3503, is further amended by adding at the end the following:

''SEC. 936. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

''(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decisionmaking, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

''(b) DEFINITIONS.—In this section:

''(1) PATIENT DECISION AID.—The term 'patient decision aid' means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

''(2) PREFERENCE SENSITIVE CARE.—The term 'preference sensitive care' means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregivers or authorized representatives regarding the benefits, harms and scientific evidence for

each treatment option, the use of such care should depend on the informed patient choice among clinically appropriate treatment options.

''(c) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR PATIENT DECISION AIDS FOR PREFERENCE SENSITIVE CARE.—

''(1) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS AND CERTIFY PATIENT DECISION AIDS.—

''(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care and a certification process for patient decision aids for use in the Federal health programs and by other interested parties, the Secretary shall have in effect a contract with the entity with a contract under section 1890 of the Social Security Act. Such contract shall provide that the entity perform the duties described in paragraph (2).

''(B) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this section, the Secretary shall enter into the first contract under subparagraph (A).

''(C) PERIOD OF CONTRACT.—A contract under subparagraph (A) shall be for a period of 18 months (except such contract may be renewed after a subsequent bidding process).

''(2) DUTIES.—The following duties are described in this paragraph:

''(A) DEVELOP AND IDENTIFY STANDARDS FOR PATIENT DECISION AIDS.—The entity shall synthesize evidence and convene a broad range of experts and key stakeholders to develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.

''(B) ENDORSE PATIENT DECISION AIDS.—The entity shall review patient decision aids and develop a certification process whether patient decision aids meet the standards developed and identified under subparagraph (A). The entity shall give priority to the review and certification of patient decision aids for preference sensitive care.

''(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS AND PATIENTS.—

''(1) IN GENERAL.—The Secretary, acting through the Director, and in coordination with heads of other relevant agencies, such as the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall establish a program to award grants or contracts—

''(A) to develop, update, and produce patient decision aids for preference sensitive care to assist health care providers in educating patients, caregivers, and authorized representatives concerning the relative safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options;

''(B) to test such materials to ensure such materials are balanced and evidence based in aiding health care providers and patients, caregivers, and authorized representatives to make informed decisions about patient care and can be easily incorporated into a broad array of practice settings; and

''(C) to educate providers on the use of such materials, including through academic curricula.

''(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)—

''(A) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

''(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy;

''(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

''(D) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

''(3) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are available to the public.

''(4) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under this section of the Agency and other agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

''(e) GRANTS TO SUPPORT SHARED DECISIONMAKING IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

''(2) SHARED DECISIONMAKING RESOURCE CENTERS.—

''(A) IN GENERAL.—The Secretary shall provide grants for the establishment and support of Shared Decisionmaking Resource Centers (referred to in this subsection as 'Centers') to provide technical assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

''(B) OBJECTIVES.—The objective of a Center is to enhance and promote the adoption of patient decision aids and shared decisionmaking through—

''(i) providing assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids; and

''(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

''(3) SHARED DECISIONMAKING PARTICIPATION GRANTS.—

''(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

''(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decisionmaking Resource Centers or comparable training.

''(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than those certified under the process identified in subsection (c).

''(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

''(f) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.''.

SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Commissioner of Food and Drugs, shall determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers.

(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall review all available scientific evidence and research on decisionmaking and social and cognitive psychology and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that provides—

(1) the determination by the Secretary under subsection (a); and

(2) the reasoning and analysis underlying that determination.

(d) AUTHORITY.—If the Secretary determines under subsection (a) that the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) CLARIFICATION.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) REPORTS.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 3509. IMPROVING WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

''(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

''(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

''(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

''(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

''(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

''(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

''(5) establish a National Women's Health Information Center to—

''(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

''(B) facilitate access to such information;

''(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

''(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

''(6) coordinate efforts to promote women's health programs and policies with the private sector; and

''(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and between the Office and health professionals and the general public.

''(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

''(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

''(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

''(d) REPORTS.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

''(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Centers;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

''(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

''(1) unique to, significantly more serious for, or significantly more prevalent in women; and

''(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) of the Public Health Service Act (42 U.S.C. 287d(a)) is amended by inserting ''and who shall report directly to the Director'' before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ''who shall report directly to the Administrator'' before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3), the following:

''(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.''.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX of the Public Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 925 and 926 as sections 926 and 927, respectively; and

(2) by inserting after section 924 the following:

''SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

''(b) PURPOSE.—The official designated under subsection (a) shall—

''(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

''(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Agency;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Agency policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).''.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

''SEC. 713. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

''(d) DEFINITIONS.—For purposes of this section:

''(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

''(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

''SEC. 1011. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Commissioner, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women's health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

''(3) provide information to women and health care providers on those areas in which differences between men and women exist;

''(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

''(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

''(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(h) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of it's powers or duties transferred unless such termination, reorganization, or transfer is approved by Congress through the adoption of a concurrent resolution of approval.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 3510. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 256a) is amended—

(1) by striking subsection (d)(3) and inserting the following:

''(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.'';

(2) in subsection (e), by adding at the end the following:

''(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved.''; and

(3) in subsection (m)—

(A) in paragraph (1), by striking ''and $3,500,000 for fiscal year 2010.'' and inserting ''$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''; and

(B) in paragraph (2), by striking ''2010'' and inserting ''2015''.

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this subtitle (or an amendment made by this subtitle), there is authorized to be appropriated

such sums as may be necessary to carry out this subtitle (and such amendments made by this subtitle).

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the ''National Prevention, Health Promotion and Public Health Council'' (referred to in this section as the ''Council'').

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Agriculture;

(3) the Secretary of Education;

(4) the Chairman of the Federal Trade Commission;

(5) the Secretary of Transportation;

(6) the Secretary of Labor;

(7) the Secretary of Homeland Security;

(8) the Administrator of the Environmental Protection Agency;

(9) the Director of the Office of National Drug Control Policy;

(10) the Director of the Domestic Policy Council;

(11) the Assistant Secretary for Indian Affairs;

(12) the Chairman of the Corporation for National and Community Service; and

(13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) PURPOSES AND DUTIES.—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(3) provide recommendations to the President and Congress concerning the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and public health goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition;

(4) consider and propose evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on individual and community levels across the United States;

(5) establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;

(6) submit the reports required under subsection (g); and

(7) carry out other activities determined appropriate by the President.

(e) MEETINGS.—The Council shall meet at the call of the Chairperson.

(f) ADVISORY GROUP.—

(1) IN GENERAL.—The President shall establish an Advisory Group to the Council to be known as the ''Advisory Group on Prevention, Health Promotion, and Integrative and Public Health'' (hereafter referred to in this section as the ''Advisory Group''). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.

(2) COMPOSITION.—

(A) IN GENERAL.—The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.

(B) REPRESENTATION.—In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes a diverse group of licensed health professionals, including integrative health practitioners who have expertise in—

(i) worksite health promotion;

(ii) community services, including community health centers;

(iii) preventive medicine;

(iv) health coaching;

(v) public health education;

(vi) geriatrics; and

(vii) rehabilitation medicine.

(3) PURPOSES AND DUTIES.—The Advisory Group shall develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

(g) NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY.—Not later than 1 year after the date of enactment of this Act, the Chairperson, in consultation with the Council, shall develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(1) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(2) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care practices to ensure Federal efforts are consistent with available standards and evidence.

(h) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress, a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet these goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(7) contains specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under paragraph (4).

(i) PERIODIC REVIEWS.—The Secretary and the Comptroller General of the United States shall jointly conduct periodic reviews, not less than every 5 years, and evaluations of every Federal disease prevention and health promotion initiative, program, and agency. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the ''Fund''), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

(1) for fiscal year 2010, $500,000,000;

(2) for fiscal year 2011, $750,000,000;

(3) for fiscal year 2012, $1,000,000,000;

(4) for fiscal year 2013, $1,250,000,000;

(5) for fiscal year 2014, $1,500,000,000; and

(6) for fiscal year 2015, and each fiscal year thereafter, $2,000,000,000.

(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs.

(d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

SEC. 4003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES.

(a) PREVENTIVE SERVICES TASK FORCE.—Section 915 of the Public Health Service Act (42 U.S.C. 299b–4) is amended by striking subsection (a) and inserting the following:

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) ESTABLISHMENT AND PURPOSE.—The Director shall convene an independent Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, Congress and other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

''(2) DUTIES.—The duties of the Task Force shall include—

''(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

''(B) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

''(C) improved integration with Federal Government health objectives and related target setting for health improvement;

''(D) the enhanced dissemination of recommendations;

''(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing the Guide recommendations; and

''(F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

''(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide's recommendations.

''(4) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(5) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

''(6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(b) COMMUNITY PREVENTIVE SERVICES TASK FORCE.—

(1) IN GENERAL.—Part P of title III of the Public Health Service Act, as amended by paragraph (2), is amended by adding at the end the following:

''SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

''(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policy-makers. Community preventive services include any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.

''(b) DUTIES.—The duties of the Task Force shall include—

''(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups;

''(2) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling;

''(3) improved integration with Federal Government health objectives and related target setting for health improvement;

''(4) the enhanced dissemination of recommendations;

''(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the Guide recommendations; and

''(6) providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

''(c) ROLE OF AGENCY.—The Director shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.

''(d) COORDINATION WITH PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(e) OPERATION.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(2) TECHNICAL AMENDMENTS.—

(A) Section 399R of the Public Health Service Act (as added by section 2 of the ALS Registry Act (Public Law 110–373; 122 Stat. 4047)) is redesignated as section 399S.

(B) Section 399R of such Act (as added by section 3 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110–374; 122 Stat. 4051)) is redesignated as section 399T.

SEC. 4004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall provide for the planning and implementation of a national public–private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through a Gateway;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies; and

(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine to provide ongoing advice on evidence-based scientific information for policy, program development, and evaluation.

(c) MEDIA CAMPAIGN.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) REQUIREMENT OF CAMPAIGN.—The campaign implemented under paragraph (1)—

(A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(C) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(E) may include the use of humor and nationally recognized positive role models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(d) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(e) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, and Medicare and Medicaid.

(f) PERSONALIZED PREVENTION PLANS.—

(1) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(2) USE.—The website developed under paragraph (1) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(g) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(h) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding provided through the Centers for Disease Control and Prevention for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this section.

(i) PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.—

(1) INFORMATION TO STATES.—The Secretary of Health and Human Services shall provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults.

(2) INFORMATION TO ENROLLEES.—Each State shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the States' efforts to increase awareness of coverage of obesity-related services.

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

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 4101. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a program to award grants to eligible entities to support the operation of school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity shall—

(A) be a school-based health center or a sponsoring facility of a school-based health center; and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum an assurance that funds awarded under the grant shall not be used to provide any service that is not authorized or allowed by Federal, State, or local law.

(3) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to awarding grants for school-based health centers that serve a large population of children eligible for medical assistance under the State Medicaid plan under title XIX of the Social Security Act or under a waiver of such plan or children eligible for child health assistance under the State child health plan under title XXI of that Act (42 U.S.C. 1397aa et seq.).

(4) LIMITATION ON USE OF FUNDS.—An eligible entity shall use funds provided under a grant awarded under this subsection only for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, as specified by the Secretary. No funds provided under a grant awarded under this section shall be used for expenditures for personnel or to provide health services.

(5) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2013, $50,000,000 for the purpose of carrying out this subsection. Funds appropriated under this paragraph shall remain available until expended.

(6) DEFINITIONS.—In this subsection, the terms ''school-based health center'' and ''sponsoring facility'' have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)).

(b) GRANTS FOR THE OPERATION OF SCHOOL-BASED HEALTH CENTERS.—Part Q of title III of the Public Health Service Act (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

''SEC. 399Z–1. SCHOOL-BASED HEALTH CENTERS.

''(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—In this section:

''(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by school-based health centers, which shall include the following:

''(A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services.

''(B) MENTAL HEALTH.—Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

''(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—

''(A) IN GENERAL.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area by the Secretary.

''(B) CRITERIA.—The Secretary shall prescribe criteria for determining the specific shortages of personal health services for medically underserved children and adolescents under subparagraph (A) that shall—

''(i) take into account any comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

''(ii) include factors indicative of the health status of such children and adolescents of an area, including the ability of the residents of such area to pay for health services, the accessibility of such services, the availability of health professionals to such children and adolescents, and other factors as determined appropriate by the Secretary.

''(3) SCHOOL-BASED HEALTH CENTER.—The term 'school-based health center' means a health clinic that—

''(A) meets the definition of a school-based health center under section 2110(c)(9)(A) of the Social Security Act and is administered by a sponsoring facility (as defined in section 2110(c)(9)(B) of the Social Security Act);

''(B) provides, at a minimum, comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with established standards, community practice, reporting laws, and other State laws, including parental consent and notification laws that are not inconsistent with Federal law; and

''(C) does not perform abortion services.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the costs of the operation of school-based health centers (referred to in this section as 'SBHCs') that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an SBHC (as defined in subsection (a)(3)); and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) evidence that the applicant meets all criteria necessary to be designated an SBHC;

''(B) evidence of local need for the services to be provided by the SBHC;

''(C) an assurance that—

''(i) SBHC services will be provided to those children and adolescents for whom parental or guardian consent has been obtained in cooperation with Federal, State, and local laws governing health care service provision to children and adolescents;

''(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the SBHC;

''(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system and through its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

''(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers co-located at the school;

''(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

''(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

''(D) such other information as the Secretary may require.

''(d) PREFERENCES AND CONSIDERATION.—In reviewing applications:

''(1) The Secretary may give preference to applicants who demonstrate an ability to serve the following:

''(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents.

''(B) Communities with high per capita numbers of children and adolescents who are uninsured, underinsured, or enrolled in public health insurance programs.

''(C) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services.

''(2) The Secretary may give consideration to whether an applicant has received a grant under subsection (a) of section 4101 of the Patient Protection and Affordable Care Act.

''(e) WAIVER OF REQUIREMENTS.—The Secretary may—

''(1) under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an SBHC for not to exceed 2 years; and

''(2) upon a showing of good cause, waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time to be determined by the Secretary.

''(f) USE OF FUNDS.—

''(1) FUNDS.—Funds awarded under a grant under this section—

''(A) may be used for—

''(i) acquiring and leasing equipment (including the costs of amortizing the principle of, and paying interest on, loans for such equipment);

''(ii) providing training related to the provision of required comprehensive primary health services and additional health services;

''(iii) the management and operation of health center programs;

''(iv) the payment of salaries for physicians, nurses, and other personnel of the SBHC; and

''(B) may not be used to provide abortions.

''(2) CONSTRUCTION.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property.

''(3) LIMITATIONS.—

''(A) IN GENERAL.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC shall not be eligible to receive additional funding under this section.

''(B) NO OVERLAPPING GRANT PERIOD.—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

''(g) MATCHING REQUIREMENT.—

''(1) IN GENERAL.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in-kind) to carry out the activities supported by the grant.

''(2) WAIVER.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year for the SBHC if the Secretary determines that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

''(h) SUPPLEMENT, NOT SUPPLANT.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

''(i) EVALUATION.—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section.

''(j) AGE APPROPRIATE SERVICES.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

''(k) PARENTAL CONSENT.—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if such individual is considered a minor under applicable State law.

''(l) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

SEC. 4102. ORAL HEALTHCARE PREVENTION ACTIVITIES.

(a) IN GENERAL.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3025, is amended by adding at the end the following:

''PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES

''SEC. 399LL. ORAL HEALTHCARE PREVENTION EDUCATION CAMPAIGN.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with professional oral health organizations, shall, subject to the availability of appropriations, establish a 5-year national, public education campaign (referred to in this section as the 'campaign') that is focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

''(b) REQUIREMENTS.—In establishing the campaign, the Secretary shall—

''(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; and

''(2) utilize science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.

''(c) PLANNING AND IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall begin implementing the 5-year campaign. During the 2-year period referred to in the previous sentence, the Secretary shall conduct planning activities with respect to the campaign.

''SEC. 399LL-1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a clinic of a hospital owned or operated by a State (or by an instrumentality or a unit of government within a State), a State or local department of health, a dental program of the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act), a health system provider, a private provider of dental services, medical, dental, public health, nursing, nutrition educational institutions, or national organizations involved in improving children's oral health; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—A grantee shall use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities.

''(d) USE OF INFORMATION.—The Secretary shall utilize information generated from grantees under this section in planning and implementing the public education campaign under section 399LL.

''SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part, such sums as may be necessary.''.

(b) SCHOOL-BASED SEALANT PROGRAMS.—Section 317M(c)(1) of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) is amended by striking ''may award grants to States and Indian tribes'' and inserting ''shall award a grant to each of the 50 States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)''.

(c) ORAL HEALTH INFRASTRUCTURE.—Section 317M of the Public Health Service Act (42 U.S.C. 247b-14) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c), the following:

''(d) ORAL HEALTH INFRASTRUCTURE.—

''(1) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.''.

(d) UPDATING NATIONAL ORAL HEALTHCARE SURVEILLANCE ACTIVITIES.—

(1) PRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as ''PRAMS'') as it relates to oral healthcare.

(B) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(i) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory with respect to States for purposes of the State reports under clause (i).

(C) FUNDING.—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term ''tooth-level surveillance'' means a clinical examination where an examiner looks at each dental surface, on each tooth in the mouth and as expanded by the Division of Oral Health of the Centers for Disease Control and Prevention.

(3) MEDICAL EXPENDITURES PANEL SURVEY.—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(4) NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.—

(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 to increase the participation of States in the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) REQUIREMENTS.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

SEC. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.

(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (DD), by striking ''and'' at the end;

(B) in subparagraph (EE), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(FF) personalized prevention plan services (as defined in subsection (hhh));''.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (hhh)''.

(b) PERSONALIZED PREVENTION PLAN SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Annual Wellness Visit

''(hhh)(1) The term 'personalized prevention plan services' means the creation of a plan for an individual—

''(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

''(B) that—

''(i) takes into account the results of the health risk assessment; and

''(ii) may contain the elements described in paragraph (2).

''(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following:

''(A) The establishment of, or an update to, the individual's medical and family history.

''(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

''(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

''(D) Detection of any cognitive impairment.

''(E) The establishment of, or an update to, the following:

''(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered under this title.

''(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.

''(F) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

''(G) Any other element determined appropriate by the Secretary.

''(3) A health professional described in this paragraph is—

''(A) a physician;

''(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

''(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

''(4)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of this subsection, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

''(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

''(ii) may be furnished—

''(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

''(II) during an encounter with a health care professional;

''(III) through community-based prevention programs; or

''(IV) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

''(B) Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 4004(f) of the Patient Protection and Affordable Care Act as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

''(C)(i) Not later than 18 months after the date of enactment of this subsection, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

''(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

''(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

''(i) ensure that health risk assessments are accessible to beneficiaries; and

''(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

''(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

''(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

''(G)(i) A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined under subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary's coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12-month period.

''(ii) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services during the period of 12 months after the date that a beneficiary's coverage begins under part B, which shall include information regarding any relevant differences between such services.

''(H) The Secretary shall issue guidance that—

''(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

''(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (N), by inserting ''other than personalized prevention plan services (as defined in section 1861(hhh)(1))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(W)''; and

(C) by inserting before the semicolon at the end the following: '', and (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(FF) (including administration of the health risk assessment) ,'' after ''(2)(EE),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' at the end;

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (G)(ii) the following new subparagraph:

''(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),''.

(4) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(d) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O), by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.

(a) DEFINITION OF PREVENTIVE SERVICES.—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395x(ddd)) is amended—

(1) in the heading, by inserting ''; Preventive Services'' after ''Services'';

(2) in paragraph (1), by striking ''not otherwise described in this title'' and inserting ''not described in subparagraph (A) or (C) of paragraph (3)''; and

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

''(3) The term 'preventive services' means the following:

''(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

''(B) An initial preventive physical examination (as defined in subsection (ww)).

''(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).''.

(b) COINSURANCE.—

(1) GENERAL APPLICATION.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4103(c)(1), is amended—

(i) in subparagraph (T), by inserting ''(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual)'' after ''80 percent'';

(ii) in subparagraph (W)—

(I) in clause (i), by inserting ''(if such subparagraph were applied, by substituting '100 percent' for '80 percent')'' after ''subparagraph (D)''; and

(II) in clause (ii), by striking ''80 percent'' and inserting ''100 percent'';

(iii) by striking ''and'' before ''(X)''; and

(iv) by inserting before the semicolon at the end the following: '', and (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 4103(c)(3)(A), is amended—

(i) by striking ''or'' before ''personalized prevention plan services''; and

(ii) by inserting before the period the following: '', or preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)), as amended by section 4103(c)(3)(B), is amended—

(i) in subparagraph (G)(ii), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (H) the following new subparagraph:

''(I) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount determined under paragraph (1)(W) or (1)(Y),''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE FOR PREVENTIVE SERVICES AND COLORECTAL CANCER SCREENING TESTS.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 4103(c)(4), is amended—

(1) in paragraph (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.''; and

(2) by adding at the end the following new sentence: ''Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January

1, 2010, if the Secretary determines appropriate, the Secretary may—

''(1) modify—

''(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

''(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

''(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.''.

(b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.

(a) CLARIFICATION OF INCLUSION OF SERVICES.—Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)) is amended to read as follows:

''(13) other diagnostic, screening, preventive, and rehabilitative services, including—

''(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

''(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

''(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;''.

(b) INCREASED FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(A) and 2004(c)(1), is amended in the first sentence—

(1) by striking '', and (4)'' and inserting '', (4)''; and

(2) by inserting before the period the following: '', and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)''.

(c) EFFECTIVE DATE.—The amendments made under this section shall take effect on January 1, 2013.

SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID.

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2303, is further amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following new subparagraph: ''; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))''; and

(2) by adding at the end the following:

''(bb)(1) For purposes of this title, the term 'counseling and pharmacotherapy for cessation of tobacco use by pregnant women' means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who—

''(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

''(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

''(2) Subject to paragraph (3), such term is limited to—

''(A) services recommended with respect to pregnant women in 'Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline', published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

''(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

''(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)), as redesignated by section 2502(a), is amended by inserting before the period at the end the following: '', except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation''.

(c) REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—

(1) GENERAL COST-SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)'' after ''complicate the pregnancy''.

(2) APPLICATION TO ALTERNATIVE COST-SHARING.—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by inserting '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))'' after ''complicate the pregnancy''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID.

(a) INITIATIVES.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

(i) successfully participate in a program described in paragraph (3); and

(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

(2) DURATION.—

(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall awards grants to States beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

(B) DURATION OF PROGRAM.—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

(3) PROGRAM DESCRIBED.—

(A) IN GENERAL.—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

(i) Ceasing use of tobacco products.

(ii) Controlling or reducing their weight.

(iii) Lowering their cholesterol.

(iv) Lowering their blood pressure.

(v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

(B) CO-MORBIDITIES.—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

(C) WAIVER AUTHORITY.—The Secretary may waive the requirements of section 1902(a)(1) (relating to statewideness) of the Social Security Act for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) available and accessible to Medicaid beneficiaries.

(D) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

(4) APPLICATION.—Following the development of program criteria by the Secretary, a

State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware and informed about such programs.

(b) EDUCATION AND OUTREACH CAMPAIGN.—

(1) STATE AWARENESS.—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

(2) PROVIDER AND BENEFICIARY EDUCATION.—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

(c) IMPACT.—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

(1) track Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure the degree to which such standards and targets are met;

(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

(d) EVALUATIONS AND REPORTS.—

(1) INDEPENDENT ASSESSMENT.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the initiatives carried out by States under this section, for the purpose of determining—

(A) the effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;

(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

(A) the specific uses of the grant funds;

(B) an assessment of program implementation and lessons learned from the programs;

(C) an assessment of quality improvements and clinical outcomes under such programs; and

(D) estimates of cost savings resulting from such programs.

(3) INITIAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

(4) FINAL REPORT.—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS.—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) DEFINITIONS.—In this section:

(1) MEDICAID BENEFICIARY.—The term ''Medicaid beneficiary'' means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

(2) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle C—Creating Healthier Communities

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;

(B) a local governmental agency;

(C) a national network of community-based organizations;

(D) a State or local non-profit organization; or

(E) an Indian tribe; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(c) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) ACTIVITIES.—An eligible entity shall implement activities detailed in the community transformation plan under paragraph (2).

(C) IN-KIND SUPPORT.—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) EVALUATION.—

(A) IN GENERAL.—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities.

(B) TYPES OF MEASURES.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;

(ii) changes in proper nutrition;

(iii) changes in physical activity;

(iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) DISSEMINATION.—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) TRAINING.—

(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans.

(3) EVALUATION.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(e) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 4202. HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.

(a) HEALTHY AGING, LIVING WELL.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and

(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC HEALTH INTERVENTIONS.—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.—

(i) IN GENERAL.—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age.

(ii) TYPES OF SCREENING ACTIVITIES.—Screening activities conducted under this subparagraph may include—

(I) mental health/behavioral health and substance use disorders;

(II) physical activity, smoking, and nutrition; and

(III) any other measures deemed appropriate by the Secretary.

(iii) MONITORING.—Grantees under this section shall maintain records of screening results under this subparagraph to establish the baseline data for monitoring the targeted population.

(D) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—

(i) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in subparagraph (C)(ii), receive clinical referral/treatment for follow-up services to reduce such risk.

(ii) MECHANISM.—

(I) IDENTIFICATION AND DETERMINATION OF STATUS.—With respect to each individual with risk factors for or having heart disease, stroke, diabetes, or any other condition for which such individual was screened under subparagraph (C), a grantee under this section shall determine whether or not such individual is covered under any public or private health insurance program.

(II) INSURED INDIVIDUALS.—An individual determined to be covered under a health insurance program under subclause (I) shall be referred by the grantee to the existing providers under such program or, if such individual does not have a current provider, to a provider who is in-network with respect to the program involved.

(III) UNINSURED INDIVIDUALS.—With respect to an individual determined to be uninsured under subclause (I), the grantee's community-based clinical partner described in paragraph (4)(D) shall assist the individual in determining eligibility for available public coverage options and identify other appropriate community health care resources and assistance programs.

(iii) PUBLIC HEALTH INTERVENTION PROGRAM.—A State or local health department shall use amounts received under a grant under this subsection to enter into contracts with community health centers or rural health clinics and mental health and substance use disorder service providers to assist in the referral/treatment of at risk patients to community resources for clinical follow-up and help determine eligibility for other public programs.

(E) GRANTEE EVALUATION.—An eligible entity shall use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of the pilot program under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees (or individuals nearing enrollment, including those who are 63 and 64 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(b) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries.

(2) MEDICARE EVALUATION OF PREVENTION AND WELLNESS PROGRAMS.—

(A) IN GENERAL.—The Secretary shall evaluate community prevention and wellness programs including those that are sponsored by the Administration on Aging, are evidence-based, and have demonstrated potential to help Medicare beneficiaries (particularly beneficiaries that have attained 65 years of age) reduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—The evaluation under subparagraph (A) shall consist of the following:

(i) EVIDENCE REVIEW.—The Secretary shall review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population. The Secretary may determine the scope of the evidence review and such issues to be considered, which shall include, at a minimum—

(I) physical activity, nutrition, and obesity;

(II) falls;

(III) chronic disease self-management; and

(IV) mental health.

(ii) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS.—The Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Assistant Secretary for Aging, shall, to the extent feasible and practicable, conduct an evaluation of existing community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which Medicare beneficiaries who participate in such programs—

(I) reduce their health risks, improve their health outcomes, and adopt and maintain healthy behaviors;

(II) improve their ability to manage their chronic conditions; and

(III) reduce their utilization of health services and associated costs under the Medicare program for conditions that are amenable to improvement under such programs.

(3) REPORT.—Not later than September 30, 2013, the Secretary shall submit to Congress a report that includes—

(A) recommendations for such legislation and administrative action as the Secretary determines appropriate to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries;

(B) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(C) the results of the evaluation under paragraph (2)(B)(ii).

(4) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $50,000,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the this subsection.

(6) MEDICARE BENEFICIARY.—In this subsection, the term ''Medicare beneficiary'' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title.

SEC. 4203. REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

''SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT.

''(a) STANDARDS.—Not later than 24 months after the date of enactment of the Affordable Health Choices Act, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the Food and Drug Administration, promulgate regulatory standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.) setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

''(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The standards issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

''(c) REVIEW AND AMENDMENT.—The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.).''.

SEC. 4204. IMMUNIZATIONS.

(a) STATE AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

''(l) AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—

''(1) IN GENERAL.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

''(2) STATE PURCHASE.—A State may obtain additional quantities of such adult vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary under this subsection.''.

(b) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:

''(m) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to award grants to States to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations.

''(2) STATE PLAN.—To be eligible for a grant under paragraph (1), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes the interventions to be implemented under the grant and how such interventions match with local needs and capabilities, as determined through consultation with local authorities.

''(3) USE OF FUNDS.—Funds received under a grant under this subsection shall be used to implement interventions that are recommended by the Task Force on Community Preventive Services (as established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) or other evidence-based interventions, including—

''(A) providing immunization reminders or recalls for target populations of clients, patients, and consumers;

''(B) educating targeted populations and health care providers concerning immunizations in combination with one or more other interventions;

''(C) reducing out-of-pocket costs for families for vaccines and their administration;

''(D) carrying out immunization-promoting strategies for participants or clients of public programs, including assessments of immunization status, referrals to health care providers, education, provision of on-site immunizations, or incentives for immunization;

''(E) providing for home visits that promote immunization through education, assessments of need, referrals, provision of immunizations, or other services;

''(F) providing reminders or recalls for immunization providers;

''(G) conducting assessments of, and providing feedback to, immunization providers;

''(H) any combination of one or more interventions described in this paragraph; or

''(I) immunization information systems to allow all States to have electronic databases for immunization records.

''(4) CONSIDERATION.—In awarding grants under this subsection, the Secretary shall consider any reviews or recommendations of the Task Force on Community Preventive Services.

''(5) EVALUATION.—Not later than 3 years after the date on which a State receives a grant under this subsection, the State shall submit to the Secretary an evaluation of progress made toward improving immunization coverage rates among high-risk populations within the State.

''(6) REPORT TO CONGRESS.—Not later than 4 years after the date of enactment of the Affordable Health Choices Act, the Secretary shall submit to Congress a report concerning the effectiveness of the demonstration program established under this subsection together with recommendations on whether to continue and expand such program.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.''.

(c) REAUTHORIZATION OF IMMUNIZATION PROGRAM.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)) is amended—

(1) in paragraph (1), by striking ''for each of the fiscal years 1998 through 2005''; and

(2) in paragraph (2), by striking ''after October 1, 1997,''.

(d) RULE OF CONSTRUCTION REGARDING ACCESS TO IMMUNIZATIONS.—Nothing in this section (including the amendments made by this section), or any other provision of this Act (including any amendments made by this Act) shall be construed to decrease children's access to immunizations.

(e) GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO VACCINES.—

(1) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the ability of Medicare beneficiaries who were 65 years of age or older to access routinely recommended vaccines covered under the prescription drug program under part D of title XVIII of the Social Security Act over the period since the establishment of such program. Such study shall include the following:

(A) An analysis and determination of—

(i) the number of Medicare beneficiaries who were 65 years of age or older and were eligible for a routinely recommended vaccination that was covered under part D;

(ii) the number of such beneficiaries who actually received a routinely recommended vaccination that was covered under part D; and

(iii) any barriers to access by such beneficiaries to routinely recommended vaccinations that were covered under part D.

(B) A summary of the findings and recommendations by government agencies, departments, and advisory bodies (as well as relevant professional organizations) on the impact of coverage under part D of routinely recommended adult immunizations for access to such immunizations by Medicare beneficiaries.

(2) REPORT.—Not later than June 1, 2011, the Comptroller General shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated $1,000,000 for fiscal year 2010 to carry out this subsection.

SEC. 4205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''; and

(2) in subitem (ii), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

''(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

''(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

''(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

''(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

''(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu board, including a drive-through menu board, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

''(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

''(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

''(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

''(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

''(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

''(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

''(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

''(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

''(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

''(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

''(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

''(II) WRITTEN FORMS.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

''(viii) VENDING MACHINES.—

''(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

''(aa) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

''(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

''(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

''(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

''(II) REGISTRATION.—Within 120 days of enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

''(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

''(x) REGULATIONS.—

''(I) PROPOSED REGULATION.—Not later than 1 year after the date of enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

''(II) CONTENTS.—In promulgating regulations, the Secretary shall—

''(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

''(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

''(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

''(xi) DEFINITION.—In this clause, the term 'menu' or 'menu board' means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.''

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343-1(a)(4)) is amended by striking ''except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)'' and inserting ''except that this paragraph does not apply to food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)''.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under subsection (a)(4) of such section;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection

(b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

''(s) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

''(2) AGREEMENTS.—The Secretary shall enter into agreements with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

''(3) WELLNESS PLANS.—

''(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual's identified risk factors:

''(i) Nutritional counseling.

''(ii) A physical activity plan.

''(iii) Alcohol and smoking cessation counseling and services.

''(iv) Stress management.

''(v) Dietary supplements that have health claims approved by the Secretary.

''(vi) Compliance assistance provided by a community health center employee.

''(B) RISK FACTORS.—Wellness plan risk factors shall include—

''(i) weight;

''(ii) tobacco and alcohol use;

''(iii) exercise rates;

''(iv) nutritional status; and

''(v) blood pressure.

''(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual involved and a control group of individuals with respect to the risk factors described in subparagraph (B).

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.''.

SEC. 4207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

''(r)(1) An employer shall provide—

''(A) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk; and

''(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

''(2) An employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

''(3) An employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.

''(4) Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.''.

Subtitle D—Support for Prevention and Public Health Innovation

SEC. 4301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall provide funding for research in the area of public health services and systems.

(b) REQUIREMENTS OF RESEARCH.—Research supported under this section shall include—

(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020, and including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(c) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

SEC. 4302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS.

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

''SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

''(a) DATA COLLECTION.—

''(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

''(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

''(B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated;

''(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and

''(D) any other demographic data as deemed appropriate by the Secretary regarding health disparities.

''(2) COLLECTION STANDARDS.—In collecting data described in paragraph (1), the Secretary or designee shall—

''(A) use Office of Management and Budget standards, at a minimum, for race and ethnicity measures;

''(B) develop standards for the measurement of sex, primary language, and disability status;

''(C) develop standards for the collection of data described in paragraph (1) that, at a minimum—

''(i) collects self-reported data by the applicant, recipient, or participant; and

''(ii) collects data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated;

''(D) survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

''(i) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

''(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 510 of the Rehabilitation Act of 1973; and

''(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities; and

''(E) require that any reporting requirement imposed for purposes of measuring quality under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities by race, ethnicity, sex, primary language, and disability status.

''(3) DATA MANAGEMENT.—In collecting data described in paragraph (1), the Secretary, acting through the National Coordinator for Health Information Technology shall—

''(A) develop national standards for the management of data collected; and

''(B) develop interoperability and security systems for data management.

''(b) DATA ANALYSIS.—

''(1) IN GENERAL.—For each federally conducted or supported health care or public health program or activity, the Secretary shall analyze data collected under paragraph (a) to detect and monitor trends in health disparities (as defined for purposes of section 485E) at the Federal and State levels.

''(c) DATA REPORTING AND DISSEMINATION.—

''(1) IN GENERAL.—The Secretary shall make the analyses described in (b) available to—

''(A) the Office of Minority Health;

''(B) the National Center on Minority Health and Health Disparities;

''(C) the Agency for Healthcare Research and Quality;

''(D) the Centers for Disease Control and Prevention;

''(E) the Centers for Medicare & Medicaid Services;

''(F) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

''(G) the Office of Rural Health;

''(H) other agencies within the Department of Health and Human Services; and

''(I) other entities as determined appropriate by the Secretary.

''(2) REPORTING OF DATA.—The Secretary shall report data and analyses described in (a) and (b) through—

''(A) public postings on the Internet websites of the Department of Health and Human Services; and

''(B) any other reporting or dissemination mechanisms determined appropriate by the Secretary.

''(3) AVAILABILITY OF DATA.—The Secretary may make data described in (a) and (b) available for additional research, analyses, and dissemination to other Federal agencies, non-governmental entities, and the public, in accordance with any Federal agency's data user agreements.

''(d) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual.

''(e) PROTECTION AND SHARING OF DATA.—

''(1) PRIVACY AND OTHER SAFEGUARDS.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that—

''(A) all data collected pursuant to subsection (a) is protected—

''(i) under privacy protections that are at least as broad as those that the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033); and

''(ii) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary; and

''(B) all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected pursuant to subsection (a).

''(2) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (c)(1).

''(f) DATA ON RURAL UNDERSERVED POPULATIONS.—The Secretary shall ensure that any data collected in accordance with this section regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations.

''(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

''(h) REQUIREMENT FOR IMPLEMENTATION.—Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.

''(i) CONSULTATION.—The Secretary shall consult with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the Bureau of the Census, the Commissioner of Social Security, and the head of other appropriate Federal agencies in carrying out this section.''.

(b) ADDRESSING HEALTH CARE DISPARITIES IN MEDICAID AND CHIP.—

(1) STANDARDIZED COLLECTION REQUIREMENTS INCLUDED IN STATE PLANS.—

(A) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 2001(d), is amended—

(i) in paragraph 4), by striking ''and'' at the end;

(ii) in paragraph (75), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after paragraph (75) the following new paragraph:

''(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act.''.

(B) CHIP.—Section 2108(e) of the Social Security Act (42 U.S.C. 1397hh(e)) is amended by adding at the end the following new paragraph:

''(7) Data collected and reported in accordance with section 3101 of the Public Health Service Act, with respect to individuals enrolled in the State child health plan (and, in the case of enrollees under 19 years of age, their parents or legal guardians), including data regarding the primary language of such individuals, parents, and legal guardians.''.

(2) EXTENDING MEDICARE REQUIREMENT TO ADDRESS HEALTH DISPARITIES DATA COLLECTION TO MEDICAID AND CHIP.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 2703 is amended by adding at the end the following new section:

''SEC. 1946. ADDRESSING HEALTH CARE DISPARITIES.

''(a) EVALUATING DATA COLLECTION APPROACHES.—The Secretary shall evaluate approaches for the collection of data under this title and title XXI, to be performed in conjunction with existing quality reporting requirements and programs under this title and title XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting such evaluation, the Secretary shall consider the following objectives:

''(1) Protecting patient privacy.

''(2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this title or title XXI.

''(3) Improving program data under this title and title XXI on race, ethnicity, sex, primary language, and disability status.

''(b) REPORTS TO CONGRESS.—

''(1) REPORT ON EVALUATION.—Not later than 18 months after the date of the enactment of this section, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

''(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status for the programs under this title and title XXI; and

''(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1852(e)(3) and other nationally recognized quality performance measures, as appropriate, on such bases.

''(2) REPORTS ON DATA ANALYSES.—Not later than 4 years after the date of the enactment of this section, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this title and under title XXI based on analyses of the data collected under subsection (c).

''(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 24 months after the date of the enactment of this section, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.''.

SEC. 4303. CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), by section 4102, is further amended by adding at the end the following:

''PART U—EMPLOYER-BASED WELLNESS PROGRAM

''SEC. 399MM. TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS.

''In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, the Director shall—

''(1) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including—

''(A) measuring the participation and methods to increase participation of employees in such programs;

''(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and

''(C) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

''(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

''SEC. 399MM–1. NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY.

''(a) IN GENERAL.—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, not later than 2 years after the date of enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

''(b) REPORT.—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

''SEC. 399MM–2. PRIORITIZATION OF EVALUATION BY SECRETARY.

''The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

"SEC. 399MM–3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.

''Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.''.

SEC. 4304. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

Title XXVIII of the Public Health Service Act (42 U.S.C. 300hh et seq.) is amended by adding at the end the following:

"Subtitle C—Strengthening Public Health Surveillance Systems

"SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

''(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—

''(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

''(2) enhancing laboratory practice as well as systems to report test orders and results electronically;

''(3) improving information systems including developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

''(4) developing and implementing prevention and control strategies.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2010 through 2013, of which—

''(1) not less than $95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

''(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

''(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).''.

SEC. 4305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—

(1) CONVENING.—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as ''the Conference'').

(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under paragraph (1), the Secretary of Health and Human Services may enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference's findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

"SEC. 409J. PAIN RESEARCH.

''(a) RESEARCH INITIATIVES.—

''(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

''(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

''(3) DEFINITION.—In this subsection, the term 'Pain Consortium' means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

''(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the 'Committee'), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The Committee shall be composed of the following voting members:

''(i) Not more than 7 voting Federal representatives appoint by the Secretary from agencies that conduct pain care research and treatment.

''(ii) 12 additional voting members appointed under subparagraph (B).

''(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

''(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

''(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

''(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

''(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

''(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

''(5) DUTIES.—The Committee shall—

''(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

''(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

''(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication of effort;

''(D) make recommendations on how best to disseminate information on pain care; and

''(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

''(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.''.

(c) PAIN CARE EDUCATION AND TRAINING.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

"SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

''(a) IN GENERAL.—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

''(b) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on—

''(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

''(2) applicable laws, regulations, rules, and policies on controlled substances, including the degree to which misconceptions and concerns regarding such laws, regulations, rules, and policies, or the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

''(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

''(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

''(5) recent findings, developments, and improvements in the provision of pain care.

''(c) EVALUATION OF PROGRAMS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

''(d) PAIN CARE DEFINED.—For purposes of this section the term 'pain care' means the assessment, diagnosis, treatment, or management of acute or chronic pain regardless of causation or body location.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under this subsection shall remain available until expended.''.

SEC. 4306. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

''(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.''.

Subtitle E—Miscellaneous Provisions

SEC. 4401. SENSE OF THE SENATE CONCERNING CBO SCORING.

(a) FINDING.—The Senate finds that the costs of prevention programs are difficult to estimate due in part because prevention initiatives are hard to measure and results may occur outside the 5 and 10 year budget windows.

(b) SENSE OF CONGRESS.—It is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.

SEC. 4402. EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program; and

(2) submit to Congress a report concerning such evaluation, which shall include conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions.

TITLE V—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

SEC. 5001. PURPOSE.

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations by—

(1) gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, including research on the supply, demand, distribution, diversity, and skills needs of the health care workforce;

(2) increasing the supply of a qualified health care workforce to improve access to and the delivery of health care services for all individuals;

(3) enhancing health care workforce education and training to improve access to and the delivery of health care services for all individuals; and

(4) providing support to the existing health care workforce to improve access to and the delivery of health care services for all individuals.

SEC. 5002. DEFINITIONS.

(a) THIS TITLE.—In this title:

(1) ALLIED HEALTH PROFESSIONAL.—The term ''allied health professional'' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ''healthcare career pathway'' means a rigorous, engaging, and high quality set of courses and services that—

(A) includes an articulated sequence of academic and career courses, including 21st century skills;

(B) is aligned with the needs of healthcare industries in a region or State;

(C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers;

(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;

(E) meets State academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable industry standards; and

(F) leads to 2 or more credentials, including—

(i) a secondary school diploma; and

(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.

(3) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).

(4) LOW INCOME INDIVIDUAL, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—

(A) LOW-INCOME INDIVIDUAL.—The term ''low-income individual'' has the meaning given that term in section 101 of the Workforce investment Act of 1998 (29 U.S.C. 2801).

(B) STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.—The terms ''State workforce investment board'' and ''local workforce investment board'', refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.

(5) POSTSECONDARY EDUCATION.—The term ''postsecondary education'' means—

(A) a 4-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of higher education; or

(B) a certificate or registered apprenticeship program at the postsecondary level offered by an institution of higher education or a non-profit educational institution.

(6) REGISTERED APPRENTICESHIP PROGRAM.—The term ''registered apprenticeship program'' means an industry skills training program at the postsecondary level that combines technical and theoretical training through structure on the job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to enhance job proficiency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.

(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 799B of the Public Health Service Act (42 U.S.C. 295p) is amended—

(1) by striking paragraph (3) and inserting the following:

''(3) PHYSICIAN ASSISTANT EDUCATION PROGRAM.—The term 'physician assistant education program' means an educational program in a public or private institution in a State that—

''(A) has as its objective the education of individuals who, upon completion of their studies in the program, be qualified to provide primary care medical services with the supervision of a physician; and

''(B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant.''; and

(2) by adding at the end the following:

''(12) AREA HEALTH EDUCATION CENTER.—The term 'area health education center' means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under subsection (a)(1) or (a)(2) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.

''(13) AREA HEALTH EDUCATION CENTER PROGRAM.—The term 'area health education center program' means cooperative program consisting of an entity that has received an award under subsection (a)(1) or (a)(2) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center program and one or more area health education centers, which carries out the required activities described in section 751(c), satisfies the program requirements in such section, has as one of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.

''(14) CLINICAL SOCIAL WORKER.—The term 'clinical social worker' has the meaning given the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).

''(15) CULTURAL COMPETENCY.—The term 'cultural competency' shall be defined by the Secretary in a manner consistent with section 1707(d)(3).

''(16) DIRECT CARE WORKER.—The term 'direct care worker' has the meaning given that term in the 2010 Standard Occupational Classifications of the Department of Labor for Home Health Aides [31–1011], Psychiatric Aides [31–1013], Nursing Assistants [31–1014], and Personal Care Aides [39–9021].

''(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

''(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'frontier health professional shortage area' means an area—

''(A) with a population density less than 6 persons per square mile within the service area; and

''(B) with respect to which the distance or time for the population to access care is excessive.

''(19) GRADUATE PSYCHOLOGY.—The term 'graduate psychology' means an accredited program in professional psychology.

''(20) HEALTH DISPARITY POPULATION.—The term 'health disparity population' has the meaning given such term in section 903(d)(1).

''(21) HEALTH LITERACY.—The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.

''(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term 'mental health service professional' means an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.

''(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term 'one-stop delivery system' means a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).

''(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term 'paraprofessional child and adolescent mental health worker' means an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.

''(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms 'racial and ethnic minority group' and 'racial and ethnic minority population' have the meaning given the term 'racial and ethnic minority group' in section 1707.

''(26) RURAL HEALTH CLINIC.—The term 'rural health clinic' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).''.

(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—

(1) in paragraph (2)—

(A) by striking ''means a'' and inserting ''means an accredited (as defined in paragraph 6)''; and

(B) by striking the period as inserting the following: ''where graduates are—

''(A) authorized to sit for the National Council Licensure EXamination-Registered Nurse (NCLEX-RN); or

''(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become an advanced education nurse as defined by section 811(b).''; and

(2) by adding at the end the following:

''(16) ACCELERATED NURSING DEGREE PROGRAM.—The term 'accelerated nursing degree program' means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing.

''(17) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term 'bridge or degree completion program' means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include, Registered Nurse (RN) to Bachelor's of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.''.

Subtitle B—Innovations in the Health Care Workforce

SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ''Commission'').

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to section 5 of the Federal Advisory Committee Act (5 U.S.C. App.).

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between urban, suburban, rural, and frontier representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professionals;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of health care services and health economics research;

(V) representatives of consumers;

(VI) labor unions;

(VII) State or local workforce investment boards; and

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978. Members of the Commission shall not be treated as special government employees under title 18, United States Code.

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(C) INITIAL APPOINTMENTS.—The Comptroller General shall make initial appointments of members to the Commission not later than September 30, 2010.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of tile 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate. Personnel of the Commission shall not be treated as employees of the Government Accountability Office for any purpose.

(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(d) DUTIES.—

(1) RECOGNITION, DISSEMINATION, AND COMMUNICATION.—The Commission shall—

(A) recognize efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(B) disseminate information on promising retention practices for health care professionals; and

(C) communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce.

(2) REVIEW OF HEALTH CARE WORKFORCE AND ANNUAL REPORTS.—In order to develop a fiscally sustainable integrated workforce that supports a high-quality, readily accessible health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning related policies; and

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area as described in paragraph (4).

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, skill sets, and demands, with projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the education and training infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), with recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq);

(D) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved community.

(4) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:

(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.

(iii) An analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.

(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.

(II) Oral health care workforce capacity at all levels.

(III) Mental and behavioral health care workforce capacity at all levels.

(IV) Allied health and public health care workforce capacity at all levels.

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.

(VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development areas that require special attention.

(5) GRANT PROGRAM.—The Commission shall—

(A) review implementation progress reports on, and report to Congress about, the State Health Care Workforce Development Grant program established in section 5102;

(B) in collaboration with the Department of Labor and in coordination with the Department of Education and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 5102(b) for grant recipients under section 5102;

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute this information to Congress, relevant Federal agencies, and to the public.

(6) STUDY.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) RECOMMENDATIONS.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(8) ASSESSMENT.—The Commission shall assess and receive reports from the National Center for Health Care Workforce Analysis established under section 761(b) of the Public Service Health Act (as amended by section 5103).

(e) CONSULTATION WITH FEDERAL, STATE, AND LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZATIONS.—

(1) IN GENERAL.—The Commission shall consult with Federal agencies (including the Departments of Health and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care organizations, professional societies, and other relevant public-private health care partnerships.

(2) OBTAINING OFFICIAL DATA.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch information necessary to enable the Commission to carry out this section.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(f) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an executive director that shall not exceed the rate of basic pay payable for level V of the Executive Schedule and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the internal organization and operation of the Commission.

(g) POWERS.—

(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;

(B) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(C) adopt procedures allowing interested parties to submit information for the Commission's use in making reports and recommendations.

(2) ACCESS OF THE GOVERNMENT ACCOUNTABILITY OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(3) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(3) GIFTS AND SERVICES.—The Commission may not accept gifts, bequeaths, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(i) DEFINITIONS.—In this section:

(1) HEALTH CARE WORKFORCE.—The term ''health care workforce'' includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(2) HEALTH PROFESSIONALS.—The term ''health professionals'' includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;

(B) national representatives of health professionals;

(C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and physician assistants;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.

SEC. 5102. STATE HEALTH CARE WORKFORCE DEVELOPMENT GRANTS.

(a) ESTABLISHMENT.—There is established a competitive health care workforce development grant program (referred to in this section as the ''program'') for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.

(b) FISCAL AND ADMINISTRATIVE AGENT.—The Health Resources and Services Administration of the Department of Health and Human Services (referred to in this section as the ''Administration'') shall be the fiscal and administrative agent for the grants awarded under this section. The Administration is authorized to carry out the program, in consultation with the National Health Care Workforce Commission (referred to in this section as the ''Commission''), which shall review reports on the development, implementation, and evaluation activities of the grant program, including—

(1) administering the grants;

(2) providing technical assistance to grantees; and

(3) reporting performance information to the Commission.

(c) PLANNING GRANTS.—

(1) AMOUNT AND DURATION.—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $150,000.

(2) ELIGIBILITY.—To be eligible to receive a planning grant, an entity shall be an eligible partnership. An eligible partnership shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employer, labor organization, a public 2-year institution of higher education, a public 4-year institution of higher education, the recognized State federation of labor, the State public secondary education agency, the State P–16 or P–20 Council if such a council exists, and a philanthropic organization that is actively engaged in providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries.

(3) FISCAL AND ADMINISTRATIVE AGENT.—The Governor of the State receiving a planning grant has the authority to appoint a fiscal and an administrative agency for the partnership.

(4) APPLICATION.—Each State partnership desiring a planning grant shall submit an application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator may reasonable require. Each application submitted for a planning grant shall describe the members of the State partnership, the activities for which assistance is sought, the proposed performance benchmarks to be used to measure progress under the planning grant, a budget for use of the funds to complete the required activities described in paragraph (5), and such additional assurance and information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

(5) REQUIRED ACTIVITIES.—A State partnership receiving a planning grant shall carry out the following:

(A) Analyze State labor market information in order to create health care career pathways for students and adults, including dislocated workers.

(B) Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways.

(C) Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships.

(D) Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure.

(E) Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling.

(F) Identify Federal or State policies or rules to developing a coherent and comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers.

(G) Participate in the Administration's evaluation and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before the State partnership receives a planning grant, such partnership and the Administrator of the Administration shall jointly determine the performance benchmarks that will be established for the purposes of the planning grant.

(7) MATCH.—Each State partnership receiving a planning grant shall provide an amount, in cash or in kind, that is not less that 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.

(8) REPORT.—

(A) REPORT TO ADMINISTRATION.—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State's performance of the activities under the grant, including the use of funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) DURATION.—An implementation grant shall be awarded for a period of no more than

2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) ELIGIBILITY.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant; or

(B) completed a satisfactory application, including a plan to coordinate with required partners and complete the required activities during the 2 year period of the implementation grant.

(4) FISCAL AND ADMINISTRATIVE AGENT.—A State partnership receiving an implementation grant shall appoint a fiscal and an administration agent for the implementation of such grant.

(5) APPLICATION.—Each eligible State partnership desiring an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administration may reasonably require. Each application submitted shall include—

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the planning grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of how the State partnership will coordinate with required partners and complete the required partnership activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of how the State partnership will collect data to report progress in grant activities; and

(H) such additional assurances as the Administration determines to be essential to ensure compliance with grant requirements.

(6) REQUIRED ACTIVITIES.—

(A) IN GENERAL.—A State partnership that receives an implementation grant may reserve not less than 60 percent of the grant funds to make grants to be competitively awarded by the State partnership, consistent with State procurement rules, to encourage regional partnerships to address health care workforce development needs and to promote innovative health care workforce career pathway activities, including career counseling, learning, and employment.

(B) ELIGIBLE PARTNERSHIP DUTIES.—An eligible State partnership receiving an implementation grant shall—

(i) identify and convene regional leadership to discuss opportunities to engage in statewide health care workforce development planning, including the potential use of competitive grants to improve the development, distribution, and diversity of the regional health care workforce; the alignment of curricula for health care careers; and the access to quality career information and guidance and education and training opportunities;

(ii) in consultation with key stakeholders and regional leaders, take appropriate steps to reduce Federal, State, or local barriers to a comprehensive and coherent strategy, including changes in State or local policies to foster coherent and comprehensive health care workforce development activities, including health care career pathways at the regional and State levels, career planning information, retraining for dislocated workers, and as appropriate, requests for Federal program or administrative waivers;

(iii) develop, disseminate, and review with key stakeholders a preliminary statewide strategy that addresses short- and long-term health care workforce development supply versus demand;

(iv) convene State partnership members on a regular basis, and at least on a semiannual basis;

(v) assist leaders at the regional level to form partnerships, including technical assistance and capacity building activities;

(vi) collect and assess data on and report on the performance benchmarks selected by the State partnership and the Administration for implementation activities carried out by regional and State partnerships; and

(vii) participate in the Administration's evaluation and reporting activities.

(7) PERFORMANCE AND EVALUATION.—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant.

(8) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

(9) REPORTS.—

(A) REPORT TO ADMINISTRATION.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State of the grant activities, including a description of the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing implementation activities, performance, and fund utilization of the State grantees, including an identification of promising practices and a profile of the activities of each State grantee.

(e) AUTHORIZATION FOR APPROPRIATIONS.—

(1) PLANNING GRANTS.—There are authorized to be appropriated to award planning grants under subsection (c) $8,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

(2) IMPLEMENTATION GRANTS.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 5103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e);

(2) by striking subsection (b) and inserting the following:

''(b) NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.—

''(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the 'National Center').

''(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 5101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

''(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

''(B) carry out the activities under section 792(a);

''(C) annually evaluate programs under this title;

''(D) develop and publish performance measures and benchmarks for programs under this title; and

''(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

''(3) COLLABORATION AND DATA SHARING.—

''(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

''(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with relevant professional and educational organizations or societies.

''(c) STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—

''(1) IN GENERAL.—The Secretary shall award grants to, or enter into contracts with, eligible entities for purposes of—

''(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

''(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

''(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

''(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

''(A) studying practice patterns; and

''(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

''(3) GUIDELINES.—A longitudinal evaluation shall comply with guidelines issued under sections 749(d)(4), 757(d)(4), and 762(a)(4).

''(4) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title.''; and

(3) in subsection (e), as so redesignated—

(A) by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—

''(A) NATIONAL CENTER.—To carry out subsection (b), there are authorized to be appropriated $7,500,000 for each of fiscal years 2010 through 2014.

''(B) STATE AND REGIONAL CENTERS.—To carry out subsection (c), there are authorized to be appropriated $4,500,000 for each of fiscal years 2010 through 2014.

''(C) GRANTS FOR LONGITUDINAL EVALUATIONS.—To carry out subsection (d), there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.''; and

(4) in paragraph (2), by striking ''subsection (a)'' and inserting ''paragraph (1)''.

(b) TRANSFERS.—Not later than 180 days after the date of enactment of this Act, the responsibilities and resources of the National Center for Health Workforce Analysis, as in effect on the date before the date of enactment of this Act, shall be transferred to the National Center for Health Care Workforce Analysis established under section 761 of the Public Health Service Act, as amended by subsection (a).

(c) USE OF LONGITUDINAL EVALUATIONS.—Section 791(a)(1) of the Public Health Service Act (42 U.S.C. 295j(a)(1)) is amended—

(1) in subparagraph (A), by striking ''or'' at the end;

(2) in subparagraph (B), by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) and reports data from such system to the national workforce database (as established under section 761(b)(2)(E)).''.

(d) PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—

(1) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—Section 748(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(2) ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.—Section 756(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(3) ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762(a) of the Public Health Service Act (42 U.S.C. 294o(a)) is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D; and

''(5) recommend appropriation levels for programs under this title, except for programs under part C or D.''.

Subtitle C—Increasing the Supply of the Health Care Workforce

SEC. 5201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE.—Section 723 of the Public Health Service Act (42 U.S.C. 292s) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraph (B) and inserting the following:

''(B) to practice in such care for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.''; and

(B) by striking paragraph (3) and inserting the following:

''(3) NONCOMPLIANCE BY STUDENT.—Each agreement entered into with a student pursuant to paragraph (1) shall provide that, if the student fails to comply with such agreement, the loan involved will begin to accrue interest at a rate of 2 percent per year greater than the rate at which the student would pay if compliant in such year.''; and

(2) by adding at the end the following:

''(d) SENSE OF CONGRESS.—It is the sense of Congress that funds repaid under the loan program under this section should not be transferred to the Treasury of the United States or otherwise used for any other purpose other than to carry out this section.''.

(b) STUDENT LOAN GUIDELINES.—The Secretary of Health and Human Services shall not require parental financial information for an independent student to determine financial need under section 723 of the Public Health Service Act (42 U.S.C. 292s) and the determination of need for such information shall be at the discretion of applicable school loan officer. The Secretary shall amend guidelines issued by the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 5202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 836(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200''; and

(3) by striking ''$13,000'' and all that follows through the period and inserting ''$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate of the loans.''.

(b) LOAN PROVISIONS.—Section 836(b) of the Public Health Service Act (42 U.S.C. 297b(b)) is amended—

(1) in paragraph (1)(C), by striking ''1986'' and inserting ''2000''; and

(2) in paragraph (3), by striking ''the date of enactment of the Nurse Training Amendments of 1979'' and inserting ''September 29, 1995''.

SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

''Subpart 3—Recruitment and Retention Programs

''SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

''(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

''(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

''(1) such qualified health professionals will agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

''(2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than $35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 3 years during the qualified health professional's—

''(A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or

''(B) employment as a pediatric medical subspecialist, pediatric surgical specialist, or child and adolescent mental health professional serving an area or population described in such paragraph.

''(c) IN GENERAL.—

''(1) ELIGIBLE INDIVIDUALS.—

''(A) PEDIATRIC MEDICAL SPECIALISTS AND PEDIATRIC SURGICAL SPECIALISTS.—For purposes of contracts with respect to pediatric medical specialists and pediatric surgical specialists, the term 'qualified health professional' means a licensed physician who—

''(i) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship; or

''(ii) has completed (but not prior to the end of the calendar year in which this section is enacted) the training described in subparagraph (B).

''(B) CHILD AND ADOLESCENT MENTAL AND BEHAVIORAL HEALTH.—For purposes of contracts with respect to child and adolescent mental and behavioral health care, the term 'qualified health professional' means a health care professional who—

''(i) has received specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

''(ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or

''(iii) is a mental health service professional who completed (but not before the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).

''(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an eligible individual unless—

''(A) the individual agrees to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population;

''(B) the individual is a United States citizen or a permanent legal United States resident; and

''(C) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

''(d) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—

''(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

''(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

''(3) demonstrate financial need.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and $20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).''.

SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5203, is further amended by adding at the end the following:

''SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and have accepted employment with a Federal, State, local, or tribal public health agency, or a related training fellowship, as recognized by the Secretary, to commence upon graduation;

''(B)(i) have graduated, during the preceding 10-year period, from an accredited educational institution in a State or territory and received a public health or health professions degree or certificate; and

''(ii) be employed by, or have accepted employment with, a Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary;

''(2) be a United States citizen; and

''(3)(A) submit an application to the Secretary to participate in the Program;

''(B) execute a written contract as required in subsection (c); and

''(4) not have received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965.

''(c) CONTRACT.—The written contract (referred to in this section as the 'written contract') between the Secretary and an individual shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant degree or certificate in accordance with the terms of the contract;

''(2) an agreement on the part of the individual that the individual will serve in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

''(A) 3 years; or

''(B) such longer period of time as determined appropriate by the Secretary and the individual;

''(3) an agreement, as appropriate, on the part of the individual to relocate to a priority service area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

''(4) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

''(5) a statement of the damages to which the United States is entitled, under this section for the individual's breach of the contract; and

''(6) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(d) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for tuition expenses incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—For each year of obligated service that an individual contracts to serve under subsection (c) the Secretary may pay up to $35,000 on behalf of the individual for loans described in paragraph (1). With respect to participants under the Program whose total eligible loans are less than $105,000, the Secretary shall pay an amount that does not exceed ⅓ of the eligible loan balance for each year of obligated service of the individual.

''(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed 39 percent of the total amount of loan repayments made for the taxable year involved.

''(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of the period of obligated service may be postponed as approved by the Secretary.

''(f) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SEC. 5205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings, as recognized by the Secretary of Health and Human Services by authorizing an Allied Health Loan Forgiveness Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1078–11) is amended—

(1) in subsection (b), by adding at the end the following:

''(18) ALLIED HEALTH PROFESSIONALS.—The individual is employed full-time as an allied health professional—

''(A) in a Federal, State, local, or tribal public health agency; or

''(B) in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''; and

(2) in subsection (g)—

(A) by redesignating paragraphs (1) through (9) as paragraphs (2) through (10), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

''(1) ALLIED HEALTH PROFESSIONAL.—The term 'allied health professional' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

''(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

''(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''.

SEC. 5206. GRANTS FOR STATE AND LOCAL PROGRAMS.

(a) IN GENERAL.—Section 765(d) of the Public Health Service Act (42 U.S.C. 295(d)) is amended—

(1) in paragraph (7), by striking ''; or'' and inserting a semicolon;

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following:

''(8) public health workforce loan repayment programs; or''.

(b) TRAINING FOR MID-CAREER PUBLIC HEALTH PROFESSIONALS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5204, is further amended by adding at the end the following:

''SEC. 777. TRAINING FOR MID-CAREER PUBLIC AND ALLIED HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, any eligible entity to award scholarships to eligible individuals to enroll in degree or professional training programs for the purpose of enabling mid-career professionals in the public health and allied health workforce to receive additional training in the field of public health and allied health.

''(b) ELIGIBILITY.—

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' indicates an accredited educational institution that offers a course of study, certificate program, or professional training program in public or allied health or a related discipline, as determined by the Secretary

''(2) ELIGIBLE INDIVIDUALS.—The term 'eligible individuals' includes those individuals employed in public and allied health positions at the Federal, State, tribal, or local level who are interested in retaining or upgrading their education.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health mid-career professionals.''.

SEC. 5207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

''(1) For fiscal year 2010, $320,461,632.

''(2) For fiscal year 2011, $414,095,394.

''(3) For fiscal year 2012, $535,087,442.

''(4) For fiscal year 2013, $691,431,432.

''(5) For fiscal year 2014, $893,456,433.

''(6) For fiscal year 2015, $1,154,510,336.

''(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

''(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.''.

SEC. 5208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330A the following:

''SEC. 330A–1. GRANTS TO NURSE–MANAGED HEALTH CLINICS.

''(a) DEFINITIONS.—

''(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term 'comprehensive primary health care services' means the primary health services described in section 330(b)(1).

''(2) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the cost of the operation of nurse-managed health clinics that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an NMHC; and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) assurances that nurses are the major providers of services at the NMHC and that at least 1 advanced practice nurse holds an executive management position within the organizational structure of the NMHC;

''(B) an assurance that the NMHC will continue providing comprehensive primary health care services or wellness services without regard to income or insurance status of the patient for the duration of the grant period; and

''(C) an assurance that, not later than 90 days of receiving a grant under this section, the NMHC will establish a community advisory committee, for which a majority of the members shall be individuals who are served by the NMHC.

''(d) GRANT AMOUNT.—The amount of any grant made under this section for any fiscal year shall be determined by the Secretary, taking into account—

''(1) the financial need of the NMHC, considering State, local, and other operational funding provided to the NMHC; and

''(2) other factors, as the Secretary determines appropriate.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''.

SEC. 5209. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 202 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking ''not to exceed 2,800''.

SEC. 5210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

''SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

''(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

''(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

''(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

''(5) WARRANT OFFICERS.—Warrant officers may be appointed to the Service for the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service shall be considered for purposes of this Act and title 37, United States Code, to be a commissioned officer within the Commissioned Corps of the Service.

''(b) ASSIMILATING RESERVE CORP OFFICERS INTO THE REGULAR CORPS.—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as officers in the Reserve Corps under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

''(c) PURPOSE AND USE OF READY RESEARCH.—

''(1) PURPOSE.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service's reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

''(2) USES.—The Ready Reserve Corps shall—

''(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

''(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel;

''(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic; and

''(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

''(d) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps.''.

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

''SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

''(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;

''(B) to provide need-based financial assistance in the form of traineeships and fellowships to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields defined in subparagraph (A);

''(C) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;

''(D) to plan, develop, and operate a program for the training of physicians teaching in community-based settings;

''(E) to provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;

''(F) to plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs to provide such training;

''(G) to plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, which may include—

''(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this section);

''(ii) developing tools and curricula relevant to patient-centered medical homes; and

''(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

''(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

''(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(b) CAPACITY BUILDING IN PRIMARY CARE.—

''(1) IN GENERAL.—The Secretary may make grants to or enter into contracts with accredited schools of medicine or osteopathic medicine to establish, maintain, or improve—

''(A) academic units or programs that improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

''(B) programs that integrate academic administrative units in fields defined in subsection (a)(1)(A) to enhance interdisciplinary recruitment, training, and faculty development.

''(2) PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any qualified applicant for such an award that agrees to expend the award for the purpose of—

''(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

''(B) substantially expanding such units or programs.

''(3) PRIORITIES IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to qualified applicants that—

''(A) proposes a collaborative project between academic administrative units of primary care;

''(B) proposes innovative approaches to clinical teaching using models of primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health care settings and integration physical and mental health provision;

''(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

''(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

''(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

''(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

''(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

''(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act; or

''(I) provide training in cultural competency and health literacy.

''(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(c) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For purposes of carrying out this section (other than subsection (b)(1)(B)), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

''(2) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

''(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $750,000 for each of fiscal years 2010 through 2014.''.

SEC. 5302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 5301, the following:

''SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes (as defined in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an institution of higher education (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 1002)) that—

''(A) is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

''(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

''(d) ELIGIBLE INDIVIDUAL.—

''(1) ELIGIBILITY.—To be eligible for assistance under this section, an individual shall be enrolled in courses provided by a grantee under this subsection and maintain satisfactory academic progress in such courses.

''(2) CONDITION OF ASSISTANCE.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatrics, disability services, long term services and supports, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to

carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.''.

SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(1) redesignating section 748, as amended by section 5103 of this Act, as section 749; and

(2) inserting after section 747A, as added by section 5302, the following:

''SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

''(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry;

''(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public heath dentistry, or dental hygiene;

''(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

''(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;

''(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);

''(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

''(G) to create a loan repayment program for faculty in dental programs; and

''(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(2) FACULTY LOAN REPAYMENT.—

''(A) IN GENERAL.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which—

''(i) individuals agree to serve full-time as faculty members; and

''(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.

''(B) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.

''(b) ELIGIBLE ENTITY.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

''(c) PRIORITIES IN MAKING AWARDS.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

''(1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.

''(2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.

''(3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.

''(4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.

''(5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

''(6) Qualified applicants that include educational activities in cultural competency and health literacy.

''(7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

''(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.

''(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(e) DURATION OF AWARD.—The period during which payments are made to an entity from an award of a grant or contract under subsection (a) shall be 5 years. The provision of such payments shall be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved to make the payments.

''(f) AUTHORIZATIONS OF APPROPRIATIONS.—For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

''(g) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.''.

SEC. 5304. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECT.

Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. 256f et seq.) is amended by adding at the end the following:

''SEC. 340G–1. DEMONSTRATION PROGRAM.

''(a) IN GENERAL.—

''(1) AUTHORIZATION.—The Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities.

''(2) DEFINITION.—The term 'alternative dental health care providers' includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

''(b) TIMEFRAME.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.

''(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be—

''(A) an institution of higher education, including a community college;

''(B) a public-private partnership;

''(C) a federally qualified health center;

''(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

''(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization providing dental services; or

''(F) a public hospital or health system;

''(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and

''(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(d) ADMINISTRATIVE PROVISIONS.—

''(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project being conducted.

''(2) DISBURSEMENT OF FUNDS.—

''(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disperse to any entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

''(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

''(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

''(f) EVALUATION.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

''(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.''.

SEC. 5305. GERIATRIC EDUCATION AND TRAINING; CAREER AWARDS; COMPREHENSIVE GERIATRIC EDUCATION.

(a) WORKFORCE DEVELOPMENT; CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

''(d) GERIATRIC WORKFORCE DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to entities that operate a geriatric education center pursuant to subsection (a)(1).

''(2) APPLICATION.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(3) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—

''(A) carry out the fellowship program described in paragraph (4); and

''(B) carry out 1 of the 2 activities described in paragraph (5).

''(4) FELLOWSHIP PROGRAM.—

''(A) IN GENERAL.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses (referred to in this subsection as a 'fellowship') that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

''(B) LOCATION.—A fellowship shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with other geriatric education centers, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary with which the geriatric education centers are affiliated.

''(C) CME CREDIT.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements. As a condition of such acceptance, the recipient shall agree to subsequently provide a minimum of 18 hours of voluntary instructional support through a geriatric education center that is providing clinical training to students or trainees in long-term care settings.

''(5) ADDITIONAL REQUIRED ACTIVITIES DESCRIBED.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to carry out 1 of the following 2 activities.

''(A) FAMILY CAREGIVER AND DIRECT CARE PROVIDER TRAINING.—A geriatric education center that receives an award under this subsection shall offer at least 2 courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are designed to provide practical training for supporting frail elders and individuals with disabilities. The Secretary shall require such Centers to work with appropriate community partners to develop training program content and to publicize the availability of training courses in their service areas. All family caregiver and direct care provider training programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate, safe, and effective use of medications for older adults.

''(B) INCORPORATION OF BEST PRACTICES.—A geriatric education center that receives an award under this subsection shall develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, and management of the psychological and behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

''(6) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

''(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of $150,000. Not more than 24 geriatric education centers may receive an award under this subsection.

''(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

''(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,800,000 for the period of fiscal year 2011 through 2014.

''(e) GERIATRIC CAREER INCENTIVE AWARDS.—

''(1) IN GENERAL.—The Secretary shall award grants or contracts under this section to individuals described in paragraph (2) to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management.

''(2) ELIGIBLE INDIVIDUALS.—To be eligible to received an award under paragraph (1), an individual shall—

''(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or student of psychology who is pursuing a doctorate or other advanced degree in geriatrics or related fields in an accredited health professions school; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(3) CONDITION OF AWARD.—As a condition of receiving an award under this subsection, an individual shall agree that, following completion of the award period, the individual will teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years under guidelines set by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal years 2011 through 2013.''.

(b) EXPANSION OF ELIGIBILITY FOR GERIATRIC ACADEMIC CAREER AWARDS; PAYMENT TO INSTITUTION.—Section 753(c) of the Public Health Service Act 294(c)) is amended—

(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively;

(2) by striking paragraph (2) through paragraph (3) and inserting the following:

''(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an Award under paragraph (1), an individual shall—

''(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or licensed dentistry, or have completed any required training in a discipline and employed in an accredited health professions school that is approved by the Secretary;

''(B) have completed an approved fellowship program in geriatrics or have completed specialty training in geriatrics as required by the discipline and any addition geriatrics training as required by the Secretary; and

''(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

''(3) LIMITATIONS.—No Award under paragraph (1) may be made to an eligible individual unless the individual—

''(A) has submitted to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, and the Secretary has approved such application;

''(B) provides, in such form and manner as the Secretary may require, assurances that the individual will meet the service requirement described in paragraph (6); and

''(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment in a health professions institution and documented commitment from such institution to spend 75 percent of the total time of such individual on teaching and developing skills in interdisciplinary education in geriatrics.

''(4) MAINTENANCE OF EFFORT.—An eligible individual that receives an Award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(3) in paragraph (5), as so designated—

(A) in subparagraph (A)—

(i) by inserting ''for individuals who are physicians'' after ''this section''; and

(ii) by inserting after the period at the end the following: ''The Secretary shall determine the amount of an Award under this section for individuals who are not physicians.''; and

(B) by adding at the end the following:

''(C) PAYMENT TO INSTITUTION.—The Secretary shall make payments to institutions which include schools of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, and pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary.''.

(c) COMPREHENSIVE GERIATRIC EDUCATION.—Section 855 of the Public Health Service Act (42 U.S.C. 298) is amended—

(1) in subsection (b)—

(A) in paragraph (3), by striking ''or'' at the end;

(B) in paragraph (4), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(5) establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.''; and

(2) in subsection (e), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

SEC. 5306. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

(a) IN GENERAL.—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(1) striking section 757;

(2) redesignating section 756 (as amended by section 5103) as section 757; and

(3) inserting after section 755 the following:

''SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

''(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

''(1) baccalaureate, master's, and doctoral degree programs of social work, as well as the development of faculty in social work;

''(2) accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

''(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

''(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this section, an institution shall demonstrate—

''(1) participation in the institutions' programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

''(2) knowledge and understanding of the concerns of the individuals and groups described in subsection (a);

''(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

''(4) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require; and

''(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

''(c) INSTITUTIONAL REQUIREMENT.—For grants authorized under subsection (a)(1), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

''(d) PRIORITY.—

''(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

''(A) are accredited by the Council on Social Work Education;

''(B) have a graduation rate of not less than 80 percent for social work students; and

''(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

''(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

''(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

''(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

''(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

''(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

''(D) offer curriculum taught collaboratively with a family on the consumer and family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

''(E) provide services through a community mental health program described in section 1913(b)(1).

''(e) AUTHORIZATION OF APPROPRIATION.—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

''(1) $8,000,000 for training in social work in subsection (a)(1);

''(2) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

''(3) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

''(4) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).''.

(b) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by striking ''sections 751(a)(1)(A), 751(a)(1)(B), 753(b), 754(3)(A), and 755(b)'' and inserting ''sections 751(b)(1)(A), 753(b), and 755(b)''.

SEC. 5307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 293e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) in paragraph (1), by striking ''for the purpose of'' and all that follows through the period at the end and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by striking subsection (b) and inserting the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

''(c) DISSEMINATION.—

''(1) IN GENERAL.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 270 and such other means as determined appropriate by the Secretary.

''(2) EVALUATION.—The Secretary shall evaluate the adoption and the implementation of cultural competency, prevention, and public health, and working with individuals with a disability training curricula, and the facilitate inclusion of these competency measures in quality measurement systems as appropriate.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to

carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.''.

(b) TITLE VIII.—Section 807 of the Public Health Service Act (42 U.S.C. 296e–1) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) by striking ''for the purpose of'' and all that follows through ''health care.'' and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by redesignating subsection (b) as subsection (d);

(3) by inserting after subsection (a) the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with the entities described in section 741(b). The Secretary shall coordinate with curricula and research and demonstration projects developed under such section 741.

''(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated and evaluated in the same manner as model curricula developed under section 741, as described in subsection (c) of such section.''; and

(4) in subsection (d), as so redesignated—

(A) by striking ''subsection (a)'' and inserting ''this section''; and

(B) by striking ''2001 through 2004'' and inserting ''2010 through 2015''.

SEC. 5308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296j) is amended—

(1) in subsection (c)—

(A) in the subsection heading, by striking ''AND NURSE MIDWIFERY PROGRAMS''; and

(B) by striking ''and nurse midwifery'';

(2) in subsection (f)—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2); and

(3) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(4) by inserting after subsection (c), the following:

''(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for support under this section are educational programs that—

''(1) have as their objective the education of midwives; and

''(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.''.

SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

(a) IN GENERAL.—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended—

(1) in the section heading, by striking ''**RETENTION**'' and inserting ''**QUALITY**'';

(2) in subsection (a)—

(A) in paragraph (1), by adding ''or'' after the semicolon;

(B) by striking paragraph (2); and

(C) by redesignating paragraph (3) as paragraph (2);

(3) in subsection (b)(3), by striking ''managed care, quality improvement'' and inserting ''coordinated care'';

(4) in subsection (g), by inserting '', as defined in section 801(2),'' after ''school of nursing''; and

(5) in subsection (h), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) NURSE RETENTION GRANTS.—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

''SEC. 831A. NURSE RETENTION GRANTS.

''(a) RETENTION PRIORITY AREAS.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs pursuant to subsection (b) or (c).

''(b) GRANTS FOR CAREER LADDER PROGRAM.—The Secretary may award grants to, and enter into contracts with, eligible entities for programs—

''(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce;

''(2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or

''(3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

''(c) ENHANCING PATIENT CARE DELIVERY SYSTEMS.—

''(1) GRANTS.—The Secretary may award grants to eligible entities to improve the retention of nurses and enhance patient care that is directly related to nursing activities by enhancing collaboration and communication among nurses and other health care professionals, and by promoting nurse involvement in the organizational and clinical decision-making processes of a health care facility.

''(2) PRIORITY.—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection (or section 831(c) as such section existed on the day before the date of enactment of this section).

''(3) CONTINUATION OF AN AWARD.—The Secretary shall make continuation of any award under this subsection beyond the second year of such award contingent on the recipient of such award having demonstrated to the Secretary measurable and substantive improvement in nurse retention or patient care.

''(d) OTHER PRIORITY AREAS.—The Secretary may award grants to, or enter into contracts with, eligible entities to address other areas that are of high priority to nurse retention, as determined by the Secretary.

''(e) REPORT.—The Secretary shall submit to the Congress before the end of each fiscal year a report on the grants awarded and the contracts entered into under this section. Each such report shall identify the overall number of such grants and contracts and provide an explanation of why each such grant or contract will meet the priority need of the nursing workforce.

''(f) ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' includes an accredited school of nursing, as defined by section 801(2), a health care facility, or a partnership of such a school and facility.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2012.''.

SEC. 5310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Section 846(a)(3) of the Public Health Service Act (42 U.S.C. 297n(a)(3)) is amended by inserting before the semicolon the following: '', or in a accredited school of nursing, as defined by section 801(2), as nurse faculty''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 810 (relating to prohibition against discrimination by schools on the basis of sex) as section 809 and moving such section so that it follows section 808;

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part I;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F;

(9) in part H—

(A) by redesignating sections 851 and 852 as sections 861 and 862, respectively; and

(B) by redesignating part H as part G; and

(10) in part I—

(A) by redesignating section 855, as amended by section 5305, as section 865; and

(B) by redesignating part I as part H.

SEC. 5311. NURSE FACULTY LOAN PROGRAM.

(a) IN GENERAL.—Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''ESTABLISHMENT'' and inserting ''SCHOOL OF NURSING STUDENT LOAN FUND''; and

(B) by inserting ''accredited'' after ''agreement with any'';

(2) in subsection (c)—

(A) in paragraph (2), by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,500, during fiscal years 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan;''; and

(B) in paragraph (3)(A), by inserting ''an accredited'' after ''faculty member in'';

(3) in subsection (e), by striking ''a school'' and inserting ''an accredited school''; and

(4) in subsection (f), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.—Title VIII of the Public Health Service Act is amended by inserting after section 846A (42 U.S.C. 297n–1) the following:

''SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may

enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

''(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a total period, in the aggregate, of at least 4 years during the 6-year period beginning on the later of—

''(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

''(2) the date on which the individual enters into an agreement under this subsection.

''(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

''(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree;

''(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

''(A) payments may not exceed $10,000 per calendar year; and

''(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan); and

''(3) for an individual who has completed a doctorate or equivalent degree in nursing—

''(A) payments may not exceed $20,000 per calendar year; and

''(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same manner as in paragraph (2)(B)).

''(d) BREACH OF AGREEMENT.—

''(1) IN GENERAL.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

''(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of liability under such paragraph if compliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

''(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

''(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

''(e) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means an individual who—

''(1) is a United States citizen, national, or lawful permanent resident;

''(2) holds an unencumbered license as a registered nurse; and

''(3) has either already completed a master's or doctorate nursing program at an accredited school of nursing or is currently enrolled on a full-time or part-time basis in such a program.

''(f) PRIORITY.—For the purposes of this section and section 846A, funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 5310, is amended to read as follows:

''SEC. 871. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated $338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016.''.

SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

''(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

''(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

''(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

''(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

''(3) to educate and provide outreach regarding enrollment in health insurance including the Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act and Medicaid under title XIX of such Act;

''(4) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

''(5) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

''(c) APPLICATION.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to target geographic areas—

''(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

''(B) with a high percentage of residents who suffer from chronic diseases; or

''(C) with a high infant mortality rate;

''(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) have documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

''(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

''(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

''(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker', as defined by the Department of Labor as Standard Occupational Classification [21–1094] means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and healthcare agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health;

''(F) by providing referral and follow-up services or otherwise coordinating care; and

''(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

''(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act)), or a consortium of any such entities.

''(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

''(B) a significant portion of which is a health professional shortage area as designated under section 332.''.

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5206, is further amended by adding at the end the following:

''SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

''(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce shortages in State and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

''(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

''(c) OTHER PROGRAMS.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

''(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in contracts under section 338I(j).

''(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $39,500,000 for each of fiscal years 2010 through 2013, of which—

''(1) $5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsections (b) and (c);

''(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b);

''(3) $5,000,000 shall be made available in each such fiscal year for the Public Health Informatics Fellowship Program under subsection (e); and

''(4) $24,500,000 shall be made available for expanding the Epidemic Intelligence Service under subsection (a).''.

SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

''PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

''SEC. 271. ESTABLISHMENT.

''(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK.—

''(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the 'Track'), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

''(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

''(B) 100 dental students annually;

''(C) 250 nursing students annually;

''(D) 100 public health students annually;

''(E) 100 behavioral and mental health professional students annually;

''(F) 100 physician assistant or nurse practitioner students annually; and

''(G) 50 pharmacy students annually.

''(2) LOCATIONS.—The Track shall be located at existing and accredited, affiliated health professions education training programs at academic health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act.

''(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

''(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

''(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

''(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care, to balance urban, tertiary, and inpatient venues.

''SEC. 272. ADMINISTRATION.

''(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The National Health Care Workforce Commission shall assist the Surgeon General in an advisory capacity.

''(b) FACULTY.—

''(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

''(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

''(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

''(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payments for educational services provided students participating in Department of Health and Human Services educational programs.

''(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

''(1) Postdoctoral, postgraduate, and technological programs.

''(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students.

''(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

''(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education for members of the health professions to the end that high standards of health care may be maintained within the United States.

''(f) AUTHORITY OF THE SURGEON GENERAL.—

''(1) IN GENERAL.—The Surgeon General is authorized—

''(A) to enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education;

''(B) to enter into contracts with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

''(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including

any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

''(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

''(E) to accept the voluntary services of guest scholars and other persons.

''(2) LIMITATION.—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track to make outlays in advance of the enactment of budget authority for such outlays.

''(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Track under an agreement described in paragraph (1) may be appointed to any position within the Track and may be permitted to perform such duties within the Track as the Surgeon General may approve.

''(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

''SEC. 273. STUDENTS; SELECTION; OBLIGATION.

''(a) STUDENT SELECTION.—

''(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures prescribed by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

''(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.

''(b) CONTRACT AND SERVICE OBLIGATION.—

''(1) CONTRACT.—Upon being admitted to the Track, a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (B), the Surgeon General agrees to provide the student with tuition (or tuition remission) and a student stipend (described in paragraph (2)) in each school year for a period of years (not to exceed 4 school years) determined by the student, during which period the student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution; and

''(ii) subject to subparagraph (B), the student agrees—

''(I) to accept the provision of such tuition and student stipend to the student;

''(II) to maintain enrollment at the Track until the student completes the course of study involved;

''(III) while enrolled in such course of study, to maintain an acceptable level of academic standing (as determined by the Surgeon General);

''(IV) if pursuing a degree from a school of medicine or osteopathic medicine, dental, public health, or nursing school or a physician assistant, pharmacy, or behavioral and mental health professional program, to complete a residency or internship in a specialty that the Surgeon General determines is appropriate; and

''(V) to serve for a period of time (referred to in this part as the 'period of obligated service') within the Commissioned Corps of the Public Health Service equal to 2 years for each school year during which such individual was enrolled at the College, reduced as provided for in paragraph (3);

''(B) a provision that any financial obligation of the United States arising out of a contract entered into under this part and any obligation of the student which is conditioned thereon, is contingent upon funds being appropriated to carry out this part;

''(C) a statement of the damages to which the United States is entitled for the student's breach of the contract; and

''(D) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this part.

''(2) TUITION AND STUDENT STIPEND.—

''(A) TUITION REMISSION RATES.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the established remission rate under this subparagraph.

''(B) STIPEND.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students under this part.

''(3) REDUCTIONS IN THE PERIOD OF OBLIGATED SERVICE.—The period of obligated service under paragraph (1)(A)(ii)(V) shall be reduced—

''(A) in the case of a student who elects to participate in a high-needs speciality residency (as determined by the National Health Care Workforce Commission), by 3 months for each year of such participation (not to exceed a total of 12 months); and

''(B) in the case of a student who, upon completion of their residency, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).

''(c) SECOND 2 YEARS OF SERVICE.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize a balance of hospital and community-based experiences, and training within interdisciplinary teams.

''(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST, BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL, PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAINING.—The Surgeon General shall establish provisions applicable with respect to dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions training institutions that train medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students for some significant period of time together, but at a minimum have a discrete and shared core curriculum.

''(e) ELITE FEDERAL DISASTER TEAMS.—The Surgeon General, in consultation with the Secretary, the Director of the Centers for Disease Control and Prevention, and other appropriate military and Federal government agencies, shall develop criteria for the appointment of highly qualified Track faculty, medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students, and graduates to elite Federal disaster preparedness teams to train and to respond to public health emergencies, natural disasters, bioterrorism events, and other emergencies.

''(f) STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student who, under regulations prescribed by the Surgeon General, is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the United States for all tuition and stipend support provided to the student.

''SEC. 274. FUNDING.

''Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.''.

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 5401. CENTERS OF EXCELLENCE.

Section 736 of the Public Health Service Act (42 U.S.C. 293) is amended by striking subsection (h) and inserting the following:

''(h) FORMULA FOR ALLOCATIONS.—

''(1) ALLOCATIONS.—Based on the amount appropriated under subsection (i) for a fiscal year, the following subparagraphs shall apply as appropriate:

''(A) IN GENERAL.—If the amounts appropriated under subsection (i) for a fiscal year are $24,000,000 or less—

''(i) the Secretary shall make available $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

''(ii) and available after grants are made with funds under clause (i), the Secretary shall make available—

''(I) 60 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

''(II) 40 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(B) FUNDING IN EXCESS OF $24,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $24,000,000 but are less than $30,000,000—

''(i) 80 percent of such excess amounts shall be made available for grants under subsection (a) to health professions schools that meet the requirements described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e)); and

''(ii) 20 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(C) FUNDING IN EXCESS OF $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

''(i) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining excess amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(D) FUNDING IN EXCESS OF $40,000,000.—If amounts appropriated under subsection (i) for a fiscal year are $40,000,000 or more, the Secretary shall make available—

''(i) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(2) NO LIMITATION.—Nothing in this subsection shall be construed as limiting the centers of excellence referred to in this section to the designated amount, or to preclude such entities from competing for grants under this section.

''(3) MAINTENANCE OF EFFORT.—

''(A) IN GENERAL.—With respect to activities for which a grant made under this part are authorized to be expended, the Secretary may not make such a grant to a center of excellence for any fiscal year unless the center agrees to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the center for the fiscal year preceding the fiscal year for which the school receives such a grant.

''(B) USE OF FEDERAL FUNDS.—With respect to any Federal amounts received by a center of excellence and available for carrying out activities for which a grant under this part is authorized to be expended, the center shall, before expending the grant, expend the Federal amounts obtained from sources other than the grant, unless given prior approval from the Secretary.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) $50,000,000 for each of the fiscal years 2010 through 2015; and

''(2) and such sums as are necessary for each subsequent fiscal year.''.

SEC. 5402. HEALTH CARE PROFESSIONALS TRAINING FOR DIVERSITY.

(a) LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 738(a)(1) of the Public Health Service Act (42 U.S.C. 293b(a)(1)) is amended by striking ''$20,000 of the principal and interest of the educational loans of such individuals.'' and inserting ''$30,000 of the principal and interest of the educational loans of such individuals.''.

(b) SCHOLARSHIPS FOR DISADVANTAGED STUDENTS.—Section 740(a) of such Act (42 U.S.C. 293d(a)) is amended by striking ''$37,000,000'' and all that follows through ''2002'' and inserting ''$51,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014''.

(c) REAUTHORIZATION FOR LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 740(b) of such Act (42 U.S.C. 293d(b)) is amended by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated, $5,000,000 for each of the fiscal years 2010 through 2014.''.

(d) REAUTHORIZATION FOR EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM A DISADVANTAGED BACKGROUND.—Section 740(c) of such Act (42 U.S.C. 293d(c)) is amended by striking the first sentence and inserting the following: ''For the purpose of grants and contracts under section 739(a)(1), there is authorized to be appropriated $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''

SEC. 5403. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended to read as follows:

''SEC. 751. AREA HEALTH EDUCATION CENTERS.

''(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

''(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

''(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term 'Program' refers to the area health education center program.

''(b) ELIGIBLE ENTITIES; APPLICATION.—

''(1) ELIGIBLE ENTITIES.—

''(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term 'eligible entity' means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which no area health education center program is in operation, the Secretary may award a grant or contract under subsection (a)(1) to a school of nursing.

''(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term 'eligible entity' means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

''(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—

''(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

''(A) Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.

''(B) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, and local workforce investment boards, and in health care safety net sites.

''(C) Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, Federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.

''(D) Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.

''(E) Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

''(F) Propose and implement effective program and outcomes measurement and evaluation strategies.

''(G) Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

''(2) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

''(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally qualified

health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.

''(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

''(C) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

''(d) REQUIREMENTS.—

''(1) AREA HEALTH EDUCATION CENTER PROGRAM.—In carrying out this section, the Secretary shall ensure the following:

''(A) An entity that receives an award under this section shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

''(i) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the school; and

''(ii) the entity receiving the award maintains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

''(B) An entity receiving funds under subsection (a)(2) does not distribute such funding to a center that is eligible to receive funding under subsection (a)(1).

''(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

''(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

''(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;

''(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

''(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

''(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

''(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

''(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

''(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs. At least 25 percent of the total required non-Federal contributions shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first 3 years the entity is funded through a grant under subsection (a)(1).

''(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under subsection (a)(1).

''(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the Secretary may reduce the per center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

''(h) PROJECT TERMS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a)(1) may not exceed—

''(A) in the case of a program, 12 years; or

''(B) in the case of a center within a program, 6 years.

''(2) EXCEPTION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

''(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 791(a) shall not apply to an area health education center funded under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

''(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

''(A) not more than 35 percent shall be used for awards under subsection (a)(1);

''(B) not less than 60 percent shall be used for awards under subsection (a)(2);

''(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

''(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

''(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

''(k) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.''.

(b) CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by striking section 752 and inserting the following:

''SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.

''(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources.

''(b) ELIGIBLE ENTITIES.—For purposes of this section, the term 'eligible entity' means an entity described in section 799(b).

''(c) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $5,000,000 for each of the fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent fiscal year.''.

SEC. 5404. WORKFORCE DIVERSITY GRANTS.

Section 821 of the Public Health Service Act (42 U.S.C. 296m) is amended—

(1) in subsection (a)—

(A) by striking ''The Secretary may'' and inserting the following:

''(1) AUTHORITY.—The Secretary may'';

(B) by striking ''pre-entry preparation, and retention activities'' and inserting the following: ''stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities''; and

(2) in subsection (b)—

(A) by striking ''First'' and all that follows through ''including the'' and inserting ''National Advisory Council on Nurse Education and Practice and consult with nursing associations including the National Coalition of Ethnic Minority Nurse Associations,''; and

(B) by inserting before the period the following: '', and other organizations determined appropriate by the Secretary''.

SEC. 5405. PRIMARY CARE EXTENSION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5313, is further amended by adding at the end the following:

''SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.

''(a) ESTABLISHMENT, PURPOSE AND DEFINITION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

''(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as 'Health Extension Agents').

''(3) DEFINITIONS.—In this section:

''(A) HEALTH EXTENSION AGENT.—The term 'Health Extension Agent' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

''(B) PRIMARY CARE PROVIDER.—The term 'primary care provider' means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

''(b) GRANTS TO ESTABLISH STATE HUBS AND LOCAL PRIMARY CARE EXTENSION AGENCIES.—

''(1) GRANTS.—The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as 'Hubs').

''(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1)—

''(A) shall consist of, at a minimum, the State health department, the entity responsible for administering the State Medicaid program (if other than the State health department), the State-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the State that train providers in primary care; and

''(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1153 of the Social Security Act, consumer groups, and other appropriate entities.

''(c) STATE AND LOCAL ACTIVITIES.—

''(1) HUB ACTIVITIES.—Hubs established under a grant under subsection (b) shall—

''(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

''(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

''(C) organize and administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and

''(D) organize State-wide or multistate networks of local-level Primary Care Extension Agencies to share and disseminate information and practices.

''(2) LOCAL PRIMARY CARE EXTENSION AGENCY ACTIVITIES.—

''(A) REQUIRED ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) shall—

''(i) assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

''(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of new knowledge and identification of important questions for research;

''(iii) participate in a national network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

''(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning.

''(B) DISCRETIONARY ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) may—

''(i) provide technical assistance, training, and organizational support for community health teams established under section 3602 of the Patient Protection and Affordable Care Act;

''(ii) collect data and provision of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

''(iii) collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

''(iv) develop measures to monitor the impact of the proposed program on the health of practice enrollees and of the wider community served; and

''(v) participate in other activities, as determined appropriate by the Secretary.

''(d) FEDERAL PROGRAM ADMINISTRATION.—

''(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall be—

''(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

''(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

''(2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(3) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

''(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

''(5) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

''(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To awards grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.''.

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES.

(a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 13951) is amended by adding at the end the following new subsection:

''(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

''(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection:

''(A) PRIMARY CARE PRACTITIONER.—The term 'primary care practitioner' means an individual—

''(i) who—

''(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

''(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

''(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

''(B) PRIMARY CARE SERVICES.—The term 'primary care services' means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

''(i) 99201 through 99215.

''(ii) 99304 through 99340.

''(iii) 99341 through 99350.

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.''.

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following sentence: ''Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.''.

(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

''(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection:

''(A) GENERAL SURGEON.—In this subsection, the term 'general surgeon' means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's enrollment under section 1866(j).

''(B) MAJOR SURGICAL PROCEDURES.—The term 'major surgical procedures' means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

''(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).''.

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by subsection (a)(2), is amended by striking ''Section 1833(x)'' and inserting ''Subsections (x) and (y) of section 1833'' in the last sentence.

(c) BUDGET-NEUTRALITY ADJUSTMENT.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by adding at the end the following new clause:

''(vii) ADJUSTMENT FOR CERTAIN PHYSICIAN INCENTIVE PAYMENTS.—Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1833 for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(II) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(II) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1833(m) by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section 332(a)(1)(A) of the Public Health Service Act) as health professional shortage areas.''.

SEC. 5502. MEDICARE FEDERALLY QUALIFIED HEALTH CENTER IMPROVEMENTS.

(a) EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.—

(1) IN GENERAL.—Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

''(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

''(1) DEVELOPMENT.—

''(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers.

''(B) COLLECTION OF DATA AND EVALUATION.—The Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this paragraph and paragraph (2), respectively, including the reporting of services using HCPCS codes.

''(2) IMPLEMENTATION.—

''(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(B), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments for Federally qualified health services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

''(B) PAYMENTS.—

''(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated amount of expenditures under this title for Federally qualified health services in the first year that the prospective payment system is implemented is equal to 103 percent of the estimated amount of expenditures under this title that would have occurred for such services in such year if the system had not been implemented.

''(ii) PAYMENTS IN SUBSEQUENT YEARS.—In the year after the first year of implementation of such system, and in each subsequent year, the payment rate for Federally qualified health services furnished in the year shall be equal to the payment rate established for such services furnished in the preceding year under this subparagraph increased by the percentage increase in the MEI (as defined in 1842(i)(3)) for the year involved.''.

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(3) in paragraph (7)(E), by inserting ''or paragraph (8)'' before the period at the end; and

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

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

''(ii) EXCEPTIONS.—This subparagraph shall not apply to—

''(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

''(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or

''(III) a hospital described in paragraph (4)(H)(v).

''(B) DISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

''(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

''(I) the number of full-time equivalent primary care residents, as defined in paragraph

(5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

''(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

''(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

''(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

''(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

''(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

''(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

''(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

''(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

''(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

''(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

''(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

''(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

''(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

''(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

''(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

''(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

''(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

''(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

''(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(H) DEFINITIONS.—In this paragraph:

''(i) REFERENCE RESIDENT LEVEL.—The term 'reference resident level' means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(ii) RESIDENT LEVEL.—The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

''(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking ''section 1886(h)(7)'' and all that follows and inserting ''paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act''.

SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking ''shall be counted and that all the time'' and inserting ''shall be counted and that—

''(i) effective for cost reporting periods beginning before July 1, 2010, all the time;'';

(2) in clause (i), as inserted by paragraph (1), by striking the period at the end and inserting ''; and'';

(3) by inserting after clause (i), as so inserted, the following new clause:

''(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.''; and

(4) by adding at the end the following flush sentence:

''Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.''.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by striking ''(iv) Effective for discharges occurring on or after October 1, 1997'' and inserting ''(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010''; and

(2) by inserting after clause (I), as inserted by paragraph (1), the following new subparagraph:

''(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 5505. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 5504, is amended—

(1) in paragraph (4)—

(A) in subparagraph (E), by striking ''Such rules'' and inserting ''Subject to subparagraphs (J) and (K), such rules''; and

(B) by adding at the end the following new subparagraphs:

''(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or

resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

''(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(2) in paragraph (5), by adding at the end the following new subparagraph:

''(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonprovider setting that is primarily engaged in furnishing patient care' means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

''(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

''(aa) is recognized as a subsection (d) hospital;

''(bb) is recognized as a subsection (d) Puerto Rico hospital;

''(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.

SEC. 5506. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

''(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

''(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

''(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

''(bb) Second, to hospitals located in the same State as the hospital that closed.

''(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

''(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

''(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

''(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

''(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.''.

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, as amended by section 5503, is amended by striking ''subsections (h)(7) and (h)(8)'' and inserting ''subsections (h)(4)(H)(vi), (h)(7), and (h)(8)''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section 1395ww(h)).

(d) EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The Secretary of Health and Human Services shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

(e) CONFORMING AMENDMENT.—Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)), as amended by section 5503(a), is amended by striking ''paragraph or paragraph (8)'' and inserting ''this paragraph, paragraph (8), or paragraph (4)(H)(vi)''.

SEC. 5507. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS; EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

''SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

''(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

''(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

''(2) REQUIREMENTS.—

''(A) AID AND SUPPORTIVE SERVICES.—

''(i) IN GENERAL.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

''(ii) TREATMENT.—Any aid, services, or incentives provided to an eligible beneficiary participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual's eligibility for, or amount of, benefits under any means-tested program.

''(B) CONSULTATION AND COORDINATION.—An eligible entity applying for a grant to carry out a demonstration project under this section shall demonstrate in the application that the entity has consulted with the State agency responsible for administering the State TANF program, the local workforce investment board in the area in which the project is to be conducted (unless the applicant is such board), the State workforce investment board established under section 111 of the Workforce Investment Act of 1998, and the State Apprenticeship Agency recognized under the Act of August 16, 1937 (commonly known as the 'National Apprenticeship Act') (or if no agency has been recognized in the State, the Office of Apprenticeship of the Department of Labor) and that the project will

be carried out in coordination with such entities.

''(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

''(3) REPORTS AND EVALUATION.—

''(A) ELIGIBLE ENTITIES.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

''(B) EVALUATION.—The Secretary shall, by grant, contract, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development, and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

''(C) REPORT TO CONGRESS.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

''(4) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE ENTITY.—The term 'eligible entity' means a State, an Indian tribe or tribal organization, an institution of higher education, a local workforce investment board established under section 117 of the Workforce Investment Act of 1998, a sponsor of an apprenticeship program registered under the National Apprenticeship Act or a community-based organization.

''(B) ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'eligible individual' means a individual receiving assistance under the State TANF program.

''(ii) OTHER LOW-INCOME INDIVIDUALS.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

''(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(D) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given that term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

''(E) STATE.—The term 'State' means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

''(F) STATE TANF PROGRAM.—The term 'State TANF program' means the temporary assistance for needy families program funded under part A of title IV.

''(G) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

''(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

''(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

''(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

''(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

''(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

''(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

''(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

''(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

''(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

''(iv) Personal care skills.

''(v) Health care support.

''(vi) Nutritional support.

''(vii) Infection control.

''(viii) Safety and emergency training.

''(ix) Training specific to an individual consumer's needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

''(x) Self-Care.

''(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

''(i) The length of the training.

''(ii) The appropriate trainer to student ratio.

''(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

''(iv) Trainer qualifications.

''(v) Content for a 'hands-on' and written certification exam.

''(vi) Continuing education requirements.

''(4) APPLICATION AND SELECTION CRITERIA.—

''(A) IN GENERAL.—

''(i) NUMBER OF STATES.—The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

''(ii) REQUIREMENTS FOR STATES.—An agreement entered into under clause (i) shall require that a participating State—

''(I) implement the core training competencies described in paragraph (3)(A); and

''(II) develop written materials and protocols for such core training competencies, including the development of a certification test for personal or home care aides who have completed such training competencies.

''(iii) CONSULTATION AND COLLABORATION WITH COMMUNITY AND VOCATIONAL COLLEGES.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

''(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

''(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

''(ii) meet the selection criteria established under subparagraph (C); and

''(iii) meet such additional criteria as the Secretary may specify.

''(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

''(i) geographic and demographic diversity;

''(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

''(iii) that the existing training standards for personal or home care aides in each participating State—

''(I) are different from such standards in the other participating States; and

''(II) are different from the core training competencies described in paragraph (3)(A);

''(iv) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

''(v) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

''(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

''(5) EVALUATION AND REPORT.—

''(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

''(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

''(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

''(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what minimum number of hours should be required.

''(B) REPORTS.—

''(i) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(ii) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(6) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term 'eligible health and long-term care provider' means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

''(i) is licensed or authorized to provide services in a participating State; and

''(ii) receives payment for services under title XIX.

''(B) PERSONAL CARE SERVICES.—The term 'personal care services' has the meaning given such term for purposes of title XIX.

''(C) PERSONAL OR HOME CARE AIDE.—The term 'personal or home care aide' means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

''(D) STATE.—The term 'State' has the meaning given that term for purposes of title XIX.

''(c) FUNDING.—

''(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $85,000,000 for each of fiscal years 2010 through 2014.

''(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

''(d) NONAPPLICATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grant awarded under this section.

''(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title.''.

(b) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is amended by striking ''fiscal year 2009'' and inserting ''each of fiscal years 2009 through 2012''.

SEC. 5508. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et. seq.), as amended by section 5303, is further amended by inserting after section 749 the following:

''SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

''(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

''(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

''(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

''(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

''(A) curriculum development;

''(B) recruitment, training and retention of residents and faculty:

''(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

''(D) faculty salaries during the development phase; and

''(2) technical assistance provided by an eligible entity.

''(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(e) PREFERENCE FOR CERTAIN APPLICATIONS.—In selecting recipients for grants under this section, the Secretary shall give preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an organization capable of providing technical assistance including an area health education center program as defined in sections 751 and 799B.

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' means an approved graduate medical residency training program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

''(3) TEACHING HEALTH CENTER.—

''(A) IN GENERAL.—The term 'teaching health center' means an entity that—

''(i) is a community based, ambulatory patient care center; and

''(ii) operates a primary care residency program.

''(B) INCLUSION OF CERTAIN ENTITIES.—Such term includes the following:

''(i) A Federally qualified health center (as defined in section 1905(l)(2)(B), of the Social Security Act).

''(ii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act).

''(iii) A rural health clinic, as defined in section 1861(aa) of the Social Security Act.

''(iv) A health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

''(v) An entity receiving funds under title X of the Public Health Service Act.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.''.

(b) NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.—Section 338C(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

''(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—Except as provided in section 338D, each individual who has entered into a written contract with the Secretary under section 338A or 338B shall provide service in the full-time clinical practice of such individual's profession as a member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.''.

(c) PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart XI—Support of Graduate Medical Education in Qualified Teaching Health Centers

''SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

''(a) PAYMENTS.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and for indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing or establishment of new approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with sponsoring approved graduate medical residency training programs.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the amount of funds appropriated under subsection (g) for such payments for that fiscal year.

''(B) LIMITATION.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments as determined under subsection (c) and (d) do not exceed the total

amount of funds appropriated in a fiscal year under subsection (g).

''(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

''(A) the updated national per resident amount for direct graduate medical education, as determined under paragraph (2); and

''(B) the average number of full-time equivalent residents in the teaching health center's graduate approved medical residency training programs as determined under section 1886(h)(4) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

''(2) UPDATED NATIONAL PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a qualified teaching health center for a fiscal year is an amount determined as follows:

''(A) DETERMINATION OF QUALIFIED TEACHING HEALTH CENTER PER RESIDENT AMOUNT.—The Secretary shall compute for each individual qualified teaching health center a per resident amount—

''(i) by dividing the national average per resident amount computed under section 340E(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B);

''(ii) by multiplying the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act (but without application of section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)) during the preceding fiscal year for the teaching health center's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(B) UPDATING RATE.—The Secretary shall update such per resident amount for each such qualified teaching health center as determined appropriate by the Secretary.

''(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

''(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

''(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers; and

''(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g).

''(3) INTERIM PAYMENT.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under paragraph (1), the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

''(e) CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS FOR GRADUATE MEDICAL EDUCATION.—Payments under this section—

''(1) shall be in addition to any payments—

''(A) for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act;

''(B) for direct graduate medical education costs under section 1886(h) of such Act; and

''(C) for direct costs of medical education under section 1886(k) of such Act;

''(2) shall not be taken into account in applying the limitation on the number of total full-time equivalent residents under subparagraphs (F) and (G) of section 1886(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and

''(3) shall not include the time in which a resident is counted toward full-time equivalency by a hospital under paragraph (2) or under section 1886(d)(5)(B)(iv) of the Social Security Act, section 1886(h)(4)(E) of such Act, or section 340E of this Act.

''(f) RECONCILIATION.—The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.

''(g) FUNDING.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $230,000,000, for the period of fiscal years 2011 through 2015.

''(h) ANNUAL REPORTING REQUIRED.—

''(1) ANNUAL REPORT.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information for the residency academic year completed immediately prior to such fiscal year:

''(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

''(B) The number of approved training positions for residents described in paragraph (4).

''(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

''(D) Other information as deemed appropriate by the Secretary.

''(2) AUDIT AUTHORITY; LIMITATION ON PAYMENT.—

''(A) AUDIT AUTHORITY.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

''(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such resident positions that is greater than the base level of primary care resident positions, as determined by the Secretary. For purposes of this subparagraph, the 'base level of primary care residents' for a teaching health center is the level of such residents as of a base period.

''(3) REDUCTION IN PAYMENT FOR FAILURE TO REPORT.—

''(A) IN GENERAL.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

''(i) the qualified teaching health center has failed to provide the Secretary, as an addendum to the qualified teaching health center's application under this section for such fiscal year, the report required under paragraph (1) for the previous fiscal year; or

''(ii) such report fails to provide complete and accurate information required under any subparagraph of such paragraph.

''(B) NOTICE AND OPPORTUNITY TO PROVIDE ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) on the basis of a qualified teaching health center's failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice to the teaching health center of such failure and the Secretary's intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

''(4) RESIDENTS.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center in any approved graduate medical residency training program.

''(i) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

''(j) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' means a residency or other postgraduate medical training program—

''(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary; and

''(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' has the meaning given that term in section 749A.

''(3) QUALIFIED TEACHING HEALTH CENTER.—The term 'qualified teaching health center' has the meaning given the term 'teaching health center' in section 749A.''.

SEC. 5509. GRADUATE NURSE EDUCATION DEMONSTRATION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital's reasonable costs (described in paragraph (2)) for the provision of

qualified clinical training to advance practice nurses.

(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

(2) COSTS DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

(1) the obligations of the eligible partners with respect to the provision of qualified training; and

(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

(4) Other items the Secretary determines appropriate and relevant.

(d) FUNDING.—

(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(e) DEFINITIONS.—In this section:

(1) ADVANCED PRACTICE REGISTERED NURSE.—The term ''advanced practice registered nurse'' includes the following:

(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ''applicable non-hospital community-based care setting'' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term ''applicable school of nursing'' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term ''demonstration'' means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term ''eligible hospital'' means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term ''eligible partners'' includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term ''qualified training'' means training—

(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title; and

(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle G—Improving Access to Health Care Services

SEC. 5601. SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS).

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

''(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

''(A) For fiscal year 2010, $2,988,821,592.

''(B) For fiscal year 2011, $3,862,107,440.

''(C) For fiscal year 2012, $4,990,553,440.

''(D) For fiscal year 2013, $6,448,713,307.

''(E) For fiscal year 2014, $7,332,924,155.

''(F) For fiscal year 2015, $8,332,924,155.

''(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(i) one plus the average percentage increase in costs incurred per patient served; and

''(ii) one plus the average percentage increase in the total number of patients served.''.

(b) RULE OF CONSTRUCTION.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by adding at the end the following:

''(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act), or a medicare-dependent share hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

''(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

''(i) nondiscrimination based on the ability of a patient to pay; and

''(ii) the establishment of a sliding fee scale for low-income patients.''.

SEC. 5602. NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish, through a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5,

United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the ''target date for publication'', as referred to in section 564(a)(5) of title 5, United Sates Code, shall be July 1, 2010.

(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 5603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking ''3-year period (with an optional 4th year'' and inserting ''4-year period (with an optional 5th year''; and

(2) in subsection (d)—

(A) by striking ''and such sums'' and inserting ''such sums''; and

(B) by inserting before the period the following: '', $25,000,000 for fiscal year 2010, $26,250,000 for fiscal year 2011, $27,562,500 for fiscal year 2012, $28,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014''.

SEC. 5604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by adding at the end the following:

''SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a qualified community mental health program defined under section 1913(b)(1).

''(2) SPECIAL POPULATIONS.—The term 'special populations' means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

''(b) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

''(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

''(A) the provision, by qualified primary care professionals, of on site primary care services;

''(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

''(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

''(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.

''(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

''(e) EVALUATION.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.''.

SEC. 5605. KEY NATIONAL INDICATORS.

(a) DEFINITIONS.—In this section:

(1) ACADEMY.—The term ''Academy'' means the National Academy of Sciences.

(2) COMMISSION.—The term ''Commission'' means the Commission on Key National Indicators established under subsection (b).

(3) INSTITUTE.—The term ''Institute'' means a Key National Indicators Institute as designated under subsection (c)(3).

(b) COMMISSION ON KEY NATIONAL INDICATORS.—

(1) ESTABLISHMENT.—There is established a ''Commission on Key National Indicators''.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) QUALIFICATIONS.—In making appointments under subparagraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) PERIOD OF APPOINTMENT.—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall be for 3 years. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as the original appointment and shall last only for the remainder of that term.

(E) DATE.—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) INITIAL ORGANIZING PERIOD.—Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a schedule for completion of the review and reports required under subsection (d).

(G) CO-CHAIRPERSONS.—The Commission shall select 2 Co-Chairpersons from among its members.

(c) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) REPORTS.—

(A) ANNUAL REPORT TO CONGRESS.—Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the appropriate Committees of Congress and the President a report that contains a detailed statement of the recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicator System.

(B) ANNUAL REPORT TO THE ACADEMY.—

(i) IN GENERAL.—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the Academy and a designated Institute a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators.

(ii) LIMITATION.—The Commission shall not have the authority to direct the Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.

(3) CONTRACT WITH THE NATIONAL ACADEMY OF SCIENCES.—

(A) IN GENERAL.—As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into an arrangement with the National Academy of Sciences under which the Academy shall—

(i) review available public and private sector research on the selection of a set of key national indicators;

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent private nonprofit organization as an Institute to implement a key national indicator system;

(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice to the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and

(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute's budget and operations.

(B) PARTICIPATION.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(C) ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.—

(i) IN GENERAL.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system by—

(I) creating its own institutional capability; or

(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) INSTITUTE.—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of 1986) with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(iii) RESPONSIBILITIES.—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(I) Identifying and selecting issue areas to be represented by the key national indicators.

(II) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(III) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.

(VII) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database.

(VIII) Responding directly to the Commission in response to any Commission recommendations and to the Academy regarding any inquiries by the Academy.

(iv) GOVERNANCE.—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incorporates advisory and control functions. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) MODIFICATION AND CHANGES.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(vi) CONSTRUCTION.—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) ANNUAL REPORT.—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this Act, and annually thereafter, submit to the Co-Chairpersons of the Commission a report that contains the findings and recommendations of the Academy.

(d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.—

(1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) GAO FINANCIAL AUDIT.—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) GAO PROGRAMMATIC REVIEW.—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commission and to the appropriate authorizing committees of Congress.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out the purposes of this section, $10,000,000 for fiscal year 2010, and $7,500,000 for each of fiscal year 2011 through 2018.

(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.

Subtitle H—General Provisions

SEC. 5701. REPORTS.

(a) REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—On an annual basis, the Secretary of Health and Human Services shall submit to the appropriate Committees of Congress a report on the activities carried out under the amendments made by this title, and the effectiveness of such activities.

(b) REPORTS BY RECIPIENTS OF FUNDS.—The Secretary of Health and Human Services may require, as a condition of receiving funds under the amendments made by this title, that the entity receiving such award submit to such Secretary such reports as the such Secretary may require on activities carried out with such award, and the effectiveness of such activities.

TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Physician Ownership and Other Transparency

SEC. 6001. LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

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

(C) by adding at the end the following new subparagraph:

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.''; and

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

''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL

EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership or investment on February 1, 2010; and

''(ii) a provider agreement under section 1866 in effect on such date.

''(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of the enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

''(C) PREVENTING CONFLICTS OF INTEREST.—

''(i) The hospital submits to the Secretary an annual report containing a detailed description of—

''(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

''(II) the nature and extent of all ownership and investment interests in the hospital.

''(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

''(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

''(II) if applicable, any such ownership or investment interest of the treating physician.

''(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(iv) The hospital discloses the fact that the hospital is partially owned or invested in by physicians—

''(I) on any public website for the hospital; and

''(II) in any public advertising for the hospital.

''(D) ENSURING BONA FIDE INVESTMENT.—

''(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

''(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

''(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

''(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

''(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

''(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

''(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

''(E) PATIENT SAFETY.—

''(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

''(I) the hospital discloses such fact to a patient; and

''(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

''(ii) The hospital has the capacity to—

''(I) provide assessment and initial treatment for patients; and

''(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

''(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

''(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

''(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

''(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

''(iv) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

''(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, and beds' means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of the date of enactment of this subsection.

''(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

''(E) APPLICABLE HOSPITAL.—In this paragraph, the term 'applicable hospital' means a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census;

''(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

''(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

''(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

''(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

''(G) PUBLICATION OF FINAL DECISIONS.—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

''(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the

process under this paragraph (including the establishment of such process).

''(4) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

''(5) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection, the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

''(6) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1866.''.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than November 1, 2011, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

SEC. 6002. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

''SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

''(a) TRANSPARENCY REPORTS.—

''(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—

''(A) IN GENERAL.—On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

''(i) The name of the covered recipient.

''(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

''(iii) The amount of the payment or other transfer of value.

''(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

''(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) cash or a cash equivalent;

''(II) in-kind items or services;

''(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

''(IV) any other form of payment or other transfer of value (as defined by the Secretary).

''(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) consulting fees;

''(II) compensation for services other than consulting;

''(III) honoraria;

''(IV) gift;

''(V) entertainment;

''(VI) food;

''(VII) travel (including the specified destinations);

''(VIII) education;

''(IX) research;

''(X) charitable contribution;

''(XI) royalty or license;

''(XII) current or prospective ownership or investment interest;

''(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;

''(XIV) grant; or

''(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

''(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

''(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

''(B) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

''(2) PHYSICIAN OWNERSHIP.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

''(A) The dollar amount invested by each physician holding such an ownership or investment interest.

''(B) The value and terms of each such ownership or investment interest.

''(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, 'physician' shall be substituted for 'covered recipient' each place it appears.

''(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

''(b) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(c) PROCEDURES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—Not later than October 1, 2011, the Secretary shall establish procedures—

''(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

''(ii) for the Secretary to make such information submitted available to the public.

''(B) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

''(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

''(i) is searchable and is in a format that is clear and understandable;

''(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment

or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(iii) contains information that is able to be easily aggregated and downloaded;

''(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

''(v) contains background information on industry-physician relationships;

''(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(vii) contains any other information the Secretary determines would be helpful to the average consumer;

''(viii) does not contain the National Provider Identifier of the covered recipient, and

''(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

''(D) CLARIFICATION OF TIME PERIOD FOR REVIEW AND CORRECTIONS.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

''(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

''(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

''(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(II) Four calendar years after the date such payment or other transfer of value was made.

''(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

''(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

''(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

''(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

''(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

''(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

''(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

''(3) RELATION TO STATE LAWS.—

''(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

''(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

''(i) not of the type required to be disclosed or reported under this section;

''(ii) described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection;

''(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

''(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

''(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

''(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(4) COVERED DEVICE.—The term 'covered device' means any device for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered drug, device, biological, or medical supply' means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(6) COVERED RECIPIENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered recipient' means the following:

''(i) A physician.

''(ii) A teaching hospital.

''(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

''(7) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

''(8) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

''(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'manufacturer of a covered drug, device, biological, or medical supply' means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

''(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

''(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient

through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

''(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

''(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

''(ii) Product samples that are not intended to be sold and are intended for patient use.

''(iii) Educational materials that directly benefit patients or are intended for patient use.

''(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

''(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(vii) Discounts (including rebates).

''(viii) In-kind items used for the provision of charity care.

''(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

''(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

''(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of such licensed non-medical professional.

''(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

''(11) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r).''.

SEC. 6003. DISCLOSURE REQUIREMENTS FOR IN-OFFICE ANCILLARY SERVICES EXCEPTION TO THE PROHIBITION ON PHYSICIAN SELF-REFERRAL FOR CERTAIN IMAGING SERVICES.

(a) IN GENERAL.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)) is amended by adding at the end the following new sentence: ''Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 6004. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6002, is amended by inserting after section 1128G the following new section:

''SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

''(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

''(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(b) DEFINITIONS.—In this section:

''(1) APPLICABLE DRUG.—The term 'applicable drug' means a drug—

''(A) which is subject to subsection (b) of such section 503; and

''(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term 'authorized distributor of record' has the meaning given that term in subsection (e)(3)(A) of such section.

''(3) MANUFACTURER.—The term 'manufacturer' has the meaning given that term for purposes of subsection (d) of such section.''.

SEC. 6005. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1150 the following new section:

''SEC. 1150A. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

''(a) PROVISION OF INFORMATION.—A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a 'PBM') that manages prescription drug coverage under a contract with—

''(1) a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan under part D of title XVIII; or

''(2) a qualified health benefits plan offered through an exchange established by a State under section 1311 of the Patient Protection and Affordable Care Act,

shall provide the information described in subsection (b) to the Secretary and, in the case of a PBM, to the plan with which the PBM is under contract with, at such times, and in such form and manner, as the Secretary shall specify.

''(b) INFORMATION DESCRIBED.—The information described in this subsection is the following with respect to services provided by a health benefits plan or PBM for a contract year:

''(1) The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM under the contract.

''(2) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs))that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

''(3) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

''(c) CONFIDENTIALITY.—Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

''(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

''(2) To permit the Comptroller General to review the information provided.

''(3) To permit the Director of the Congressional Budget Office to review the information provided.

''(4) To States to carry out section 1311 of the Patient Protection and Affordable Care Act.

''(d) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same

manner as such provisions apply to a manufacturer with an agreement under that section.''.

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 6101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

''(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

''(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

''(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

''(2) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(3) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

''(4) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

''(5) DEFINITIONS.—In this subsection:

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

''(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

''(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

''(i) a skilled nursing facility (as defined in section 1819(a)); or

''(ii) a nursing facility (as defined in section 1919(a)).

''(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

''(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

''(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

''(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

''(vi) an individual, contact information for the individual; and

''(vii) any other person or entity, such information as the Secretary determines appropriate.''.

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(B) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1128H the following new section:

''SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

''(a) DEFINITION OF FACILITY.—In this section, the term 'facility' means—

''(1) a skilled nursing facility (as defined in section 1819(a)); or

''(2) a nursing facility (as defined in section 1919(a)).

''(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

''(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

''(2) DEVELOPMENT OF REGULATIONS.—

''(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program shall, in the case of

an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

''(C) EVALUATION.—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(3) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subsection, the term 'compliance and ethics program' means, with respect to a facility, a program of the operating organization that—

''(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(B) includes at least the required components specified in paragraph (4).

''(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

''(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(c) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

''(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.''.

SEC. 6103. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

''(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

''(I) that were committed inside the facility;

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

''(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups; and

''(iv) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–3(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In

order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i–3(f)) is amended by adding at the end the following new paragraph:

''(8) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

''(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

''(I) that were committed inside of the facility; and

''(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups;

''(iv) skilled nursing facility employees and their representatives; and

''(v) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of the Social Security Act (42 U.S.C. 1396r(f)) is amended by adding at the end of the following new paragraph:

''(10) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.''.

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:

''(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:

''(V) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing

facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

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

(B) by striking the semicolon at the end of subparagraph (C) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;''.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

(e) DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall ensure that the Department of Health and Human Services, as part of the information provided for comparison of nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

(1) The documentation on nursing facilities that is available to the public.

(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

(3) General information on consumer rights with respect to nursing facilities.

(4) The nursing facility survey process (on a national and State-specific basis).

(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State.

SEC. 6104. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) REPORTING OF DIRECT CARE EXPENDITURES.—

''(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

''(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

''(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

''(A) Spending on direct care services (including nursing, therapy, and medical services).

''(B) Spending on indirect care (including housekeeping and dietary services).

''(C) Capital assets (including building and land costs).

''(D) Administrative services costs.

''(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.''.

SEC. 6105. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(f) STANDARDIZED COMPLAINT FORM.—

''(1) DEVELOPMENT BY THE SECRETARY.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

''(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

''(i) a resident of a facility; and

''(ii) any person acting on the resident's behalf.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6106. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(g) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(2) include resident census data and information on resident case mix;

''(3) include a regular reporting schedule; and

''(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

SEC. 6107. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented;

(2) any problems associated with such system or its implementation; and

(3) how such system could be improved.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

SEC. 6111. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

(B) by adding at the end the following new subclauses:

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

(B) by adding at the end the following new subclauses:

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including where evidence suggests that a number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the ''Special Focus Facility'' program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the demonstration project under this section.

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

(h) DEFINITIONS.—In this section:

(1) ADDITIONAL DISCLOSABLE PARTY.—The term ''additional disclosable party'' has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(3) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under this section.

(2) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6113. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(h) NOTIFICATION OF FACILITY CLOSURE.—

''(1) IN GENERAL.—Any individual who is the administrator of a facility must—

''(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

''(ii) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

''(2) RELOCATION.—

''(A) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

''(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

''(A) shall be subject to a civil monetary penalty of up to $100,000;

''(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

''(C) shall be subject to any other penalties that may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to section 1128I(h), shall terminate''; and

(2) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''subsection (c)(2) and section 1128I(h)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

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

(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 6121. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph

(1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ''conviction for a relevant crime'' means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term ''disqualifying information'' means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ''finding of patient or resident abuse'' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''SEC. 1181. (a) DEFINITIONS.—In this section:

''(1) BOARD.—The term 'Board' means the Board of Governors established under subsection (f).

''(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH; RESEARCH.—

''(A) IN GENERAL.—The terms 'comparative clinical effectiveness research' and 'research' mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

''(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

''(3) CONFLICT OF INTEREST.—The term 'conflict of interest' means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual's decisions in matters related to the Institute or the conduct of activities under this section.

''(4) REAL CONFLICT OF INTEREST.—The term 'real conflict of interest' means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

''(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

''(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative's already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

''(b) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

''(1) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be known as the 'Patient-Centered Outcomes Research Institute' (referred to in this section as the 'Institute') which is neither an agency nor establishment of the United States Government.

''(2) APPLICATION OF PROVISIONS.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

''(3) FUNDING OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the 'PCORTF') under section 9511 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Institute to carry out this section.

''(c) PURPOSE.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

''(d) DUTIES.—

''(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

''(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

''(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

''(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

''(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

''(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

''(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

''(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

''(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

''(i) CONTRACTS.—

''(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

''(aa) Appropriate agencies and instrumentalities of the Federal Government.

''(bb) Appropriate academic research, private sector research, or study-conducting entities.

''(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

''(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

''(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

''(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

''(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

''(IV) subject to clause (iv), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication;

''(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

''(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

''(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

''(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

''(iv) REQUIREMENTS FOR PUBLICATION OF RESEARCH.—Any research published under clause (ii)(IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 5 years).

''(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis as appropriate.

''(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular subtypes, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

''(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as appropriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

''(3) DATA COLLECTION.—

''(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI, as well as provide access to the data networks developed under section 937(f) of the Public Health Service Act, as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

''(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

''(4) APPOINTING EXPERT ADVISORY PANELS.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

''(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

''(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

''(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

''(5) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

''(6) ESTABLISHING METHODOLOGY COMMITTEE.—

''(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

''(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under

subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

''(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

''(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

''(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

''(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

''(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

''(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

''(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

''(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

''(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

''(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

''(C) USE OF EXISTING PROCESSES.—

''(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

''(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

''(8) RELEASE OF RESEARCH FINDINGS.—

''(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

''(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

''(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

''(iii) include limitations of the research and what further research may be needed as appropriate;

''(iv) not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations; and

''(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

''(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term 'research findings' means the results of a study or assessment.

''(9) ADOPTION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

''(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

''(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

''(B) the research project agenda and budget of the Institute for the following year;

''(C) any administrative activities conducted by the Institute during the preceding year;

''(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

''(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

''(e) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

''(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

''(f) BOARD OF GOVERNORS.—

''(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

''(A) The Director of Agency for Healthcare Research and Quality (or the Director's designee).

''(B) The Director of the National Institutes of Health (or the Director's designee).

''(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

''(i) 3 members representing patients and health care consumers.

''(ii) 5 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

''(iii) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

''(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

''(v) 1 member representing quality improvement or independent health service researchers.

''(vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

''(2) QUALIFICATIONS.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

''(3) TERMS; VACANCIES.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to

the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

''(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

''(5) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

''(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

''(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

''(g) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

''(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

''(2) REVIEW AND ANNUAL REPORTS.—

''(A) REVIEW.—The Comptroller General of the United States shall review the following:

''(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

''(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

''(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the methods and products used to disseminate research, the types of training conducted and supported, and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under such section.

''(iv) Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

''(v) Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the Patient-Centered Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code of 1986 are appropriate and whether such sources of funding should be continued or adjusted.

''(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

''(h) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

''(1) PUBLIC COMMENT PERIODS.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

''(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

''(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

''(A) Information contained in research findings as specified in subsection (d)(9).

''(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducing such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

''(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

''(D) Subsequent comments received during each of the public comment periods.

''(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

''(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

''(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

''(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

''(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

''(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

''(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

''(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

''(j) RULES OF CONSTRUCTION.—

''(1) COVERAGE.—Nothing in this section shall be construed—

''(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

''(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.''.

(b) DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3606, is further amended by inserting after section 936 the following:

''SEC. 937. DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.

''(a) IN GENERAL.—

''(1) DISSEMINATION.—The Office of Communication and Knowledge Transfer (referred to in this section as the 'Office') at the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality), in consultation with the National Institutes of Health, shall broadly disseminate the research findings that are published by the Patient Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act (referred to in this section as the 'Institute') and other government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers. The Office shall also develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for profit, and academic sources.

''(2) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute's research findings and government-funded research relevant to comparative clinical effectiveness research to physicians, health

care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans. Materials, forums, and media used to disseminate the findings, informational tools, and resource databases shall—

''(A) include a description of considerations for specific subpopulations, the research methodology, and the limitations of the research, and the names of the entities, agencies, instrumentalities, and individuals who conducted any research which was published by the Institute; and

''(B) not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment.

''(b) INCORPORATION OF RESEARCH FINDINGS.—The Office, in consultation with relevant medical and clinical associations, shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation.

''(c) FEEDBACK.—The Office shall establish a process to receive feedback from physicians, health care providers, patients, and vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans about the value of the information disseminated and the assistance provided under this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude the Institute from making its research findings publicly available as required under section 1181(d)(8) of the Social Security Act.

''(e) TRAINING OF RESEARCHERS.—The Agency for Health Care Research and Quality, in consultation with the National Institutes of Health, shall build capacity for comparative clinical effectiveness research by establishing a grant program that provides for the training of researchers in the methods used to conduct such research, including systematic reviews of existing research and primary research such as clinical trials. At a minimum, such training shall be in methods that meet the methodological standards adopted under section 1181(d)(9) of the Social Security Act.

''(f) BUILDING DATA FOR RESEARCH.—The Secretary shall provide for the coordination of relevant Federal health programs to build data capacity for comparative clinical effectiveness research, including the development and use of clinical registries and health outcomes research data networks, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records.

''(g) AUTHORITY TO CONTRACT WITH THE INSTITUTE.—Agencies and instrumentalities of the Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this part, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and instrumentalities.''.

(c) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a), is amended by adding at the end the following new section:

''LIMITATIONS ON CERTAIN USES OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''SEC. 1182. (a) The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

''(b) Nothing in section 1181 shall be construed as—

''(1) superceding or modifying the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1862(l)(1); or

''(2) authorizing the Secretary to deny coverage of items or services under such title solely on the basis of comparative clinical effectiveness research.

''(c)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.

''(2) Paragraph (1) shall not be construed as preventing the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under title XVIII based upon a comparison of the difference in the effectiveness of alternative treatments in extending an individual's life due to the individual's age, disability, or terminal illness.

''(d)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that precludes, or with the intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

''(2)(A) Paragraph (1) shall not be construed to—

''(i) limit the application of differential copayments under title XVIII based on factors such as cost or type of service; or

''(ii) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under such title based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual's life due to that individual's age, disability, or terminal illness.

''(3) Nothing in the provisions of, or amendments made by the Patient Protection and Affordable Care Act, shall be construed to limit comparative clinical effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.

''(e) The Patient-Centered Outcomes Research Institute established under section 1181(b)(1) shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.''.

(d) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a) and amended by subsection (c), is amended by adding at the end the following new section:

''TRUST FUND TRANSFERS TO PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND

''SEC. 1183. (a) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the 'PCORTF') under section 9511 of the Internal Revenue Code of 1986, of the following:

''(1) For fiscal year 2013, an amount equal to $1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

''(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to $2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

''(b) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.''.

(e) PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

''SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Patient-Centered Outcomes Research Trust Fund' (hereafter in this section referred to as the 'PCORTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

''(b) TRANSFERS TO FUND.—

''(1) APPROPRIATION.—There are hereby appropriated to the Trust Fund the following:

''(A) For fiscal year 2010, $10,000,000.

''(B) For fiscal year 2011, $50,000,000.

''(C) For fiscal year 2012, $150,000,000.

''(D) For fiscal year 2013—

''(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(ii) $150,000,000.

''(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

''(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(ii) $150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

''(2) TRUST FUND TRANSFERS.—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

''(3) LIMITATION ON TRANSFERS TO PCORTF.—No amount may be appropriated or transferred to the PCORTF on and after the date of any expenditure from the PCORTF which is not an expenditure permitted under this section. The determination of whether an expenditure is so permitted shall be made without regard to—

''(A) any provision of law which is not contained or referenced in this chapter or in a revenue Act, and

''(B) whether such provision of law is a subsequently enacted provision or directly or indirectly seeks to waive the application of this paragraph.

''(c) TRUSTEE.—The Secretary of the Treasury shall be a trustee of the PCORTF.

''(d) EXPENDITURES FROM FUND.—

''(1) AMOUNTS AVAILABLE TO THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subject to paragraph (2), amounts in the PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act for carrying out part D of title XI of the Social Security Act (as in effect on the date of enactment of such Act).

''(2) TRANSFER OF FUNDS.—

''(A) IN GENERAL.—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appropriated or credited to the PCORTF for each of fiscal years 2011 through 2019 to the Secretary of Health and Human Services to carry out section 937 of the Public Health Service Act.

''(B) AVAILABILITY.—Amounts transferred under subparagraph (A) shall remain available until expended.

''(C) REQUIREMENTS.—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

''(i) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality) to carry out the activities described in section 937 of the Public Health Service Act; and

''(ii) 20 percent to the Secretary to carry out the activities described in such section 937.

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary of the Treasury based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

''(f) TERMINATION.—No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in such Trust Fund after such date shall be transferred to the general fund of the Treasury.''.

(B) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

''Sec. 9511. Patient-centered outcomes research trust fund.''.

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter B—Insured and Self-Insured Health Plans

''Sec. 4375. Health insurance.
''Sec. 4376. Self-insured health plans.
''Sec. 4377. Definitions and special rules.

''SEC. 4375. HEALTH INSURANCE.

''(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of $2 ($1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

''(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B), such arrangement shall be treated as a specified health insurance policy, and the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for policy years ending in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year ending after September 30, 2012, there is hereby imposed a fee equal to $2 ($1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by 1 or more employers for the benefit of their employees or former employees,

''(B) by 1 or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for plan years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for plan years ending in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means

any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being members of the Armed Forces of the United States or veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

"Subchapter A—Policies Issued By Foreign Insurers".

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

(f) TAX-EXEMPT STATUS OF THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subsection 501(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.''.

SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under subsection (e)(2) of such section, shall terminate on the date of enactment of this Act.

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

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

(1) in paragraph (1)(A), by adding at the end the following: ''Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).'';

(2) by redesignating paragraph (2) as paragraph (7); and

(3) by inserting after paragraph (1) the following:

''(2) PROVIDER SCREENING.—

''(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

''(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

''(i) shall include a licensure check, which may include such checks across States; and

''(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

''(I) a criminal background check;

''(II) fingerprinting;

''(III) unscheduled and unannounced site visits, including preenrollment site visits;

''(IV) database checks (including such checks across States); and

''(V) such other screening as the Secretary determines appropriate.

''(C) APPLICATION FEES.—

''(i) INDIVIDUAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a physician, physician assistant, nurse practitioner, or clinical nurse specialist) with respect to which screening is conducted under this paragraph in an amount equal to—

''(I) for 2010, $200; and

''(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

''(ii) INSTITUTIONAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

''(I) for 2010, $500; and

''(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

''(iii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

''(iv) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

''(D) APPLICATION AND ENFORCEMENT.—

''(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX , or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

''(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

''(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

''(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

''(E) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

''(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not

more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX. and the CHIP program under title XXI.

''(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

''(4) INCREASED DISCLOSURE REQUIREMENTS.—

''(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title , title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

''(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

''(5) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any past-due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

''(B) DEFINITIONS.—In this paragraph:

''(i) IN GENERAL.—The term 'applicable provider of services or supplier' means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

''(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term 'obligated provider of services or supplier' means a provider of services or supplier that owes a past-due obligation under the program under this title (as determined by the Secretary).

''(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

''(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

''(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

''(7) COMPLIANCE PROGRAMS.—

''(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

''(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

''(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.''.

(b) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4302(b), is amended—

(A) in subsection (a)—

(i) by striking ''and'' at the end of paragraph (75);

(ii) by striking the period at the end of paragraph (76) and inserting a semicolon; and

(iii) by inserting after paragraph (76) the following:

''(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (ii);''; and

(B) by adding at the end the following:

''(ii) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(77), the requirements of this subsection are the following:

''(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1886(j)(2).

''(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1886(j)(3).

''(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

''(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

''(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

''(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1886(j)(6).

''(ii) EXCEPTION.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

''(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

''(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1866(j)(7) for providers or suppliers within a particular industry or category.

''(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

''(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

''(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

''(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

''(8) OTHER STATE OVERSIGHT.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.''.

(2) DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATES.—The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each State agency with responsibility for administering a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act or a child health plan under title XXI the name, national provider identifier, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under title XVIII or under the CHIP program under title XXI that is terminated from participation under that program within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act, within 90 days of such date).

(3) CONFORMING AMENDMENT.—Section 1902(a)(23) of the Social Security Act (42

U.S.C. 1396a), is amended by inserting before the semicolon at the end the following: ''or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium''.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by section 2101(d), is amended—

(1) by redesignating subparagraphs (D) through (M) as subparagraphs (E) through (N), respectively; and

(2) by inserting after subparagraph (C), the following:

''(D) Subsections (a)(77) and (ii) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).''.

SEC. 6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002, 6004, and 6102, is amended by inserting after section 1128I the following new section:

''SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

''(a) DATA MATCHING.—

''(1) INTEGRATED DATA REPOSITORY.—

''(A) INCLUSION OF CERTAIN DATA.—

''(i) IN GENERAL.—The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

''(I) The programs under titles XVIII and XIX (including parts A, B, C, and D of title XVIII).

''(II) The program under title XXI.

''(III) Health-related programs administered by the Secretary of Veterans Affairs.

''(IV) Health-related programs administered by the Secretary of Defense.

''(V) The program of old-age, survivors, and disability insurance benefits established under title II.

''(VI) The Indian Health Service and the Contract Health Service program.

''(ii) PRIORITY FOR INCLUSION OF CERTAIN DATA.—Inclusion of the data described in subclause (I) of such clause in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause shall be included in the Integrated Data Repository as appropriate.

''(B) DATA SHARING AND MATCHING.—

''(i) IN GENERAL.—The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

''(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:

''(I) The Commissioner of Social Security.

''(II) The Secretary of Veterans Affairs.

''(III) The Secretary of Defense.

''(IV) The Director of the Indian Health Service.

''(iii) DEFINITION OF SYSTEM OF RECORDS.—For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.

''(2) ACCESS TO CLAIMS AND PAYMENT DATABASES.—For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, United States Code, and subject to any information systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

''(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

''(1) IN GENERAL.—Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of protecting the integrity of the programs under titles XVIII and XIX, obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—

''(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

''(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1128B(f)) regardless of how the item or service is paid for, or to whom such payment is made.

''(2) INCLUSION OF CERTAIN INFORMATION.—Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under title XVIII or XIX, including a prescribing physician's medical records for an individual who is prescribed an item or service which is covered under part B of title XVIII, a covered part D drug (as defined in section 1860D–2(e)) for which payment is made under an MA–PD plan under part C of such title, or a prescription drug plan under part D of such title, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under titles XVIII and XIX.

''(c) ADMINISTRATIVE REMEDY FOR KNOWING PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD SCHEME.—

''(1) IN GENERAL.—In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose an appropriate administrative penalty commensurate with the offense or conspiracy.

''(2) APPLICABLE INDIVIDUAL.—For purposes of paragraph (1), the term 'applicable individual' means an individual—

''(A) entitled to, or enrolled for, benefits under part A of title XVIII or enrolled under part B of such title;

''(B) eligible for medical assistance under a State plan under title XIX or under a waiver of such plan; or

''(C) eligible for child health assistance under a child health plan under title XXI.

''(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

''(1) IN GENERAL.—If a person has received an overpayment, the person shall—

''(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

''(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

''(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—

''(A) the date which is 60 days after the date on which the overpayment was identified; or

''(B) the date any corresponding cost report is due, if applicable.

''(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

''(4) DEFINITIONS.—In this subsection:

''(A) KNOWING AND KNOWINGLY.—The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31, United States Code.

''(B) OVERPAYMENT.—The term ''overpayment'' means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

''(C) PERSON.—

''(i) IN GENERAL.—The term 'person' means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)).

''(ii) EXCLUSION.—Such term does not include a beneficiary.

''(e) INCLUSION OF NATIONAL PROVIDER IDENTIFIER ON ALL APPLICATIONS AND CLAIMS.—The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under titles XVIII and XIX that qualify for a national provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.''.

(b) ACCESS TO DATA.—

(1) MEDICARE PART D.—Section 1860D–15(f)(2) of the Social Security Act (42 U.S.C. 1395w–116(f)(2)) is amended by striking ''may be used by'' and all that follows through the period at the end and inserting ''may be used—

''(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

''(i) carrying out this section; and

''(ii) conducting oversight, evaluation, and enforcement under this title; and

''(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.''.

(2) DATA MATCHING.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) in clause (vii), by striking ''or'' at the end;

(B) in clause (viii), by inserting ''or'' after the semicolon; and

(C) by adding at the end the following new clause:

''(ix) matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse, including matches of a system of records with non-Federal records;''.

(3) MATCHING AGREEMENTS WITH THE COMMISSIONER OF SOCIAL SECURITY.—Section

205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

''(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

''(i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the system of records of the Department of Health and Human Services; and

''(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

''(B) For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.''.

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR STATES THAT FAIL TO REPORT ENROLLEE ENCOUNTER DATA IN THE MEDICAID STATISTICAL INFORMATION SYSTEM.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (23), by striking ''or'' at the end;

(2) in paragraph (24), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new paragraph:.

''(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary).''.

(d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—

(1) PERMISSIVE EXCLUSIONS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(16) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.—Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.''.

(2) CIVIL MONETARY PENALTIES.—

(A) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(i) in paragraph (1)(D), by striking ''was excluded'' and all that follows through the period at the end and inserting ''was excluded from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law.'';

(ii) in paragraph (6), by striking ''or'' at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

''(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

''(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

''(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section;'';

(iv) in the first sentence—

(I) by striking the ''or'' after ''prohibited relationship occurs;''; and

(II) by striking ''act)'' and inserting ''act; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)''; and

(v) in the second sentence, by striking ''purpose)'' and inserting ''purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact)''.

(B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROGRAMS.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(i) in subparagraph (C), by striking ''or'' at the end;

(ii) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105–33), by striking the period at the end and inserting a semicolon;

(iii) by redesignating subparagraph (D), as added by section 4523(c) of such Act, as subparagraph (E) and striking the period at the end and inserting ''; or''; and

(iv) by adding at the end the following new subparagraphs:

''(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) and designated by the Secretary under regulations);

''(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

''(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

''(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

''(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII or a State health care program (as defined in section 1128(h));

''(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

''(i) the items or services are not offered as part of any advertisement or solicitation;

''(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

''(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

''(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

''(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA–PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D–2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively.''.

(e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-ONLY CASES.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a–7(f)) is amended by adding at the end the following new paragraph:

''(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.''.

(f) HEALTH CARE FRAUD.—

(1) KICKBACKS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.''.

(2) REVISING THE INTENT REQUIREMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b), as amended by paragraph (1), is amended by adding at the end the following new subsection:

''(h) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.''.

(g) SURETY BOND REQUIREMENTS.—

(1) DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(16)(B) of the Social Security Act (42 U.S.C. 1395m(a)(16)(B)) is amended by inserting ''that the Secretary determines is commensurate with the volume of the billing of the supplier'' before the period at the end.

(2) HOME HEALTH AGENCIES.—Section 1861(o)(7)(C) of the Social Security Act (42 U.S.C. 1395x(o)(7)(C)) is amended by inserting ''that the Secretary determines is commensurate with the volume of the billing of the home health agency'' before the semicolon at the end.

(3) REQUIREMENTS FOR CERTAIN OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

''(n) REQUIREMENT OF A SURETY BOND FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) IN GENERAL.—The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

''(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).''.

(h) SUSPENSION OF MEDICARE AND MEDICAID PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) MEDICARE.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by subsection (g)(3), is amended by adding at the end the following new subsection:

''(o) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

''(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

''(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

''(3) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection and section 1903(i)(2)(C).''.

(2) MEDICAID.—Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

(A) in subparagraph (A), by striking ''or'' at the end; and

(B) by inserting after subparagraph (B), the following:

''(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or''.

(i) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—

(1) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

''(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.''; and

(B) in paragraph (4)(A), by inserting ''until expended'' after ''appropriation''.

(2) INDEXING OF AMOUNTS APPROPRIATED.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended—

(i) in subclause (III), by inserting ''and'' at the end;

(ii) in subclause (IV)—

(I) by striking ''for each of fiscal years 2007, 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2006''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking subclause (V).

(B) OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Section 1817(k)(3)(A)(ii) of such Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amended—

(i) in subclause (VIII), by inserting ''and'' at the end;

(ii) in subclause (IX)—

(I) by striking ''for each of fiscal years 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2007''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking subclause (X).

(C) FEDERAL BUREAU OF INVESTIGATION.—Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395i(k)(3)(B)) is amended—

(i) in clause (vii), by inserting ''and'' at the end;

(ii) in clause (viii)—

(I) by striking ''for each of fiscal years 2007, 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2006''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking clause (ix).

(D) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395i(k)(4)(C)) is amended by adding at the end the following new clause:

''(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.''.

(j) MEDICARE INTEGRITY PROGRAM AND MEDICAID INTEGRITY PROGRAM.—

(1) MEDICARE INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(i) in paragraph (3), by striking ''and'' at the end;

(ii) by redesignating paragraph (4) as paragraph (5); and

(iii) by inserting after paragraph (3) the following new paragraph:

''(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and''.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(i) EVALUATIONS AND ANNUAL REPORT.—

''(1) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

''(2) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

''(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Insurance Trust Fund under section 1841, to carry out this section; and

''(B) the effectiveness of the use of such funds.''.

(C) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting '', or otherwise,'' after ''entities''.

(2) MEDICAID INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1936(c)(2) of the Social Security Act (42 U.S.C. 1396u–6(c)(2)) is amended—

(i) by redesignating subparagraph (D) as subparagraph (E); and

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

''(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.''.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1936(e) of the Social Security Act (42 U.S.C. 1396u–7(e)) is amended—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following new paragraph:

''(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.''.

(k) EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking ''individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both'' and inserting ''beneficiaries (as defined in section 1128A(i)(5)) of that program''.

SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.—Section 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) by striking subsection (a) and inserting the following:

''(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).'';

(2) by striking subsection (d) and inserting the following:

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1921(b) information reported under section 1921(a).

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.'';

(3) by striking subsection (f) and inserting the following:

''(f) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1921.''; and

(4) in subsection (g)—

(A) in paragraph (1)(A)—

(i) in clause (iii)—

(I) by striking ''or State'' each place it appears;

(II) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively; and

(III) by inserting after subclause (I) the following new subclause:

''(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction''; and

(ii) by striking clause (iv) and inserting the following:

''(iv) Exclusion from participation in a Federal health care program (as defined in section 1128B(f)).'';

(B) in paragraph (3)—

(i) by striking subparagraphs (D) and (E); and

(ii) by redesignating subparagraph (F) as subparagraph (D); and

(C) in subparagraph (D) (as so redesignated), by striking ''or State''.

(b) INFORMATION REPORTED BY STATE LAW OR FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the Social Security Act (42 U.S.C. 1396r–2) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''SYSTEM.—The State'' and all that follows through the semicolon and inserting SYSTEM.—

''(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:'';

(ii) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively, and indenting appropriately;

(iii) in subparagraph (A)(iii) (as so redesignated)—

(I) by striking ''the license of'' and inserting ''license or the right to apply for, or renew, a license by''; and

(II) by inserting ''nonrenewability,'' after ''voluntary surrender,''; and

(iv) by adding at the end the following new subparagraph:

''(B) OTHER FINAL ADVERSE ACTIONS.—The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency.''; and

(B) in paragraph (2), by striking ''the authority described in paragraph (1)'' and inserting ''a State licensing or certification agency or State law or fraud enforcement agency'';

(2) in subsection (b)—

(A) by striking paragraph (2) and inserting the following:

''(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners;'';

(B) in each of paragraphs (4) and (6), by inserting '', but only with respect to information provided pursuant to subsection (a)(1)(A)'' before the comma at the end;

(C) by striking paragraph (5) and inserting the following:

''(5) to State law or fraud enforcement agencies,'';

(D) by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

''(7) to health plans (as defined in section 1128C(c));'';

(3) by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

''(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

''(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

''(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

''(2) CORRECTIONS.—Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

''(e) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

''(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

''(g) REFERENCES.—For purposes of this section:

''(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term 'State licensing or certification agency' includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

''(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term 'State law or fraud enforcement agency' includes—

''(A) a State law enforcement agency; and

''(B) a State medicaid fraud control unit (as defined in section 1903(q)).

''(3) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'final adverse action' includes—

''(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

''(ii) State criminal convictions related to the delivery of a health care item or service;

''(iii) exclusion from participation in State health care programs (as defined in section 1128(h));

''(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

''(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

''(B) EXCEPTION.—Such term does not include any action with respect to a malpractice claim.''; and

(4) in subsection (h), as so redesignated, by striking ''The Secretary'' and all that follows through the period at the end and inserting ''In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1128E.''.

(c) CONFORMING AMENDMENT.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a–7c(a)(1)) is amended—

(1) in subparagraph (C), by adding ''and'' after the comma at the end;

(2) in subparagraph (D), by striking '', and'' and inserting a period; and

(3) by striking subparagraph (E).

(d) TRANSITION PROCESS; EFFECTIVE DATE.—

(1) IN GENERAL.—Effective on the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall implement a transition process under which, by not later than the end of the transition period described in paragraph (5), the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank established under section 1128E of the Social Security Act (as in effect before the effective date specified in paragraph (6)) and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). During such transition process, the Secretary shall have in effect appropriate procedures to ensure that data collection and access to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank are not disrupted.

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b).

(3) FUNDING.—

(A) AVAILABILITY OF FEES.—Fees collected pursuant to section 1128E(d)(2) of the Social Security Act prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the Secretary, without fiscal year limitation, for payment of costs related to the transition process described in paragraph (1). Any such fees remaining after the transition period is complete shall be available to the Secretary, without fiscal year limitation, for payment of the costs of operating the National Practitioner Data Bank.

(B) AVAILABILITY OF ADDITIONAL FUNDS.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.

(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term ''transition period'' means the period that begins on the date of enactment of this Act and ends on the later of—

(A) the date that is 1 year after such date of enactment; or

(B) the effective date of the regulations promulgated under paragraph (2).

(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)(1)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows through the semicolon and inserting ''period ending 1 calendar year after the date of service;''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

(2) PART B.—

(A) Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)(B)) is amended—

(i) in subparagraph (B), in the flush language following clause (ii), by striking ''close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)'' and inserting ''period ending 1 calendar year after the date of service''; and

(ii) by adding at the end the following new sentence: ''In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.''

(B) Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(i) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows through the semicolon and inserting ''period ending 1 calendar year after the date of service;''; and

(ii) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2010.

(2) SERVICES FURNISHED BEFORE 2010.—In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) shall be filed not later that December 31, 2010.

SEC. 6405. PHYSICIANS WHO ORDER ITEMS OR SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking ''physician'' and inserting ''physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j)''.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ''in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),'' before ''or, in the case of services''.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting '', or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),'' after ''a physician''.

(c) APPLICATION TO OTHER ITEMS OR SERVICES.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D–2(e) of such Act (42 U.S.C. 1395w–102), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w–4(k)(3)(B)).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 6406. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph

''(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.''.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc) is further amended—

(1) in subparagraph (U), by striking at the end ''and'';

(2) in subparagraph (V), by striking the period at the end and adding ''; and''; and

(3) by adding at the end the following new subparagraph:

''(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.''.

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting '', ordering, referring for furnishing, or certifying the need for'' after ''furnishing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 6407. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking ''and such services'' and inserting ''such services''; and

(B) by inserting after ''care of a physician'' the following: '', and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary''.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking ''and'' before ''(iii)''; and

(B) by inserting after ''care of a physician'' the following: '', and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary''.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended—

(1) by striking ''ORDER.—The Secretary'' and inserting ''ORDER.—

''(i) IN GENERAL.—The Secretary''; and

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

''(ii) REQUIREMENT FOR FACE TO FACE ENCOUNTER.—The Secretary shall require that such an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.''.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the

Social Security Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 6408. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 5002(d)(2)(A), is amended—

(1) in paragraph (6), by striking ''or'' at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

''(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

''(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;''; and

(3) in the first sentence—

(A) by striking ''or in cases under paragraph (7)'' and inserting ''in cases under paragraph (7)''; and

(B) by striking ''act)'' and inserting ''act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph)''.

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by inserting ''timely'' before ''inspect''; and

(B) in subparagraph (B), by inserting ''timely'' before ''audit and inspect''.

(2) MARKETING VIOLATIONS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w—27(g)(1)) is amended—

(A) in subparagraph (F), by striking ''or'' at the end;

(B) by inserting after subparagraph (G) the following new subparagraphs:

''(H) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

''(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

''(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

''(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;''; and

(C) by adding at the end the following new sentence: ''The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.''.

(3) PROVISION OF FALSE INFORMATION.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended by inserting ''except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,'' after ''for each such determination,''.

(c) OBSTRUCTION OF PROGRAM AUDITS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting ''OR AUDIT'' after ''INVESTIGATION''; and

(2) by striking ''investigation into'' and all that follows through the period and inserting ''investigation or audit related to—''

''(i) any offense described in paragraph (1) or in subsection (a); or

''(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) EXCEPTION.—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.

SEC. 6409. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an ''SRDP''). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information related to the disclosure.

(4) Such other factors as the Secretary considers appropriate.

(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

SEC. 6410. ADJUSTMENTS TO THE MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES COMPETITIVE ACQUISITION PROGRAM.

(a) EXPANSION OF ROUND 2 OF THE DME COMPETITIVE BIDDING PROGRAM.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended—

(1) in subparagraph (B)(i)(II), by striking ''70'' and inserting ''91''; and

(2) in subparagraph (D)(ii)—

(A) in subclause (I), by striking ''and'' at the end;

(B) by redesignating subclause (II) as subclause (III); and

(C) by inserting after subclause (I) the following new subclause:

''(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and''.

(b) REQUIREMENT TO EITHER COMPETITIVELY BID AREAS OR USE COMPETITIVE BID PRICES BY 2016.—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395m(a)(1)(F)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by inserting ''(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)'' after ''may''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are recompeted in accordance with section 1847(b)(3)(B).''.

SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) EXPANSION TO MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking ''that the records'' and inserting ''that—

''(A) the records'';

(B) by inserting ''and'' after the semicolon; and

(C) by adding at the end the following:

''(B) not later than December 31, 2010, the State shall—

''(i) establish a program under which the State contracts (consistent with State law

and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

''(ii) provide assurances satisfactory to the Secretary that—

''(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

''(II) from such amounts recovered, payment—

''(aa) shall be made on a contingent basis for collecting overpayments; and

''(bb) may be made in such amounts as the State may specify for identifying underpayments;

''(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

''(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

''(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

''(bb) that section 1903(d) shall apply to amounts recovered under the program; and

''(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and''.

(2) COORDINATION; REGULATIONS.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010.

(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title'';

(2) in paragraph (2), by striking ''parts A and B'' and inserting ''this title'';

(3) in paragraph (3), by inserting ''(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)'' after ''2010'';

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title''; and

(5) by adding at the end the following:

''(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

''(A) ensure that each MA plan under part C has an anti- fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(B) ensure that each prescription drug plan under part D has an anti- fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

''(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.''.

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include such reports recommendations for expanding or improving the program.

Subtitle F—Additional Medicaid Program Integrity Provisions

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after ''1128A,'' the following: ''terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title,''.

SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6401(b), is amended by inserting after paragraph (77) the following:

''(78) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

''(A) has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;

''(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

''(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period;''.

SEC. 6503. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by section 6502(a), is amended by inserting after paragraph (78), the following:

''(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;''.

SEC. 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after ''necessary'' the following: ''and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine''.

(b) MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by section 6503, is amended by inserting after paragraph (79) the following new paragraph:

''(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States;''.

SEC. 6506. OVERPAYMENTS.

(a) EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.—

(1) IN GENERAL.—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(A) in subparagraph (C)—

(i) in the first sentence, by striking ''60 days'' and inserting ''1 year''; and

(ii) in the second sentence, by striking ''60 days'' and inserting ''1-year period''; and

(B) in subparagraph (D)—

(i) in inserting ''(i)'' after ''(D)''; and

(ii) by adding at the end the following:

''(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) CORRECTIVE ACTION.—The Secretary shall promulgate regulations that require States to correct Federally identified claims

overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.

SEC. 6507. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by adding ''and'' after the semi-colon; and

(C) by adding at the end the following new clause:

''(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);''; and

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

''(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

''(A) Not later than September 1, 2010:

''(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

''(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

''(iii) Notify States of—

''(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

''(II) how States are to incorporate such methodologies into claims filed under this title.

''(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).''.

SEC. 6508. GENERAL EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle G—Additional Program Integrity Provisions

SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

(a) PROHIBITION.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following:

''SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

''No person, in connection with a plan or other arrangement that is multiple employer welfare arrangement described in section 3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee organization, the Secretary, or any State, or the representative or agent of any such person, State, or the Secretary, concerning—

''(1) the financial condition or solvency of such plan or arrangement;

''(2) the benefits provided by such plan or arrangement;

''(3) the regulatory status of such plan or other arrangement under any Federal or State law governing collective bargaining, labor management relations, or intern union affairs; or

''(4) the regulatory status of such plan or other arrangement regarding exemption from state regulatory authority under this Act.

This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40)(A).''.

(b) CRIMINAL PENALTIES.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' before ''Any person''; and

(2) by adding at the end the following:

''(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 10 years or fined under title 18, United States Code, or both.''.

(c) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

''Sec. 519. Prohibition on false statement and representations.''.

SEC. 6602. CLARIFYING DEFINITION.

Section 24(a)(2) of title 18, United States Code, is amended by inserting ''or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974,'' after ''1954 of this title''.

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

''SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.

''The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.''.

SEC. 6604. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

''SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

''The Secretary may, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1986, and regardless of whether the law of the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40(A).''.

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6601, is further amended by adding at the end the following:

''Sec. 520. Applicability of State law to combat fraud and abuse.''.

SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO ISSUE ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURES ORDERS AGAINST PLANS THAT ARE IN FINANCIALLY HAZARDOUS CONDITION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6604, is further amended by adding at the end the following:

''SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS IN FINANCIALLY HAZARDOUS CONDITION.

''(a) IN GENERAL.—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in section 3(40), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

''(b) HEARING.—A person that is adversely affected by the issuance of a cease and desist order under subsection (a) may request a hearing by the Secretary regarding such order. The Secretary may require that a proceeding under this section, including all related information and evidence, be conducted in a confidential manner.

''(c) BURDEN OF PROOF.—The burden of proof in any hearing conducted under subsection (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

''(d) DETERMINATION.—Based upon the evidence presented at a hearing under subsection (b), the cease and desist order involved may be affirmed, modified, or set aside by the Secretary in whole or in part.

''(e) SEIZURE.—The Secretary may issue a summary seizure order under this title if it appears that a multiple employer welfare arrangement is in a financially hazardous condition.

''(f) REGULATIONS.—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

''(g) EXCEPTION.—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term 'multiple employer welfare arrangement' under section 3(40(A).''.

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6604, is further amended by adding at the end the following:

''Sec. 521. Administrative summary cease and desist orders and summary seizure orders against health plans in financially hazardous condition.''.

SEC. 6606. MEWA PLAN REGISTRATION WITH DEPARTMENT OF LABOR.

Section 101(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(g)) is amended—

(1) by striking ''Secretary may'' and inserting ''Secretary shall''; and

(2) by inserting ''to register with the Secretary prior to operating in a State and may, by regulation, require such multiple employer welfare arrangements'' after ''not group health plans''.

SEC. 6607. PERMITTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.

Section 504 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

''(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any of the following entities or their agents, consultants, or employees:

''(1) A State insurance department.

''(2) A State attorney general.

''(3) The National Association of Insurance Commissioners.

''(4) The Department of Labor.

''(5) The Department of the Treasury.

''(6) The Department of Justice.

''(7) The Department of Health and Human Services.

''(8) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

''(e) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.''.

Subtitle H—Elder Justice Act

SEC. 6701. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Elder Justice Act of 2009''.

SEC. 6702. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 6703(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.

(a) ELDER JUSTICE.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting ''**AND ELDER JUSTICE**'' after ''**SOCIAL SERVICES**'';

(B) by inserting before section 2001 the following:

''Subtitle A—Block Grants to States for Social Services'';

and

(C) by adding at the end the following:

''Subtitle B—Elder Justice

''SEC. 2011. DEFINITIONS.

''In this subtitle:

''(1) ABUSE.—The term 'abuse' means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

''(2) ADULT PROTECTIVE SERVICES.—The term 'adult protective services' means such services provided to adults as the Secretary may specify and includes services such as—

''(A) receiving reports of adult abuse, neglect, or exploitation;

''(B) investigating the reports described in subparagraph (A);

''(C) case planning, monitoring, evaluation, and other case work and services; and

''(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

''(3) CAREGIVER.—The term 'caregiver' means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

''(4) DIRECT CARE.—The term 'direct care' means care by an employee or contractor who provides assistance or long-term care services to a recipient.

''(5) ELDER.—The term 'elder' means an individual age 60 or older.

''(6) ELDER JUSTICE.—The term 'elder justice' means—

''(A) from a societal perspective, efforts to—

''(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

''(ii) protect elders with diminished capacity while maximizing their autonomy; and

''(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

''(7) ELIGIBLE ENTITY.—The term 'eligible entity' means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

''(8) EXPLOITATION.—The term 'exploitation' means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

''(9) FIDUCIARY.—The term 'fiduciary'—

''(A) means a person or entity with the legal responsibility—

''(i) to make decisions on behalf of and for the benefit of another person; and

''(ii) to act in good faith and with fairness; and

''(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

''(10) GRANT.—The term 'grant' includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

''(11) GUARDIANSHIP.—The term 'guardianship' means—

''(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

''(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

''(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

''(12) INDIAN TRIBE.—

''(A) IN GENERAL.—The term 'Indian tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term 'Indian tribe' includes any Pueblo or Rancheria.

''(13) LAW ENFORCEMENT.—The term 'law enforcement' means the full range of potential responders to elder abuse, neglect, and exploitation including—

''(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

''(B) prosecutors;

''(C) medical examiners;

''(D) investigators; and

''(E) coroners.

''(14) LONG-TERM CARE.—

''(A) IN GENERAL.—The term 'long-term care' means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

''(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term 'loss of capacity for self-care' means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one's financial affairs, and other activities the Secretary determines appropriate.

''(15) LONG-TERM CARE FACILITY.—The term 'long-term care facility' means a residential care provider that arranges for, or directly provides, long-term care.

''(16) NEGLECT.—The term 'neglect' means—

''(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

''(B) self-neglect.

''(17) NURSING FACILITY.—

''(A) IN GENERAL.—The term 'nursing facility' has the meaning given such term under section 1919(a).

''(B) INCLUSION OF SKILLED NURSING FACILITY.—The term 'nursing facility' includes a

skilled nursing facility (as defined in section 1819(a)).

''(18) SELF-NEGLECT.—The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

''(A) obtaining essential food, clothing, shelter, and medical care;

''(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

''(C) managing one's own financial affairs.

''(19) SERIOUS BODILY INJURY.—

''(A) IN GENERAL.—The term 'serious bodily injury' means an injury—

''(i) involving extreme physical pain;

''(ii) involving substantial risk of death;

''(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

''(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

''(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

''(20) SOCIAL.—The term 'social', when used with respect to a service, includes adult protective services.

''(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term 'State legal assistance developer' means an individual described in section 731 of the Older Americans Act of 1965.

''(22) STATE LONG-TERM CARE OMBUDSMAN.—The term 'State Long-Term Care Ombudsman' means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.

''SEC. 2012. GENERAL PROVISIONS.

''(a) PROTECTION OF PRIVACY.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

''(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice—

''(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

''(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

''(3) may be unambiguously deduced from the elder's life history.

''PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

''Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

''SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

''(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the 'Council').

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Council shall be composed of the following members:

''(A) The Secretary (or the Secretary's designee).

''(B) The Attorney General (or the Attorney General's designee).

''(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

''(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

''(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

''(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

''(f) DUTIES.—

''(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

''(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

''(A) describes the activities and accomplishments of, and challenges faced by—

''(i) the Council; and

''(ii) the entities represented on the Council; and

''(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

''(g) POWERS OF THE COUNCIL.—

''(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

''(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

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

''SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

''(a) ESTABLISHMENT.—There is established a board to be known as the 'Advisory Board on Elder Abuse, Neglect, and Exploitation' (in this section referred to as the 'Advisory Board') to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

''(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

''(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

''(d) TERMS.—

''(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

''(A) 9 shall be appointed for a term of 3 years;

''(B) 9 shall be appointed for a term of 2 years; and

''(C) 9 shall be appointed for a term of 1 year.

''(2) VACANCIES.—

''(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

''(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

''(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

''(f) DUTIES.—

''(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

''(2) COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

''(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

''(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best

practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

''(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

''(A) information on the status of Federal, State, and local public and private elder justice activities;

''(B) recommendations (including recommended priorities) regarding—

''(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

''(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

''(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

''(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

''(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

''(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

''(g) POWERS OF THE ADVISORY BOARD.—

''(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

''(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

''(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

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

''SEC. 2023. RESEARCH PROTECTIONS.

''(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

''(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term 'legally authorized representative' means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

''SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this subpart—

''(1) for fiscal year 2011, $6,500,000; and

''(2) for each of fiscal years 2012 through 2014, $7,000,000.

''Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

''SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

''(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

''(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

''(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

''(d) AUTHORIZED ACTIVITIES.—

''(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that receives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

''(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

''(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

''(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

''(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

''(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $4,000,000;

''(2) for fiscal year 2012, $6,000,000; and

''(3) for each of fiscal years 2013 and 2014, $8,000,000.

''PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

''SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

''(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

''(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

''(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

''(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

''(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

''(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

''(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

''(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

''(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

''(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

''(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

''(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

''(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

''(ii) the establishment of motivational and thoughtful work organization practices;

''(iii) the creation of a workplace culture that respects and values caregivers and their needs;

''(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

''(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

''(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

''(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

''(5) DEFINITIONS.—In this subsection:

''(A) COMMUNITY-BASED LONG-TERM CARE.—The term 'community-based long-term care' has the meaning given such term by the Secretary.

''(B) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

''(i) A long-term care facility.

''(ii) A community-based long-term care entity (as defined by the Secretary).

''(b) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.—

''(1) GRANTS AUTHORIZED.—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(2) USE OF GRANT FUNDS.—Funds provided under grants under this subsection may be used for any of the following:

''(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

''(B) Making improvements to existing computer software and hardware.

''(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

''(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

''(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

''(4) PARTICIPATION IN STATE HEALTH EXCHANGES.—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 3013(f) of the Public Health Service Act) under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

''(5) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(c) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

''(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

''(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

''(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

''(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

''(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $20,000,000;

''(2) for fiscal year 2012, $17,500,000; and

''(3) for each of fiscal years 2013 and 2014, $15,000,000.

''SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

''(a) SECRETARIAL RESPONSIBILITIES.—

''(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

''(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

''(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

''(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

''(D) conducts research related to the provision of adult protective services; and

''(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

''(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

''(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

''(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

''(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

''(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to '0.75' were a reference to '0.1'.

''(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

''(3) AUTHORIZED ACTIVITIES.—

''(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

''(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

''(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

''(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

''(c) STATE DEMONSTRATION PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

''(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be used by States and local units of government to conduct demonstration programs that test—

''(A) training modules developed for the purpose of detecting or preventing elder abuse;

''(B) methods to detect or prevent financial exploitation of elders;

''(C) methods to detect elder abuse;

''(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

''(E) other matters relating to the detection or prevention of elder abuse.

''(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

''SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

''(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

''(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

''(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

''(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

''(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

''(A) for fiscal year 2011, $5,000,000;

''(B) for fiscal year 2012, $7,500,000; and

''(C) for each of fiscal years 2013 and 2014, $10,000,000.

''(b) OMBUDSMAN TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

''SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

''(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

''(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the eligible entity may require in order to conduct such evaluation; or

''(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

''(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

''(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

''(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

''(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

''(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

''(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

''(4) APPLICATIONS.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

''(5) REPORTS.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

''(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

''(1) EVALUATIONS.—The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an evaluation of whether the funding provided under the grant is expended only for the purposes for which it is made.

''(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

''SEC. 2045. REPORT.

''Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

''(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

''(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

''SEC. 2046. RULE OF CONSTRUCTION.

''Nothing in this subtitle shall be construed as—

''(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

''(2) creating a private cause of action for a violation of this subtitle.''.

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

''(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

''(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

''(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such

abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6005, is amended by inserting after section 1150A the following new section:

''REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

''SEC. 1150B. (a) DETERMINATION AND NOTIFICATION.—

''(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least $10,000 in such Federal funds during the preceding year.

''(2) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

''(3) COVERED INDIVIDUAL DEFINED.—In this section, the term 'covered individual' means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

''(b) REPORTING REQUIREMENTS.—

''(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

''(2) TIMING.—If the events that cause the suspicion—

''(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

''(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

''(c) PENALTIES.—

''(1) IN GENERAL.—If a covered individual violates subsection (b)—

''(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

''(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

''(4) EXTENUATING CIRCUMSTANCES.—

''(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

''(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term 'underserved population' means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

''(i) areas or groups that are geographically isolated (such as isolated in a rural area);

''(ii) racial and ethnic minority populations; and

''(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

''(d) ADDITIONAL PENALTIES FOR RETALIATION.—

''(1) IN GENERAL.—A long-term care facility may not—

''(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

''(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

''(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

''(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

''(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(f) DEFINITIONS.—In this section, the terms 'elder justice', 'long-term care facility', and 'law enforcement' have the meanings given those terms in section 2011.''.

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term ''nurse aide'' has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—

(i) who should be included in the registry;

(ii) how such a registry would comply with Federal and State privacy laws and regulations;

(iii) how data would be collected for the registry;

(iv) what entities and individuals would have access to the data collected;

(v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;

(vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 4301; and

(vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)) would be provided as part of a national nurse aide registry.

(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant resources, including the following:

(i) The Department of Health and Human Services Office of Inspector General Report, Nurse Aide Registries: State Compliance and Practices (February 2005).

(ii) The General Accounting Office (now known as the Government Accountability Office) Report, Nursing Homes: More Can Be Done to Protect Residents from Abuse (March 2002).

(iii) The Department of Health and Human Services Office of the Inspector General Report, Nurse Aide Registries: Long-Term Care Facility Compliance and Practices (July 2005).

(iv) The Department of Health and Human Services Health Resources and Services Administration Report, Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated Data Needs (2004) (in particular with respect to chapter 7 and appendix F).

(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.

(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).

(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the Social Security Act, as added by section 1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed $500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 6703(a), is amended—

(A) in the heading of section 2001, by striking ''TITLE'' and inserting ''SUBTITLE''; and

(B) in subtitle 1, by striking ''this title'' each place it appears and inserting ''this subtitle''.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears;

(ii) in the heading of paragraph (2), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(iii) in the heading of paragraph (3)(B), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting ''subtitle 1 of'' before ''title XX''; and

(ii) by striking ''such title'' and inserting ''such subtitle''; and

(B) in section 1128A(i)(1), by inserting ''subtitle 1 of'' before ''title XX''.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

SEC. 6801. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the ''Biologics Price Competition and Innovation Act of 2009''.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(l) PATENTS.—

''(1) CONFIDENTIAL ACCESS TO SUBSECTION (k) APPLICATION.—

''(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the 'subsection (k) applicant') and the sponsor of the application for the reference product (referred to in this subsection as the 'reference product sponsor'), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

''(B) IN GENERAL.—

''(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the 'confidential information').

''(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

''(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the 'outside counsel'), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, provided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

''(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained

by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

''(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

''(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

''(F) EFFECT OF INFRINGEMENT ACTION.—In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in paragraph (6), the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

''(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

''(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

''(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

''(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

''(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

''(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

''(3) LIST AND DESCRIPTION OF PATENTS.—

''(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

''(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

''(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

''(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

''(i) may provide to the reference product sponsor a list of patents to which the subsection (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application;

''(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

''(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

''(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

''(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

''(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

''(4) PATENT RESOLUTION NEGOTIATIONS.—

''(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

''(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

''(5) PATENT RESOLUTION IF NO AGREEMENT.—

''(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

''(B) EXCHANGE OF PATENT LISTS.—

''(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

''(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

''(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

''(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

''(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

''(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

''(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

''(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

''(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

''(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

''(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k) applicant shall provide the Secretary with notice and a copy of such complaint.

''(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

''(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

''(A) is issued to, or exclusively licensed by, the reference product sponsor after the

date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

''(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

''(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

''(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

''(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforcement, and infringement with respect to any patent that is—

''(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

''(ii) not included, as applicable, on—

''(I) the list of patents described in paragraph (4); or

''(II) the lists of patents described in paragraph (5)(B).

''(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

''(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

''(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

''(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

''(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by adding ''or'' at the end; and

(iii) by inserting after subparagraph (B) the following:

''(C)(i) with respect to a patent that is identified in the list of patents described in section 351(l)(3) of the Public Health Service Act (including as provided under section 351(l)(7) of such Act), an application seeking approval of a biological product, or

''(ii) if the applicant for the application fails to provide the application and information required under section 351(l)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(l)(3)(A)(i) of such Act,''; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product'';

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking ''and'' at the end;

(ii) in subparagraph (C), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking the period and inserting '', and'';

(iii) by inserting after subparagraph (C) the following:

''(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(l)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.''; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking ''and (C)'' and inserting ''(C), and (D)''; and

(C) by adding at the end the following:

''(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

''(i) that is identified, as applicable, in the list of patents described in section 351(l)(4) of the Public Health Service Act or the lists of patents described in section 351(l)(5)(B) of such Act with respect to a biological product; and

''(ii) for which an action for infringement of the patent with respect to the biological product—

''(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(l)(6) of such Act; or

''(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

''(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

''(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act, including as provided under section 351(l)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.''.

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: '', or section 351 of the Public Health Service Act''.

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: ''or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health

Service Act, any necessary clinical study or studies''.

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

''(n) NEW ACTIVE INGREDIENT.—

''(1) NON-INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for interchangeability with the reference product, shall be considered to have a new active ingredient under this section.

''(2) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.''.

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) FOLLOW-ON BIOLOGICS USER FEES.—

(1) DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 735(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)(B)) is amended by striking ''section 351'' and inserting ''subsection (a) or (k) of section 351''.

(B) EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) AUDIT.—

(i) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(I) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II)(aa) such ratio determined under subclause (I); to

(bb) the ratio of the costs of reviewing applications for biological products under section 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(ii) ALTERATION OF USER FEE.—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such clause differ by more than 5 percent, then the Secretary shall alter the user fee applicable to applications submitted under such section 351(k) to more appropriately account for the costs of reviewing such applications.

(iii) ACCOUNTING STANDARDS.—The Secretary shall perform an audit under clause (i) in conformance with the accounting principles, standards, and requirements prescribed by the Comptroller General of the United States under section 3511 of title 31, United State Code, to ensure the validity of any potential variability.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2012.

(g) PEDIATRIC STUDIES OF BIOLOGICAL PRODUCTS.—

(1) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

''(m) PEDIATRIC STUDIES.—

''(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (i), (j), (k), (l), (p), and (q) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(3) MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports

thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(4) EXCEPTION.—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.''.

(2) STUDIES REGARDING PEDIATRIC RESEARCH.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting '', biological products,'' after ''including drugs''.

(B) INSTITUTE OF MEDICINE STUDY.—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

''(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

''(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

''(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.''.

(h) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the 12-year period described in subsection (k)(7) of such section 351.

SEC. 7003. SAVINGS.

(a) DETERMINATION.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of this subtitle.

(b) USE.—Notwithstanding any other provision of this subtitle (or an amendment made by this subtitle), the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

SEC. 7101. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

''(M) A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

''(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act), and that meets the requirements of subparagraph (L)(i).

''(O) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.''.

(b) EXTENSION OF DISCOUNT TO INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking ''outpatient'' each place it appears; and

(2) in subsection (b)—

(A) by striking ''OTHER DEFINITION'' and all that follows through ''In this section'' and inserting the following: ''OTHER DEFINITIONS.—

''(1) IN GENERAL.—In this section''; and

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

''(2) COVERED DRUG.—In this section, the term 'covered drug'—

''(A) means a covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act); and

''(B) includes, notwithstanding paragraph (3)(A) of section 1927(k) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.''.

(c) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) in clause (i), by adding ''and'' at the end;

(B) in clause (ii), by striking ''; and'' and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), as amended by subsection (b)—

(A) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E); respectively; and

(B) by inserting after subparagraph (B), the following:

''(C) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—

''(i) IN GENERAL.—A hospital described in subparagraph (L), (M), (N), or (O) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except as permitted or provided for pursuant to clauses (ii) or (iii).

''(ii) INPATIENT DRUGS.—Clause (i) shall not apply to drugs purchased for inpatient use.

''(iii) EXCEPTIONS.—The Secretary shall establish reasonable exceptions to clause (i)—

''(I) with respect to a covered outpatient drug that is unavailable to be purchased through the program under this section due to a drug shortage problem, manufacturer noncompliance, or any other circumstance beyond the hospital's control;

''(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price; or

''(III) to reduce in other ways the administrative burdens of managing both inventories of drugs subject to this section and inventories of drugs that are not subject to this section, so long as the exceptions do not create a duplicate discount problem in violation of subparagraph (A) or a diversion problem in violation of subparagraph (B).

''(iv) PURCHASING ARRANGEMENTS FOR INPATIENT DRUGS.—The Secretary shall ensure that a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, purchasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.''.

(d) MEDICAID CREDITS ON INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended by striking subsection (c) and inserting the following:

''(c) MEDICAID CREDIT.—Not later than 90 days after the date of filing of the hospital's most recently filed Medicare cost report, the hospital shall issue a credit as determined by the Secretary to the State Medicaid program for inpatient covered drugs provided to Medicaid recipients.''.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section and section 7102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(2) EFFECTIVENESS.—The amendments made by this section and section 7102 shall be effective and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 7102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) INTEGRITY IMPROVEMENTS.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

''(d) IMPROVEMENTS IN PROGRAM INTEGRITY.—

''(1) MANUFACTURER COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent

overcharges and other violations of the discounted pricing requirements specified in this section.

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, which shall include the following:

''(I) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the calculation of ceiling prices under such subsection.

''(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

''(III) Performing spot checks of sales transactions by covered entities.

''(IV) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take, such corrective action as is appropriate in response to such price discrepancies.

''(ii) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge by the manufacturers, including the following:

''(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

''(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment to relevant pricing data and exceptional circumstances such as erroneous or intentional overcharging for covered drugs.

''(iii) The provision of access through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized re-disclosure.

''(iv) The development of a mechanism by which—

''(I) rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

''(II) appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

''(v) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

''(vi) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act;

''(II) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

''(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

''(2) COVERED ENTITY COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements specified under subsection (a)(5).

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of procedures to enable and require covered entities to regularly update (at least annually) the information on the Internet website of the Department of Health and Human Services relating to this section.

''(ii) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (i).

''(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing covered drugs to State Medicaid agencies in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

''(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

''(v) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those to which covered entities are subject under subsection (a)(5)(E), through one or more of the following actions:

''(I) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturers in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

''(II) Where the Secretary determines a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such program for a reasonable period of time to be determined by the Secretary.

''(III) Referring matters to appropriate Federal authorities within the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 353).

''(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—

''(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under this section, and claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(A) or (a)(5)(B), including appropriate procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

''(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

''(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the ceiling price described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(A) or (a)(5)(B) have occurred;

''(ii) establish such deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

''(iii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer's product have exceeded the applicable ceiling price under this section, and may submit such documents and information to the administrative official or body responsible for adjudicating such claim;

''(iv) require that a manufacturer conduct an audit of a covered entity pursuant to subsection (a)(5)(D) as a prerequisite to initiating administrative dispute resolution proceedings against a covered entity;

''(v) permit the official or body designated under clause (i), at the request of a manufacturer or manufacturers, to consolidate claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

''(vi) include provisions and procedures to permit multiple covered entities to jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entities are members.

''(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated under subparagraph (A) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.''.

(b) CONFORMING AMENDMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: ''Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price'), and shall require that the manufacturer offer each

covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price.''; and

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 7101(c), by inserting ''after audit as described in subparagraph (D) and'' after ''finds,''.

SEC. 7103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM.

(a) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that examines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the ''340B program'') are receiving optimal health care services.

(b) RECOMMENDATIONS.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000,000 individuals who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is implemented.

(2) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

TITLE VIII—CLASS ACT

SEC. 8001. SHORT TITLE OF TITLE.

This title may be cited as the ''Community Living Assistance Services and Supports Act'' or the ''CLASS Act''.

SEC. 8002. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT.

(a) ESTABLISHMENT OF CLASS PROGRAM.—

(1) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 4302(a), is amended by adding at the end the following:

''TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

''SEC. 3201. PURPOSE.

''The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

''(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

''(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs;

''(3) alleviate burdens on family caregivers; and

''(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

''SEC. 3202. DEFINITIONS.

''In this title:

''(1) ACTIVE ENROLLEE.—The term 'active enrollee' means an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

''(2) ACTIVELY EMPLOYED.—The term 'actively employed' means an individual who—

''(A) is reporting for work at the individual's usual place of employment or at another location to which the individual is required to travel because of the individual's employment (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual's position); and

''(B) is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.

''(3) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means each of the following activities specified in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(4) CLASS PROGRAM.—The term 'CLASS program' means the program established under this title.

''(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term 'Eligibility Assessment System' means the entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.

''(6) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

''(i) has paid premiums for enrollment in such program for at least 60 months;

''(ii) has earned, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year; and

''(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

''(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

''(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

''(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISEASES.—The terms 'hospital', 'nursing facility', 'intermediate care facility for the mentally retarded', and 'institution for mental diseases' have the meanings given such terms for purposes of Medicaid.

''(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—The term 'CLASS Independence Advisory Council' or 'Council' means the Advisory Council established under section 3207 to advise the Secretary.

''(9) CLASS INDEPENDENCE BENEFIT PLAN.—The term 'CLASS Independence Benefit Plan' means the benefit plan developed and designated by the Secretary in accordance with section 3203.

''(10) CLASS INDEPENDENCE FUND.—The term 'CLASS Independence Fund' or 'Fund' means the fund established under section 3206.

''(11) MEDICAID.—The term 'Medicaid' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(12) POVERTY LINE.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(13) PROTECTION AND ADVOCACY SYSTEM.—The term 'Protection and Advocacy System' means the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15043).

''SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.

''(a) PROCESS FOR DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

''(A) PREMIUMS.—

''(i) IN GENERAL.—Beginning with the first year of the CLASS program, and for each year thereafter, subject to clauses (ii) and (iii), the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.

''(ii) NOMINAL PREMIUM FOR POOREST INDIVIDUALS AND FULL-TIME STUDENTS.—

''(I) IN GENERAL.—The monthly premium for enrollment in the CLASS program shall not exceed the applicable dollar amount per month determined under subclause (II) for—

''(aa) any individual whose income does not exceed the poverty line; and

''(bb) any individual who has not attained age 22, and is actively employed during any period in which the individual is a full-time student (as determined by the Secretary).

''(II) APPLICABLE DOLLAR AMOUNT.—The applicable dollar amount described in this subclause is the amount equal to $5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for each year occurring after 2009 and before such year.

''(iii) CLASS INDEPENDENCE FUND RESERVES.—At such time as the CLASS program has been in operation for 10 years, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis that accumulated reserves in the CLASS Independence Fund would not decrease in that year. At such time as the Secretary determines the CLASS program demonstrates a sustained ability to finance expected yearly expenses with expected yearly premiums and interest credited to the CLASS Independence Fund, the Secretary may decrease the required amount of CLASS Independence Fund reserves.

''(B) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

''(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

''(i) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

''(ii) The individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment.

''(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

''(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

''(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

''(ii) AMOUNT SCALED TO FUNCTIONAL ABILITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

''(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

''(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

''(E) COORDINATION WITH SUPPLEMENTAL COVERAGE OBTAINED THROUGH THE EXCHANGE.—The benefits allow for coordination with any supplemental coverage purchased through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

''(2) REVIEW AND RECOMMENDATION BY THE CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall—

''(A) evaluate the alternative benefit plans developed under paragraph (1); and

''(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

''(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

''(b) ADDITIONAL PREMIUM REQUIREMENTS.—

''(1) ADJUSTMENT OF PREMIUMS.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual's enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

''(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

''(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, and waste, fraud, and abuse, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary (but maintaining a nominal premium for enrollees whose income is below the poverty line or who are full-time students actively employed).

''(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

''(I) has attained age 65;

''(II) has paid premiums for enrollment in the program for at least 20 years; and

''(III) is not actively employed.

''(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

''(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

''(ii) CREDIT FOR PRIOR MONTHS IF REENROLLED WITHIN 5 YEARS.—An individual who reenrolls in the CLASS program after such a 90-day period and before the end of the 5-year period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the program shall be—

''(I) credited with any months of paid premiums that accrued prior to the individual's lapse in enrollment; and

''(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

''(D) NO LONGER STATUS AS A FULL-TIME STUDENT.—An individual subject to a nominal premium on the basis of being described in subsection (a)(1)(A)(ii)(I)(bb) who ceases to be described in that subsection, beginning with the first month following the month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year).

''(E) PENALTY FOR REENROLLMENT AFTER 5-YEAR LAPSE.—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required for the individual shall be the age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by the greater of—

''(i) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program and ends with the month preceding the month in which the reenollment is effective; or

''(ii) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

''(2) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the year.

''(3) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with subparagraphs (D) and (E) of paragraph (1)) shall be used to—

''(A) determine the monthly premium for enrollment in the CLASS program; or

''(B) prevent an individual from enrolling in the program.

''(c) SELF-ATTESTATION AND VERIFICATION OF INCOME.—The Secretary shall establish procedures to—

''(1) permit an individual who is eligible for the nominal premium required under subsection (a)(1)(A)(ii), as part of their automatic enrollment in the CLASS program, to self-attest that their income does not exceed the poverty line or that their status as a full-time student who is actively employed;

''(2) verify, using procedures similar to the procedures used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii) of the Social Security Act and consistent with the requirements applicable to the conveyance of data and information under section 1942 of such Act, the validity of such self-attestation; and

''(3) require an individual to confirm, on at least an annual basis, that their income does not exceed the poverty line or that they continue to maintain such status.

''SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

''(a) AUTOMATIC ENROLLMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the CLASS program by an employer of such individual in the same manner as an employer may elect to automatically enroll employees in a plan under section 401(k), 403(b), or 457 of the Internal Revenue Code of 1986.

''(2) ALTERNATIVE ENROLLMENT PROCEDURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

''(A) who is self-employed;

''(B) who has more than 1 employer; or

''(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary.

''(3) ADMINISTRATION.—

''(A) IN GENERAL.—The Secretary and the Secretary of the Treasury shall, by regulation, establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer.

''(B) FORM.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

''(b) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to

waive enrollment in the CLASS program at any time in such form and manner as the Secretary and the Secretary of the Treasury shall prescribe.

''(c) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an individual described in this paragraph is an individual—

''(1) who has attained age 18;

''(2) who—

''(A) receives wages on which there is imposed a tax under section 3201(a) of the Internal Revenue Code of 1986; or

''(B) derives self-employment income on which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986;

''(3) who is actively employed; and

''(4) who is not—

''(A) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

''(B) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act (42 U.S.C. 402(x)(1)(A)(ii)).

''(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

''(e) PAYMENT.—

''(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages or self-employment income of such individual in accordance with such procedures as the Secretary, in coordination with the Secretary of the Treasury, shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

''(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary, in coordination with the Secretary of the Treasury, shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program—

''(A) who does not have an employer who elects to deduct and withhold premiums in accordance with subparagraph (A); or

''(B) who does not earn wages or derive self-employment income.

''(f) TRANSFER OF PREMIUMS COLLECTED.—

''(1) IN GENERAL.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during that year.

''(2) TRANSFERS BASED ON ESTIMATES.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of the amounts collected in accordance with subparagraphs (A) and (B) of paragraph (5). Proper adjustments shall be made in amounts subsequently transferred to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

''(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which—

''(1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has elected to waive enrollment in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretaries shall establish, only during an open enrollment period established by the Secretaries that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

''(2) an individual shall only be permitted to disenroll from the program (other than for nonpayment of premiums) during an annual disenrollment period established by the Secretaries and in such form and manner as the Secretaries shall establish.

''SEC. 3205. BENEFITS.

''(a) DETERMINATION OF ELIGIBILITY.—

''(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

''(2) ELIGIBILITY ASSESSMENTS.—

''(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

''(i) establish an Eligibility Assessment System (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act) to provide for eligibility assessments of active enrollees who apply for receipt of benefits;

''(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

''(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

''(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance the sliding scale established under the plan).

''(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED ENROLLEES PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

''(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

''(ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

''(iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from the date of discharge from the hospital, facility, or institution.

''(D) APPEALS.—The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

''(b) BENEFITS.—An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

''(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1)(D) that—

''(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

''(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

''(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

''(3) ADVICE AND ASSISTANCE COUNSELING.—Advice and assistance counseling in accordance with subsection (e).

''(4) ADMINISTRATIVE EXPENSES.—Advocacy services and advise and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3203(b)(3).

''(c) PAYMENT OF BENEFITS.—

''(1) LIFE INDEPENDENCE ACCOUNT.—

''(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

''(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits paid into a Life Independence Account for obtaining assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions.

''(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

''(i) crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit;

''(ii) allowing the beneficiary to access such account through debit cards; and

''(iii) accounting for withdrawals by the beneficiary from such account.

''(D) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

''(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs

allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care, and Medicaid shall provide secondary coverage for such care.

''(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

''(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

''(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary's daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

''(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term 'home and community-based services' means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

''(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

''(I) IN GENERAL.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1934 of the Social Security Act (42 U.S.C. 1396u–4), the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

''(II) INSTITUTIONALIZED RECIPIENTS OF PACE PROGRAM SERVICES.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

''(2) AUTHORIZED REPRESENTATIVES.—

''(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

''(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

''(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

''(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

''(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

''(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

''(i) the total amount of the accrued deferred benefits; or

''(ii) the applicable annual benefit.

''(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

''(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

''(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

''(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

''(i) IN GENERAL.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

''(I) the death of a beneficiary; or

''(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

''(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

''(6) REQUIREMENT TO RECERTIFY ELIGIBILITY FOR RECEIPT OF BENEFITS.—An eligible beneficiary shall periodically, as determined by the Secretary—

''(A) recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits; and

''(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

''(7) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

''(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

''(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

''(A) information regarding how to access the appeals process established for the program;

''(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

''(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

''(2) ensure that the System and such counselors comply with the requirements of subsection (h).

''(e) ADVICE AND ASSISTANCE COUNSELING.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

''(1) accessing and coordinating long-term services and supports in the most integrated setting;

''(2) possible eligibility for other benefits and services;

''(3) development of a service and support plan;

''(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;

''(5) available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

''(6) such other services as the Secretary, by regulation, may require.

''(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

''(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

''(h) PROTECTION AGAINST CONFLICT OF INTERESTS.—The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

''(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

''(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

''(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

''(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

''(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

''(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

''(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

''SEC. 3206. CLASS INDEPENDENCE FUND.

''(a) ESTABLISHMENT OF CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'CLASS Independence Fund'. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments. The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

''(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

''(2) to pay the administrative expenses related to the Fund and to investment under subsection (b); and

''(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

''(b) INVESTMENT OF FUND BALANCE.—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 1841(d) of the Social Security Act (42 U.S.C. 1395t).

''(c) BOARD OF TRUSTEES.—

''(1) IN GENERAL.—With respect to the CLASS Independence Fund, there is hereby created a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

''(2) DUTIES.—

''(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

''(i) Hold the CLASS Independence Fund.

''(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

''(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i).

''(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

''(B) REPORT.—The report provided for in subparagraph (A)(ii) shall—

''(i) include—

''(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

''(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

''(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year; and

''(IV) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

''(ii) be printed as a House document of the session of the Congress to which the report is made.

''(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

''SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

''(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the 'CLASS Independence Advisory Council'.

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

''(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

''(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines, as determined by the Secretary.

''(2) TERMS.—

''(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

''(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

''(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

''(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

''(1) the development of the CLASS Independence Benefit Plan under section 3203;

''(2) the determination of monthly premiums under such plan; and

''(3) the financial solvency of the program.

''(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

''(e) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

''(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

''SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGULATIONS; ANNUAL REPORT.

''(a) SOLVENCY.—The Secretary shall regularly consult with the Board of Trustees of the CLASS Independence Fund and the CLASS Independence Advisory Council, for purposes of ensuring that enrollees premiums are adequate to ensure the financial solvency of the CLASS program, both with respect to fiscal years occurring in the near-term and fiscal years occurring over 20- and 75-year periods, taking into account the projections required for such periods under subsections (a)(1)(A)(i) and (b)(1)(B)(i) of section 3202.

''(b) NO TAXPAYER FUNDS USED TO PAY BENEFITS.—No taxpayer funds shall be used for payment of benefits under a CLASS Independent Benefit Plan. For purposes of this subsection, the term 'taxpayer funds' means any Federal funds from a source other than premiums deposited by CLASS program participants in the CLASS Independence Fund and any associated interest earnings.

''(c) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

''(d) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

''(1) The total number of enrollees in the program.

''(2) The total number of eligible beneficiaries during the fiscal year.

''(3) The total amount of cash benefits provided during the fiscal year.

''(4) A description of instances of fraud or abuse identified during the fiscal year.

''(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program, ensure the solvency of the program, or to prevent the occurrence of fraud or abuse.

''SEC. 3209. INSPECTOR GENERAL'S REPORT.

''The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

''(1) The eligibility determination process.

''(2) The provision of cash benefits.

''(3) Quality assurance and protection against waste, fraud, and abuse.

''(4) Recouping of unpaid and accrued benefits.

''SEC. 3210. TAX TREATMENT OF PROGRAM.

''The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services.''.

(2) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6505, is amended by inserting after paragraph (80) the following:

''(81) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish; and''.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (a)(2), is amended by inserting after paragraph (81) the following:

''(82) provide that, not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

''(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

''(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

''(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from relying on family members for the provision of personal care services.''.

(c) PERSONAL CARE ATTENDANTS WORKFORCE ADVISORY PANEL.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, the salaries, wages, and benefits of such workers, and access to the services provided by such workers.

(2) MEMBERSHIP.—In appointing members to the Personal Care Attendants Workforce Advisory Panel, the Secretary shall ensure that such members include the following:

(A) Individuals with disabilities of all ages.

(B) Senior individuals.

(C) Representatives of individuals with disabilities.

(D) Representatives of senior individuals.

(E) Representatives of workforce and labor organizations.

(F) Representatives of home and community-based service providers.

(G) Representatives of assisted living providers.

(d) INCLUSION OF INFORMATION ON SUPPLEMENTAL COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act and coverage available for purchase through a Exchange established under section 1311 of the Patient Protection and Affordable Care Act that is supplemental coverage to the benefits provided under a CLASS Independence Benefit Plan under that program, and information regarding how benefits provided under a CLASS Independence Benefit Plan differ from disability insurance benefits.''; and

(2) in paragraph (3), by striking ''2010'' and inserting ''2015''.

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) take effect on January 1, 2011.

(f) RULE OF CONSTRUCTION.—Nothing in this title or the amendments made by this title are intended to replace or displace public or private disability insurance benefits, including such benefits that are for income replacement.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

''SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

''(a) IMPOSITION OF TAX.—If—

''(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

''(2) there is any excess benefit with respect to the coverage,

there is hereby imposed a tax equal to 40 percent of the excess benefit.

''(b) EXCESS BENEFIT.—For purposes of this section—

''(1) IN GENERAL.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

''(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

''(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

''(B) an amount equal to $\frac{1}{12}$ of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

''(3) ANNUAL LIMITATION.—For purposes of this subsection—

''(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

''(B) APPLICABLE ANNUAL LIMITATION.—The annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

''(C) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (D)—

''(i) 2013.—In the case of 2013, the dollar limit under this subparagraph is—

''(I) in the case of an employee with self-only coverage, $8,500, and

''(II) in the case of an employee with coverage other than self-only coverage, $23,000.

''(ii) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

''(I) the dollar amount in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by $1,350, and

''(II) the dollar amount in clause (i)(II) (determined after the application of subparagraph (D)) shall be increased by $3,000.

''(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2013, each of the dollar amounts under clauses (i) and (ii) shall be

increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

''(I) such amount as so in effect, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for '1992' in subparagraph (B) thereof), increased by 1 percentage point.

If any amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

''(D) TRANSITION RULE FOR STATES WITH HIGHEST COVERAGE COSTS.—

''(i) IN GENERAL.—If an employee is a resident of a high cost State on the first day of any month beginning in 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employee shall be an amount equal to the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(ii)).

''(ii) APPLICABLE PERCENTAGE.—The applicable percentage is 120 percent for 2013, 110 percent for 2014, and 105 percent for 2015.

''(iii) HIGH COST STATE.—The term 'high cost State' means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates had the highest average cost during 2012 for employer-sponsored coverage under health plans. The Secretary's estimate shall be made on the basis of aggregate premiums paid in the State for such health plans, determined using the most recent data available as of August 31, 2012.

''(c) LIABILITY TO PAY TAX.—

''(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

''(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

''(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

''(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

''(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

''(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

''(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

''(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

''(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

''(A) IN GENERAL.—Each employer shall—

''(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

''(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

''(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

''(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

''(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

''(A) IN GENERAL.—The term 'applicable employer-sponsored coverage' means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

''(B) EXCEPTIONS.—The term 'applicable employer-sponsored coverage' shall not include—

''(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1)(A) or for long-term care, or

''(ii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

''(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

''(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

''(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

''(2) DETERMINATION OF COST.—

''(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

''(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

''(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

''(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

''(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

''(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

''(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

''(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

''(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

''(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

''(2) LIMITATIONS ON PENALTY.—

''(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

''(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

''(i) such failure was due to reasonable cause and not to willful neglect, and

''(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

''(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

''(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) COVERAGE DETERMINATIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

''(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than

self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

''(2) QUALIFIED RETIREE.—The term 'qualified retiree' means any individual who—

''(A) is receiving coverage by reason of being a retiree,

''(B) has attained age 55, and

''(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

''(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term 'employees engaged in a high-risk profession' means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).

''(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

''(A) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

''(B) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term by section 9832(b)(2).

''(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan.

''(7) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(8) TAXABLE PERIOD.—The term 'taxable period' means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

''(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

''(10) DENIAL OF DEDUCTION.—For denial of a deduction for the tax imposed by this section, see section 275(a)(6).

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by section 1513, is amended by adding at the end the following new item:

''Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W–2.

(a) IN GENERAL.—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', and'', and by adding after paragraph (13) the following new paragraph:

''(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

''(A) coverage to which paragraphs (11) and (12) apply, or

''(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(b) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2010.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''20 percent''.

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''15 percent'' and inserting ''20 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

''(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation that is not an organization exempt from tax under section 501(a).

''(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.''.

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting ''amounts in consideration for property,'' after ''wages,'',

(2) by inserting ''gross proceeds,'' after ''emoluments, or other'', and

(3) by inserting ''gross proceeds,'' after ''setting forth the amount of such''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

''(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—

''(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

''(A) meets the community health needs assessment requirements described in paragraph (3),

''(B) meets the financial assistance policy requirements described in paragraph (4),

''(C) meets the requirements on charges described in paragraph (5), and

''(D) meets the billing and collection requirement described in paragraph (6).

''(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

''(A) IN GENERAL.—This subsection shall apply to—

''(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

''(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

''(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than 1 hospital facility—

''(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

''(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

''(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

''(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

''(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

''(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

''(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

''(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

''(ii) is made widely available to the public.

''(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

''(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

''(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

''(ii) the basis for calculating amounts charged to patients,

''(iii) the method for applying for financial assistance,

''(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

''(v) measures to widely publicize the policy within the community to be served by the organization.

''(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

''(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

''(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and

''(B) prohibits the use of gross charges.

''(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

''(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).''.

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

''SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

''If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.''.

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

''Sec. 4959. Taxes on failures by hospital organizations.''.

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary's delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking ''and'' at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

''(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

''(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

''(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).''.

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking ''and'' at the end of subparagraph (B), by inserting ''and'' at the end of subparagraph (C), and by adding at the end the following new subparagraph:

''(D) section 4959 (relating to taxes on failures by hospital organizations),''.

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,300,000,000 as—

(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:	The percentage of such sales taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $125,000,000	10 percent
More than $125,000,000 but not more than $225,000,000	40 percent
More than $225,000,000 but not more than $400,000,000	75 percent
More than $400,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity's branded prescription drug sales on the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under subsection (a).

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''branded prescription drug sales'' means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) BRANDED PRESCRIPTION DRUGS.—

(A) IN GENERAL.—The term ''branded prescription drug'' means—

(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(i), the term ''prescription drug'' means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) EXCLUSION OF ORPHAN DRUG SALES.—The term ''branded prescription drug sales'' shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(4) SPECIFIED GOVERNMENT PROGRAM.—The term ''specified government program'' means—

(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

(C) the Medicaid program under title XIX of the Social Security Act,

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

(2) MEDICARE PART B PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.

(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.—The Secretary of Defense shall report, for each covered entity and for each branded prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) SECRETARY.—For purposes of this section, the term ''Secretary'' includes the Secretary's delegate.

(i) GUIDANCE.—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) APPLICATION OF SECTION.—This section shall apply to any branded prescription drug sales after December 31, 2008.

(k) CONFORMING AMENDMENT.—Section 1841(a) of the Social Security Act is amended by inserting ''or section 9008(c) of the Patient Protection and Affordable Care Act of 2009'' after ''this part''.

SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,000,000,000 as—

(A) the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year, bear to

(B) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year.

(2) GROSS RECEIPTS FROM SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the gross receipts from medical device sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $25,000,000	50 percent
More than $25,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from medical device sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) MEDICAL DEVICE SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''medical device sales'' means sales for use in the United States of any medical device, other than the sales of a medical device that—

(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than $100 per unit, or

(B) has been classified in class I under such section.

(2) UNITED STATES.—For purposes of paragraph (1), the term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term ''medical device'' means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) intended for humans.

(e) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(f) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of such covered entity during such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(g) SECRETARY.—For purposes of this section, the term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(h) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section, including identification of medical devices described in subsection (d)(1)(A) and with respect to the treatment of gross receipts from sales of medical devices to another covered entity or to another entity by reason of the application of subsection (c)(2).

(i) APPLICATION OF SECTION.—This section shall apply to any medical device sales after December 31, 2008.

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $6,700,000,000 as—

(A) the sum of—

(i) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, plus

(ii) 200 percent of the covered entity's third party administration agreement fees that are taken into account during the preceding calendar year, bears to

(B) the sum of—

(i) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year, plus

(ii) 200 percent of the aggregate third party administration agreement fees of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000	50 percent
More than $50,000,000	100 percent.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	The percentage of third party administration agreement fees that are taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $10,000,000	50 percent
More than $10,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any entity which provides health insurance for any United States health risk.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks, or

(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term ''United States health risk'' means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—For purposes of this section, the term ''third party administration agreement fees'' means, with respect to any covered entity, amounts received from an employer which are in excess of payments made by such covered entity for health benefits under an arrangement under which such employer self-insures the United States health risk of its employees.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk and third party administration agreement fees for such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(2) UNITED STATES.—The term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—The term ''health insurance'' shall not include insurance for long-term care or disability.

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section.

(j) APPLICATION OF SECTION.—This section shall apply to any net premiums written after December 31, 2008, with respect to health insurance for any United States health risk, and any third party administration agreement fees received after such date.

SEC. 9011. STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall conduct a study on the effect (if any) of the provisions of sections 9008, 9009, and 9010 on—

(1) the cost of medical care provided to veterans, and

(2) veterans' access to medical devices and branded prescription drugs.

(b) REPORT.—The Secretary of Veterans Affairs shall report the results of the study under subsection (a) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate not later than December 31, 2012.

SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9013. MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ''7.5 percent'' and inserting ''10 percent''.

(b) TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer or such taxpayer's spouse has attained age 65 before the close of such taxable year.''.

(c) CONFORMING AMENDMENT.—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking ''by substituting '10 percent' for '7.5 percent' '' and inserting ''without regard to subsection (f) of such section''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) IN GENERAL.—Section 162(m) of the Internal Revenue Code of 1986 is amended by

adding at the end the following new subparagraph:

''(6) SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.—

''(A) IN GENERAL.—No deduction shall be allowed under this chapter—

''(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds $500,000, or

''(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds $500,000 reduced (but not below zero) by the sum of—

''(I) the applicable individual remuneration for such disqualified taxable year, plus

''(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting 'December 31, 2009' for 'December 31, 2012' in the matter preceding subclause (I)).

''(B) DISQUALIFIED TAXABLE YEAR.—For purposes of this paragraph, the term 'disqualified taxable year' means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

''(C) COVERED HEALTH INSURANCE PROVIDER.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'covered health insurance provider' means—

''(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

''(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).

''(ii) AGGREGATION RULES.—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

''(D) APPLICABLE INDIVIDUAL REMUNERATION.—For purposes of this paragraph, the term 'applicable individual remuneration' means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

''(E) DEFERRED DEDUCTION REMUNERATION.—For purposes of this paragraph, the term 'deferred deduction remuneration' means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

''(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term 'applicable individual' means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

''(i) who is an officer, director, or employee in such taxable year, or

''(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

''(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

''(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.

SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—

(1) IN GENERAL.—Section 3101(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''In addition'' and inserting the following:

''(1) IN GENERAL.—In addition'',

(B) by striking ''the following percentages of the'' and inserting ''1.45 percent of the'',

(C) by striking ''(as defined in section 3121(b))—'' and all that follows and inserting ''(as defined in section 3121(b)).'', and

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

''(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.5 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

''(A) in the case of a joint return, $250,000, and

''(B) in any other case, $200,000.''.

(2) COLLECTION OF TAX.—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) SPECIAL RULES FOR ADDITIONAL TAX.—

''(1) IN GENERAL.—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer's spouse.

''(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

''(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.''.

(b) SECA.—

(1) IN GENERAL.—Section 1401(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''In addition'' and inserting the following:

''(1) IN GENERAL.—In addition'', and

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

''(2) ADDITIONAL TAX.—

''(A) IN GENERAL.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31, 2012, a tax equal to 0.5 percent of the self-employment income for such taxable year which is in excess of—

''(i) in the case of a joint return, $250,000, and

''(ii) in any other case, $200,000.

''(B) COORDINATION WITH FICA.—The amounts under clauses (i) and (ii) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.''.

(2) NO DEDUCTION FOR ADDITIONAL TAX.—

(A) IN GENERAL.—Section 164(f) of such Code is amended by inserting ''(other than the taxes imposed by section 1401(b)(2))'' after ''section 1401)''.

(B) DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting ''(determined without regard to the rate imposed under paragraph (2) of section 1401(b))'' after ''for such year''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH ORGANIZATIONS.

(a) IN GENERAL.—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(5) NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9017. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new chapter:

''CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES

''Sec. 5000B. Imposition of tax on elective cosmetic medical procedures.

''SEC. 5000B. IMPOSITION OF TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

''(a) IN GENERAL.—There is hereby imposed on any cosmetic surgery and medical procedure a tax equal to 5 percent of the amount paid for such procedure (determined without regard to this section), whether paid by insurance or otherwise.

''(b) COSMETIC SURGERY AND MEDICAL PROCEDURE.—For purposes of this section, the term 'cosmetic surgery and medical procedure' means any cosmetic surgery (as defined in section 213(d)(9)(B)) or other similar procedure which—

''(1) is performed by a licensed medical professional, and

''(2) is not necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

''(c) PAYMENT OF TAX.—

''(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the procedure is performed.

''(2) COLLECTION.—Every person receiving a payment for procedures on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the procedure is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

''(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for cosmetic surgery and medical procedures are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the procedure.''.

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 48 the following new item:

''CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to procedures performed on or after January 1, 2010.

Subtitle B—Other Provisions

SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

''SEC. 139D. INDIAN HEALTH CARE BENEFITS.

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income does not include the value of any qualified Indian health care benefit.

''(b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—For purposes of this section, the term 'qualified Indian health care benefit' means—

''(1) any health service or benefit provided or purchased, directly or indirectly, by the Indian Health Service through a grant to or a contract or compact with an Indian tribe or tribal organization, or through a third-party program funded by the Indian Health Service,

''(2) medical care provided or purchased by, or amounts to reimburse for such medical care provided by, an Indian tribe or tribal organization for, or to, a member of an Indian tribe, including a spouse or dependent of such a member,

''(3) coverage under accident or health insurance (or an arrangement having the effect of accident or health insurance), or an accident or health plan, provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, include a spouse or dependent of such a member, and

''(4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for a program or service relating to medical care provided by the Federal government to Indian tribes or members of such a tribe.

''(c) DEFINITIONS.—For purposes of this section—

''(1) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given such term by section 45A(c)(6).

''(2) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term by section 4(l) of the Indian Self-Determination and Education Assistance Act.

''(3) MEDICAL CARE.—The term 'medical care' has the same meaning as when used in section 213.

''(4) ACCIDENT OR HEALTH INSURANCE; ACCIDENT OR HEALTH PLAN.—The terms 'accident or health insurance' and 'accident or health plan' have the same meaning as when used in section 105.

''(5) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

''(d) DENIAL OF DOUBLE BENEFIT.—Subsection (a) shall not apply to the amount of any qualified Indian health care benefit which is not includible in gross income of the beneficiary of such benefit under any other provision of this chapter, or to the amount of any such benefit for which a deduction is allowed to such beneficiary under any other provision of this chapter.''.

(b) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 139C the following new item:

''Sec. 139D. Indian health care benefits.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits and coverage provided after the date of the enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by an Indian tribe or tribal organization that are not within the scope of this section, and

(2) benefits provided prior to the date of the enactment of this Act.

SEC. 9022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans), as amended by this Act, is amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (i) the following new subsection:

''(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

''(1) IN GENERAL.—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.

''(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term 'simple cafeteria plan' means a cafeteria plan—

''(A) which is established and maintained by an eligible employer, and

''(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

''(3) CONTRIBUTION REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

''(i) a uniform percentage (not less than 2 percent) of the employee's compensation for the plan year, or

''(ii) an amount which is not less than the lesser of—

''(I) 6 percent of the employee's compensation for the plan year, or

''(II) twice the amount of the salary reduction contributions of each qualified employee.

''(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

''(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

''(D) DEFINITIONS.—For purposes of this paragraph—

''(i) SALARY REDUCTION CONTRIBUTION.—The term 'salary reduction contribution' means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

''(ii) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with respect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

''(iii) HIGHLY COMPENSATED EMPLOYEE.—The term 'highly compensated employee' has the meaning given such term by section 414(q).

''(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 416(i).

''(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

''(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

''(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

''(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an employer may elect to exclude under the plan employees—

''(i) who have not attained the age of 21 before the close of a plan year,

''(ii) who have less than 1 year of service with the employer as of any day during the plan year,

''(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or

''(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

''(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

''(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

''(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

''(i) IN GENERAL.—If—

''(I) an employer was an eligible employer for any year (a 'qualified year'), and

''(II) such employer establishes a simple cafeteria plan for its employees for such year,

then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

''(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

''(D) SPECIAL RULES.—

''(i) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

''(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

''(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term 'applicable nondiscrimination requirement' means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).

''(7) COMPENSATION.—The term 'compensation' has the meaning given such term by section 414(s).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2010.

SEC. 9023. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

(a) IN GENERAL.—Subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 48C the following new section:

''SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

''(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.

''(b) QUALIFIED INVESTMENT.—

''(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project.

''(2) LIMITATION.—The amount which is treated as qualified investment for all taxable years with respect to any qualifying therapeutic discovery project shall not exceed the amount certified by the Secretary as eligible for the credit under this section.

''(3) EXCLUSIONS.—The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project shall not take into account any cost—

''(A) for remuneration for an employee described in section 162(m)(3),

''(B) for interest expenses,

''(C) for facility maintenance expenses,

''(D) which is identified as a service cost under section 1.263A-1(e)(4) of title 26, Code of Federal Regulations, or

''(E) for any other expense as determined by the Secretary as appropriate to carry out the purposes of this section.

''(4) CERTAIN PROGRESS EXPENDITURE RULES MADE APPLICABLE.—In the case of costs described in paragraph (1) that are paid for property of a character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.

''(5) APPLICATION OF SUBSECTION.—An investment shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.

''(c) DEFINITIONS.—

''(1) QUALIFYING THERAPEUTIC DISCOVERY PROJECT.—The term 'qualifying therapeutic discovery project' means a project which is designed—

''(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,

''(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions, or

''(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.

''(2) ELIGIBLE TAXPAYER.—

''(A) IN GENERAL.—The term 'eligible taxpayer' means a taxpayer which employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application under subsection (d)(2).

''(B) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (m) or (o) of section 414, shall be so treated for purposes of this paragraph.

''(3) FACILITY MAINTENANCE EXPENSES.—The term 'facility maintenance expenses' means costs paid or incurred to maintain a facility, including—

''(A) mortgage or rent payments,

''(B) insurance payments,

''(C) utility and maintenance costs, and

''(D) costs of employment of maintenance personnel.

''(d) QUALIFYING THERAPEUTIC DISCOVERY PROJECT PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Not later than 60 days after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

''(B) LIMITATION.—The total amount of credits that may be allocated under the program shall not exceed $1,000,000,000 for the 2-year period beginning with 2009.

''(2) CERTIFICATION.—

''(A) APPLICATION PERIOD.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).

''(B) TIME FOR REVIEW OF APPLICATIONS.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

''(C) MULTI-YEAR APPLICATIONS.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).

''(3) SELECTION CRITERIA.—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

''(A) shall take into consideration only those projects that show reasonable potential—

''(i) to result in new therapies—

''(I) to treat areas of unmet medical need, or

''(II) to prevent, detect, or treat chronic or acute diseases and conditions,

''(ii) to reduce long-term health care costs in the United States, or

''(iii) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and

''(B) shall take into consideration which projects have the greatest potential—

''(i) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and

''(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

''(4) DISCLOSURE OF ALLOCATIONS.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such applicant.

''(e) SPECIAL RULES.—

''(1) BASIS ADJUSTMENT.—For purposes of this subtitle, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

''(2) DENIAL OF DOUBLE BENEFIT.—

''(A) BONUS DEPRECIATION.—A credit shall not be allowed under this section for any investment for which bonus depreciation is allowed under section 168(k), 1400L(b)(1), or 1400N(d)(1).

''(B) DEDUCTIONS.—No deduction under this subtitle shall be allowed for the portion of the expenses otherwise allowable as a deduction taken into account in determining the credit under this section for the taxable year which is equal to the amount of the credit determined for such taxable year under subsection (a) attributable to such portion. This subparagraph shall not apply to expenses related to property of a character subject to an allowance for depreciation the basis of which

is reduced under paragraph (1), or which are described in section 280C(g).

''(C) CREDIT FOR RESEARCH ACTIVITIES.—

''(i) IN GENERAL.—Except as provided in clause (ii), any expenses taken into account under this section for a taxable year shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.

''(ii) EXPENSES INCLUDED IN DETERMINING BASE PERIOD RESEARCH EXPENSES.—Any expenses for any taxable year which are qualified research expenses (within the meaning of section 41(b)) shall be taken into account in determining base period research expenses for purposes of applying section 41 to subsequent taxable years.

''(f) COORDINATION WITH DEPARTMENT OF TREASURY GRANTS.—In the case of any investment with respect to which the Secretary makes a grant under section 9023(e) of the Patient Protection and Affordable Care Act of 2009—

''(1) DENIAL OF CREDIT.—No credit shall be determined under this section with respect to such investment for the taxable year in which such grant is made or any subsequent taxable year.

''(2) RECAPTURE OF CREDITS FOR PROGRESS EXPENDITURES MADE BEFORE GRANT.—If a credit was determined under this section with respect to such investment for any taxable year ending before such grant is made—

''(A) the tax imposed under subtitle A on the taxpayer for the taxable year in which such grant is made shall be increased by so much of such credit as was allowed under section 38,

''(B) the general business carryforwards under section 39 shall be adjusted so as to recapture the portion of such credit which was not so allowed, and

''(C) the amount of such grant shall be determined without regard to any reduction in the basis of any property of a character subject to an allowance for depreciation by reason of such credit.

''(3) TREATMENT OF GRANTS.—Any such grant shall not be includible in the gross income of the taxpayer.''.

(b) INCLUSION AS PART OF INVESTMENT CREDIT.—Section 46 of the Internal Revenue Code of 1986 is amended—

(1) by adding a comma at the end of paragraph (2),

(2) by striking the period at the end of paragraph (5) and inserting '', and'', and

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

''(6) the qualifying therapeutic discovery project credit.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 49(a)(1)(C) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''and'' at the end of clause (iv),

(B) by striking the period at the end of clause (v) and inserting '', and'', and

(C) by adding at the end the following new clause:

''(vi) the basis of any property to which paragraph (1) of section 48D(e) applies which is part of a qualifying therapeutic discovery project under such section 48D.''.

(2) Section 280C of such Code is amended by adding at the end the following new subsection:

''(g) QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified investment (as defined in section 48D(b)) otherwise allowable as a deduction for the taxable year which—

''(A) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or qualified clinical testing expenses (as defined in section 45C(b)) if the credit under section 41 or section 45C were allowed with respect to such expenses for such taxable year, and

''(B) is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—

''(i) the amount disallowed as a deduction by reason of section 48D(e)(2)(B), and

''(ii) the amount of any basis reduction under section 48D(e)(1).

''(2) SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.—In the case of expenses described in paragraph (1)(A) taken into account in determining the credit under section 48D for the taxable year, if—

''(A) the amount of the portion of the credit determined under such section with respect to such expenses, exceeds

''(B) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)),

the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

''(3) CONTROLLED GROUPS.—Paragraph (3) of subsection (b) shall apply for purposes of this subsection.''.

(d) CLERICAL AMENDMENT.—The table of sections for subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

''Sec. 48D. Qualifying therapeutic discovery project credit.''.

(e) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(1) IN GENERAL.—Upon application, the Secretary of the Treasury shall, subject to the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the amount of 50 percent of such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(2) APPLICATION.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(d)(2) of the Internal Revenue Code of 1986 for a credit under such section for the taxable year of the applicant which begins in 2009 shall be considered to be an application for a grant under paragraph (1) for such taxable year.

(B) TAXABLE YEARS BEGINNING IN 2010.—An application for a grant under paragraph (1) for a taxable year beginning in 2010 shall be submitted—

(i) not earlier than the day after the last day of such taxable year, and

(ii) not later than the due date (including extensions) for filing the return of tax for such taxable year.

(C) INFORMATION TO BE SUBMITTED.—An application for a grant under paragraph (1) shall include such information and be in such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year for the qualified investment with respect to which such application is made.

(3) TIME FOR PAYMENT OF GRANT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any grant under paragraph (1) during the 30-day period beginning on the later of—

(i) the date of the application for such grant, or

(ii) the date the qualified investment for which the grant is being made is made.

(B) REGULATIONS.—In the case of investments of an ongoing nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

(4) QUALIFIED INVESTMENT.—For purposes of this subsection, the term ''qualified investment'' means a qualified investment that is certified under section 48D(d) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

(5) APPLICATION OF CERTAIN RULES.—

(A) IN GENERAL.—In making grants under this subsection, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986. In applying such rules, any increase in tax under chapter 1 of such Code by reason of an investment ceasing to be a qualified investment shall be imposed on the person to whom the grant was made.

(B) SPECIAL RULES.—

(i) RECAPTURE OF EXCESSIVE GRANT AMOUNTS.—If the amount of a grant made under this subsection exceeds the amount allowable as a grant under this subsection, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess portion of the grant relates had ceased to be a qualified investment immediately after such grant was made.

(ii) GRANT INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a grant made under paragraph (1), the identity of the person to whom such grant was made, or a description of the investment with respect to which such grant was made be treated as return information for purposes of section 6103 of the Internal Revenue Code of 1986.

(6) EXCEPTION FOR CERTAIN NON-TAXPAYERS.—The Secretary of the Treasury shall not make any grant under this subsection to—

(A) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof),

(B) any organization described in section 501(c) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code,

(C) any entity referred to in paragraph (4) of section 54(j) of such Code, or

(D) any partnership or other pass-thru entity any partner (or other holder of an equity or profits interest) of which is described in subparagraph (A), (B) or (C).

In the case of a partnership or other pass-thru entity described in subparagraph (D), partners and other holders of any equity or profits interest shall provide to such partnership or entity such information as the Secretary of the Treasury may require to carry out the purposes of this paragraph.

(7) SECRETARY.—Any reference in this subsection to the Secretary of the Treasury shall be treated as including the Secretary's delegate.

(8) OTHER TERMS.—Any term used in this subsection which is also used in section 48D of the Internal Revenue Code of 1986 shall have the same meaning for purposes of this subsection as when used in such section.

(9) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under section 46(6) of the Internal Revenue Code of 1986 by reason of section 48D of such Code for any investment for

which a grant is awarded under this subsection.

(10) APPROPRIATIONS.—There is hereby appropriated to the Secretary of the Treasury such sums as may be necessary to carry out this subsection.

(11) TERMINATION.—The Secretary of the Treasury shall not make any grant to any person under this subsection unless the application of such person for such grant is received before January 1, 2013.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Senate Committee on Energy and Natural Resources. The hearing will be held on Thursday, December 3, 2009, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on H.R. 3276, the American Medical Isotopes Production Act of 2009.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150, or by e-mail to Rosemarie_Calabro @energy.senate.gov

For further information, please contact Jonathan Epstein at (202) 224–3357 or Rosemarie Calabro at (202) 224–5039.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on November 19, 2009, at 9:30 a.m.

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

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on November 19, 2009, in room 253 of the Russell Senate Office Building.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session to conduct a hearing on November 19, 2009, at 10:30 a.m., in room SD–366 of the Dirksen Senate Office Building.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on November 19, 2009, at 3:30 p.m.

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

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet, during the session of the Senate, to conduct a hearing entitled ''Hearing on Nominations for Commissioner and for General Counsel of the Equal Employment Opportunity Commission'' on November 19, 2009. The hearing will commence at 10 a.m. in room 430 of the Dirksen Senate Office Building.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m. to conduct a hearing entitled ''The Fort Hood Attack: A Preliminary Assessment.''

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

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

COMMITTEE ON INDIAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 2:15 p.m. in Room 628 of the Dirksen Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on November 19, 2009, at 10 a.m. in SD–226 of the Dirksen Senate Office Building, to conduct an executive business meeting.

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

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

PRIVILEGES OF THE FLOOR

Mr. AKAKA. Mr. President, I ask unanimous consent that Dr. Andrea Buck, a physician detailed to the Veterans' Affairs Committee staff from the VA Inspector General's Office be granted the privilege of the floor for the duration of the debate on S. 1963.

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

Mr. LEAHY. Mr. President, I ask unanimous consent that Rachel Pelham of my staff be given the privilege of the floor for the rest of the day.

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

Mr. GRASSLEY. Mr. President, I ask unanimous consent for Randoe Dice, a detailee on my staff, Ben Bremen, Anne Pick, and Joseph Moon, interns on my staff, be granted the privileges of the floor during debate of H.R. 3590.

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

IRAN'S HUMAN RIGHTS VIOLATIONS

Mr. KAUFMAN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 355, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 355) expressing the sense of the Senate that the Government of the Islamic Republic of Iran has systematically violated its obligations to uphold human rights provided for under its constitution and international law.

There being no objection, the Senate proceeded to consider the resolution.

Mr. LEVIN. Mr. President, recent events have made abundantly clear that the Government of the Islamic Republic of Iran is failing, and failing badly, to live up to its own professed ideals and its international commitments to protect the human rights of its citizens and others. I urge my colleagues to join with me in supporting a

resolution, S. Res. 355, submitted today, condemning Iran's deplorable human rights record, calling for an immediate release of those wrongfully imprisoned in violation of their rights, and urging the restoration of meaningful human rights to all of Iran's citizens.

Iran's 1979 constitution, the result of a revolution against years of political and human-rights abuses by the regime of the Shah, guarantees fundamental rights and freedoms. Moreover, Iran is a signatory to four major human rights treaties. And yet its shameful record of executions that contravene international standards; of repression of the rights of women and minorities, including religious minorities; of outrageous attacks on the rights of peaceful assembly and protest; and of unwarranted arrest and detention of foreigners, including Americans, all make a mockery of these commitments.

Just last week, the Iranian Government again demonstrated its contempt for human rights and the rule of law when it announced it would pursue espionage charges against three young Americans who crossed Iran's border with Iraq. These allegations are just the latest telling example on a long list of abuses.

American Robert Levinson has been missing in Iran for more than two years, during which the Iranian regime has denied having any information on his whereabouts and has blocked international attempts to discover his fate. In January 2009, the Iranian Government jailed Iranian-American journalist Roxana Saberi and charged and convicted her of espionage after a one-hour show trial that mocked even the most basic standards of due process and law, and then sentenced her to eight years in prison before releasing her a few months later. Esha Momeni, a student at California State University, Northridge, was imprisoned last fall for her peaceful activities in support of women's rights in Iran. The regime's abuses have even touched Nobel peace prize winner Shrin Ebadi, whose Center for Defenders of Human Rights was forced to close by the government in December 2008.

None of these recent abuses, however, as deplorable as they are, have shocked the conscience of the world so severely as the Iranian Government's actions in response to this year's disputed presidential elections. Prompted by justifiable concern that their will had been thwarted in a rigged election, thousands of Iranian citizens took to the streets, firmly but peacefully exercising their rights and demanding the democracy their government purports to embody. The regime's response was to launch violent, heavy-handed attacks against these peaceful protestors, using government security forces and paramilitary militias under government control to repress the legitimate expression of a valid grievance. The United Nations High Commissioner for Human Rights reports that this violence resulted in at least a dozen deaths, and hundreds of injuries.

In the aftermath, the Iranian Government imprisoned dozens of its citizens and conducted a mass trial of more 100 of them, many of whom bore clear signs of physical abuse. The government sentenced at least four of these prisoners to death on the basis of dubious confessions, likely produced under duress and abuse.

It is proper and appropriate for the Senate to make clear its determination that these acts violate international human rights standards, Iran's own professed commitments, and common decency. The resolution introduced today would record the Senate's condemnation of Iran's woeful human rights record; remind the Iranian government of its domestic and international commitments to human rights; call for the immediate release of all those held for their peaceful exercise of rights of free expression, assembly and association; and urge Iran to extend full legal rights to those imprisoned. It calls for the Iranian Government to guarantee humane treatment of those in detention; to halt immediately state-sanctioned violence against its own citizens; to allow unrestricted communication and access to information; and to respect the rights of the Iranian people to free speech, a free press, free expression of religion, freedom of association, and freedom of assembly.

It is a tragic irony that the government perpetrating these deplorable acts of violence and abuse came to power three decades ago because the Iranian people rejected the abuses and violence of a previous regime. Now following in the repressive footsteps of that previous regime, the current Iranian Government has been widely condemned by the community of nations. Passage of this resolution would add the U.S. Senate's loud and clear voice of condemnation to the many voices inside Iran, and out, calling for the restoration of basic human rights for the Iranian people.

Mr. KAUFMAN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table en bloc; that any statements relating to the resolution be printed in the RECORD without intervening action or debate.

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

The resolution (S. Res. 355) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 355

Whereas the 1979 Constitution of the Islamic Republic of Iran supposedly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1968), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which its ratified on June 24, 1975);

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including flogging, and amputations;

(2) high incidence and increase in the rate of executions carried out in the absence of internationally recognized safeguards, including public executions and executions of juvenile offenders;

(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning;

(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidation against women's rights defenders, and continuing discrimination against women and girls;

(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities;

(6) ongoing, systematic, and serious restrictions of freedom of peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship of expression in online forums such as blogs and websites; and

(7) severe limitations and restrictions on freedom of religion and belief, including arbitrary arrest, indefinite detention, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that sets out a mandatory death sentence for apostasy, the abandoning of one's faith;

Whereas, since March 9, 2007, Robert Levinson, a United States citizen, has been missing in the Islamic Republic of Iran, and the Government of Iran has provided little information on his whereabouts or assistance in ensuring his safe return to the United States;

Whereas Ja'far Kiani was publicly stoned to death in July 2007 in the Islamic Republic of Iran in contravention of an order from the Head of the Judiciary granting a temporary stay of execution;

Whereas, since May 2008, Reza Taghavi, a 71-year-old Iranian-American, has been imprisoned without a trial or formal charges;

Whereas, on October 15, 2008, authorities in the Islamic Republic of Iran jailed Esha Momeni, a graduate student at California State University, Northridge, for her peaceful activities in connection with the women's rights movement in the Islamic Republic of Iran, and refused to grant her permission to leave Iran for 10 months following her release from prison in November 2008;

Whereas Iranian-American journalist Roxana Saberi was jailed in January 2009 and sentenced in a closed-door, one-hour trial to eight years in prison for charges of espionage before her release in May 2009;

Whereas, on June 19, 2009, the United Nations High Commissioner for Human Rights expressed concerns about the increasing number of illegal arrests not in conformity with the law and the illegal use of excessive force in responding to protests following the June 12, 2009, elections, resulting in at least dozens of deaths and hundreds of injuries;

Whereas the Government of Iran closed the Center for Defenders of Human Rights, headed by Nobel Peace prize winner Shirin Ebadi, in December 2008, and the Association of Iranian Journalists in August 2009, the country's largest independent association for journalists;

Whereas, on August 1, 2009, authorities in the Islamic Republic of Iran began a mass trial of over 100 individuals in connection with election protests, most of whom were held incommunicado for weeks, in solitary confinement, with little or no access to their lawyers and families, many of whom showed signs of torture and drugging;

Whereas, in early October 2009, the judiciary of the Islamic Republic of Iran sentenced four individuals to death after the disputed presidential election, without providing the individuals adequate access to legal representation during their trials;

Whereas the Supreme Leader of Iran, Ali Khamenei, issued a statement on October 28, 2009, effectively criminalizing dissent regarding the national election in the Islamic Republic of Iran this past June, further restricting the right to freedom of expression;

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all persons;

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used brutal force to disperse thousands of protesters, resulting in a number of injuries and arrests, in violation of international standards regarding the proportionate use of force against peaceful demonstrations;

Whereas the Government of Iran expelled students from universities, particularly over the past two years, in reprisal for their being critical of the government;

Whereas the Government of Iran has imposed restrictions on the travel of individuals, including artists and filmmakers since the recent elections, in reprisal for their political views or their criticism of the government, such as those presently imposed on human rights lawyer Abdolfattah Soltani, human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and

Whereas, according to Amnesty International, at least 346 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning: Now, therefore, be it

Resolved, That the Senate—

(1) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly;

(2) condemns the Government of Iran's human rights violations and calls on the Government of Iran to hold those responsible accountable for their actions;

(3) reminds the Government of Iran of its constitutional obligations under its 1979 Constitution and four international covenants to which it is a signatory;

(4) calls for the immediate release from detention of opposition figures, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association;

(5) urges the Government of Iran to ensure that anyone placed on trial for committing acts of violence or other clearly criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by independent counsel, and guarantees that no statements shall be admitted into evidence that were shown to have been obtained through torture, inhumane, or degrading treatment;

(6) calls for the Government of Iran to ensure those currently in detention are treated humanely, to provide detainees immediate prompt access to their families, lawyers, and any medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and

(7) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the ''freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, or in print, in the form of art, or through any other media of his choice''.

ORDER FOR PRINTING OF AMENDMENT NO. 2786

Mr. KAUFMAN. I ask unanimous consent that amendment No. 2786 be printed.

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

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the President pro tempore, and in consultation with the ranking member of the Senate Committee on Finance, pursuant to Public Law 103–296, appoints Jagadeesh Gokhale, of Maryland, vice Sylvester Schieber, of Michigan, as a member of the Social Security Advisory Board.

ORDERS FOR FRIDAY, NOVEMBER 20, 2009

Mr. KAUFMAN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:45 a.m. tomorrow, Friday, November 20; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume debate on the motion to proceed to H.R. 3590, as provided for under the previous order.

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

PROGRAM

Mr. KAUFMAN. Mr. President, there will be no rollcall votes during tomorrow's session of the Senate. The next vote will occur at 8 p.m. on Saturday, November 21. That vote will be on the motion to invoke cloture on the motion to proceed to H.R. 3590.

ORDER FOR ADJOURNMENT

Mr. KAUFMAN. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order, following the remarks of Senators BROWNBACK and HATCH.

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

The Senator from Utah.

Mr. HATCH. Mr. President, I thank my colleague.

HEALTH CARE REFORM

Mr. HATCH. Mr. President, I would like to take my time to talk about the critical issue of health care reform as this body stands at a historic crossroad on this national challenge.

We have never seen anything like the issues facing our country right now. The line between private businesses and public government has never been so blurred. Just look at this chart I have in the Chamber. Government effectively owns several of our Nation's institutions: insurance companies, financial institutions, banks and automobile manufacturers. CEOs have been fired by government bureaucrats, and Washington is now in the business of dictating salaries in the private sector. With government takeovers on the rise, drastic labor law changes being pushed forward, and sweeping new corporate taxes circling overhead, we are truly moving toward a European-style government at a time when most European countries are moving away from it.

I deliver these remarks with a heavy heart because what could have been a strong, bipartisan bill reflecting our collective and genuine desire for responsible health care reform on one-sixth of the American economy continues to be an extremely partisan exercise, pushing for more Federal spending, bigger government, and higher taxes as a flawed solution.

At the outset, let me make one point as clearly as possible. We are all for reform, everybody on this floor. Every Republican colleague whom I have talked to wants to reform our current health care system. Ensuring access to affordable and quality health care for every American is not a Republican nor is it a Democrat issue or idea; it is an American issue. Our Nation expects us to solve this challenge in an open, honest, and responsible manner.

Clearly, health care spending continues to grow too fast. This year will mark the largest ever 1-year jump in the health care share of our GDP—a full percentage point, to 17.6 percent. Growing health care costs translate directly into higher coverage costs.

Since the last decade, the cost of health coverage has increased by 120 percent—three times the growth of inflation and four times the growth of

wages. Rising costs is the primary driver behind why we continue to see a rising number of uninsured in our country and why an increasing number of businesses find it hard to compete in a global market. Without addressing this central problem, we cannot have a real and sustainable health care reform bill.

Unfortunately, the Senate health bill, according to the nonpartisan Congressional Budget Office, will actually increase Federal spending by $160 billion in the next 10 years instead of lowering it. Mr. President, you heard me right: It will increase spending.

After the rushed stimulus bill, Americans are rightly concerned about what is being pushed through this Democratic Congress. The rush to pass something that will affect every American life and business has raised concerns all around our Nation. In a recent Gallup Poll, a majority of Americans believed their health care costs could actually get worse under the Democratic health care plans. So why are Americans so skeptical and concerned? Because they are being promised the impossible. They are being told that this trillion-dollar addition of taxpayer dollars to our health care system will actually preserve their current benefits, not raise their taxes, and it will reduce the Federal deficit. Even David Copperfield would be hard pressed to pull off this trick.

Many Americans recently had a firsthand encounter with the efficiency of the Federal Government in administering the H1N1 vaccination around the country. Their experience consisted of standing in long lines for several hours in sterile government buildings, only to be told they were suddenly out of doses.

Republicans in Congress agree with the majority of Americans who believe that just throwing more hard-earned taxpayer dollars at a problem will not deliver meaningful reform. Simply telling the American people that the solution for solving a $2 trillion health care system is to simply spend another $2.5 trillion just does not make sense.

With nearly a half trillion dollars in new taxes, this big stack of papers is a textbook example of the liberal tax-and-spend philosophy. Now compare that with the Constitution of the United States. This little booklet contains the whole Constitution of the United States. Yet we have a health care bill that is 2,024 pages long. Come on. That is an example of the liberal tax-and-spend philosophy we see around here.

Here are some of the highlights of this piece—this piece of equipment, this bill, this massive, massive bill; I can hardly lift the darn thing—$28 billion in new taxes on employers through a mandate that will disproportionately affect low-income Americans, and all at a time when our unemployment rate stands at an unacceptable 10.2 percent; $8 billion in new taxes on Americans who fail to buy a Washington-defined level of health care coverage; $372 billion in new taxes on everything from insurance premiums, to prescription drugs, to hearing devices and wheelchairs—all of which are going to be passed on to the consumers, most all of whom are earning less than $200,000 a year. As I said, there is no such thing as a free lunch, especially when Washington is inviting you over.

Representatives from both the Congressional Budget Office, CBO, and the Joint Committee on Taxation, JCT, have testified before the Finance Committee that these taxes will be passed on to the consumers. That is you and me. That is you and me and every other constituent in this country. So even though the bill tries to hide these costs as indirect taxes, average Americans who purchase health plans, use prescription drugs, and buy medical devices—everything from hearing aids to crutches—will end up footing the bill.

By the way, we all know when this bill is fully implemented it will cost significantly more. Every time Washington tells you something will cost $1, you can count on it costing $10. History is prologue. Medicare started off with a $65 million—that is with an ''m''—a year budget and now it has a $400 billion budget. So look for these taxes only to go up in the future, as we have just given the Federal Government a whole new checkbook, if we pass this bill.

Let me also talk a little bit about the myth of this health care reform proposal actually reducing the deficit. Here is the harsh reality: The Congressional Budget Office recently reported that our national deficit for fiscal year 2009 alone was a shocking $1.4 trillion.

Let me put this in perspective. We have exploding deficits. In 2008, it was $459 billion—the last year of the Bush administration. In the first year of the Obama administration, it is $1.4 trillion. It is more than three times our deficit from last year and almost 10 percent of the entire economy. This is the largest yearly deficit since 1945. This should send shivers down the spine of every American out there. We are literally drowning this Nation and the future of this Nation in a sea of red ink.

The biggest bait-and-switch on the American people about the bill's impact on the deficit is a simple math trick. If something is expensive to do for a full 10-year period, just do it for 5 years and call it 10 years. Most of the major spending provisions of the bill do not go into effect until 2014 or even later—coincidentally, after the 2012 Presidential elections. So what we are seeing is not a full 10-year score but, rather, a 5- to 6-year score.

Now chart 3: This is the real cost of the Senate plan. The CBO score—because it only scores, really, basically 5 or 6 years because major provisions of the bill are not implemented until 2014, in some respects up to 2015—they claim, is only $849 billion, or less than $1 trillion. But the full 10-year score, according to the Senate Budget Committee, fully implemented, if you do it for 10 years, is $2.5 trillion. The House bill is even at a more astonishing level of $3 trillion.

Let me go to chart 4, because in our current fiscal environment, where the government will have to borrow nearly 43 cents of every $1 it spends this year, let's think hard about what we are doing to our country and our future generations.

For months, I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraints while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the basis for a sustainable, fiscally responsible, and bipartisan reform. These include reforming the health insurance market for every American by making sure no American is denied coverage simply based on a preexisting condition; protecting the coverage for almost 85 percent of Americans who already have coverage they like by making it more affordable—this means reducing costs by rewarding quality and coordinated care, by giving families more information on the cost and choices of their coverage and treatment options, by discouraging frivolous lawsuits, and by promoting prevention and wellness measures.

We should give States flexibility to design their own unique approaches to health care reform in accordance with their own demographics. Utah is not New York and New York is not Utah. Actually, what works in New York will most likely not work in New York, let alone Utah. As we move forward on health care reform, it is important to recognize that every State has its own unique mix of demographics and each State has developed its own institutions to address its challenges. And each has its own successes.

There is an enormous reservoir of expertise, experience, and field-tested reform out there. We should take advantage of that by placing States at the center of health care reform efforts so they can use approaches that best reflect their needs and challenges. We should utilize the principle of federalism by having 50 State laboratories where we can look at the other States and see what works and what does not. Utah is a State where we have a tremendous health care system. It is rated one of the top three in this Nation. Wouldn't other States be benefited by looking at the Utah system, or Minnesota? The Minnesota system is a very good system, according to what they tell me. We could learn from them. You could learn from all 50

States what to do and what not to do. Utah has taken important and aggressive steps toward sustainable health care reform. The current efforts to introduce a defined contribution health benefits system and implement the Utah Health Exchange are laudable accomplishments.

Just like you, I strongly believe a one-size-fits-all Washington solution is not the right approach. We should empower small businesses and self-employed entrepreneurs—the job-creating engines and lifeblood of our economy—to buy affordable coverage by giving them the same purchasing advantages as the large companies.

Unfortunately, the path we are taking in Washington right now is simply spend another $2.5 trillion of taxpayer money to further expand the role of the Federal Government. Republicans want to sit down and write a bill together to achieve sustainable reform that we can all afford. We do not believe in the ''our way or the highway'' approach on an issue that will affect every American life and every American business.

Republicans have put forth ideas, both comprehensive and incremental, through this health care reform debate, especially during committee considerations.

These ideas were either summarily rejected on party line votes or simply stripped out in the dark of the night before the final version was released. And this version is no exception. This version was done in the back rooms of the Capitol with the White House and very few Senators cobbling together what they thought would be a compromise between the HELP bill and the Finance Committee bill, and maybe even with some consideration to the House bill. There was no real bipartisan work on this bill. There was no real attempt to try and bring people together. It was strictly a partisan bill, as have been the HELP Committee bill, primarily the Finance Committee bill, and above all, the House bill.

I am especially disappointed that the President and the Democratic leadership in the House and the Senate have chosen to pursue the creation of a new government-run plan—one of the most divisive issues in health care reform—rather than focusing on broad areas of compromise that can lead us toward bipartisan health care reform legislation. At a time when major government programs such as Medicare and Medicaid are already on a path to fiscal insolvency, creating a brandnew government program will only worsen our long term financial outlook. To put this in perspective, as of this year, Medicare has a liability of almost $38 trillion, which, in turn, translates into a financial burden of more than $300,000 per American family over time.

So what is the Washington solution to address this crisis? We will take up to $500 billion out of this bankrupt program and use it to expand another bankrupt program—Medicaid—and create a brandnew Washington-run plan, a Washington government-run plan. I am not an economist, but I know that taking money out of one bankrupt program to create another is not a good idea. We should be reforming Medicare and Medicaid for our people, but instead we keep spending, and to take $500 billion out of Medicare which has a $38 trillion unfunded liability to create another government run program I think is immoral. It is certainly not very economically sound. I could keep going, but the point here is simple: Washington is not the answer.

The impact of a new government program on families who currently have private insurance of their choice is also alarming. A recent study estimated that cost shifting from government payers already costs families with private insurance nearly $1,800 more per year. This is nothing more than another hidden government tax. Do you all get that? Because Medicare pays doctors 20 percent less and pays hospitals 30 percent less, and other providers even less, those who have private health insurance have to pick up the cost, and it averages $1,800 per family. Think about that. That is because government has been running those programs. Creating another government plan will further increase these costs on our families in Utah and across this country.

Let me take a couple of minutes to talk about process. The Democratic leadership spent almost—well, they took 6 weeks behind closed doors to write this bill. It is only fair to expect that we will at least have 72 hours to review these—I said 2,024 but it is 2,074—pages. This thing right here. This is the bill. My gosh, 2,074 pages. Tolstoy's ''War and Peace'' was about a little more than 1400 pages. This is a bill—we ought to have at least 72 hours to review these 2,074 pages before beginning any Senate floor action.

We are going to vote on Saturday at 8 o'clock on whether we should proceed, but it won't be proceeding to this bill, it is going to be proceeding to a shell bill. If they are able to proceed, then they will bring up a substitute bill which will be the bill they have worked on for 6 weeks in closed rooms. It will be a shell bill that will get it going. It is a shell game, between you and me, one that is done right here in Washington by people who believe the Federal Government is the last answer to everything.

As a bill that affects every American life and every American business, 2,074 pages is too big and it is too important not to have full public review. In fact, I think 72 hours is not enough. We need a lot more time. We are talking about one-sixth of the American economy.

To enact true health care reform, we have to come together as one to write a responsible bill for the American families who are faced with rising unemployment and out-of-control health care costs.

Our national debt is ready to double in the next 5 years. Look at that. The red lines are the projected national debt under the current administration. That debt is projected to double in the next 5 years and triple in the next 10 years. Let me tell you who catches onto this. It is our friends over in China to whom we owe $800 billion. Think about it. They are concerned about the devaluation of the American dollar because they see us being profligate here in Washington.

Let's slow down and think about what we are doing to our future generations. I think there is still time to press the reset button and write a bill together that every one of us can support and be proud of. Right now, Republicans aren't just standing in the way. We actually believe we can do a bipartisan bill if we had a chance, if we had a real, good faith effort by both sides. The HELP Committee bill wasn't done that way. We did have a markup in the HELP Committee and almost every substantive amendment was voted down on a party line vote. The same thing basically happened in the Finance Committee, although I have to say that the distinguished Senator from Montana, the chairman of the Finance Committee, made every effort to try and bring people together. I give him a lot of credit for it. But he was so severely restricted by his side that there was no way people could support it. I was a member of the Gang of 7, but I began to realize what the final bill was going to be. I couldn't support it, so I thought the honorable thing to do, instead of coming out of every one of our meetings and finding fault with what they were talking about, was to leave the Gang of 7, and I did that. I felt bad doing it because I wanted to help work on a bipartisan bill. But the distinguished chairman was so restricted by his side that there was no way we could have a bipartisan bill out of that committee. It is disappointing to me, as somebody who has worked on so many health care matters over the years—everything from Hatch-Waxman to the orphan drug bill to the CHIP bill—you can name it—that we didn't have the guts or the ability to sit down and work this thing out together.

Now we are going to get sold a bill of goods here that doesn't make sense. This is a travesty. It is a travesty. It is hard to believe they think they can pawn this off on the American people. My gosh. I know some of the folks who have done this are well intentioned, but not for this stuff. I was going to say something else, but I want to be very kind here.

The Constitution—this is the whole Constitution, the most important document, political document in the history of the world. Plus it has a lot of

interesting material in the back, plus an index and so forth, but that is it, right there. Here is what one-sixth of the American economy is going to be if we allow it to go forward. I personally believe we ought to kill this bill and then we ought to sit down and work it out together. If there were a real bona fide attempt to do that, I have no doubt we could do it. We have done it in the past.

One of the things I found most disappointing is that the polls show that 85 percent of the people who have insurance are relatively happy with it. Yes, they would like premiums to go down, they would like to be able to have it be even better, but they are basically happy with their health care coverage. If you deduct the 6 million people who work for businesses that provide health insurance but they don't take it—they would rather have the money—and you deduct the 11 million people who qualify for CHIP, the child health care program, which is a Hatch-Kennedy bill, by the way; or they qualified for Medicaid—if you deduct those 11 million people, and then you deduct the 9 million people who earn over $75,000 a year and can afford their own health insurance, and then you take away the illegal aliens, it comes down to 7 million to 12 million people who need health insurance. Think about that. We are going to throw out the whole system of health care that 85 percent of the people basically believe is worthwhile over, 7 to 12 million people whom we could help in a way that would be reasonable; and we are going to change our health care system from State-run systems and bring it right here to Washington where a bunch of Federal bureaucrats who are far removed from people in the States will determine every aspect of health care in our lives, and run our health care system into the ground even further, as they have Medicare and Medicaid, without the appropriate reforms that would keep those programs that could be great programs and are great programs in some ways, going. They will say, well, aren't those government programs? Yes, they are government programs, and they are both deeply in debt. Medicare goes into insolvency by 2017. Medicaid is also going bankrupt. What are we going to do, saddle our young people for the rest of their lives with untold expenses? We are going to saddle them with this huge stack of paper? My gosh. No wonder we are in such deep financial difficulties in this country.

If we are going to rely on the Federal Government to solve our problems, we are making the most tragic mistake we possibly can. The Federal Government could participate, but let me tell you, if we work on a bipartisan bill—let me make one last point. If you have a bill that affects one-sixth of the American economy—and whatever passes here, if it does, will be a bill that will be concerned with one-sixth of our American economy—if you have a bill that is that important and you can't get 75 or 80 votes in the Senate, you know that is a lousy bill, and you know it is a partisan bill, and you know it hasn't been well thought out, and you know it is one sided, and you know it is going to cause an uproar throughout this country that has never been seen before—it already is—and you know it won't work, yet we are going to saddle this country with this monstrosity. I have to tell you, I can hardly believe it. I can hardly lift it. I am not exactly weak. All I can say is that it is a huge monstrosity.

Think of the Constitution. There is the whole Constitution right there, yet we have a health care bill this big. I am concerned about it, as you can see, and I am worked up about it, because there are some of us who would like to work together and do a bipartisan bill, but we have to be honest about it, there hasn't been any chance to do it. This bill in particular has been worked on in the back rooms between the White House and very few Senators, and without any input from our side at all, frankly, ignoring many of the good things that have been expressed on our side.

I hope we will think this through and I hope we won't pass this. I hope we can then sit down and do a bill that will work, that will not burden our future generations.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I am glad to follow my colleague from Utah. I have great admiration and affection for him. He has done a lot of good, bipartisan legislation. I hope my colleagues will heed his word. He is good to his word, and he would be willing to do a bipartisan bill.

On top of that, if the Democratic leadership would back up and do a bipartisan bill, the American people would cheer. They would think this was extraordinary, and we could get something substantive done and not this monster.

I am ranking member of the Joint Economic Committee, and we had Secretary Geithner in to testify today. I disagree with a number of things he has done. He is a bright and energetic man with a lot of experience. I noted to him—and he knows this is the case—that we are $12 trillion in the hole. We are hemorrhaging money at the Federal level. Why on Earth we would do the fiscally insane thing of adding a multitrillion dollar entitlement program, when we are $12 trillion in the hole and hemorrhaging Federal money, and you have the President just back from seeing the bankers in China, who have nearly a trillion dollars of our debt? As a Senator and as an American, I don't like that we are dependent upon the Chinese for that much money. I don't think the American people like that. Why on Earth would we do this? He said that people are mad out there. We talked ahead of time, and he said that people are upset across the country. I said, yes, they are, and it is because of this. They are mad and they are scared. Neither of those is a situation where you ought to try to force something through on people who are mad and scared about it. They are mad about things being rammed through, and they are scared about the level of debt and deficit, and they are adding this scale of entitlement on top of an already broken fiscal situation.

The rest of the world is yelling at the United States to get your fiscal house in order, and we are going to add a multitrillion dollar entitlement program, when we all know we ought to get our fiscal house in order. Then the way it is paid for is to raise taxes $½ trillion in a weak economy. That is going to hurt the economic expansion and job creation we need. Then you are supposedly going to save $400 billion out of Medicare, which I noted to him. That song has been tried in the past. We had these fixes that we were going to reduce payments to providers, to the physician community. For 4 years now in a row we have changed and said we were going to do this provider cut—a minor provider cut—and then Congress said that is too much, we are not going to do that. We will fill that back up. For three or four of those, I have voted for that.

Then there is the idea that we are going to cut $400 billion out of Medicare, which is already on a fiscally irresponsible track and going broke. We are going to take $400 billion out of that. That is not going to happen. If it did happen, it would wreck Medicare. This is a bad idea at a bad time. We should not do this. We should not do it this way.

I want to focus more of my comments on a narrower piece of this, which has gotten a lot of focus in the House and should get focus in the Senate. It is the radical expansion of Federal funding of abortions that is in this bill. Let's put it on its bottom line. They should put the Stupak language in the Senate bill, and instead the Capps language is in the bill. The Capps language will expand Federal financing of abortion—Federal taxpayer funding of abortion. The Stupak language is something we have supported here for 30 years. It is the Hyde language—the language that 64 Democrats voted for in the House. Instead, in this bill you have Federal taxpayer funding of abortions, something we have not done for 30 years. They are going to build it into this bill. The President has said that he wants—he has said multiple times it is one of his goals to lower the incidence of abortion. This

bill, if we pass it, will provide, for the first time in 30 years, taxpayer funding of abortion and will expand abortions—counter to what the President has said multiple times.

Nobody who is pro-life should vote for this bill. This is a radical expansion of abortion funding. It is a radical expansion of abortion. I was and remain very disappointed that the Senate leadership and my Democratic colleagues have attempted to insert radical abortion policy through the Democratic health care bill. Abortion is not health care. Any Senator who votes on the motion to proceed to this health care bill is voting in favor of abortion and the expansion of abortion and against life.

This is the biggest pro-life vote in the Senate in years. This will have more impact on abortions in the United States—an expansion of it—than anything we have seen in years. We have been on a downward trajectory on abortion because both sides have agreed; Democrats have said abortions should be safe, legal, and rare. Former President Clinton and others have said this will make taxpayer funding of abortion—this will expand it. And there is nothing rare about it.

Relevant abortion language in the health care bill to which I am referring could be found on pages 116 to 124. The National Right to Life Committee described the language and said it is completely unacceptable. The Democratic health care bill would explicitly authorize abortion to be covered under the government option, and there must be abortion coverage in every insurance market in the country. The abortion language included in the bill is a radical departure from over 30 years of bipartisan Federal policy prohibiting Federal taxpayer dollars from paying for elective abortions. The language in the bill explicitly authorizes the Secretary of Health and Human Services to include abortion in the public option and permits government subsidies in plans that pay for abortion. We have had a long dispute in Congress and in this body about abortion. We have not had a dispute to near that degree—some, but not near the level of dispute on the taxpayer funding of abortion, because most people are opposed to that—most people in America. They may say, OK, I am all right with abortion, but I don't support Federal taxpayer funding of it. That has been a broad, bipartisan support here for some time. It is explicitly in this bill. It is the Capps language. It is commonly referred to as that. It is in the Senate bill and contains a clever accounting gimmick that proponents say separates private and public funds for abortion coverage.

However, it has been proven that the Capps measure would include both abortion coverage and funding in the government-run public option, as well as for those plans in the insurance exchange.

The only acceptable abortion language is the Stupak-Pitts amendment that passed the House this fall with a quarter of the Democrat caucus voting for it—64 Democrats voted for the Stupak-Pitts compromise language. Representative Bart Stupak, the Democratic author, tailored the true compromise amendment on abortion with the principles set forth in the Hyde amendment, which has been the longstanding position of the Congress.

The Hyde amendment simply says we will not use Federal funds for abortion, which is what a vast majority of Americans support. The Hyde amendment has always enjoyed bipartisan support since its inception in 1977, over three decades ago.

What we should have in the health bill is language that applies the Hyde amendment as it already applies to all other federally funded health care programs, including SCHIP, Medicare, Medicaid, Indian health services, veterans health, military health care programs, and the Federal Employees Health Benefits Program. That is what should be in this.

Representative STUPAK explained the issue very clearly in an op-ed. He wrote yesterday:

> The Capps amendment [which is the basis of the Senate language] departed from Hyde in several important and troubling ways: by mandating that at least one plan in the health insurance exchange provide abortion coverage, by requiring a minimum $1 monthly charge for all covered individuals that would go toward paying for abortions and by allowing individuals receiving federal affordability credits to purchase health insurance plans that cover abortion . . . Hyde currently prohibits direct federal funding of abortion . . . The Stupak amendment is a continuation of this policy—nothing more, nothing less.

I commend Representative STUPAK for his hard work and ability to reach across the aisle to engage his Democratic and Republican colleagues on this issue. A quarter of the Democrats found the Stupak-Pitts compromise worthy of support. But a majority of the American people support keeping the Hyde principles in the Senate health care bill.

I hope we can convince our colleagues in the Senate to follow Mr. STUPAK's lead and do the right thing and vote against the motion to proceed. Voting for the motion to proceed is to endorse the Capps language, which is an expansion of Federal taxpayer funding of abortion.

The American people agree with the Stupak compromise, not the phony language in the Senate bill that would federally fund abortions.

The American people agree it is wrong to smuggle radical abortion policy into this health care bill. The American people agree we should not allow funds to flow from a U.S. Treasury account to reimburse for abortion services.

A CNN/Opinion Research Corporation poll showed that more than 6 in 10 Americans favor the Stupak-Pitts prohibition on the use of Federal funds for abortion. A recent study conducted by International Communications Research found that more than two-thirds of Americans are opposed to using Federal dollars to fund abortion. The American people feel this way because they know that forcing taxpayers to fund abortions is fiscally irresponsible and morally indefensible.

Beyond the funding issue, the Senate bill also does not include the codification of the Hyde-Weldon conscience provision. Instead, it replaces real conscience protections with language that violates the human dignity and religious freedom of organizations and religious institutions that have moral objections to participating in abortion.

A provision on page 123 reads:

> No individual health care provider or health care facility may be discriminated against because of a willingness or unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortion.

One other objection for the pro-life community is that there is nothing in the bill that would prevent school-based health clinics from referring for abortion or helping minors make arrangements for abortions without parental knowledge.

The administrators running the Medicaid Program from 1973 to 1976 funded as many as 300,000 abortions per year, until the Hyde amendment was enacted in 1976. In the past, in that period from 1973 to 1977, when there was Federal funding of abortions, the Federal government—the taxpayers—funded as many as 300,000 abortions per year with taxpayer dollars. That was until the Hyde amendment was enacted in 1976, because the American people despise doing this. They disagree with that. Whether they are pro-choice or pro-life, they don't want taxpayer dollars to go for this. If they are pro-life, they are saying those are my taxpayer dollars and I am funding this, which I so disagree with doing. This is a beautiful, dignified human life, and my dollars are being used to kill it.

When the Commonwealth of Massachusetts recently passed its State-mandated insurance, Commonwealth Care, without an explicit exclusion of abortion, abortions there were also funded immediately. In fact, according to the Commonwealth Care Web site, abortion is considered covered ''outpatient medical care.'' The Federal Government should not go down this road.

As stated earlier, the President has stated on multiple occasions that it is his goal to lower the incidence of abortion. If that is what he wants to do, if we want to do more than pay lipservice

to that reality, we should consider the fact that when Federal funding is not available, fewer abortions occur, or when Federal funding is available, as we have seen in the past, many thousands more occur.

Only the Stupak amendment would lower the incidence of abortion. The current language of the Senate bill would accomplish the opposite and increase abortions. If you are a pro-life Senator, you cannot vote for this bill. This is an expansion. You cannot vote for the procedural vote to go to the bill for the expansion that this will do.

In summary, I will make it clear that the Stupak language is what we need to fix the shell game that would allow public funds to pay for the destruction of innocent human life in the Senate health bill. Unfortunately, language currently within the health bill is a nonstarter and is wrong. It doesn't apply to the longstanding principles of the Hyde amendment. Let's maintain the status quo and not get into the business of publicly funding abortions in America.

I urge my colleagues to think seriously about the precedent being lined out in the health bill if the Senate decides it is going to force the American public to pay for abortions, whether they agree or not.

I urge my colleagues to vote against the motion to proceed to this health care bill. This is not just a procedural vote. It is an enormously important vote because it is the one opportunity for the Senate to stand for life and against taxpayer funding of abortions. Voting in favor of this motion to proceed is a vote against life.

I remind my colleagues, this is the biggest vote on abortion in the Senate in years. Let's not change our current Federal policy to force the American public to pay for government-subsidized abortions, please.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. WHITEHOUSE. Mr. President, I rise in this great Chamber of debate, this greatest deliberative body, to speak about the upcoming debate on health care on which, thanks to the extraordinary work of our leader, Senator HARRY REID, we are about to embark. I am here to urge that we in the Senate lift the tone and direction of our national debate.

Let me start by saying I appreciate and enjoy vigorous debate. Senator BYRD gave an eloquent eulogy for Senator Kennedy, noting that our beloved, late colleague saw politics as a contact sport. There is nothing wrong with a clean hit in the public arena. Nobody here needs to tiptoe around. A well-marshaled argument, buttressed by the facts, is a beautiful thing, even when delivered hot. Dynamic and vigorous debate is how a democracy sorts through the thorny issues we face. What an ideal time now would be for strong, reasoned arguments about health care reform in the Senate in the coming weeks.

Contrast what we have heard for months on the airwaves and in town-hall meetings: charged buzzwords such as ''death panels,'' ''socialized medicine,'' ''benefits for illegal immigrants,'' and ''rationing of care''—words that inflame passions and ignite fear rather than making a reasoned case for advancing an alternative.

Worse, these messages have been delivered with a crudeness and a venom; for example, the President portrayed with a Hitler mustache. That is unprecedented in my experience in government. Many of us felt President Bush was less than truthful, but for 8 years, no one yelled out in a State of the Union Address: ''You lie.'' Yet this September, 179 Republicans in the House of Representatives of the Congress of the United States voted to support their heckler comrade.

The media, so often in our history a check on the use of falsehood and distortion by powerful interests, has too often been a part of the problem, not part of the solution. For significant parts of the media, facts do not need to be true to be repeated, conclusions do not need to be logical to be reached, and spin is the order of the day.

FOX News the other day launched an attack on President Obama for having too many so-called czars. Let's set aside that George Bush had more. FOX showed a graphic of 30 officials whom, it said, ''didn't have to be confirmed,'' 9 of whom actually had been confirmed by this Senate. My young niece did a better fact-checking job at her summer job for a literary magazine than that.

Recently, FOX used footage from a different event to make attendance at a Republican rally look bigger. A constituent sent me a letter expressing concern that she heard on the Glenn Beck show that President Obama was planning a national civilian security force that would report only to him, akin to the Nazi SS. What did I think of that, she asked. This was a well-meaning Rhode Islander.

We checked, and it turned out the President had given a speech about expanding the Peace Corps, AmeriCorps, the Foreign Service, and other government service programs. I ask you, Mr. President, in what fevered and distorted imagination does national service to AmeriCorps, to the Peace Corps or in the Foreign Service become an SS-type militia? Yet Mr. Beck actually said that.

Another rightwing piece on President Obama's support for AmeriCorps suggested a parallel with Hitler Youth.

Its author said:

> If I need to make my point, I'm going to make it in a provocative manner, because that's how it attracts attention.

The truth should provide terrets through which arguments must run—but not now. As a very well-regarded Philadelphia columnist wrote of the Republican right, ''if they can get some mileage . . . nothing else matters.''

He went on to decry the ''conservative paranoia'' and ''lunacy'' afoot in our national debate.

The editor of the Manchester Journal Inquirer editorial page wrote of the GOP, which he called this ''once great and now mostly shameful party,'' that it ''has gone crazy,'' that it is ''more and more dominated by the lunatic fringe,'' and that it has ''poisoned itself with hate.''

He concluded:

> They no longer want to govern. They want to emote.

The respected Maureen Dowd of the New York Times, in her column eulogizing her friend, the late William Safire, lamented the ''vile and vitriol of today's howling pack of conservative pundits.''

Even the staid, old U.S. Chamber of Commerce has descended into such irresponsible advocacy that Apple, PG&E, Levi Strauss & Company, PNM Resources, Nike, and Exelon have distanced themselves from it, PNM citing the Chamber's ''recent theatrics.''

There comes a point when debate unhinges from reality. When that happens, you leave the sunlit fields of argument and deliberation and you enter a shadowy realm of sloganeering, fear mongering, and propaganda. In these dark and twisted Halls, democracy suffers as debate seeks to scare people or deceive them rather than informing or explaining. It is so easy if you want to go there.

Of course, you can get seniors up in arms by telling them their final years will be subject to the whims of death panels. Of course, you can inflame the passions of people without health insurance by telling them their tax dollars will go to provide health insurance to illegal immigrants. Of course, you can provoke people's attention by telling them reform will keep them from their doctors. But none of these claims is true.

The respected head of the Mayo Clinic recently described the health care antics we have witnessed as ''mud'' and ''scare tactics.''

A well-regarded Washington Post writer with a quarter century of experience, married to a Bush administration official, noted about the House health care bill: ''The appalling amount of misinformation being peddled by its opponents.'' She called it a ''flood of sheer factual misstatements

about the health-care bill'' and noted of the House Republicans that ''[t}he falsehood-peddling began at the top. . . .''

Her ultimate question was this:

Are the Republican arguments against the bill so weak that they have to resort to these misrepresentations and distortions?

Where does this lead? The ill-informed, the gullible, those already on the razor's edge of anger about the very election of this President may well be tipped by all this poisonous propaganda into actions we would all regret—I hope we would all regret. When do anger and frustration fomented in this debate begin to spill over into dangerous or violent acts? When does some havoc occur, such that we all look back with sorrow and wish we had better leashed our dogs of rhetorical war? Where do we restore civility and reason to the health care debate before it gets too late?

I say history's charge to the Senate is to rise above the poison of our recent public debate. This greatest deliberative body is intended to set an example for public argument, not get swept into its downward spiral. We may find agreement; we may not. At the end of the day, some of us may be happy and others of us not. Some may lose and some may win. But the Senate will go on.

After the health care debate has raged through this great Chamber, other debates will follow, and ultimately what will matter more than the outcome of those debates is whether our proud American democracy has come through them with its head held high.

When debate and our democracy lose its footing in the facts, when things are said for public effect without regard to whether they are true, when the din of strife blots out the voice of reason, something of great and lasting value to America is sacrificed.

Democracy does not prosper on a diet of propaganda and fear. The current tone of much of our debate is, frankly, unworthy of us. Most in America agree something must be done to fix our health care system. If we can agree something must be done, it should not be difficult to debate our differences as to what must be done in a civil, thoughtful, and factual manner. Let the Senate be the place where we take a stand, rejecting the incivility and falsehood that has surrounded us on our public airwaves. Through history, that is what this Chamber, at its best, has always achieved and needs now to achieve again.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the Senate resume the motion to proceed to H.R. 3590 at 10 a.m. under the debate limitations previously ordered.

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

Mr. WHITEHOUSE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

ADJOURNMENT UNTIL 9:45 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:45 a.m. tomorrow.

Thereupon, the Senate, at 7:51 p.m., adjourned until Friday, November 20, 2009, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

BROADCASTING BOARD OF GOVERNORS

VICTOR H. ASHE, OF TENNESSEE, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2010, VICE JAMES K. GLASSMAN, RESIGNED.

WALTER ISAACSON, OF LOUISIANA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE STEVEN J. SIMMONS, TERM EXPIRED.

WALTER ISAACSON, OF LOUISIANA, TO BE CHAIRMAN OF THE BROADCASTING BOARD OF GOVERNORS, VICE JAMES K. GLASSMAN, RESIGNED.

MICHAEL LYNTON, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE MARK MCKINNON, TERM EXPIRED.

SUSAN MCCUE, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2011, VICE JOAQUIN F. BLAYA, TERM EXPIRED.

MICHAEL P. MEEHAN, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2010, VICE D. JEFFREY HIRSCHBERG, TERM EXPIRED.

DENNIS MULHAUPT, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2011, VICE BLANQUITA WALSH CULLUM, TERM EXPIRED.

DANA M. PERINO, OF THE DISTRICT OF COLUMBIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE EDWARD E. KAUFMAN, RESIGNED.

S. ENDERS WIMBUSH, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2010, VICE NORMAN J. PATTIZ, TERM EXPIRED.

CONFIRMATION

Executive nomination confirmed by the Senate, Thursday, November 19, 2009:

THE JUDICIARY

DAVID F. HAMILTON, OF INDIANA, TO BE UNITED STATES CIRCUIT JUDGE FOR THE SEVENTH CIRCUIT.

EXTENSIONS OF REMARKS

CONGRATULATING CAROL STREAM FIRE PROTECTION DISTRICT CHIEF MICHAEL KANZIA ON HIS RETIREMENT

HON. PETER J. ROSKAM

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. ROSKAM. Madam Speaker, I am pleased to rise today to recognize the long and distinguished service of Carol Stream Fire Protection District Chief Michael Kanzia on the occasion of his retirement. On September 30 of this year, Chief Kanzia concluded his loyal service to the community he has been faithfully serving since 1976.

On November 19, the Village of Carol Stream will gather to celebrate Chief Kanzia's impressive career, from his time as an on-call firefighter to his days as Fire Chief.

Day in and out Chief Kanzia led the men and women of the Carol Stream Fire Protection District as they risked their lives to protect our communities. His leadership is reflected in their bravery and courage.

Madam Speaker and Distinguished Colleagues, please join me in celebrating this special occasion and the long years of service and commitment that it represents.

RECOGNITION OF ARTHUR ''ARTIE'' HILL, SR. ON HIS LIFETIME ACHIEVEMENT IN THE COMMUNITY

HON. GREGORY W. MEEKS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MEEKS of New York. Madam Speaker, I would like to take a moment to recognize and honor Arthur B. "Artie" Hill, Sr. on his lifetime achievement in the community. Arthur B. "Artie" Hill, Sr. was born in New York City on April 2, 1922. "Artie" Hill, Sr. graduated from John Jay College in 1966 and received his MPA degree from City University of New York in 1973.

On September 16, 1946, Arthur B. "Artie" Hill began his career in law enforcement as a patrolman, retiring after 27 years of service as assistant chief, commanding officer of the Special Operations Division. Arthur B. "Artie" Hill, Sr. began a career of over 17 years at UPS on January 15, 1973 where he held several management positions throughout the company, eventually retiring on September 30, 1990 as Vice President of Public Affairs.

Arthur B. "Artie" Hill served as an alternate delegate to Democratic National Convention from New York in 1980 and 1984. Arthur B. "Artie" Hill is a distinguished member and affiliate of numerous organizations, including his service as Director of the New York City Municipal Water Finance Authority, the Apollo Theater Foundation and AmeriChoice Northeast Managed Heath Care Systems of New York, Inc.; Trustee of North General Hospital; Life Member of the NAACP; Member of the Sigma Pi Phi Fraternity "Boule," Kappa Alpha Psi Fraternity, National Association of Guardsmen, Comus Club Inc., National Organization of Black Law Enforcement Executives (NOBLE), 100 Black Men, 369th Veteran's Association, Shriners and Prince Hall Masons;

In May 2008, the North General Hospital's Board of Trustees opened the new Arthur B. and Patricia Hill VIP Patient Room on the Hospital's sixth floor. Hill is a former board member and long-time supporter of North General Hospital and has helped ensure that the people of Harlem continue to have access to excellent healthcare. At 87 years old, Arthur B. "Artie" Hill, Sr. remains a tireless advocate for a number of causes in the community. I would like to take a moment to have the House of Representatives recognize and honor Arthur B. "Artie" Hill, Sr. on his lifetime achievement in the community.

THE CITY OF TEMECULA CELEBRATES ITS 20TH ANNIVERSARY AS A CITY

HON. DARRELL E. ISSA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. ISSA. Madam Speaker, I rise today to congratulate the City of Temecula, on the celebration of its 20th Anniversary as a City on December 1, 2009.

Since its founding, the City of Temecula has quadrupled in population and continues to provide improvements and amenities to its citizens to ensure a high quality of life. Temecula has also prioritized the protection of its citizens, instigating both regional and federal projects like the Murrieta Creek Flood Control Project. Furthermore, the city has partnered regionally to create jobs through economic development, road improvements, and funding to enhance the community's ability to serve its citizens.

As one of California's pioneering communities, the City of Temecula diligently works to preserve its rich historical culture, providing a wealth of cultural opportunities to its citizens through establishments like the Temecula Theater, History Museum, and Children's Museum. The city also values its strong relationship with the Pechanga Band of Luiseno Indians.

On the occasion of its 20th Anniversary as a City, I encourage the citizens of Temecula to reflect on both the present and historical significance of their community and how it makes the City of Temecula one of America's most livable cities.

HONORING SIG SANCHEZ OF GILROY, CA ON THE OCCASION OF HIS RETIREMENT

HON. MICHAEL M. HONDA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. HONDA. Madam Speaker, I rise along with my colleagues Ms. ZOE LOFGREN, Mr. JERRY MCNERNEY, and Ms. ANNA ESHOO to honor Sig Sanchez, a truly dedicated public servant of California's 15th Congressional District. Sig, a resident of Gilroy, California, will retire this December, after 55 years of exemplary public service in Santa Clara County. His most recent service included 29 years as a Director and five-time Chairman of the Board of Directors of the Santa Clara Valley Water District. Prior to this, Mr. Sanchez served as an elected member of the Santa Clara County Board of Supervisors for 18 years, a Gilroy City Councilmember for 14 years, and Mayor of the City of Gilroy for five years.

During his busy and productive career, Mr. Sanchez has also been an active member of numerous national, state, and local water resource affiliations, including the Agricultural Water Advisory Committee, Central Valley Project Authority, Pajaro River Watershed Flood Prevention Authority, San Luis & Delta Mendota Water Authority Board and Finance Committee, Uvas/Llagas Flood Control and Watershed Advisory Committee, Santa Clara Valley Water Commission, Santa Clara Valley Water District Board Ad Hoc Audit Committee, and the South County Regional Wastewater Authority.

Even while dedicating so much of his time to water issues, Sig did not lose focus on the big picture, helping to strengthen the local community through his efforts with HOPE Rehabilitation, Wheeler Hospital Foundation Board, South Valley Hospital, Health Dimensions Inc., Odd-Fellows and Rebekah Children's Home, and the Gilroy Elks Club.

In 1991, Mr. Sanchez was inducted into the Gilroy Hall of Fame and was honored and recognized with a 10-mile portion of state Highway Route 101 named for him. His work as a farmer and businessman, along with his years as public servant to the water community as a leader during very tumultuous times, has won him the hearts and good will of all who know him.

Our community is grateful to Sig Sanchez for his dedication to public service and contributions to the residents of Santa Clara County, and we wish him well in retirement.

PERSONAL EXPLANATION

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. GERLACH. Madam Speaker, unfortunately, on Wednesday, November 18, 2009, I missed six recorded votes on the House floor. Had I been present, I would have voted "nay" on rollcall 896, "nay" on rollcall 897, "nay" on rollcall 898, "yea" on rollcall 899, "yea" on rollcall 900, and "yea" rollcall 901.

CONGRATULATING JOHN "HUT" HUTSON, WILLIAM C. JENKINS, DAVID F. LUCIER, PETER MARTINEZ, PAT CHORPENNING, JOAN E. SISCO AND CARL G. SCHNEIDER—INDUCTEES TO THE ARIZONA VETERANS HALL OF FAME

HON. HARRY E. MITCHELL

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MITCHELL. Madam Speaker, I rise today to congratulate John "Hut" Hutson, William C. Jenkins, David F. Lucier, Peter Martinez, Pat Chorpenning, Joan E. Sisco and Carl G. Schneider, the Class of 2009 inductees to the Arizona Veterans Hall of Fame. These citizens are recognized for their exemplary service for our country.

For both bravely serving our country and inspiring those outside their military service, 19 Arizona residents were selected to be part of the Arizona Veterans Hall of Fame. In a state boasting more than 600,000 veterans, I am truly honored to represent five of this year's recipients.

The Arizona Veterans Hall of Fame Society annually rewards and honors veterans for their continued service to the community. Each recipient of the prestigious award is personally selected by the Office of Governor Jan Brewer in partnership with the Arizona Department of Veterans' Services.

These veterans represent the courage and patriotism that is so revered by many Americans. It is people like this that I am continuously thinking of and am proud to serve. As members of the Hall of Fame Society, I am sure these veterans will carry on inspiring and serving our community.

Madam Speaker, please join me in recognition of John "Hut" Hutson, William C. Jenkins, David F. Lucier, Peter Martinez, Pat Chorpenning, Joan E. Sisco and Carl G. Schneider's exceptional service.

THANKING GEORGE MCNEILL FOR HIS SERVICE TO THE RIPON SOCIETY

HON. THOMAS E. PETRI

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. PETRI. Madam Speaker, I rise today to recognize George McNeill for his many years of service to the Ripon Society.

For the past five years, George has served as Chief Administrative Officer of the organization. In this position, he has not only run the day-to-day affairs of the group, he has also helped position it as one of the leading voices of centrist Republican thought in Washington, D.C.

As one of the founders of the Ripon Society, I have to confess—when we established the organization in 1962, we could only dream of some of the things it has achieved since that time. Through his hard work and dedication, not only as the Chief Administrative Officer since 2004, but also as a member of the Ripon Board of Directors dating back to 2001, George has helped turn that dream into a reality.

In the process, he has not only made a difference in the life of the Ripon Society, he has also added another impressive chapter to his own rich and full life. It is a life that has taken George from the streets of his birthplace in the Bronx to the hills of his ancestral home in Scotland, from the jungles of his tour of duty in Vietnam to the meadows of his current home in Danby, Vermont. It is also a life dedicated to service, and one that has revolved around his loving family and devoted friends.

George has indeed worn many titles in his lifetime, earning the respect of friend and foe alike along the way. But the title that he is perhaps most proud of is that of husband and father. George and his wife Barbara are the proud parents of two wonderful daughters—Megan and Caitlin.

George recently announced that he is retiring as Chief Administrative Officer of the Ripon Society. It is a real loss for the organization. Those of us who have worked with and gotten to know George over the past several years will miss him and are sorry to see him go. But we also understand that, after five years of commuting weekly back and forth between Vermont and Washington, the time has come to return home.

We thank George McNeill for his service to the Ripon Society. We honor him for his many contributions to the group and for advancing policy debate in Washington. And we wish him all the best in the years ahead.

RECOGNIZING NOVEMBER AS NATIONAL DIABETES MONTH

HON. DIANA DeGETTE

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, Nov. 19, 2009

Ms. DEGETTE. Madam Speaker, this week the co-chairs of the Congressional Diabetes Caucus joined with 129 original cosponsors to introduce H. Res. 914, a resolution supporting the observance of National Diabetes Month.

The resolution encourages people in the United States to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease. It also recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for type 2 diabetes. Finally, it supports decreasing the prevalence of diabetes, developing better treatments and working toward an eventual cure for type 1 and type 2 diabetes.

Since diabetes afflicts nearly 24 million Americans and is the seventh leading cause of death, we must increase awareness and encourage the research to find cures. National Diabetes Month is observed every November and is an excellent way to build awareness about both type 1 and type 2 diabetes. Too many people are not familiar with the differences between type 1 and type 2 diabetes and how they are treated, what the risk factors are, and what sort of research is needed to make progress in the fight against this disease.

That is why the mission of the Congressional Diabetes Caucus is to educate Members of Congress and their staff about diabetes. It is also our mission to support legislation and other efforts to improve diabetes research, education, and treatment.

The legislative priorities of the Congressional Diabetes Caucus support the goals and ideals of National Diabetes Month. For example, H.R. 1995, The Eliminating Disparities in Diabetes Prevention, Access and Care Act, is designed to promote research, treatment, and education regarding diabetes in minority populations. This specific focus will help us address the unique challenges faced by minority populations and provide more effective treatment and education.

H.R. 1625, the Equity and Access for Podiatric Physicians Under Medicaid Act, would classify podiatrists as physicians for purposes of direct reimbursement through the Medicaid program. Podiatry is critical to the treatment and understanding of diabetes.

The Medicare Diabetes Self-Management Training Act, H.R. 2425, would make a technical clarification to recognize certified diabetes educators (CDE) as providers for Medicare diabetes outpatient self-management training services (DSMT). CDEs are the only health professionals who are specially trained and uniquely qualified to teach patients with diabetes how to improve their health and avoid serious diabetes-related complications. The 1997 authorizing DSMT statute did not include CDEs as Medicare providers. This exclusion has made it increasingly difficult to ensure that DSMT is available to patients who need these services, particularly those with unique cultural needs or who reside in rural areas.

Another bill that is a priority of the caucus is the Preventing Diabetes in Medicare Act, H.R. 2590. This bill would extend Medicare coverage to medical nutrition therapy (MNT) services for people with pre-diabetes and other risk factors for developing type 2 diabetes. Under current law, Medicare pays for MNT provided by a Registered Dietitian for beneficiaries with diabetes and renal diseases. Unfortunately, Medicare does not cover MNT for beneficiaries diagnosed with pre-diabetes. Nutrition therapy services have proven very effective in preventing diabetes by providing access to the best possible nutritional advice about how to handle their condition. By helping people with pre-diabetes manage their condition, Medicare will avoid having to pay for the much more expensive treatment of diabetes.

In addition, we are working hard to pass, H.R. 3668, and reauthorize the Special Diabetes Programs for Type I Diabetes and Indians. This program provides federal funding for the

Special Statutory Funding Program for Type I Diabetes Research at the National Institutes of Health and the Special Diabetes Program for Indians at the Indian Health Service. H.R. 3668 would extend these critical programs through 2016 and increase funding for both programs to $200 million a year.

I want to thank my colleague, Congressman MIKE CASTLE, for his many years of leadership working together with me as Co-Chair of the Diabetes Caucus. I also want to thank the many Members who are supporting this effort and both sides of the House leadership for their bipartisan support of diabetes issues. I look forward to working with the Congressional Diabetes Caucus to pass the important legislation we are promoting and continuing to further the goals of National Diabetes Month.

TRIBUTE TO COLONEL LEWIS MILLETT

HON. KEN CALVERT

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CALVERT. Madam Speaker, I rise today to honor and pay tribute to an individual from my Congressional District whose dedication to defending the people of this country and preserving the basic freedoms and liberties that we hold so dear earned him the highest military award our country has to offer. Medal of Honor recipient Colonel Lewis Millett passed away on November 14, 2009. He was a true American hero and today I ask the U.S. House of Representatives to honor and remember him and his 31 years of service.

Colonel Millett was born in Mechanic Falls, ME, on December 15, 1920. He enlisted in the Army Air Corps in 1940 and served as an air gunner, then joined the Canadian Army when it appeared the United States would not enter World War II.

Millett returned to the U.S. Army in 1942 upon the United States' entrance into World War II and served in the 1st Armored Division. After making sergeant, he was awarded a battlefield commission.

According to his Medal of Honor Citation, then-Captain Millett distinguished himself "above and beyond the call of duty in action" in Korea, after he and his men came under heavy enemy fire on February 7, 1951.

Captain Millett ordered and led a bayonet counterattack up the hill, killing enemy soldiers in hand-to-hand assault during which he was wounded by a grenade blast. Despite the adverse conditions Captain Millett's company had taken the hill by early afternoon.

Captain Millett was presented the Medal of Honor by President Harry S. Truman in July 1951. He retired as a colonel in 1973 after a 31-year career in which he served in World War II, the Korean conflict and the Vietnam conflict.

Other notable military decorations awarded to Colonel Millett include the Distinguished Service Cross, the Silver Star, two Legions of Merit, three Bronze Stars, four Purple Hearts and three Air Medals.

Colonel Millett's dedication to his country is a testament to a life of service and a legacy that lives on through his sacrifices. Today let us pledge to always remember Colonel Lewis Millett—the goodness he brought to our world and the sacrifices he made will never be forgotten.

IN MEMORY OF SGT. EDUVIGES WOLF

HON. MAXINE WATERS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. WATERS. Madam Speaker, I rise today to honor the memory of Sgt. Eduviges Preciado Wolf of Hawthorne, CA. Sgt. Wolf was an army sergeant assigned to the 704th Brigade Support Battalion, 4th Brigade Combat Team, 4th Infantry Division, out of Fort Carson, Colorado. Sgt. Wolf was a hero who gave her life in service to her country.

Sgt. Wolf, also known as "Duvi," dreamed of serving in the U.S. military as a child who emigrated to the United States from Mexico with her family. As soon as Duvi was able, she joined the United States military so that she could fulfill her lifelong dream to serve and protect her country. She met her husband Josh at Fort Bragg. Together they had 2 daughters: 3-year-old Isabel and 1-year-old Valerie. Both Duvi and Josh were deployed to Afghanistan, where they served in separate units. Tragically, Duvi recently died in an insurgent attack while in Afghanistan. She was 24 years old.

Earlier this month on Veterans Day, I had the honor and privilege of participating in events with veterans and their families in my congressional district—in Hawthorne and Inglewood, California. I was deeply moved by the families of our servicemembers. Not only do servicemembers make major sacrifices, but so do their families. They live with the harsh realities of war and its implications on them. Spouses must sacrifice long-term career planning, and children are oftentimes forced to transfer to different schools throughout the country. Tragically, as is the reality of combat theater, some of our troops do not make it home.

Today, I salute and thank Sgt. Wolf, along with all of our Nation's past and present heroes who sacrificed a great deal in service to their country.

I expressed my condolences to Duvi's sister Cecilia in Hawthorne on Veterans Day, and I know that her friends and family are still mourning. It is my hope that they will find comfort and peace in the loving memories and the distinguished legacy of service that Duvi leaves behind.

IN HONOR OF JOHN GAFFANEY

HON. DUNCAN HUNTER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. HUNTER. Madam Speaker, today I rise in honor of a man who dedicated his life to helping others, Mr. John Gaffaney of San Diego, California. Tragically, John was killed on November 5, 2009, a victim of the horrible events at Fort Hood.

John was a man of sacrifice and devotion who spent his life counseling others. After 15 years in the Army National Guard, he went on to work for the San Diego County Department of Health and Human Services. After spending the last 22 years investigating cases of elderly abuse and neglect for San Diego County, John once again answered the call of duty and re-enlisted in the Army Reserves. He arrived at Fort Hood only a few short weeks ago to prepare for deployment to Afghanistan to help other soldiers cope with the trauma of war.

Madam Speaker, John Gaffaney was a man of integrity and will be greatly missed by all of San Diego, especially his wife Christine and son Matthew. I ask that this body honor John and the rest of the fallen at Fort Hood for their dedication and sacrifice to this country.

RECOGNITION OF BILL LANE'S LEGACY AS AN EDUCATOR

HON. MARY JO KILROY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. KILROY. Madam Speaker, I rise today to honor Bill Lane for a lifetime of service to the Worthington community. Bill Lane built a legacy as a dedicated and innovative educator for three decades. He passed away in 2008, but he will be remembered for his extensive service to our community.

Bill Lane began teaching at Thomas Worthington High School in the 1950's. He went on to become the high school principal, the assistant superintendent, and the interim superintendent of the Worthington Schools. He was a creative and farsighted educator who contributed greatly to the school's development until his retirement in 1981. As well as overseeing the creation of a large, complex, and modern high school, Bill Lane helped to form the Linworth Campus. This alternative school allows students to make choices about their education, take responsibility, and learn through experiential education.

In addition to his loyal service to our schools, Bill Lane was active in several local organizations. As a member of the Worthington Historical Society, he helped organize its semi-annual Antiques Sale. He was also involved in the St. John's Episcopal Church, Kiwanis, and a men's prayer group.

To honor the service of this visionary educator, those who knew him have formed the Friends of Bill Lane to raise money for a plaque honoring Bill's career at Thomas Worthington High School. They also are planning to establish a teaching grant in his name through the Worthington Educational Association. They have received donations and support from people throughout the community who remember Bill Lane's devotion and character. His contributions to our school system will not be forgotten, and I am proud to recognize and honor this highly-esteemed and dedicated educator for a lifetime of service.

RICHARD SALINARDI

HON. MICHAEL E. McMAHON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MCMAHON. Madam Speaker, I rise today to honor Richard Salinardi. Mr. Salinardi has done extensive work with the developmentally disabled population for the past 40 years. He has ensured that disabled individuals in my district have had their voices heard.

Mr. Salinardi has spent much of his career improving the treatment of developmentally disabled individuals. From his 30 years of teaching developmentally disabled adults through his decades volunteering his time and knowledge, he has helped these individuals become productive members of our community.

Richard serves as the Executive Director of Lifestyles for the Disabled Inc., overseeing all aspects of the agency. Richard has taken an aggressive and innovative approach, yielding remarkable results.

While the Lifestyles for the Disabled family continues to grow, Richard has maintained a solid connection to his roots. As an alumnus of Wagner College, Mr. Salinardi started a program to have students from his alma mater volunteer their time at Lifestyles, maximizing their college experiences.

Mr. Salinardi continues to volunteer his time with Special Olympics at Wagner College. The Special Olympics program at Wagner started 35 years ago with 10 athletes and has grown to over 500 athletes, training year-round. Since 1975, Richard has served as the Staten Island Area Coordinator and currently serves as the Chairman of the Board of Special Olympics of New York.

Mr. Salinardi is a truly great American and a dedicated community leader. Because of the devotion of Richard Salinardi, I know that disabled individuals on Staten Island and around New York City are in good hands.

Madam Speaker, I ask that my colleagues join me in commending Richard Salinardi for his dynamic leadership and acknowledging the impact he has made on the developmentally disabled of Staten Island.

THANKING RICK KESSLER FOR HIS SERVICE TO THE RIPON SOCIETY

HON. THOMAS E. PETRI

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. PETRI. Madam Speaker, as Bill Gates once said, "Great organizations demand a high level of commitment by the people involved."

I rise today to recognize Rick Kessler, whose commitment to one particular organization—the Ripon Society—has not only spanned three decades, but has left a lasting impact on public policy debate in the United States.

In 1962, as a student attending Harvard University, I helped found the Ripon Society. The intent was to provide Republicans with a place where they could debate the issues and discuss the challenges of the day.

Rick's involvement with Ripon dates back to the early 1980s. He had been involved with John Anderson's presidential campaign, where he served as National Finance Director before going on to serve on the Inaugural Committee for President Reagan.

Rick joined the Ripon Society as Executive Director in 1981 and immediately set out to revitalize the organization. Among his accomplishments, Rick created the Congressional Advisory Board; the nonpartisan Ripon Educational Fund Transatlantic Conference; the Congressional Liaison Board; the Rough Rider Awards Dinner; and he oversaw the rejuvenation of The Ripon Forum, the Society's journal of thought and opinion. More than anything, though, Rick carried the organization on his shoulders through good times and bad.

In 2004, Rick was invited to follow in the footsteps of the Honorable Bill Frenzel and become the President of the Ripon Society. He has served in this role with great distinction.

Rick also was busy raising a family. He and his wife Daphne have been married for 21 years, and are the proud parents of two wonderful children, their daughter Sam and son Ryan.

After five years as President, Rick recently announced that he is stepping down and becoming President Emeritus of the Ripon Society. I would like to take this opportunity to thank him for all that he has done for Ripon. What started out 47 years ago as a seed on the Harvard campus has become a strong and sturdy tree in Washington, DC, today.

It is a tree rooted in ideas, and one whose growth over the past 30 years would not have been possible without the dedication and commitment of Rick Kessler.

I thank him for his service.

EARMARK DECLARATION

HON. ROB BISHOP

OF UTAH

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. BISHOP of Utah. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 2996, the Interior-Environment Appropriations Act, 2010.

Requesting Member: ROB BISHOP

Bill number: H.R. 2996

Account: Forest Service Land Acquisition

Legal name and address of requesting entity: The Trust for Public Land, 660 Pennsylvania Avenue SE, Suite 401, Washington, DC 20003

Description of project: The Bonneville Shoreline Trail was initiated in 1990 to complete a trail corridor along the prehistoric shoreline of Lake Bonneville and along the foothills of the Wasatch mountains from Ogden to Provo. This partnership has been so successful that the communities in Cache and Box Elder counties have worked to extend the trail north. The 150-acre North Ogden property is a priority for protection by the U.S. Forest Service. The property serves as important habitat for deer and elk and as an important buffer for fire protection for the rapidly developing area along the Wasatch Front. The property also provides watershed protection for neighboring areas in addition to key recreational resources.

The North Ogden program is a partnership effort to fill in the boundaries of the national forest along the BST in North Ogden and Pleasant View. In 2005, a five-mile stretch of the BST along North Ogden and Pleasant View was secured through a trail easement along an existing utility corridor granted to the nonprofit Weber Pathways. The property available for protection this year is critical to the North Ogden program because it will bring Forest Service ownership to this stretch of the BST and add critical trail access to the citizens in this area of the state. Protection of this property will also protect beautiful views of the foothills of the Wasatch Front and Ben Lomond Peak, one of Weber County's most important landmarks, while conserving important wildlife habitat and winter range along this rapid growth area.

RECOGNIZING THE RETIREMENT OF CHARLES HILDEBRAND FROM THE SOCIAL SECURITY ADMINISTRATION

HON. JEFF MILLER

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MILLER of Florida. Madam Speaker, I rise today to recognize Mr. Charles Hildebrand, a community leader and public servant who is retiring from over thirty-five years of service with the Social Security Administration. Charles spent his career serving others, and I am proud to honor this dedication and service.

After graduating from South Carolina State College, Charles started his federal career in 1970 as a program specialist with the U.S. Department of Agriculture. He moved to the Social Security Administration in 1973 as a claim representative in Newark, New Jersey. From 1974 to 1977, Charles also served as the vice president of American Federation of Government Employees Local 2389.

Over the course of his career with the Social Security Administration, Charles worked as an operations supervisor, a level 2 manager, an analyst for the Georgia and North Florida area office staffs, and a level 1 manager. He graduated from the Atlanta Leadership Development Program in 1991. The SSA twice awarded him the agency's highest honor, the Commissioner's Citation.

Charles is also a community service leader. He serves as the 2009–2010 Chairman for the EscaRosa Combined Federal Campaign local agency application review committee and the non-military agencies committee. He is also chair of the North Florida E-service and Integrity/Anti Fraud cadres. As chairman of the board of the Beach Institute Historic Association, Charles oversaw the development of a low-income rehabilitation project to serve the underprivileged in our area.

Madam Speaker, on behalf of the United States Congress, I am honored to recognize

Charles Hildebrand for his service to the people of Northwest Florida. He has been a dedicated public servant for forty years. My wife Vicki and I wish all the best for Charles, his wife, Iris, and his children, Nikki and Amii, as they embark on this next endeavor in their lives.

CONGRATULATING PROFESSOR PANNING

HON. CHRISTOPHER JOHN LEE

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. LEE of New York. Madam Speaker, I wish to congratulate SUNY Brockport Professor Anne Panning on being named the 2009 New York Professor of the Year. This is a tremendous accomplishment and the western New York community is proud to have Professor Panning as a member of our community.

After receiving her undergraduate degree from Augsburg College, Anne went on to receive her master of fine arts degree from Bowling Green State University and then her doctorate from the University of Hawaii.

She has received much praise from her students and fellow literary scholars alike. In a review for her 2007 work Super America, the New York Times wrote that it "radiates infectious optimism."

In addition to teaching several classes at SUNY Brockport, Anne also co-directs the Brockport Writers Forum, one of the foremost reading series in the country. The Forum has had a significant impact on the direction of Brockport's English department on both the undergraduate and graduate level, and Anne has played an integral part in the Forum's continued success along with her co-director, poet Ralph Black.

Anne has won several awards for her fiction and nonfiction writing and also for her teaching, including the Flannery O'Connor Award for short fiction, the Chancellor's Award for Excellence in Teaching, the Lillian Fairchild Award, and now, the New York Professor of the Year.

Madam Speaker, I again wish to congratulate Professor Panning on being named the New York State Professor of the Year, and wish her much continued success.

HONORING DETROIT CATHOLIC CENTRAL COACH TONY MAGNI AND CATHOLIC CENTRAL SHAMROCKS' CROSS COUNTRY TEAM

HON. THADDEUS G. McCOTTER

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MCCOTTER. Madam Speaker, today I rise to honor and acknowledge Detroit Catholic Central Coach Tony Magni and the entire Catholic Central Shamrocks' Cross Country Team on their Division 1 State Championship.

I am a proud graduate of Detroit Catholic Central High School. As a student, I learned how important it was to work hard, seek out knowledge, and fight for the less fortunate. I played sports at Catholic Central, so I know how important sports are in teaching our children the importance of teamwork and motivation.

On November 7, 2009, at the Michigan International Speedway, Shamrock Ricky Galindo came in third at the race and led the Shamrocks all season. The Shamrocks suffered from several injuries early in the season, but Coach Magni never lost confidence in the team's ability to persevere in the end. Not surprisingly, Magni has won five cross country championships since 1983 and is known as an extraordinarily talented coach.

Madam Speaker, Coach Magni and the entire Detroit Catholic Central Shamrocks cross country team worked tirelessly and productively to earn their state championship. I ask my colleagues to join me in congratulating Coach Magni and the Shamrocks for reaching this milestone and recognizing the coach and team's contribution to the community and our country.

TOMPKINS LODGE OF THE FREE AND ACCEPTED MASONS

HON. MICHAEL E. McMAHON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MCMAHON. Madam Speaker, I rise today to honor the Tompkins Lodge of the Free and Accepted Masons that is now celebrating its 150th anniversary. This fraternal order has had a rich and long history filled with dedication to and compassion for the people of our community.

The Tompkins Lodge's history dates as far back as the American Revolution when British officers and colonist met in the Guyon-Clark homestead in the New Dorp section of Staten Island. The War of 1812 brought a halt to Masonic activity on Staten Island but the lodge was reconvened in 1819 in the home of Vice President Daniel D. Tompkins, who also served as Grand Master of Mason of New York State. They met in various homes until 1825 when the Richmond Lodge had its first meeting on the top floor of the Nautilus Lodge.

In 1839, the anti-Masonic movement had grown in New York and many lodges around the State surrendered their charters, but the Richmond Lodge stood firm and weathered out the storm. In May 1856, the lodge moved to the room occupied by the former Richmond Lodge, where it remained until a massive fire ripped through the Tompkinsville section of Staten Island.

After many years in their location, the Tompkins Lodge moved in 1908 to their current location above the Stapleton Office of the U.S. Postal Service.

From national programs such as their hospitals and senior living homes, to their works around Staten Island, the Tompkins Lodge is at the forefront of community service on Staten Island. Throughout their long and prestigious history, the Tompkins Lodge of the Free and Accepted Masons has volunteered their time and skills to the improvement of our community.

Madam Speaker, I ask that my colleagues join me in commending the Tompkins Lodge of the Free and Accepted Masons for the vigorous devotion to the people of New York's 13th Congressional District for the past 150 years.

AMB. LYNDON OLSON SPEECH—IMPORTANCE OF CIVILITY IN AMERICAN LIFE AND POLITICS

HON. CHET EDWARDS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. EDWARDS of Texas. Madam Speaker, I rise today to enter into the CONGRESSIONAL RECORD wise words from Ambassador Lyndon Olson that we would all do well to follow.

In a time of such little civility in our public discourse, Ambassador Lyndon Olson reminds us what is best about America. It is the strength of our values, our character, and common respect for our fellow man and woman that make our nation great.

We must strive to protect and nurture those values of common respect for one another if we are to grow as a nation.

REMARKS OF AMBASSADOR LYNDON OLSON UPON ACCEPTING THE TEXAS LEGACY AWARD FROM THE CENTER FOR PUBLIC POLICY PRIORITIES AT THE EIGHTH ANNUAL TEXAS LEGACY LUNCHEON NOVEMBER 12, 2009, AUSTIN, TEXAS

Thank you very much for this honor. I appreciate the kind remarks of my friend Congressman Edwards. I also appreciate the opportunity today to talk to this distinguished group about a concern of mine.

I want to talk with you about civility, both in society in general and in our politics in particular.

I encourage you to think back . . . for some of us way back . . . to those report cards we got in first grade. Most everyone had different type cards and categories, but they were pretty much variations on the same basic theme. I'm not talking about your arithmetic or reading or penmanship grades. I'm talking about the comportment column, with things such as Exercises self-control . . . respects the rights of others . . . shows kindness and consideration for others . . . indicates willingness to cooperate . . . uses handkerchief (important even before the H1N1 virus) . . . and, my favorite was usually right up at the top of that 6–week report card and it's of particular significance to our discussion . . . "Plays well with others."

We were being taught about and graded on one of the most fundamental skills of our civilization: how to get along with others. There is a reason that plays well with others was one of the first things we were taught and evaluated on. And folks, I don't think we're getting a very good grade on plays well with others these days. Many of us don't even want to play with someone we don't like or agree with.

Where did all of this come from? In the majority of my life this hasn't been the case. Those of us in this room over 40 or 50 didn't grow up in anything like this environment. We didn't live like this. Not in our communities . . . not in our politics. We lived in a political world with strong feelings and positions, yes. And we took swings at each other

politically. But it didn't come down, to the moral equivalent of street brawls and knife fights. Politics has always been a contact sport, but the conflict didn't permeate every aspect of our society and rise to today's level of social and verbal hostility. It is very unhealthy. And I'm not sure what to do about it. But I know it when I see it and hear it. And I know it is time we focus as much attention on our civil behavior as we do on achieving our personal and partisan agendas. How we do that, I don't know. But I want to raise the issue, ask the questions, and encourage you all to give it your consideration as well.

We live in an era of rudeness, in society in general, in the popular culture, and in our political life. Our culture today, in fact, rewards incivility, crudeness, and cynicism. You can get on TV, get your own talk show or reality series if you out-shout and offend the other guy. Everyone screams, no one listens. We produce a lot of heat but little light. The proclivity is to demonize our opponent. People don't just disagree . . . the challenge to the other is a battle to the death. Character assassination, verbal abuse, obnoxious behavior, and an overbearing attention on scandal and titillation—all that isn't just reserved to day-time TV anymore—it's the currency of prime-time, of late night, of cable news, of the Internet, and of society in general.

What happened to us? Should this be a sign of alarm? Is the problem selfishness—we won't be denied, we must be immediately gratified? We want everything we've ever seen in the movies? How do we live and get along like our parents and their generation? They had to sacrifice. They didn't get what they wanted when they wanted it. Is today's need for instant gratification a problem?

We are more inclusive today . . . and that is a good thing—but has that good made for increased tensions?

Is it the 24-hour news cycle? The 24-hour news cycle demands instantaneous news, which feeds off of controversy, scandal, and easy answers to difficult questions. There is scant time for reflection or reasoned analysis. Market forces demand instantaneous information and jarring entertainment values, not sober analysis or wisdom. The news media are more prone to focus on the loudest, the most outrageous, and the most partisan actors. And given the rise of the political consultant class, candidates and campaigns are louder, more outrageous, and meta-partisan. Political consultants have helped create a permanent campaign where politics takes precedence over governance. The political consultants egg on all this for profit, creating controversy where little or none exists so the message, the theme of the day, is played out on TV and the media. They're paid handsomely to cause strife and create conflict in order to raise hackles, money, and attention . . . fomenting issues to suit their agenda. It's all about the message, not the solution, not the negotiation, the debate, the compromise to move forward. It's about who is controlling the message, who is defining the message, who is creating the message, who is keeping the conflict alive often where none existed before the consultant decided one was needed. Is this what keeps us at each other's throats?

Is it talk radio, attack TV? Is it the talk shows, the shout festivals where absolute hyperbole is the only currency? Mean-spirited hyperbole and hyper-partisanship breeds cynicism. Citizens are increasingly cynical about politics and about their government's ability to work. The damage to the ship of state, to the fabric of the nation begs repair. Whose job is it to change course and effect the necessary repairs? I'm not sure I have the answer to that, but I propose that in a room full of policy makers and politicians, men and women who talk to the media, who work in the public arena, who hire consultants, who set agendas, maybe we have a role to play in making things better.

You know, I can say that there are some people in this room, people I consider dear friends, who understand this problem and I believe share my concern. To those friends I say, you and I both know that we disagree very fundamentally on some very big issues but the truth is that we could care less about our disagreements and are more concerned about where we can find consensus and reasons to work and live together to construct a better future. I consider this kind of commitment to trust and open dialogue crucial to maintaining a sustainable society.

And indeed, isn't it about building a better future for our community, for our country, for our children? I say that even on the most intractable of issues, there is room for constructive debate, for consensus building, for the search for some common ground.

President Johnson once said to his Democratic colleague, Gov. George Wallace of Alabama, during the crisis of civil rights in the South: ''What do you want left behind? You want a great, big marble monument that says, 'George Wallace: He built.' Or do you want a little piece of scrawny pine lying there that says, 'George Wallace: He hated' ''?

The people I know in this room are builders. But we are confronting a world today where hate seems to be a predominant factor in the crisis of incivility confronting our politics.

Where are the rules that govern conduct? What happens eventually after this continuous rancor tears the fabric of our society completely asunder? Can we survive with this tenor . . . taking no prisoners, giving no quarter?

I'm asking these questions because you folks here are blessed with skills, talent, experience and a commitment to a positive public policy. You understand the importance of maintaining and protecting our commonweal where we strive to serve our clients, our community, our country, and our state. If civil discourse self-destructs, we cannot move on the issues that matter. Think of this as an environmental crisis . . . the environment being our civil society and our very ability to live and work and prosper together.

I don't want to sound pious or preachy here, but if we are to prevail as a free, self-governing people, we must work together. We shouldn't try to destroy our opponents just because we disagree. We have to govern our tongues. The Proverbs tells us, chapter 18, verse 12, ''Death and life are in the power of the tongue.'' How we choose to use words—for good or for wrong—is clearly our choice. The health of our democracy depends upon a robust public discourse.

Recognize that I am not saying that conflict in our political life is to be avoided. Hardly so. It is not only proper but necessary for candidates to vigorously debate the issues of our day and examine their opponents' records. Don't let people confuse civility with goody two-shoes niceness and mere etiquette. Civility is a robust, tough, substantive civic virtue, critical to both civil society and the future of our republic. Civility entails speaking directly, passionately, and responsibly about who we are and what we believe. Divisions based on principles are healthy for the nation. Vigorous and passionate debate helps us to define issues and to sharpen positions.

Conflict cannot, should not be avoided in our public lives any more than we can avoid conflict with the people we love. But just as member of a household, as a family learn ways of settling their differences without inflicting real damage on each other, so we, in our politics, must find constructive ways of resolving disputes and differences.

Our work is here. We build from the base. We will foster change first by our example . . . by working together, respecting one another, and negotiating our differences in good faith and with mutual respect. Civility is neither a small nor inconsequential issue. The word comes from the French civilite which is often translated as ''politeness.'' But it means much more. It suggests an approach to life . . . living in a way that is civilized. The words ''civilized,'' ''civilité,'' and ''city'' share a common etymology with a word meaning ''member of the household.'' To be civilized is to understand that we live in a society as in a household. There are certain rules that allow family members to live peacefully within a household. So, too, are there rules of civility that allow us to live peacefully within a society. As we all learned in 1st grade a long time ago, we owe certain responsibilities to one another. Perhaps we spend a lifetime learning how to play well with others. So be it. It is a crucial goal for a civil society. Thank you.

IN RECOGNITION OF THE SERVICE OF J.E. ''GENE'' SMITH

HON. JEFF MILLER

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MILLER of Florida. Madam Speaker, I rise today to recognize Mr. J.E. "Gene" Smith, a national and community leader who is retiring from almost thirty years of service with the Choctawhatchee Electric Cooperative. Gene spent his career serving others and giving back to our community, and I am proud to honor this dedication and service.

As the son of a gas utility worker, Gene became interested in utility work at a young age. He began his career with Huntsville Utilities in Huntsville, Alabama before moving to another utility job in Jefferson City, Tennessee. By the time Gene was 28, he was manager of a Sweetwater, Tennessee utility. In 1978, he moved to the world of electric cooperatives and went to work as the general manager of Escambia River Electric Cooperative in Jay, Florida. Three years later, Gene moved a few miles east to DeFuniak Springs to work for the Choctawhatchee Electric Cooperative (CHELCO). He has served as Chief Executive Officer and General Manager of CHELCO since 1981.

While at CHELCO, Gene has made a lasting impression on the electric cooperative community. He served on the board of the National Rural Utilities Cooperative Finance Corporation from 1988 to 1993 with two years spent as the board's president. He also served on the board of the National Cooperative Services Corporation from 1995 to 2003 and as a trustee on the PowerSouth Energy Cooperative Board, representing CHELCO since

1981. Gene has been chairman of the Florida Electric Cooperative Association and the National Food and Energy Council Board. Because of his outstanding work on behalf of electric cooperatives, Gene was featured in American Executive Magazine in 2007. In February, the National Rural Electric Cooperative Association's Board of Directors will present Gene with the Clyde T. Ellis Award. This award recognizes an individual who goes above and beyond the call of duty in furthering the principles and progress of rural electrification and the development and utilization of natural resources.

Beyond his expansive career accomplishments, Gene Smith has spent a lifetime dedicated to community service. He serves on the United Way of Okaloosa and Walton Counties, the Board of Trustees of Northwest Florida State College, the Okaloosa County Economic Development Council Executive Committee, and the Rotary Club. He is also a very active member of the All Sports organization which raises money for local youth-oriented non-profit organizations with an emphasis on sports. Local beneficiaries include the YMCA, Boys & Girls Club, and Special Olympics.

Madam Speaker, on behalf of the United States Congress, I am honored to recognize Gene Smith for his service to the people of the United States. He is a dedicated community servant and national business leader. My wife Vicki and I wish all the best for Gene and his family as they embark on this next endeavor in their lives.

COMMENDING CENTURYLINK'S COMMITMENT TO LOUISIANA

HON. RODNEY ALEXANDER

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. ALEXANDER. Madam Speaker, it is with deep appreciation for this company's many contributions to Louisiana that I rise today to commend CenturyLink.

The telecommunications provider has an impressive track record of success. In July, CenturyLink was formed through the acquisition of Embarq Corporation by CenturyTel Inc., becoming the nation's fourth largest traditional telephone company. It is currently one of three Fortune 500 companies headquartered in Louisiana, and more importantly, it has been one of the state's top private-sector employers for many years.

CenturyLink, which has approximately 20,000 employees in 33 states, announced yesterday it will add 350 jobs in Louisiana while maintaining its headquarters in Monroe for at least the next decade.

The recent decision by CenturyLink to stay and grow in the Monroe area is a testament to the strong and skilled workforce found in Northeast Louisiana. During this time of economic uncertainty, CenturyLink is actively working to create new jobs in our communities. I am confident the remarkable progression of CenturyLink will continue to provide great opportunities for the residents of our area.

I ask my colleagues to join me in saluting CenturyLink and its commitment to building a stronger Louisiana.

RECOGNIZING THE SIGNIFICANT ACHIEVEMENT OF THE UNIVERSITY OF SOUTH ALABAMA JAGUARS

HON. JO BONNER

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. BONNER. Madam Speaker, I am very proud to bring to the attention of the House the outstanding achievement of the University of South Alabama Jaguar football team. The University of South Alabama is located in my Congressional district.

During 2009, the NCAA Division III Jaguars, under head coach Joey Jones, delivered a perfect 7–0 season.

The undefeated Jaguars made history not only for their unblemished record on the gridiron this year, but also for the fact that until this year, the Jaguars never had a football team. What's more, they didn't even have a marching band until this year.

The Jaguars' 2009 inaugural season was nothing short of a Cinderella performance, capped by an impressive 35–0 final game victory over the Huntingdon College Hawks on November 12. The average inaugural season game attendance was an impressive 18,000.

Speaking at USA's Media Day on November 16, Jaguars Head Coach Joey Jones put their victory into context: "Number one, it makes a statement that South Alabama is here to build a Division I football program."

This summer the Jaguars took on a daunting task and they defied the odds by building on the basics and truly working together as a team. With this winning combination, they will surely succeed in reaching Division I.

I would like to congratulate the USA coaching staff and the team: Head coach Joey Jones and coaches Bill Clark, Kurt Crain, Greg Gregory, Mitch Rodrigue, John Turner, Jeff Bailey, Barrett Parker, Dameyune Craig, Chuck Dunn, Tommy Perry, Brian Turner, Duwan Walker, Brendt Bedsole, and Justin Schwind.

The USA Jaguars: Aiman Al-Selwadi, Kendell Bagnerise, Ken Barefield, Cori Barnett, Ryne Baxter, Nick Bear, Logan Bennett, Paul Bennett, Corey Besteda, Heath Blount, Kevin Bone, Jake Bowen, Chase Brown, Christian Brown, Zach Brownell, Chris Brunson, Nick Brunson, Eddy Cabrera, Randon Carnathan, Sean Ceballos, Michel Chapuseaux, Josh Chestang, Trey Clark, Chris Cooke, Richard Courtney, Clifton Crews, Andy Dalgleish, Josh Dees, Marquise Diamond, Jaime Driskell, Justin Dunn, Drew Ezell, Darrow Fisher, Lionel Fuentes, Scott Garber, Lamontis Gardner, Myles Gibbon, Gabe Graham, Anton Graphenreed, Sean Greenwood, Jon Griffin, Brett Hancock, Dalvin Harris, Danzel Harris, Tim Harvey, Gage Hayes, Kevin Helms, Charlie Higgenbotham, Ellis Hill, Greg Hollinger, Bryson James, Dustin James, Kenneth Johnson, Romelle Jones, Sean Kennedy, Brian Krauskopf, James Land, Bryant Lavender, T.J. Lawrence, John Leech, Corwin Malone, Andrew Martin, Gabriel Mass, Santuan McGee, Lawson McGlon, Darrius McMullin, Jordan Means, Tyler Miller, Jerron Mitchell, Anthony Mostella, Jerry Nettles, Taylor Noon, Chad Orrell, Nick Owens, Jeremy Pacillo, Alex Page, Andrew Paschall, John Mark Patrick, Steven Pease, Alex Phifer, Cory Pittman, Rob Powell-Deppe, Philip Press, Chris Pugh, Erling Riis, Donte Rome, Zack Rone, Brandon Ross, Richard Ross, Matt Saucier, Donald Scott, Ryan Scott, Paul Silvey, Brennan Sim, Levi Slaydon, Courtney Smith, Eli Smith, Tremain Smith, Chris Stitt, Robby Stoner, Alex Tamariz, Anthony Taylor, Josh Terry, Tony Threatt, Ralph Turner, Gabe Ukwuoma, Kelly Vail, Corey Waldon, Justin Walker, Carlton Wallace, Zac Westmoreland, Alex Williams, Enrique Williams, Montavious Williams, Michael Wilson and Lim Windham.

Much credit also goes to President Gordon Moulton and the Board of Trustees and the alumni for their vision and support of the inaugural USA football program.

The Jaguars' story is inspiring to us all, and I know that I speak for the entire community when I wish them congratulations on a job well done.

Can't wait for 2010. Go Jags!

HONORING THE LIFE OF LT. COL. (RET.) RICHARD KLEIN DERRIDINGER

HON. GUS M. BILIRAKIS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. BILIRAKIS. Madam Speaker, I want to pay tribute to retired LTC Richard Klein Derridinger of Tampa, Florida, who passed away on September 4, 2009 after a long illness.

Dick was a successful businessman, decorated military veteran, and devoted family man. Born on March 4, 1932, in Easton, Pennsylvania, Dick grew up in Chambersburg. He was a hard working young man and a devoted Eagle Scout. He attended Corpus Christi School and played football at Chambersburg High School. Dick then attended Gettysburg College and joined the Air Force to fly in Vietnam.

Returning to the United States, Dick continued to serve as an instructor pilot for single engine fighters and became Captain of an air-refueling tanker for 6 years. His last assignment was Chief of Flight Tests at Rome Air Development Center where he earned the Flying Safety Award for saving the crew, passengers, cargo, and the aircraft after the KC–135 he was piloting experienced multiple mechanical failures. In addition to earning other decorations, he was awarded the Distinguished Flying Cross and the Bronze Star for Valor.

Dick earned his masters degree in Systems Management from the University of Southern California, and after retiring from the Air Force, he became President of Air North in Vermont, and then president of Dolphin Airways in Tampa, Florida. Dick was an avid entrepreneur and started several additional businesses in Florida including a gift shop, a sheet metal business, and an interior landscaping company.

Our hearts are with Dick's wife, Dawn, and his children and grandchildren in this time of sorrow. I hope my colleagues will join me honoring this remarkable man who was a lifelong patriot dedicated to his country and his family. His humility, kindness, and compassion continue to inspire those who knew him and he will be greatly missed in our community.

IN SUPPORT OF U.S. SOUTHERN COMMAND'S EFFORTS IN EL SALVADOR

HON. KENDRICK B. MEEK

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MEEK of Florida. Madam Speaker, I rise to recognize the humanitarian assistance efforts of the U.S. Southern Command, whose headquarters is in south Florida.

Last week, El Salvador was hit with torrential rain storms, causing massive flooding and mudslides that devastated parts of that country.

Nearly 200 people were killed. Many thousands more were left stranded and in immediate need of assistance.

The very next day—the same day our Nation paused to celebrate Veterans Day—U.S. troops deployed nearby in Honduras boarded helicopters bound for the affected areas. These troops spent their Veterans' Day partnering with their counterparts in El Salvador, supporting them in saving lives and fulfilling a mission of cooperation that continues to serve our Nation well.

In just four days our troops distributed more than 217,000-pounds of aid to villages completely isolated due to damaged roads and bridges. They brought food, water, milk, clothing and other emergency necessities.

I understand that these airlifts were the only source of lifesaving supplies for the stranded village.

So, Madam Speaker, I rise to offer my thoughts and prayers to the people of El Salvador, and to also express my appreciation and admiration for the members of U.S. Southern Command.

HONORING JUDGE SOLOMON CASSEB, JR.

HON. CHARLES A. GONZALEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. GONZALEZ. Madam Speaker, I rise today to speak of sad tidings. The south Texas legal community lost a great leader and a great friend on October 16, 2009, when Judge Solomon Casseb, Jr. passed away at the age of 94.

A native San Antonian, Judge Casseb attended Central Catholic High School, St. Mary's University, and obtaining his law license at the University of Texas Law School in 1938. After several years in private practice, he enlisted as a private in the United States Army Air Corps during World War II, and was honorably discharged as a Major by the time he returned from overseas. He then practiced law until his appointment and two subsequent elections to serve as a Judge of the 57th District Court in Bexar County. He presided over many important cases during his career, though none may be more famous than 1984's Texaco case, which resulted in what was the largest award of damages in history.

During his time on the bench, Judge Casseb was repeatedly honored by his colleagues in the legal community time and again as an outstanding jurist, and the endowed Judge Solomon Casseb Jr. Research Professorship in Law at the University of Texas Law School stands as a tribute to the esteem in which he was held.

Before and after he obtained senior status in 1985, Judge Casseb worked to improve the lives of the people of South Texas outside of his official duties as well. He was a co-trustee of the Lamar Bruni Vergara Trust and was a bold and diligent advocate for the poorest citizens of his community.

Solomon Casseb Jr. was a great judge, a great friend, and a great man. His family, friends, and all those who had the privilege to know him will miss him deeply.

THIS THANKSGIVING IN HONOR OF ALL THE ARMED FORCES AND THEIR FAMILIES

HON. JOE WILSON

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. WILSON of South Carolina. Madam Speaker, I submit a heartfelt poem penned by Capitol Guide Albert Caswell, entitled "This Thanksgiving" in honor of all the members of the Armed Forces and their families who are separated by war and death this Thanksgiving. Our thoughts go out to all of them this Thanksgiving. Bless them all.

This is a special Thanksgiving as we recognize the success of Cold War veterans from Korea to Vietnam and across the world who achieved victory on the 20th anniversary of the fall of the Berlin Wall inspired by Ronald Reagan, Margaret Thatcher, and Pope John Paul II working with Lech Walesa of Poland and Vaclav Havel of Czechoslovakia.

The spirit of Ronald Reagan is kept alive by Young America's Foundation preservation of the Reagan Ranch, Ranco del Cielo (Ranch of the Sky) in California.

THIS THANKSGIVING

This
Thanksgiving . . .
Be thankful, when you're at home . . .
With your family all at peace, remember all of those so all alone . . .
Who on battlefields can not be home . . .
Families at dinner tables with tears in eyes . . .
And all of those who upon battlefields of honor died . . .
The ones who so live without the ones, they so can not live without . . . who now so cry . . .
And all of those children, whose daddies and mommies, can't wipe those tears from their eyes . . .
And not watch their children grow and smell that pumpkin pie . . .
The ones who but gave, That Last Full Measure!
One's Life, The Greatest of All Treasures . . .
The ones without arms and legs . . .
As their fine eyes they gave . . .
Showing us all, of what a hero is made!
So Few, but for so many . . .
Have carried that load . . .
Have bore all of the heartache so . . .
And when you watch that touchdown run . . .
While, holding your loved ones . . . having all that fun . . .
But, let your thoughts to them so run . . .
The ones who died, for what is true . . .
And all of those out on the front, the face of death must so view . . .
And the loved ones at home, each day who wait by the door . . . the phone . . .
Bow down now upon your knees . . .
And ask our Lord God, so please . . . to bless all of these . . . The Families . . .
Who with such heartache, and will never see another day of peace . . .
And as you say grace . . .
Say a prayer for all of those Heroes of such splendid grace . . .
Who did not so hesitate . . .
And all of those families, whose loved ones for them now so wait . . .
Who sit, with one less spot at the Thanksgiving table set . . .
Be ever thankful, for what they gave . . . and have to yet . . .
On this day of days . . .
Give Thanks, Be Thankful for all of those who gave!
This Thanksgiving . . .

PRAISING NEBRASKA'S HONOR FLIGHTS

HON. ADRIAN SMITH

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SMITH of Nebraska. Madam Speaker, a week ago, our Nation celebrated Veterans Day. I rise today to honor a couple who have done a great service for Nebraska's Veterans.

Bill and Evonne Williams have organized seven Heartland Honor Flights which made it possible for 1,454 World War II veterans to come to Washington D.C. in 2008 and 2009 to receive the recognition they deserve.

Veterans participating were able to visit the World War II memorial, as well as other points of interest here in the Nation's capital.

I know their visit to Washington was a trip of a lifetime for each and every one of them, and I know I speak for all of us when I thank them for their service to our country. Bill and Evonne also deserve our thanks for making these moments possible. Without their dedication and commitment, we would not have been able to honor these men and women who have helped make our Nation great.

HONORING THE 102ND INFANTRY AND THE 250TH ENGINEER COMPANY OF THE CONNECTICUT ARMY NATIONAL GUARD

HON. JOE COURTNEY

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. COURTNEY. Madam Speaker, I rise today to honor the deployment of 102nd Infantry Battalion and the 250th Engineer Company. On November 15, 2009, Connecticut sent off 700 soldiers from the two Connecticut National Guard units to be deployed to Iraq and Afghanistan in support of Operation Iraqi Freedom and Operation Enduring Freedom.

The logistical and tactical work that the Connecticut soldiers will do in Iraq and Afghanistan is critical to the Nation's success in the two conflicts. The 102nd Infantry will deploy to Afghanistan to partner with the Afghan security forces to assist, train and mentor the Afghan Army, Police, and Border Police forces in order to strengthen, stabilize and legitimize the Government of Afghanistan. The 250th Engineer Company will work in Iraq to provide bridging support for theater mobility, and to ensure rapid emplacement of bridging assets in the event that routes in their area of operations become impassable.

The Connecticut National Guard currently has nearly 500 Soldiers and Airmen mobilized and deployed to Kuwait, Iraq and Afghanistan in support of counterterrorism missions. This is the largest single deployment of Connecticut Army National Guardsmen since the Korean War and will bring our total number of deployed Soldiers and Airmen to 1,200.

The 250th Engineer Company, commanded by Captain Charles Taylor of Hamden is based in my district out of New London. The unit's motto is "No Bridge too Far," which refers to its primary mission of supporting our combat forces by literally building bridges over otherwise inaccessible terrain and rivers. In Iraq, the 250th will be a part of the drawdown of our forces and equipment there—a massive, historic undertaking in the history of our military.

This will be no easy feat—about 3.1 million pieces of equipment of all sorts, over 100,000 vehicles, military and civilian, 24,000 short tons of ammunition, over 120,000 containers of supplies, and around 120,000 U.S. military personnel that have to be moved out of Iraq, mostly through Kuwait.

This past weekend, I had the honor of joining many of my colleagues in the Connecticut Congressional Delegation, state officials and Adjutant General Thaddeus Martin in a moving and well attended "send off' ceremony for the 102nd and 250th. The ceremony, of course, was one of mixed emotions. On the one hand, these men and women represent the best of what our State and Nation has to offer. They have trained and worked to be the very best at what they do—and we are so proud of them. However, on the other hand, Connecticut is sending its own to do a hard and dangerous job.

The eyes of Connecticut and the families of these soldiers are on them, eagerly awaiting their safe return. But soon, the eyes of the world will be on them. And all of us in Connecticut will be so proud to watch the work that they do. Their missions in Iraq and Afghanistan are critical to America's mission to secure and keep the peace in the world's most troubled regions, and all of us from Connecticut are proud to say these dedicated men and women are our fellow citizens."

I ask all of my colleagues to join with me in honoring these men and women who defend our Nation every day. We thank them for their service and look forward to welcoming them home again after a successful deployment.

TRIBUTE TO CHARLES EDWARD McNEIL

HON. JO BONNER

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. BONNER. Madam Speaker, the City of Mobile recently lost a dear friend with the passing of Charles Edward McNeil, and I rise today to pay tribute to his memory. Mr. McNeil was a remarkable businessman, active citizen and committed U.S. Army Air Force pilot. He will be remembered by all as a man devoted to his family, his faith, and his country.

A graduate of Marion Military Institute, Mr. McNeil later attended the University of Alabama before volunteering for the U.S. Army Air Force during World War II. A decorated pilot, he was captured behind enemy lines after being shot down by the Germans and remained in captivity until the end of the war.

Coming home with two bronze stars, the Air Medal with Oak Leaf Cluster and two Purple Hearts, Mr. McNeil began a life of entrepreneurship that was as impressive as his dedication to his country.

His resume included a career with Protective Life Insurance Company, co-founder and director of Commercial Guaranty Bank, board member of SouthTrust Bank, and founding copartner in the McNeil, Jackson and Ahrens Financial group. He also held membership in the Million Dollar Roundtable since 1946. But that was just the beginning.

Mr. McNeil also found the time to serve his community as president of the Mobile County School Board for no less than 17 years and he maintained active membership in many philanthropic, civic clubs and service agency boards.

An avid sportsman and outdoorsman, Mr. McNeil exemplified the indomitable spirit of our Gulf Coast community. His love of life and tireless devotion to uplifting the lives of so many around him will be missed.

Madam Speaker, I ask my colleagues to join me in remembering a dedicated and generous community leader and a dear friend. Our condolences go out to his wife, Evelyn Adelia Bell; his children, Millie McNeil, Marilyn Peyronni, Charles McNeil and John McNeil; and his seven grandchildren and five great grandchildren.

Mobile—and indeed our entire state—lost a true leader and our thoughts and prayers are with his family.

RECOGNIZING IDA FIORELLA FOR HER UPCOMING BIRTHDAY

HON. BRIAN HIGGINS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. HIGGINS. Madam Speaker, I rise today to recognize Ms. Ida Fiorella, a longtime Buffalo resident who will be celebrating her 95th birthday this December 26th.

Ida was born in Buffalo's West Side on December 26th, 1914. The daughter of Italian immigrants Joseph Pizzuto and Maria Cordaro Pizzuto, Ida attended Buffalo's public schools and went on to work in her family-owned grocery store at the intersection of Prospect and Virginia located in Buffalo, New York.

Ida's brother Russell Pizzuto, now deceased, served honorably and was wounded in World War II; he was the father of six children.

Ida and her family were parishioners at St. Anthony's Church where she married her husband, Vincent (Jimmy) Fiorella on November 11th, 1940. Together Ida and Jim raised their three children, Russell, Bonnie, and Joseph, on Buffalo's West Side. Their marriage spanned 50 years until Jim passed away on March 19th, 1991.

When her children were grown, Ida went on to a successful career in retail sales. She spent a number of years at Hengerer's downtown, then at the Sample Shop on Hertel Avenue, and finally at Joseph's on Deleware Avenue, all located in Buffalo.

Ida is a wonderful homemaker, avid Italian cook, and premier pie maker. One of her proudest accomplishments was encouraging all of her children to go on to receive a college education.

Ida loves meeting and entertaining people and is very independent. Even to this day she does all of her own cooking, baking, and only stopped driving after her car was no longer road worthy. Ida still attends church and is a very devoted Catholic.

Madam Speaker, it is my honor to recognize Ms. Ida Fiorella as she approaches the celebration of her 95th birthday. I congratulate Ida for her many contributions to her family, friends, and community and wish her many more years of happiness.

HONORING THE 100TH ANNIVERSARY OF DRAUGAS

HON. DANIEL LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. LIPINSKI. Madam Speaker, I rise today to honor the Draugas newspaper on its 100th year of daily publication.

Draugas was founded in Wilkes-Barre, Pennsylvania in 1909 as a Lithuanian language Roman Catholic paper and moved to Chicago in 1916. The location changed a few times in its early years, but Draugas has been located at 4545 W. 63rd St. in Chicago since 1957. Many Lithuanian-Americans live on the Southwest Side of Chicago and in the surrounding suburbs I represent, and they greatly

appreciate the reporting and cultural commentary that Draugas provides.

Draugas serves approximately 10,000 daily readers. It is the only Catholic paper to be published daily in both the United States and Canada, and the only paper outside of Lithuania to be published in Lithuanian. In an effort to reach younger generations of Lithuanian-Americans, Draugas plans the publication of an English language edition in the near future.

An event honoring the newspaper's 100th anniversary took place in Willow Springs on October 17 and a Bishops Conference and Catholic Mass were held in Chicago on October 18 to honor Draugas and Lithuania's millennium.

I ask you to join me in honoring Draugas for its dedication to reporting, community service, and the preservation of Lithuanian culture around the world.

HONORING REVEREND E. THURMAN WALKER

HON. CHARLES A. GONZALES

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. GONZALEZ. Madam Speaker, I rise today with a heavy heart, to report the passing of the Revered E. Thurman Walker after a long illness. For more than 22 years, Reverend Walker was a leader in the city of San Antonio, first as assistant pastor and for the past 16 years as the senior pastor of Antioch Missionary Baptist Church.

Under Reverend Walker's leadership, Antioch grew to three thousand members and opened the Christian Academy, a private school at the Church, in 1995, and the Antioch Community Transformation Network, an organization dedicated to community service, in 2000. Reverend Walker was the spiritual leader of his congregation, but he insisted that the church play a role in the whole community and in the daily lives of all San Antonians. The church has been a pillar in the San Antonio community for a long time, but its role and reach increased under Reverend Walker as well. He forged alliances with other churches, particularly through the Community Churches for Social Action, and with other religious and social service organizations and with the city's political and business leaders. As his wife, Jo Angelia Walker, recalled his words, "If the church is doing nothing to serve and minister to the community then we might as well lock up the doors, close down and go home!"

Reverend Walker gave a voice to so many different groups of people in San Antonio's community, uniting people around their shared ideals and helping them to productive discussions even when their views diverged, always seeking out the best path for every one. He touched the lives of so many men, women, and children during his too short life. Though he may be gone, that legacy will live on forever.

STATEMENT OF CONGRESSMAN JOHN LEWIS ON THE GLOBAL SYMPOSIUM OF PEACEFUL NATIONS

HON. JOHN LEWIS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. LEWIS of Georgia. Madam Speaker, I rise today to recognize the Global Symposium of Peaceful Nations and the countries awarded for being the most peaceful in the world.

Let me begin by congratulating those Nations that were selected to participate in the Symposium—Australia, Botswana, Canada, Chile, Costa Rica, the Czech Republic, Denmark, Japan, Malawi, New Zealand, Norway, Oman, Qatar, Singapore, Slovenia, South Korea, Uruguay, and Vietnam.

Earlier this year, I led a congressional delegation to India to commemorate the 50th anniversary of Dr. Martin Luther King, Jr. and Mrs. Coretta Scott King's visit to follow in the footsteps of Gandhi. Soon afterwards, my good friend Mrs. Harriet Fulbright, widow of the late, great Senator J. William Fulbright, and her staff introduced me to the Global Peace Index and the Symposium.

Mahatma Gandhi once said,"Peace will not come out of a clash of arms but out of justice lived and done by unarmed nations in the face of odds." As Mrs. Fulbright explained the symposium and the GPI, I was impressed by the methodology of the research, the focus on peace, and the true commitment to improving the global community.

Every year Vision of Humanity researchers develop the Global Peace Index, GPI, based on a variety of economic and analytical factors. The results are based on a variety of economic and social indicators that rank over 140 countries on their peacefulness and evaluate the economic benefit of peace. The Global Symposium of Peaceful Nations then brings together representatives from the two most peaceful countries in each of the nine global regions on the GPI.

While here, the delegates engage in comprehensive dialogue about how to build and maintain peace. The countries that participate in the forum have unique histories, perspectives, and domestic and regional realities, but they must be commended in their significant progress in combating domestic poverty and making strides towards creating more peaceful communities. Together, we have a collective responsibility to combat poverty and violence and promote peace, diplomacy, and stability.

I hope that all my colleagues will find time to review the report and the Symposium summary. Again, let me commend the Global Symposium for this international forum highlighting the strategies and benefits of global peace.

REVEREND JESSE JACKSON, SR.

HON. MELVIN L. WATT

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. WATT. Madam Speaker, today I rise to recognize to honor the outstanding achievements of Reverend Jesse L. Jackson, Sr.

Twenty-five years ago, Reverend Jackson took an historic step when he ran for President of the United States, becoming only the second African-American to run for that office. He received over eighteen percent of the total Democratic primary vote and won five primaries and caucuses.

The numbers, while impressive, don't begin to convey the broad impact of his candidacy. Reverend Jackson motivated millions of new voters to register to vote and become engaged in the electoral process. His example of hope and achievement reaffirmed the self-worth of an entire generation of young African-American men and women. His candidacy was not a compromised, watered-down one. It demanded publicly that the national political agenda include the issues affecting a "Rainbow Coalition" of individuals, including African-Americans, Hispanics, Arab-Americans, Asian-Americans, Native Americans, gays, lesbians, farmers, the poor and the working class, and it started a whole new public dialogue.

Reverend Jackson challenged us to think bigger and inspired many others to pursue careers in public service. He paved the way for many of us in this body to run for political office and laid the foundation for the candidacy, nomination and election of President Barack Obama, our most recent historic candidacy and election.

Rev. Jackson's place in American history was legend long before his presidential candidacy—through his activism at North Carolina A & T University and leadership of civil rights demonstrations in Greensboro, North Carolina, his work with Dr. Rev. Martin Luther King, Jr. at the S.C.L.C. and the formation of Operation PUSH and the Rainbow/PUSH Coalition. But his presidential run twenty-five years ago solidified his place in history and continues to be an inspiration for all Americans today.

Rev. Jackson, thank you for all that you have done.

HONORING ANNE BURKHOLDER

HON. ADRIAN SMITH

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SMITH of Nebraska. Madam Speaker, I rise today in honor of Anne Burkholder, the Nebraska Cattlemen's Beef Association's Beef Quality Assurance Program Producer of the Year, for her dedication to ensuring Nebraska beef producers, practices ensure safe, wholesome, and quality beef and beef products.

Anne is a wife, mother of three young children, and a cattle feedyard owner and operator with 3,000 head of cattle. Anne grew up in urban West Palm Beach, Florida, before moving to Cozad, Nebraska where she became a key producer in Nebraska's cattle industry.

After she married her husband, Anne went from a neophyte ranch hand to becoming part owner and manager of one of the most progressive cattle feeding operations in Nebraska.

In her work, she has experienced every aspect of the feedyard business—from operating the feed truck, scooping bunks, cattle nutrition plans, vaccinations, you name it. Her determination and dedication to her family, community, and industry are nothing short of impressive.

I look forward to seeing what she will accomplish in the future.

RECOGNITION OF STEVE BAERTSCHE BEING INDUCTED INTO THE FARM SCIENCE REVIEW HALL OF FAME

HON. MARY JO. KILROY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. KILROY. Madam Speaker, I rise today to commend Steve Baertsche on his induction into the Farm Science Review Hall of Fame on September 22, 2009. Mr. Baertsche was inducted as one of five members of the 20th Hall of Fame Class.

Mr. Baertsche recently retired as the Assistant Director for Ohio State University Extension. OSU Extension seeks to bring the knowledge of the university to those Ohioans who do not have regular access to campuses around the state. Extension fulfills the land-grant mission of the Ohio State University by interpreting research developed by the Ohio Agricultural Research and Development Center, Ohio State, and other land-grant universities, so that Ohioans can use scientifically-based information to improve their lives. OSU Extension serves a vital role by strengthening communities through research-based educational programming.

Mr. Baertsche led OSU Extension's leadership effort for more than 15 years and helped enhance the program's presence at the Farm Science Review, FSR. FSR manager Chuck Gamble stated that, "Steve Baertsche's leadership was much appreciated. His understanding of Extension and its mission definitely led to the success of Ohio State University research and educational efforts at Farm Science Review. He took Extension to a higher level."

I am privileged to say that Steve Baertsche is one of my constituents. I would like to congratulate Mr. Baertsche again, and I thank him for his service and his work to instruct Ohioans how to better their lives through education.

EXPRESSING CONDOLENCES AND CELEBRATING THE LIFE OF JOHN O'QUINN

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I rise today to honor an incredibly gifted personal injury lawyer and dedicated philanthropist, Mr. John O'Quinn.

Mr. O'Quinn spent his career serving others by fighting to make sure the most vulnerable members of our society received justice. As a lawyer, his unwavering commitment to his clients was legendary, and throughout his legal career, he used his unique personality and staggering intellect as an advocate for the powerless. In his life, he was named one of the 100 Most Influential Lawyers in America by the National Law Journal, 100 Legal Legends of Texas by Texas Lawyer magazine, Five Best Texas Trial Lawyers of the Past Century by the Houston Chronicle, and was recognized in Harvard Law's "Best Lawyers in America."

It is important to note, however, that Mr. O'Quinn's remarkable capacity in the courtroom was only one part of his dynamic personality. As a notable philanthropist, he handsomely endowed his alma mater, the University of Houston, by helping to fund the John O'Quinn Law Library and the John O'Quinn Field at Robertson Stadium. He served as a Regent for the university as well as a Trustee for the law school foundation. Additionally, he assisted numerous other charitable organizations including the Children's Assessment Center, the Women's Center, Baylor College of Medicine, the End Hunger Network, St. Luke's Episcopal Hospital, and the South Texas College of Law Advocacy Center.

Madam Speaker, the world truly lost a gracious soul with the untimely death of John O'Quinn. I ask my fellow colleagues to join me in both honoring this brilliant attorney and celebrating his life and countless accomplishments. He will be truly missed.

HONORING CAPTAIN DANIEL C. RHODES ON BEING NAMED "MARINE OF THE YEAR"

HON. DANIEL LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. LIPINSKI. Madam Speaker, I rise today to honor Captain Daniel Rhodes of La Grange, Illinois on being named the 2009 Marine Corps Times Marine of the Year. All our service men and women make extraordinary sacrifices and are worthy of acclaim. But the Marine Corps Times has chosen a truly exemplary member of our Armed Forces for this incredible honor.

Growing up in La Grange and attending Lyons Township High School, Daniel Rhodes always knew he would be a Marine. His strong faith and passion for community service are a tribute to his parents, who have spent the last 10 years in Lima, Peru running an orphanage. With their selflessness as his guide, Daniel Rhodes enlisted in the Marines in May 2001 with an uncommon drive and certainty of purpose.

Then First Lieutenant Rhodes served as the commander of Weapons Company, 1st Battalion, 3rd Marines in Karmah, Iraq starting in August 2008. With just two years of experience as an officer, he commanded 200 Marines and more than 500 Iraqi militia members, functioning as both a warrior and a mentor. Daniel Rhodes and his men used emergency relief funds to commence more than 30 service projects in the area in and around Karmah. The results included the refurbishment of 21 schools, four bridges, two water treatment plants, two roads, a community center, and two factories, as well as the development of an adult literacy program. These projects helped thousands of Iraqis and are examples of the kinds of critical but often unsung efforts that lie at the heart of our military's work in Iraq.

During his personal time while deployed, Daniel Rhodes authored a book on military ethics that is now used throughout his battalion. He also incorporated discussion of ethics and leadership into his company's weekly routine. Truly, Daniel Rhodes is a man of uncommon ability and unimpeachable character.

Upon his return to Hawaii, Daniel Rhodes was promoted to Captain and named commander of Charlie Company, 1/3. There he developed a relationship with Aloha United Way, and continued to be involved in community service projects, helping to refurbish vacant public housing units and assisting with food drives along with his men.

After eight years, Captain Daniel Rhodes left the service this past July to continue his education and to spend more time with his wife, Marine Captain Elizabeth Jackson. I have no doubt that he will accomplish more great things in life. I ask you to join me in honoring Captain Daniel Rhodes for his outstanding service and recognition as the 2009 Marine of the Year.

FOREIGN STUDENTS SOCIAL SECURITY NUMBERS REFORM ACT OF 2009

HON. SAM JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SAM JOHNSON of Texas. Madam Speaker, I rise today to introduce the Foreign Students Social Security Numbers Reform Act. Simply put, this bill would prohibit foreign students from receiving Social Security numbers. In no way however would this bill prohibit foreign students from getting jobs as they can do so now. As is currently the case, foreign students may receive Social Security numbers for work purposes even though they do not need to pay Social Security taxes on any of their earnings.

Given that the real purpose of a Social Security number is to track workers' earnings on which they have paid Social Security taxes, it makes no sense that we are giving out numbers to those who are here temporarily and do not pay Social Security taxes. Moreover, a 2007 Inspector General report found that some foreign students "may have obtained Social Security numbers for purposes other than on-campus employment or other authorized work". After all, these are highly prized numbers.

So rather than giving out numbers to those who don't really need them, we should instead work to better safeguard numbers to those

who should have the numbers in the first place. Also this likely will prevent foreign students from overstaying their welcome.

I urge my colleagues to cosponsor this legislation.

HONORING THE LIFE AND SERVICE OF MAJ. L. EDUARDO CARAVEO OF WOODBRIDGE, VA

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise to honor the life and service of Maj. L. Eduardo Caraveo, who was among the 13 killed in the tragic shootings at Fort Hood, Texas, earlier this month.

Maj. Caraveo, a resident of Woodbridge, Va., was a Medical Service Corps Officer in the U.S. Army Reserves who had arrived at Fort Hood just one day prior to the shootings. He was preparing to deploy to Afghanistan, where he was to provide stress counseling to deployed service members.

He was active in his adopted home of Prince William County, where he spent time counseling prison inmates. He also offered his services for anger management training and couples therapy.

A native of Ciudad Juarez, Mexico, Maj. Caraveo came to the United States as a teenager and became the first in his family to graduate from college. He received his undergraduate degree from the University of Texas at El Paso and earned a doctorate in psychology from the University of Arizona.

According to local news accounts, he was a generous, giving friend and father who enjoyed spending time playing in the yard with his children.

Maj. Caraveo is survived by his wife, Angela Rivera; their son and her two daughters; three children from a previous marriage and six siblings.

Madam Speaker, I ask my colleagues to join me in honoring the remarkable life and service of Maj. Caraveo and the lives of the twelve others killed on that tragic day at Fort Hood. Their brave service, and that of their families, will never be forgotten and we extend our sympathies to them.

DR. HANS R. WILHELMSEN

HON. C.A. DUTCH RUPPERSBERGER

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. RUPPERSBERGER. Madam Speaker, I rise before you today to honor Dr. Hans R. Wilhelmsen, 33 Degree Sovereign Grant Inspector General, for his distinguished service to the principals of the Masonry, Scottish Rite, and Grand Lodge.

Dr. Wilhelmsen was raised as a Master Mason in December 1982. He received the 32 degree in the Scottish Rite, Valley of Baltimore in the Spring Class of 1983. In 1991, he became an Honorary Past Master of Pythagoras Lodge and received the Knight Commander Court of Honor in 1995. Dr. Wilhelmsen was coroneted a 33 degree mason in 1997.

During the early years of his Masonic journey, Dr. Wilhelmsen's time was devoted mainly to plastic and reconstructive surgery. He is a 1959 Magna Cum Laude graduate of the University of Maryland School of Dentistry. Inspired by the lectures of Dr. Milton Edgerton, Professor of Plastic Surgery, Wilhelmsen matriculated to the University School of Medicine. In 1963, Dr. Wilhelmsen obtained his medical degree in General Surgery. He completed Plastic Surgery training in 1965 at the University of Pittsburgh.

While much of his time was dedicated to plastic and reconstructive surgery, Dr. Wilhelmsen dedicated the spare time he had to Masonry. In 1995, he was appointed to the Scottish Rite Holding Company. Wilhelmsen progressed to assisting the Sovereign Grand Inspector General, Dr. Bernard E. Rothman. In 2003, he was coroneted Sovereign Grand Inspector General in Maryland and Active Member of the Supreme Council. Three years later, Dr. Wilhelmsen was awarded the highest honor that is given by the Grand Lodge of Maryland for his contribution to masonry in the State of Maryland. A portrait of him is now mounted in the Pillars of Charity Portrait Gallery at the House of Temple in Washington, D.C.

Dr. Wilhelmsen's medical and personal philosophy emphasizes treating all people with respect and dignity. He is a tireless worker for his patients, whose lives have been enriched by his professional manner and surgical ability. Though his profession left little time for extracurricular activities, Dr. Wilhelmsen has remained actively involved in Masonry.

Madam Speaker, I ask that you join with me today to honor Dr. Hans R. Wilhelmsen for his commitment to Masonry, Scottish Rite, and Grand Lodge. Dr. Wilhelmsen's enthusiasm and commitment is a remarkable asset to the Masonic organization.

IN RECOGNITION OF THE 20TH ANNIVERSARY OF THE BILL NICHOLS STATE VETERANS HOME

HON. MIKE ROGERS

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. ROGERS of Alabama. Madam Speaker, I respectfully request the attention of the House to pay recognition to an important day for the Bill Nichols State Veterans Home in Alexander City, Alabama.

This important Veterans facility opened November 30, 1989, and was named after William "Bill" Nichols, who was instrumental in making Alabama's first state veterans home a reality. Congressman Nichols, a World War II Veteran and recipient of the Bronze Star and Purple Heart, was first elected to the U.S. House of Representatives in 1966 and served until his passing in December of 1988.

The Bill Nichols State Veterans Home is a 150-bed skilled nursing home for our Veterans, and because of its excellent quality of care, has well over 100 Veterans awaiting admission. To date, over 1,500 of our heroes have resided there.

The Bill Nichols State Veterans Home was awarded the 2009 Quality Award from the American Health Care Association for its commitment to continuous quality improvement in long-term care. On November 30, 2009, the facility and its proud employees will host a 20th Anniversary Celebration program followed by a luncheon and open house.

I would like to congratulate this facility, its proud employees and the community for reaching this important milestone. These Alabamians are shining examples of dedication for the brave men and women who have served our country in uniform and I wish them all the best at this important occasion.

THE TAXPAYER INVESTMENT PROTECTION ACT

HON. MARK STEVEN KIRK

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. KIRK. Madam Speaker, with little more than the blink of an eye, the American taxpayers have lost $25 billion—with no transparency, accountability or justification.

In December 2008, the Treasury Department loaned General Motors $13 billion. In the spring, Treasury loaned GM another $6 billion. Days before GM declared bankruptcy, the Obama administration poured in another $30 billion—just in time to convert taxpayer loans to equity and take ownership of this American giant. All of these funds came from the Troubled Asset Relief Program—a bailout never intended for such purposes. As the Congressional Oversight Panel wrote last month, "the use of TARP funds for the automotive industry raises questions regarding both presidents' authority to use these funds under EESA legislation and, more broadly, under the U.S. Constitution."

Last month, the ex-"Car Czar" Steve Rattner, the Government Accountability Office and the TARP Congressional Oversight Panel independently estimated the taxpayers' $49 billion investment in GM to be worth about $25 billion. The government's "Bridge Loan to Nowhere" lost half of the taxpayers' money. This is only one company. The U.S. taxpayer owns debt and equity securities in other private corporations, including Chrysler ($12.5 billion), Citigroup ($45 billion) and AIG ($41 billion). How much are taxpayers losing on nearly $100 billion invested in these struggling firms?

Today, I introduce the "Taxpayer Investment Protection Act," which sets a December 2010 deadline for the Treasury Secretary to divest the federal government's ownership of private firms. These TARP-funded government investments add to the Treasury's $12 trillion debt burden and put taxpayer funds at risk for greater loss. The time has come to protect the taxpayer from any more losses and set a timetable for withdrawal to get the government out of private business.

HONORING THE PANTRY OF BROWARD, INC.

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. HASTINGS of Florida. Madam Speaker, I rise today to honor an organization that has helped countless individuals in my community. The Pantry of Broward, Inc., is a not for profit organization that provides food and support services to low-income seniors and to grandparents raising grandchildren.

In Florida alone, there are 147,893 grandparents raising grandchildren, yet 8 percent of grandparent caregivers live in poverty, as do nearly 10 percent of all seniors. For those who live in Broward County, and the children who rely on them, the Pantry of Broward is an indispensible resource.

Each month, the Pantry of Broward delivers a 60 pound box of food items to hundreds of seniors. However, the Pantry of Broward is much more than a food bank. They also provide seniors with transportation services, legal assistance, access to affordable medical care, and a slew of other resources that make life just a little bit easier for Broward's struggling seniors.

Whether an individual needs help finding affordable housing, is having trouble understanding complicated medical or insurance forms, or simply needs a pair of eyeglasses fixed, the Pantry of Broward is there to help.

Seniors in south Florida, like those around the Nation, have worked hard and provided for themselves and others their entire lives, yet often, despite incredible need, they are too proud to ask for a helping hand. For this reason, the Pantry of Broward provides assistance in a caring, dignified manner, mindful of their clients' privacy and self-esteem.

Madam Speaker, while we in Congress work to revive our Nation's economy, it is organizations like the Pantry of Broward that serve as a lifeline to the seniors and families in our districts struggling to make it from one day to the next. I am truly grateful for the services they provide to my constituents and commend them on their extraordinary work.

CELEBRATING 30TH ANNIVERSARY OF SEATTLE'S DOWNTOWN EMERGENCY SERVICE CENTER

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. McDERMOTT. Madam Speaker, today I rise to offer special recognition to Seattle's Downtown Emergency Service Center, DESC, on its thirtieth anniversary. For three decades, this non-profit organization has committed itself to serve the most vulnerable homeless populations of Seattle with shelter, services, advocacy, and housing.

DESC began as a partnership among the City of Seattle, the Greater Seattle Council of Churches, and Washington Advocates for the Mentally Ill to address the shortage of shelter and services for a growing population of homeless persons in the Seattle area. On November 19, 1979, with fourteen staff, DESC opened its doors to nearly 200 homeless adults as an overnight emergency shelter in the ballroom of the Morrison Hotel, in Seattle's historic Pioneer Square. A year later, DESC became a Mental Health Care licensed agency. Since its early years, DESC has been a leader in developing programs that provide a full continuum of care to address the root causes of homelessness.

In 1985, DESC was selected as a pilot location for the national "Health Care for the Homeless" program to integrate chemical dependency, mental health, and nursing with shelter services. In 1989, DESC enhanced its local outreach program by sending clinically trained staff to the streets to seek out and establish first contact with Seattle's most vulnerable homeless men and women. That novel practice has become the standard outreach strategy used in most major U.S. cities today.

In addition, DESC began developing permanent supportive housing for the hardest-to-serve homeless men and women. In 1997, it opened the Lyon Building with 64 apartments for homeless adults affected by HIV/AIDS, mental illness and/or addiction, implementing a "Harm Reduction" model. That same year, it also introduced the "Housing First" model to Seattle with the opening of the Kerner Scott House: 40 apartments for formerly homeless, mentally ill, and/or addiction-challenged adults. In 2005, DESC expanded its "Housing First" model with the opening of the 1811 Eastlake, a 75-unit building for late-stage chronic inebriates, typically high users of public services.

Over the years, DESC has received dozens of awards and widespread recognition for its innovative housing projects and intensive services. In 2004 and in 2005, it received the Metlife Award for Excellence in Affordable Housing, making it the only organization to win the award in two successive years. In 1999, the U.S. Department of Housing and Urban Development awarded its "Best Practice Award" to DESC for innovation in developing services that later became industry standards. Most recently, DESC won the 2007 Maxwell Award of Excellence for its 1811 Eastlake project. A study published in the Journal of the American Medical Association in 2009 revealed that the 1811 Eastlake program has saved taxpayers $4 million dollars annually.

Madam Speaker, for more than thirty years, DESC has served disabled and vulnerable homeless adults through a continuum of care model that not only helps people survive but breaks the vicious cycle of homelessness. Today, it has become one of the largest multi-service centers for homeless adults in the Pacific Northwest, employing more than 300 employees who provide permanent supportive housing, clinical and emergency services, and overnight shelter. DESC is an invaluable asset to our community, to the Seattle-King County Coalition to End Homelessness, and to our nationwide efforts to address homelessness. I extend my best wishes and commend DESC's Executive Director Bill Hobson, its Board of Directors, its staff, and its clients on "30 years of opening doors to end homelessness." I know DESC will continue to lead the way with thoughtful, innovative answers to our most challenging social issues.

HONORING THE LIFE AND SERVICE OF DEA SPECIAL AGENT FORREST LEAMON OF DALE CITY, VA

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise to honor the lives of three local men, who recently died in a tragic helicopter crash while serving with the U.S. Drug Enforcement Agency in Afghanistan.

Their work was a critical part of recent U.S. efforts to disrupt drug trafficking that is believed to be funding Taliban insurgents in Afghanistan. These were the first DEA fatalities since the war began even though the agency has been operating in Afghanistan since 2005.

Special Agent Forrest Leamon was a resident of Woodbridge, Va., and had served in Afghanistan since 2007. Special Agent Chad Michael was a resident of Quantico, Va., and recently arrived in Afghanistan. Special Agent Michael Weston was a resident of Washington, D.C., and until recently served in the DEA's Richmond field office.

The crash also claimed the lives of seven U.S. service members.

During a memorial ceremony, Attorney General Eric Holder praised Special Agent Leamon as "always willing to accept tough assignments. When the opportunity came to volunteer—to volunteer—to work in Afghanistan, the most dangerous assignment available, he stepped up again."

Leamon was born in Ukiah, Calif., and would have celebrated his 38th birthday this Sunday. He is survived by his wife, Ana, and their soon-to-be born child; his parents, Richard and Sue Leamon, of Fortuna, Calif.; two sisters; a niece and two nephews; his grandmother; as well as aunts, uncles and cousins.

Madam Speaker, I ask that my colleagues join me in honoring the lives and service of these brave men and extending our sympathies to their families.

HONORING WILSON HALLIDAY PIPKIN

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Wilson Halliday Pipkin, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 96, and in earning the most prestigious award of Eagle Scout.

Wilson has been very active with his troop participating in many scout activities. Over the many years Wilson has been involved with scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Wilson Halliday Pipkin for his accomplishments with the Boy Scouts of

America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

COMMEMORATING THE BIRTHDAY OF PRESIDENT ZACHARY TAYLOR

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. WOLF. Madam Speaker, I rise today to commemorate the birthday of a great American president, Zachary Taylor.

Zachary Taylor was born on a farm in Barboursville, Virginia, on November 24, 1784. His father had served with George Washington in the Revolutionary War and his family members were prominent planters. Zachary Taylor had a 40-year military career in the U.S. Army, serving in the War of 1812, Black Hawk War, Second Seminole War, and the Mexican-American War, where he earned the nickname "Old Rough and Ready," because of his willingness to share his troops' hardships. Taylor became a national hero after facing overwhelming odds to triumph in a battle against the Mexican General Santa Anna at Buena Vista.

This extraordinary record of service to the Nation was further enhanced when Zachary Taylor was elected president of the United States in 1848. Under his administration, the Department of the Interior was created. Much of Taylor's administration was focused on the issue of the expansion of slavery, with the Compromise of 1850 coming shortly after his death.

Madam Speaker, I call the attention of the House to the life, legacy, and accomplishments of Zachary Taylor on the upcoming 225th anniversary of his birthday.

INTRODUCTION OF THE JUSTICE FOR SURVIVORS OF SEXUAL ASSAULT ACT

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mrs. MALONEY. Madam Speaker, today, I am proud to introduce this important bipartisan legislation with my colleagues, Representatives HELLER, NADLER, KENNEDY, CAPPS, WAXMAN, SPEIER, MCGOVERN, ISRAEL, GRIJALVA, RICHARDSON, PERRIELLO, ENGEL, DELAHUNT, COSTA, WATSON, HALL (NY), STARK, CHU, NORTON, MOORE (KS), and HOLT. The companion bill has been introduced in the Senate by Senators FRANKEN, GRASSLEY, HATCH, and FEINSTEIN.

I have been working on the issue of DNA technology since 2001 when I, along with former Representative Steve Horn, held a hearing in the Government Reform Committee where we heard from a courageous rape survivor, Debbie Smith.

It was for Debbie, and the thousands of rape survivors like her, that I authored "The Debbie Smith Act" to provide Federal funding to process the unconscionable backlog of DNA evidence. This legislation passed as part of the Justice for All Act of 2004, authorizing the necessary funding to start processing the backlog through the creation of the Debbie Smith DNA Backlog Grant Program. Since 2004, millions of dollars in funding have been appropriated under the Debbie Smith DNA Backlog Grant Program.

Despite the availability of funding and some progress made, the national backlog continues to persist. Recent media reports have documented that across the country, backlogs continue to rise and sexual assaults occur that might otherwise have been prevented were the kits processed in a timely manner. This bill addresses the continuing rape kit backlog and several other problems that work to deny justice to victims of sexual assault—including the denial of free rape kits to survivors of sexual assault, and the shortage of trained health professionals capable of administering rape kit exams.

By creating incentives for jurisdictions to eliminate their rape kit backlogs, process their incoming rape kits in a timely manner, and publicly report their backlog numbers, this legislation would go a long way to ensuring that the purpose and intent of the Debbie Smith Act be fully realized.

According to the Rape, Abuse, & Incest National Network, every two minutes someone is sexually assaulted somewhere in the United States. DNA evidence does not forget and it cannot be intimidated. By processing this evidence, we can prevent rapists from attacking more innocent victims and ensure that the survivors and their families receive justice.

RECOGNIZING NEW YORK YANKEES OWNER GEORGE STEINBRENNER III

HON. JOSÉ E. SERRANO

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SERRANO. Madam Speaker, I rise today to recognize the New York Yankees owner, George Steinbrenner III. I recently sponsored a resolution congratulating the Yankees on their 27th World Series win. Since the World Series victory was dedicated to Mr. Steinbrenner, I wanted to honor his dedication to the city of New York and the Yankees. He has owned the franchise for 36 years, the longest serving owner in Yankee history.

Mr. Steinbrenner always has had a longstanding interest in coaching and sports management. He began as an athletic director and baseball/football coach at an Ohio high school. In 1955, he became an assistant football coach for Northwestern University. The following year in 1956, he was an assistant coach for the Purdue University football team.

By 1961, he led a team of investors in the purchase of the Cleveland Pipers of the National Industrial Basketball League, which soon joined the American Basketball League, ABL. In May of 1962, Steinbrenner got the coveted young rookie, Jerry Lucas, to play for the Pipers. That same year the Pipers won the ABL Championship. Under his ownership, Steinbrenner made history by having the first African-American coach in professional basketball, John McClendon.

It was not until 1973 that Mr. Steinbrenner became part of a now historic deal when he bought the Yankees for $10 million from Columbia Broadcasting Company, CBS. When Mr. Steinbrenner took ownership of the Yankees, they were a team in decline. After the 1962 season, the glory days were winding down for the Yankees. In 1966, they finished last in the American League, which had not happened since 1912. As owner, Mr. Steinbrenner took over a Yankees franchise that needed rebuilding from the bottom up. He accepted nothing less than victory and made sure everyone in the Yankees organization worked together towards that goal. Within 4 years, Steinbrenner had directed the team back to its winning ways by helping guide the Yankees to World Series championships in 1977 and 1978.

This winning tradition has continued over the years. Overall, under his management, the Yankees have brought home 7 world championships, 11 American League pennants, and 16 division titles. Many Yankee legends have played for the team during Steinbrenner's tenure as owner. Derek Jeter was quoted in the Associated Press after the recent World Series win as saying that, "He's the reason we're here. First of all, we wouldn't be in this stadium if it wasn't for him. We wouldn't have this group together if it wasn't for him. This is a special moment. We all tried to win it for him. He deserves it."

There is no question that George Steinbrenner has changed and modernized major league baseball and professional sports. A Yankees franchise that sold for $10 million in 1973 has grown to a current value of $1.5 billion under Steinbrenner's leadership.

Mr. Steinbrenner is also a dedicated and generous philanthropist. He established the Gold Shield Foundation in Tampa Bay and the Silver Shield Foundation in New York City, both of which financially support families of fallen police officers. Among many other endeavors, he has donated funds to the University of North Carolina at Chapel Hill, the Massachusetts Institute of Technology (MIT), Ohio State, the University of Florida, and most notably, given $1 million to the Hokie Spirit Memorial Fund at Virginia Tech University. These are just a few of his many efforts to assist other organizations.

Although Mr. Steinbrenner was not in attendance at the 27th Yankee World Championship, his legacy was an important part of the franchise's victory. The message displayed over the field on that November night says it all: "Boss this is for you!"

Madam Speaker, it is an honor to recognize Mr. Steinbrenner for his long dedication towards the City of New York, my borough of the Bronx, and the great success that he has brought to the New York Yankees organization.

INTRODUCING THE INCREASING ACCESS TO VOLUNTARY SCREENING FOR HIV/AIDS AND STIS ACT OF 2009

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. HASTINGS of Florida. Madam Speaker, I rise to introduce the Increasing Access to Voluntary Screening for HIV/AIDS and Sexually Transmitted Infections Act of 2009, a bill that will reduce the spread and morbidities associated with HIV/AIDS and other sexually transmitted infections, STIs.

Fifty percent of sexually active Americans will contract an STI at some point in their lives, and 15 million STIs are reported each year in the United States. Many of these infections are asymptomatic for an extended amount of time and often remain undiagnosed, or diagnosed at later stages resulting in increased rates of mortality, morbidity, disability, and transmission.

The Centers for Disease Control and Prevention, CDC, and the United States Preventive Services Task Force recommend that voluntary screening for HIV/AIDS and other STIs be integrated into routine clinical care. However, stigma, culture, language, lack of education, cost, limited resources, and inaccurate perceptions of risk contribute to insufficient screening for HIV/AIDS and STIs. And, these same factors have exacerbated the instances of transmission and late detection of HIV/AIDS and STIs over the past decade.

The Increasing Access to Voluntary Screening for HIV/AIDS and STIs Act of 2009 takes an aggressive and multifaceted approach to combating HIV/AIDS and STIs by increasing access to voluntary screening and other preventative methods while preserving patient rights and confidentiality.

Among other things, my bill includes 83 percent Federal Medical Assistance Percentages, FMAP, rate for the screening of HIV/AIDS and other STIs and requires all private health insurance plans to cover screening for HIV/AIDS and other STIs. My bill provides grants to Federally Qualified Health Centers to serve individuals who cannot access screening because they lack insurance coverage or sufficient income. And, my bill urges the Centers for Medicare and Medicaid Services (CMS) to implement a broad and comprehensive approach to covering screening for HIV/AIDS, and encourages CMS to take steps to reimburse screening for other STIs.

Additionally, the Increasing Access to Voluntary Screening for HIV/AIDs and STIs Act of 2009 supports access to early medical and mental treatment. It includes language from the Early Treatment for HIV/AIDS Act, ETHA, and requires testing facilities to link patients to appropriate medical and mental health services.

Lastly, the bill will make screening and other preventative services more accessible to groups that have been historically underrepresented in public health interventions for HIV/AIDS and other STIs. It requires the Director of the CDC to work with appropriate entities to track screening trends for HIV/AIDS and STIs among people with disabilities, and ensure that comprehensive sex education materials are accessible to these individuals. The bill directs the Secretary of Health and Human Services to take the appropriate steps to ensure that all women have equal access to screening for cervical cancer regardless of sexual behavior or sexual orientation. And, this bill directs the Secretary of Health and Human Services to improve research efforts concerning the prevention, spread and transmission of HIV/AIDS and STIs in the transgender community.

Madam Speaker, voluntary and routine screening for HIV/AIDS and other STIs is an effective and low-cost approach to decreasing the life-threatening and life-altering effects of these infections. I urge my colleagues to support this important bill that includes a comprehensive and evidence based strategy to improve the overall health of our nation.

RECOGNITION OF THE VIENNA INN

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise today to celebrate the 50th Anniversary of a landmark in Northern Virginia, the Vienna Inn. Located in the heart of the Town of Vienna, the Inn continues to bring together people from all walks of life. You always feel welcome and you can always find a good meal and great conversation.

The Vienna Inn is a part of the fabric that makes up the Town of Vienna. Its walls, with vintage black and white pictures, sports memorabilia, and other oddities, tell Northern Virginia's story. First opened in 1960 by Mollie and Mike Abraham, the Vienna Inn took over what was then Freddy's Cafe. Dating back to when the tavern was first built in 1925, the Inn also has served as an ice cream parlor and a sandwich shop.

Mollie and Mike sought to establish a local restaurant that would encourage the community to come together and share their common experiences in a relaxed setting. As Mollie Abraham once said, "You could sit at a table with strangers and by the end of the night be friends".

Mike and Mollie became fixtures of our community, supporting local sports teams and community events. In fact, when Mollie was not making jokes with patrons she could be found umpiring local tennis matches, volunteering with the Americans for Democratic Action, and serving as a regional board member with the National Organization for Women.

The Abraham family's business grew into a local treasure, with people coming from all over the National Capital Region for a famous Vienna Inn hot dog and a pint of beer. As the business grew, the Abrahams hired their son, Philip, a Culinary Institute of America graduate, as their head chef. Mollie credits her son's home-style cooking with helping the Inn remain so popular within the community.

After 40 years of service to the community, Mollie sold the Vienna Inn to Marty Volk in 2000. To Mollie, selling the Vienna Inn to Mr. Volk was like keeping the business in the family. Marty has been a customer since he was a 6-year-old, and he understands the rich history and the tradition of the Vienna Inn.

Today, the Vienna Inn is still the same as it was 50 years ago. You'll see business leaders at the bar eating a hot dog with the local plumber and a soccer team enjoying chili dogs at the corner table. Of course, the "Vienna Inn Corner Club" still claims one corner of the bar every weekday afternoon. Madam Speaker, I ask my colleagues to join me in congratulating the Vienna Inn on 50 years of service to the Town of Vienna. I and many other loyal patrons from across Northern Virginia wish the Inn many more years of continued success.

CONGRATULATIONS TO THE SPIRIT OF WAXAHACHIE

HON. JOE BARTON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. BARTON of Texas. Madam Speaker, I rise today to congratulate the Spirit of Waxahachie Indian Marching Band for officially being recognized as one of the top 10 high school bands in the State of Texas. This achievement represents the highest marching award that the Waxahachie Marching Band has earned in the school's history.

This is "the little band that could." With only 122 members on the field, they were the smallest band in the UIL 4A State Band Contest to make the finals. And from all accounts, their performance of their 2009 marching show entitled "A Kinetic Mind" encompassed every meaning within "kinetic"—constant motion, fast-paced, and high energy, literally electrifying the crowd inside the Alamodome.

Now let me explain how big this accomplishment actually is. There are hundreds of Division 4A bands in the State of Texas, and in November, only 26 qualified to compete for the title. The Spirit of Waxahachie Indian Marching Band finished eighth and I couldn't be more proud of what these students accomplished on the field.

But it is what they do in the classroom and in the community that makes them even more special. These teens begin practicing and training over the summer, dedicating several hours each day to learn the music and routines required to achieve excellence. This alone is quite a feat when you consider just how hot it is in Waxahachie in August.

But these are first and foremost students whose determination and dedication not only applies to the band program, but to their academic and community efforts as well. Once they leave class and band practice ends—these teens keep working. A majority of them are involved with community service projects and volunteer with organizations all over the city.

These students, their directors and their supporters have truly exemplified their title as The Spirit of Waxahachie. I am proud to represent them here in Congress and once again congratulate them for proving that hard work and dedication lead to great accomplishments.

The Spirit of Waxahachie Indian Marching Band includes:

Directors: Rich Armstrong—Head Director, Reggie Cook—Assistant, Kendra Ray—Assistant, Dan Francis—Assistant, Donnie Owens—Assistant, Johnny Young—Percussion Instructor, Layci Dagley—Percussion Instructor, Denise Armstrong—Color Guard Instructor.

Drum Majors: Tiffany Neal, Haley Nutt.

Section Leaders: Scott Tipton—Drumline Captains, Tiffany Hinman—Color Guard Captain, Ashley Maass—Flute, Brittany Haines—Clarinet, Kaitlyn O'Brien—Saxophone, Ryan Popp—Trumpet, Carissa Needham—Horn, David Hale—Trombone, Trey Speer—Baritone, Mikey Kirton—Tuba.

Band Members: Samuel Allelo—Euphonium, Eline Andreasen—Bb Clarinet, Jack Ansell—Trombone, Sarah Arnold—French Horn, Maria Baez—Trumpet, Katy Behning—Trumpet, Michelle Boggs—Color Guard, Logan Bowers—Drumline, James Bridges—Trumpet, Jessica Cadena—Bb Clarinet, William Carter—Tenor Sax, Jerrin Castillo—Drumline, Jake Chastain—Trombone, Kyle Clayton—Drumline, Ethan Craig—French Horn, Alyssa Cupp—Bb Clarinet, Ben Davis—Front Ensemble, Maddie Devore—Drumline, Jesse Dillinger—French Horn, Justin Donelson—French Horn, Kendall Drew—Tuba, Dayvetta Dvorak—Bb Clarinet, Tedra Edmonson—Color Guard, Jacob Engel—Front Ensemble, Taylor Engel—Trumpet, Stephen Erickson—Trumpet, Travis Featherston—Drumline, Marrisa Gallegos—Color Guard, Miranda Galvan—Color Guard, Dan Gandara—Front Ensemble, Hannah Gentry—Color Guard, Richard Gonzales—Trumpet, Ellen Gordon—Color Guard, Sydney Graf—Color Guard, Victoria Guajardo—Flute, Tiffany Haines—French Horn, Allison Hale—Flute, Sha' Quita Hall—Color Guard, Shane Hartis—Front Ensemble, Andrew Harwell—Trumpet, Zachary Hatchel—Trumpet, Marieta Hawkins—Flute, Kelsey Hayes—Bb Clarinet, Jackie Hernandez—Color Guard, Jack Herrington—Euphonium, Jacob Hill—Drumline, Hayli Howard—Tuba, D'Layni Huff—Drumline, David Hummer—French Horn, Cameron Ingram—Flute, Lauren Johnson—Drumline, Kallen Jones—Trumpet, Brady Kelley—Alto Sax, Kaitlynn Kerbow—Flute, Chelsea Kimberlin—Bb Clarinet, Sarah Kinney—Bb Clarinet, Albreshia Lawrence—Flute, Nicholas Lopez—Bb Clarinet, Melinda Louque—Tenor Sax, Toni Madrid—Alto Sax, Kimberly Mares—Color Guard, Hannah Marshall—Trombone, Melissa Martinez—Alto Sax, Manny Mata—Euphonium, Caleb McCutchen—Front Ensemble, Karis McGrew—Color Guard, Kaci McMahan—Drumline, Josh McMurray—Trumpet, Reagan McMurray—Euphonium, Alex Meade—Bb Clarinet, Michael Mederos—Trumpet, Max Mills—Tuba, Carlos Monge—Alto Sax, Ashley Moon—Flute, Tanner Morehead—Euphonium, Faith Morgan—Bb Clarinet, Lauren Moritz—Flute, Yousef Muwaquet—Trombone, Laura Nottingham—Flute, Tiffany Oglesby—Alto Sax, Nathan Owens—Tuba, Jordan Palmer—Alto Sax, James Perkins—Euphonium, Kelsey Peyrot—Drumline, Danielle Phillips—Bass Clarinet, Molly Prescott—Color Guard, Marisa Price—Drumline, Dillon Pryor—Front Ensemble, Jeremy Quintana—Trumpet, Scott Quintana—Trombone, Bridget Reid—Bb Clarinet, Craig Renfro—Tuba, Milka Reyna—Flute, Bradley Richardson—Trumpet, Daniel Richardson—Alto Sax, Hannah Ritchie—Color Guard, Marissa Rodriguez—Bb Clarinet, Emily Rolen—Bb Clarinet, Jacque Rosso—Color Guard, Audra Russell—Bb Clarinet, Adrian Salvador—Front Ensemble, Sara Sanchez—Drumline, Jared Schueler—Alto Sax, Dillon Shepherd—Trumpet, Natalie Shoemake—French Horn, Breanna Simpson—Flute, Taylor Smith—Drumline, Brooke Stembridge—Bass Clarinet, Cole Stembridge—Trombone, Collin Stephenson—Tenor Sax, Tiffany Sweet—Bass Clarinet, Rance Taylor—Trombone, Jenna Thomas—Trumpet, Corey Troxell—Trombone, Felcia Tunson—Color Guard, Amanda Unarut—Percussion, Christina Unarut—Color Guard, Tanner Underwood—French Horn, Samuel Vasquez—Alto Sax, Sarah Warren—Euphonium, Wiebke Wenholt—Color Guard, Reed White—Trumpet, Kora Woodard—Front Ensemble, Taylor Wright—Drumline, Andrew Zimmerman—Trumpet, James Zimmerman—Trombone.

CHARLES GOLDEN

HON. MICHAEL E. McMAHON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MCMAHON. Madam Speaker, I rise today to honor Charles Golden as he celebrates his 90th birthday this month. Mr. Golden is the grandfather of my constituent Stevie Lacy-Pendleton, and I honor him for being a great community role model.

Throughout his life, Mr. Golden overcame many adversities. As the only son born into a family of young women, much was expected of him after his father's death. Still only a child when his father died, he took a job in the coalmines of Virginia to help support his family through the Great Depression. It was a different time in America. There were few jobs available especially for African-Americans, so Mr. Golden considered himself lucky, even blessed to have a job, no matter how difficult it was on a day to day basis.

An early work accident left him unable to join the military, but it opened a door to higher education. He applied and was accepted to Central State, which later became Central State University. Throughout his college years, he continued to work and send money home, at times holding more than one job.

Upon graduation, he became one of the few African-American engineers in America. He was hired by a federal defense contractor in Dayton, Ohio spending his entire career with them and retiring after over 40 years of service in 1989. During his 40 plus years as an engineer, he mentored countless young people as they began their engineering careers.

He has always been a great community leader. He became an active member of the Middle Run Baptist Church which was founded by freed slaves and is one of the oldest such institutions in the country. As a member of the Middle Run Baptist Church for over 50 years, he serves as a senior deacon, assistant treasurer and a member of the men's choir. He supervises church maintenance and repairs, and cooks for the weekly breakfast program that is open to church members and non members alike. He also fills in as the driver of the church bus which helps transport seniors and people with disabilities.

He was married to his devoted wife Frances for more than 50 years before her passing a number of years ago. Mr. Golden puts his religious beliefs into everyday action. He is a role model for young and old.

Madam Speaker, I ask that my colleagues join me in commending Charles Golden as we join with the members of his church who honored him on November 13, 2009, as a man who overcame insurmountable obstacles, and as the quiet man who has touched and made a difference in so many lives.

THE DIABETES PREVENTION ACT OF 2009

HON. SUSAN A. DAVIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mrs. DAVIS of California. Madam Speaker, I rise today to address a serious and expanding health problem. Rates of type 2 diabetes continue to rise—despite our knowledge of how to prevent it—and it is time we took action to reverse the disturbing trend.

Thirty years ago, there was no known or proven strategy to fight the onset of type 2 diabetes. Now, we know how to delay onset of this disease, or prevent it completely, according to the National Institutes of Health, NIH. And yet, we are not using this potentially lifesaving knowledge to our greatest benefit.

Meanwhile, those who develop the illness still suffer from and can't always properly recognize its symptoms, including fatigue and vision problems. When type 2 diabetes causes those symptoms to progress, it can lead to detrimental and heartbreaking results.

Furthermore, the cost to care for diabetes patients reached $174 billion in 2007, and that number is only expected to get larger. The illness is a growing problem in the population as a whole, and appears to be increasing among children and adolescents, according to the Centers for Disease Control and Prevention, CDC. It makes sense to work to prevent onset of type 2 diabetes. This will both ensure quality of life for patients and reduce overall health spending—especially when the number of Americans at risk is predicted to grow.

I am introducing the Diabetes Prevention Act of 2009 to put our medical knowledge to use to reduce and delay instances of type 2 diabetes. Through the CDC, communities will be able to apply for grants to establish prevention programs designed to assist those diagnosed with pre-diabetes. Working with local medical officials, the programs will help patients with good diet, exercise plans, and other lifestyle changes needed to prevent or delay onset of the illness.

The Diabetes Prevention Act of 2009 builds on the success community organizations have had with similar programs in preventing illness. It is crucial that we address this serious problem and act now to stem the number of cases of type 2 diabetes developing in our country.

I urge consideration of the legislation.

RECOGNITION OF SPRINGFIELD NARFE CHAPTER 893

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise today to recognize the National Active and Retired Federal Employees Springfield Chapter 893 and applaud its dedication and service to the local community. This chapter of NARFE enjoys the second largest membership in the country, and continues to carry out NARFE's mission of safeguarding and enhancing the benefits of America's active and retired federal employees, and their survivors.

At a recent meeting this chapter took a moment to remember and reflect on friends and family who have served in the armed forces. Of particular note was a poem written by Chaplain Margaret Yowell entitled "What Is a Veteran?"

"WHAT IS A VETERAN?"

He is the cop on the beat who spent six months in Saudi Arabia sweating two gallons a day and making sure the armored personnel carriers didn't run out of fuel. He is the barroom loudmouth whose overgrown frat-boy behavior is outweighed a hundred times in the cosmic scales by four hours of exquisite bravery near the 38th parallel.

She is the nurse who fought against futility and went to sleep sobbing every night for two solid years in Da Nang. He is the POW who went away one person and came back another—or didn't come back at all. He is the Quantico drill instructor that has never seen combat—but has saved countless lives by turning young men into Marines, and teaching them to watch each other's backs.

He is the parade-riding Legionnaire who pins on his ribbons and medals with a prosthetic hand. He is the career quartermaster who watches the ribbons and medals pass him by.

He is the three anonymous heroes in The Tomb of the Unknowns, whose presence at the Arlington National Cemetery must forever preserve the memory of all the anonymous heroes whose valor dies unrecognized with them on the battlefield or in the ocean's sunless deep. He is the older guy at the supermarket—palsied now and slow—who helped liberate a Nazi death camp and who wishes all day long that his wife were still alive to hold him when the nightmares come.

He is an ordinary and yet an extraordinary human being—a person who offered some of his life's most vital years in the service of his country, and who sacrificed his ambitions so others would not have to sacrifice theirs.

So remember, each time you see someone who has served our country, just lean over and say Thank You. That's all most people need, and in most cases it will mean more than any medals they could have been awarded or were awarded.

Madam Speaker, I ask my colleagues to join me in thanking Chaplain Margaret Yowell and the National Active and Retired Federal Employees Springfield Chapter 893 for their dedication and service to our brothers and sisters who have so bravely served their country. Our veterans have made the ultimate sacrifice to their nation, and I am proud to work with NARFE to ensure we uphold our commitment to our federal employees and service men and women.

OUR UNCONSCIONABLE NATIONAL DEBT

HON. MIKE COFFMAN

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. COFFMAN of Colorado. Madam Speaker, this morning our national debt was $12,030,202,701,513.91. I should note this week is the first time our debt has broken the 12 trillion level.

On January 6, 2009, the start of the 111th Congress, the national debt was $10,638,425,746,293.80.

The national debt has increased by $1,391,776,955,220.11 so far this year.

According to the non-partisan Congressional Budget Office, the forecast deficit for this year is $1.6 trillion. That means that so far this year, we borrowed and spent $4.4 billion a day more than we have collected, passing that debt and its interest payments to our children and all future Americans.

IN RECOGNITION OF THE 63RD WEDDING ANNIVERSARY OF MR. AND MRS. A. NORMAN BANTZ

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CANTOR. Madam Speaker, I respectfully request the attention of the House to pay recognition to an important day in the lives of Mr. and Mrs. A. Norman Bantz.

On November 16, 2009, Norman and Gloria Bantz celebrated their 63rd wedding anniversary. Norman was born on July 17, 1921, and his wife, Gloria, was born on November 16, 1922.

The couple married on November 16, 1946 at Annunciation Church in Crestwood, New York.

Over the years, Norman and Gloria have been blessed with 6 children, Alexandra Louise, Rita Marie, Ralph Fredrick, Margaret Elizabeth, Katherine Mary, and Peter James; 13 grandchildren, and 7 great grandchildren.

On November 16, the couple along with their family and friends celebrated their anniversary at the home of their daughter.

I would like to congratulate, Norman and Gloria, for reaching this important milestone in their lives. They are shining examples of love and dedication for us all, and I wish them and their family all the best at this important occasion.

HONORING CARY LIGHTSEY

HON. ADAM H. PUTNAM

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. PUTNAM. Madam Speaker, I rise today to honor a nationally recognized leader in protecting the environment and a sixth generation Florida rancher, Cary Lightsey of Lake Wales, Florida, who was awarded the 2009 Southeastern Farmer of the Year.

The Sunbelt Agricultural Exhibition Southeastern Farmer of the Year Award honors excellence in agricultural production and management, leadership in community and farm organizations, and recognizes family contributions in producing safe, abundant supplies of food, fiber and shelter for U.S. consumers. Cary Lightsey, as the sixth award recipient to come from the state of Florida, represents some of the best of American agriculture.

It is a great privilege to recognize Cary Lightsey and his family for their many achievements and contributions to the fanning industry and to their community.

Brahma Island, a large secluded region in Lake Kissimmee, is home to 28 endangered species, 14 nests of bald eagles and 300-year-old oaks, ancient Indian settlements, wild game, and commercial beef cattle. This island, owned by Cary Lightsey, and the Lightsey Cattle Co., is preserved in its natural state and will remain so through a perpetual conservation easement. On the island and his other ranches, Lightsey raises over 7,000 head of commercial cattle.

Lightsey and his family have been innovative leaders in methods to market cattle, development of replacement stock, as well as expansion and vertical integration into the cattle market throughout the United States. In addition to raising livestock on the island, Lightsey offers ecological tours and guided hunts for wild hogs and exotic deer.

Cary Lightsey was the first Florida rancher to use conservation easements. By keeping 40 percent of his ranches in native land use, Lightsey has been able to make extensive use of conservation easements that cover about 70 percent of his ranching properties. With the easements, Lightsey retains ownership of the land and receives benefits from environmental and governmental organizations in return for giving up his rights to develop the land.

In addition to these conservation and livestock endeavors, Lightsey has been involved in several other innovative ventures including harvesting palmetto berries used for a prostate cancer medicine, relocating threatened gopher turtles onto his ranches, and his latest effort, raising Wagyu cattle for the Japanese beef market. He has also established new grass varieties used for forages and treatments for water flow nutrients, sharing these technologies with other Florida ranchers.

Cary Lightsey has made valuable contributions to his community through numerous civic activities as well. Each year he donates cattle to the Florida State Fair Futurity Steer Show, is active in the Polk County Youth Fair, and has served on numerous conservation and water management district land boards.

I stand today to commend Cary Lightsey and his family, including his wife, three children and grandchildren for this honor, which was said to be have been bestowed due to his entrepreneurial spirit, good business judgment, sound farming practices, high ethical standards and leadership in his family, community, state and nation. The 2009 Sunbelt Expo Southeastern Farmer of the Year title was also awarded to Lightsey for his sensitivity to the

environment, his response to community and social concerns, and his "abiding devotion to his family, his faith and his nation."

Madam Speaker, I am honored to represent this great American.

HONORING CHRIS MARROU

HON. CHARLES A. GONZALEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. GONZALEZ. Madam Speaker, I rise today to honor the end of an era. For just shy of 35 years, Chris Marrou has anchored the news broadcast at San Antonio's KENS–5 television. On November 24, 2009, he will give his final broadcast.

Though he spent his youngest days in San Marcos, TX, Chris was born in San Antonio and has lived in the city for most of his life. He was among the first students at Robert E. Lee High School. After being voted "Most Likely to Succeed" by his graduating class, it was off to Princeton University where he began his career in broadcasting on the campus radio station, WPRB. Upon graduating, Chris returned to San Antonio, working first in radio, for KITE and KBAT, before moving into television with WOAI, where he soon began covering sports. San Antonio lost him briefly when a Dallas radio station lured him away, but he soon returned, taking over the anchor spot at KENS–5 television on December 24, 1973. And what a Christmas present that was.

Over the past 36 years Chris has been one of the most trusted and respected voices in San Antonio and South Texas, even during his brief sojourn in Boston. He has won numerous awards from the Texas Associated Press Broadcasters and other organizations. Not content with just one career, however, Chris began attending St. Mary's University School of Law, graduating with his Juris Doctor in 2007, the same year he was voted "Best TV News Anchor" by the San Antonio Express-News. After passing the Texas bar later that year, he founded the firm of Ramíriz, Marrou & Martínez de Vara, P.L.L.C. with some of his law school classmates.

Chris Marrou has been a great friend to the City of San Antonio, a familiar and trusted friend, welcomed into the homes, and hearts, of millions of people at 6 p.m. and 10 p.m. every night. He will be greatly missed, though we wish him the best as he moves into the next phase of his life.

COMMENDING BETA GAMMA CHAPTER (VSU) OF ALPHA PHI ALPHA

HON. ROBERT C. "BOBBY" SCOTT

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SCOTT of Virginia. Madam Speaker, I rise today along with my colleague Rep. RANDY FORBES, to call attention to a group of young students from Petersburg, Virginia, who have distinguished themselves, their University, and the Commonwealth of Virginia.

I direct my colleagues' attention to the brothers of the Beta Gamma Chapter of Alpha Phi Alpha fraternity at Virginia State University. Over the last three years the Beta Gamma chapter has partnered with Big Brothers Big Sisters and has maintained one hundred percent chapter membership participation rate. They are the first, and only, Alpha Phi Alpha chapter in the country to accomplish this remarkable achievement. I would like to applaud my brothers for volunteering to be responsible role models for at-risk youth, helping them to reach their full potential and to lead vibrant, successful lives.

Alpha Phi Alpha fraternity was founded on December 4, 1906, at Cornell University in Ithaca, New York. As the first intercollegiate Greek letter fraternity established for African Americans, Alpha Phi Alpha initially served as a brotherhood and study and support group for minority students at Cornell, but it also recognized the need to help correct the educational, economic, political and social injustices faced by African Americans.

From that initial foundation at Cornell, the core Alpha Phi Alpha principles of scholarship, fellowship, good character and the uplifting of humanity were established. Alpha Phi Alpha now has a presence on hundreds of college campuses as well as in hundreds of alumni chapters in 44 States. The presence is also felt here in Washington, where nine members of the U.S. Congress are members of Alpha Phi Alpha fraternity.

In 1991, an agreement was entered into between Alpha Phi Alpha and Big Brothers Big Sisters of America to unite their efforts to transform communities and the lives of young African Americans. The men of Alpha Phi Alpha have become thoroughly engaged in recruiting volunteers, and cultivating a positive relationship and experience with their Little Brothers.

The brothers of Beta Gamma continue this proud tradition by proactively engaging the Petersburg community's schools and families, in addition providing one-on-one youth mentoring for children at-risk of slipping through the cracks of our society. Studies show that the regular presence of a responsible adult provides lasting, positive impacts on the life of a child. Those children mentored by the Big Brothers of Beta Gamma chapter will be less likely to use drugs and alcohol, will perform better in school, and will have healthier family relationships.

Today, I rise to recognize these young gentlemen for their genuine concern for their local community and for their dedication to public service.

RECOGNIZING CAKES BY HAPPY EATERY

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise today to recognize a sign of recovery and reinvestment in our nation's economy. On November 19, 2009, "Cakes by Happy Eatery" opens its doors for business in Manassas, Virginia.

This family-owned business was established in 1986 as the "Happy Eatery Restaurant and Bakery." It previously operated in Alexandria, Virginia as a traditional Chinese restaurant with an in-house bakery for 17 years. In 2002, the business moved to a location in Centreville, Virginia and became "Cakes by Happy Eatery." During this move, the family decided to undergo more than just a name and location change. They also transformed the business model and focused all of their talents and efforts on becoming a full-service bakery.

This has proven to be a successful business decision. The family's recipes and catering services have been well received and the business has outgrown its Centreville location. The new Manassas location will expand the family's services and responsibilities. The matriarch, Mrs. Fu-Mei Wu, will act as the chief quality control manager. Mrs. Wu's daughters will continue to be involved in the bakery's everyday business. Victoria Wu will oversee daily operations. Charlotte Wu Homme will handle advertising and Emily Wu-Rorrer will continue to create the popular bakery's new products.

Madam Speaker, I ask that my colleagues join me in commending the Wu family for creating jobs by opening a new "Cakes by Happy Eatery" location. I admire the Wu family for their hard work, and I hope for their continued success.

HONORING SIMON HUGHES

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. POE of Texas. Madam Speaker, recently the Texas record for the largest gator killed on state property was broken by 110 pounds. The new state record stands at 800 pounds and 12-foot-6-inches. The remarkable thing is that the shooter, Simon Hughes, had only a year of experience under his belt. Even more remarkable was that the shooter is a five year old from Goodrich Texas, near Lake Livingston.

Simon Hughes is the son of Scott Hughes a sixth generation rancher also from East Texas. Mr. Scott Hughes was reasonably worried that something "real big was out there" and driving smaller gators into his stock ponds. He then obtained a state permit to kill the alligators populating his 5,000 acre ranch near the Lake. Mr. Hughes also took his son, a mere first grader, along for a hunt seeing as he already had been taught gun safety since he was "big enough to walk and stand in a deer blind." When the gator came upon Simon, he screamed "holy moly," and shot the beast that was twenty times his size with his new junior-sized .410-gauge shotgun.

Madam Speaker, in true cowboy fashion Simon wants the world to know that he was never afraid for a second. Texas commends Simon for his bravery and outstanding accuracy at such a young age.

TRIBUTE TO RABBI STEVEN FOSTER AND SENATOR JOYCE FOSTER

HON. DIANA DeGETTE

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. DEGETTE. Madam Speaker, I would like to recognize the extraordinary accomplishments of a distinguished couple in the 1st Congressional District of Colorado, Rabbi Steven Foster and State Senator Joyce Foster. Rabbi Foster has announced that he will retire in June 2010 after four decades at Denver's Temple Emanuel, the oldest Jewish congregation in Colorado. On this occasion, I rise to pay tribute to the Fosters and to their exceptional service to our community and our world.

The Fosters moved to Denver in 1970, when Rabbi Foster accepted his first position as an ordained rabbi at Temple Emanuel after receiving degrees in Hebrew Letters at Hebrew Union College in Cincinnati. Together they have raised three children and have made Denver a better place for all its residents.

The first Temple Emanuel with which Rabbi Foster was affiliated was in his hometown of Milwaukee, where he grew up attending the synagogue during the emerging civil rights movement. By the time of his bar mitzvah, he was determined he would become a rabbi. As a senior in college at the University of Wisconsin-Madison, he traveled to Alabama to walk in the historic Freedom March led by Dr. Martin Luther King to the state capitol in Montgomery. His actions marked a lifelong commitment to social justice.

Rabbi Foster has been an activist for social justice, an advocate for interfaith outreach, and a spiritual leader to the thousands of Temple Emanuel congregants. Rabbi Foster's work has included founding the Temple Emanuel Preschool and Kindergarten, Herzl Day School, and Stepping Stones to a Jewish Me, an outreach program for interfaith families. He has served on the boards of Planned Parenthood of the Rocky Mountains, National Council of Justice and Peace, United Way, and Allied Jewish Federation, to name just a few.

Rabbi Foster has taken on all these tasks while also tirelessly devoting himself to the spiritual needs of his flock. Never reticent to speak out and take action on social issues, Rabbi Foster has worked assiduously against the death penalty and for racial equality, reproductive rights, and the rights of lesbian, gay, bisexual, and transgender people. In the words of Rabbi Foster, ''Either we are all created in God's image, or we're not.'' Temple Emanuel's largest community service project, Mitzvah Day, embodies Rabbi Foster and Temple Emanuel's commitment to social justice, as hundreds of families go into the Denver community and perform good deeds.

Joyce Foster grew up in Benton Harbor, Michigan. She was educated at Lake Michigan College and Roosevelt University and Northwestern University in Chicago, where she met Rabbi Foster. In 1977, she began a 16-year career at Jewish Family Service in Denver, where, as Director of Employment Services, she worked with many refugees from the former Soviet Union and Pacific Rim countries. In 1993, she ran for Denver City Council. Upon her election, she became the first Jewish woman to sit on the Council. She subsequently spent 10 years representing District 4 and served as Council President during 2001–2002. As a Councilwoman and Council President, she was a leader on transportation, land use issues, and regional cooperation between the City and its surrounding suburbs. She represented Denver on the Denver Regional Council of Governments Board, and developed close working relationships with other cities and counties, business and transportation organizations, and state agencies such as the Colorado Department of Transportation. One of her signature accomplishments was working with Denver middle and high school students to help build a skate park in downtown Denver, which helped reduce crime and benefited the community by providing an after-school activity for young people.

After retiring from the Denver City Council, in 2008 Joyce Foster was elected to represent her community as Senate Senator for Colorado's District 35. As a State Senator, Joyce Foster has been a champion for access to health care as a basic human right and for high-quality education for all children. Named by Denver's 5280 magazine as one of four Colorado ''Freshman Legislators to Watch,'' Senator Foster has earned a reputation as a savvy legislator who reaches across the aisle to serve the public good.

On behalf of the citizens of the 1st Congressional District, I wish to express our gratitude to Rabbi Steven Foster and Senator Joyce Foster. Through their commitment to public service and social justice, they have made our community a better place. We look forward the continued involvement of this remarkable couple in our civic life. Please join me in commending these distinguished public servants.

HONORING MRS. DEBBIE SPERO FOR RECEIVING THE JOHN CAMPANIUS HOLM AWARD

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. GORDON of Tennessee. Madam Speaker, I rise today to honor Mrs. Debbie Spero, recipient of the 2009 John Campanius Holm Award.

Each year, the National Weather Service honors Cooperative Weather Observers with this prestigious award, named after John Holm. During the years 1644 and 1645, Holm recorded observations of the local weather twice a day, and he is the first known person to have kept these observations.

Since September 1, 1985, Debbie Spero has been involved with the NWS Cooperative Observer Program in Bethpage, Tennessee, reporting daily weather and precipitation data to the Army Corps of Engineers. Her reports are used to document the climate of Middle Tennessee and are also used by local NWS officials to verify forecasts, warnings and precipitation patterns.

Through her 24 year involvement, Debbie has been an incredibly reliable observer. Her observations are complete and in near real time. When she has been unable to make her observations because of illness or travel, she has enlisted help to ensure as few breaks in the record as possible.

In her spare time, Debbie is an active community member. As a Girl Scout leader for more than 14 years, her troop has helped serve underprivileged girls in the Bethpage area by meeting with them weekly. Debbie also works as a Youth Leader at Grace Baptist Church and has served as President of the Bethpage Parent Teacher Organization.

Each year, the John Campanius Holm award is given to only 25 Cooperative Observers from more than 11,000 in the program. The award is based on complete and accurate observations, outstanding enthusiasm for imparting observational knowledge, and civic involvement in the community. The award is only given to active observers of more than 20 years.

Debbie, thank you for your hard work and dedication in serving your community. I wish you all the best in the years to come.

CONGRATULATIONS TO PRESIDENT HAMID KARZAI

HON. JOE WILSON

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. WILSON of South Carolina. Madam Speaker, as co-chairman of the Afghanistan Caucus, I want to congratulate President Hamid Karzai on his inauguration for a second term in Afghanistan. In his speech, I am pleased President Karzai stated that he is committed to tackling corruption and restoring security in his nation.

I support the position of Secretary of State Hillary Clinton, who attended the inauguration, that President Karzai has his chance to ''have accountability and tangible results that will improve the lives of the people.'' In my nine visits to Afghanistan, I have learned of the dedication of Defense Minister Abdul Raheem Wardak and Interior Minister Haneef Atmar. I know firsthand of the capabilities of the Afghan police and army units, who were trained by my former National Guard unit, the 218th Brigade led by Brigadier General Bob Livingston, 2007–2008, of the South Carolina Army National Guard.

It is vitally important that in order for Afghanistan to turn the corner, the U.S. must do everything promised to the people of Afghanistan to provide for a secure and stable society. We must grant the necessary resources with our NATO allies to President Karzai to get the job done.

I was grateful to learn last night at a dinner with Slovak Foreign Minister Miroslav Lajcak to commemorate the 20th anniversary of the Velvet Revolution that Slovakia is doubling its troop commitment in Afghanistan. Slovakia is a revered partner of America promoting freedom and democracy.

CONGRATULATING TURKEY AND ARMENIA FOR THEIR STEPS TOWARS PEACE

HON. DAN BURTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. BURTON of Indiana. Madam Speaker, last month in Zurich, Switzerland, with the strong support of the United States, the foreign ministers of Turkey and Armenia took an unprecedented step forward in their efforts to overcome decades of animosity and distrust between their two countries.

Almost before the ink was dry special interest groups in both countries and abroad who profit from the status quo were attacking the deal which means that there are still immense hurdle left before Turkey and Armenia full normalize diplomatic and bilateral relations. Nevertheless, the two protocols offering a ''road map'' signed on October 10, 2009, is the right course of action for both countries. The process is very fragile, but enjoys the support of the international community.

The protocols have been submitted to the Turkish and Armenian parliaments for debate and ratification. The stage is now set for the two parliaments to both deliberate the contents of and hopefully pass the protocols. It will not be an easy vote but the political, economic and international benefits for both sides are enormous; that is if Turks and Armenians are willing to take the chance for real peace; and willing to give up business as usual.

For years I have come to this Floor advocating that issues concerning Turkey and Armenia should be resolved at the negotiating table by the two countries in question. I urge my colleagues to strongly support this process.

INTRODUCTION OF THE CLEAN RENEWABLE WATER SUPPLY BOND ACT OF 2009

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. BECERRA. Madam Speaker, I rise today to introduce the Clean Renewable Water Supply Bond Act of 2009 with Representative GINNY BROWN-WAITE. This legislation would authorize public water agencies to issue tax credit bonds as a financing vehicle for certain innovative new water supply technologies.

Drought, global climate change, population growth, and increased competition for urban, agricultural, and environmental needs have combined to create potential water shortages of crisis proportions in the decades ahead unless Congress acts quickly to invest in new, alternative water supply facilities.

Fresh water is a limited resource in high demand. Population growth continues to strain available and quickly diminishing water supplies, leading to a growing need for new investments in water supply and treatment facility projects. The U.S. General Accounting Office has stated that even under normal water conditions, 36 States anticipate water shortages in the next 10 years.

However, innovative technologies exist that can help provide new sources of clean water while helping to improve the environment. While the costs of these technologies continue to decline, the initial capital expenditures required to build their infrastructure is still too high to use conventional financing mechanisms. A deeper subsidy is needed and can be achieved through the use of tax credit bonds.

This legislation would authorize the use of tax credit bonds, Clean Renewable Water Supply bonds, or ''CREWS'', to finance certain kinds of innovative water supply facilities. These facilities include water-recycling facilities, projects to clean up and use impaired groundwater, and both seawater and brackish groundwater desalination projects. These CREWS bonds would be issued by public water agencies in exactly the same way as those agencies can presently issue conventional tax-exempt municipal bonds.

The proceeds from the sale of the bonds would result in an interest-free loan to the water agency. Instead of the agency having to make interest payments to the bondholders, as would be the case with conventional tax-exempt municipal bonds, the Federal Government would provide the bondholders with a tax credit equal to what the interest payments would have been. Under the proposal, the agency would save over $60 million in interest payments on a $100 million water supply project, which is the type of subsidy necessary to offset the upfront capital expenditure.

Working with Representative BROWN-WAITE, I hope this Congress moves with all due speed to consider and pass this vital legislation. Let me also take this opportunity to invite all of my colleagues to join me in sponsoring this bill that takes concrete action to address our nation's future water needs.

PERSONAL EXPLANATION

HON. BART STUPAK

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. STUPAK. Madam Speaker, on Monday, November 2, 2009 through the morning of Friday, November 6, 2009, I could not be present for votes due to a family funeral back in Michigan.

Had I been present, I would have voted as follows:

House Rollcall Vote 832. I would have voted ''yes.''

House Rollcall Vote 833. I would have voted ''yes.''

House Rollcall Vote 834. I would have voted ''yes.''

House Rollcall Vote 835. I would have voted ''yes.''

House Rollcall Vote 836. I would have voted ''yes.''

House Rollcall Vote 837. I would have voted ''yes.''

House Rollcall Vote 838. I would have voted ''yes.''

House Rollcall Vote 839. I would have voted ''yes.''

House Rollcall Vote 840. I would have voted ''yes.''

House Rollcall Vote 841. I would have voted ''yes.''

House Rollcall Vote 842. I would have voted ''yes.''

House Rollcall Vote 843. I would have voted ''yes.''

House Rollcall Vote 844. I would have voted ''yes.''

House Rollcall Vote 845. I would have voted ''yes.''

House Rollcall Vote 846. I would have voted ''yes.''

House Rollcall Vote 847. I would have voted ''yes.''

House Rollcall Vote 848. I would have voted ''yes.''

House Rollcall Vote 849. I would have voted ''yes.''

House Rollcall Vote 850. I would have voted ''no.''

House Rollcall Vote 851. I would have voted ''yes.''

House Rollcall Vote 852. I would have voted ''yes.''

House Rollcall Vote 853. I would have voted ''yes.''

House Rollcall Vote 854. I would have voted ''yes.''

House Rollcall Vote 855. I would have voted ''yes.''

House Rollcall Vote 856. I would have voted ''yes.''

House Rollcall Vote 857. I would have voted ''yes.''

House Rollcall Vote 858. I would have voted ''yes.''

House Rollcall Vote 859. I would have voted ''yes.''

House Rollcall Vote 860. I would have voted ''yes.''

House Rollcall Vote 861. I would have voted ''yes.''

House Rollcall Vote 862. I would have voted ''yes.''

House Rollcall Vote 863. I would have voted ''yes.''

House Rollcall Vote 864. I would have voted ''yes.''

House Rollcall Vote 865. I would have voted ''yes.''

House Rollcall Vote 866. I would have voted ''yes.''

House Rollcall Vote 867. I would have voted ''yes.''

PERSONAL EXPLANATION

HON. JOHN A. YARMUTH

OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. YARMUTH. Madam Speaker, I was unable to cast the recorded votes for rollcalls 896, 897, and 898. Had I been present I would have voted ''yes'' for these measures.

HONORING LT. FLORENCE BACONG CHOE

HON. DUNCAN HUNTER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. HUNTER. Madam Speaker, today I rise in recognition of Lieutenant Florence Bacong Choe of San Diego, California. Lt. Choe was a victim of a tragic shooting that occurred at Forward Operating Base Shaheen in Afghanistan's Northern Balkh province on March 27, 2009.

According to friends and family, Lt. Choe was all Navy. She was born at San Diego Naval Hospital and grew up in San Diego, where she graduated from Monte Vista High School in 1991. After graduating from the University of California, San Diego with a degree in Biology in 1997, she continued her education and received a Masters degree in Public Health Care Administration from San Diego State University in 2001. Following the events of September 11, 2001, Lt. Choe visited the San Diego Navy recruitment office and enlisted as a Lieutenant Junior Grade in the U.S. Navy Medical Service Corps.

While serving in her capacity as Healthcare Administrator for Medical and Surgical Services at the National Navy Medical Center in Bethesda, Maryland, she met her future husband, Lieutenant Commander Chong "Jay" Choe. They were married on June 21, 2004 and in 2006, they welcomed the birth of their daughter, Kristin Bacong Choe.

A dedicated service member, Lt. Choe fulfilled various duties in the Navy Medical Corps in Japan and San Diego before deploying to Afghanistan in May of 2008. It was during this deployment where she made the ultimate sacrifice after a shooter, disguised as an Afghan Army soldier, opened fire and killed Lt. Choe and Lt. J.G. Francis L. Toner IV.

Madam Speaker, for Lt. Choe it was never about self, but about family, friends and country. She dedicated her extensive knowledge about the medical field to provide quality care for the men and women of the U.S. Navy. For her, and the thousands of others who have given their lives in the name of freedom and democracy, I ask that this body continue to do its best to ensure their deaths were not in vain. May God continue to watch over the family and friends of Lt. Florence Bacong Choe as her memory, passion and dedication to our country continue to live on as we moved forward to a better tomorrow.

RECOGNITION OF THE 211TH REGIONAL SUPPORT GROUP

HON. SOLOMON P. ORTIZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. ORTIZ. Madam Speaker, I rise today to recognize the 211th Regional Support Group from Corpus Christi, Texas, for their tireless efforts to ensure the security and well being of not only the country of Iraq but the United States as well.

Deployed on December 1, 2008, this unit worked in the face of grave danger and performed in an exemplary fashion in the management of installation and camp activities.

Sixty members of this unit will be returning to my district on Saturday, November 21, and it is my honor and privilege to welcome them home.

Our Reservists put their lives on hold, to fulfill the duties asked of them. I have the greatest respect for our service men and women who selflessly disregard their own safety in order to voluntarily serve our country.

Today, I ask that my colleagues join me in commemorating the 211th Regional Support Group of Corpus Christi, Texas, for their service to this nation.

HONORING ST. HUGO OF THE HILLS IN BLOOMFIELD HILLS, MICHIGAN

HON. GARY C. PETERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. PETERS. Madam Speaker, I rise today to recognize and honor the selection of St. Hugo of the Hills in Bloomfield Hills, Michigan, as a 2009 Blue Ribbon School. This prestigious award is the highest honor bestowed by the United States Department of Education. That St. Hugo earned this designation is a testament to the dedication of its administration, teachers, staff, students, parents and community members, whose hard work of self-evaluation, review and goal-setting for the future has proved exemplary.

The Blue Ribbon Schools designation is reserved for schools that provide only the most rigorous academic programs or which have made only the most dramatic strides in improving their students' academic achievement. In fact, St. Hugo School was the only private school in Michigan to receive the award this year. St. Hugo of the Hills has a long-celebrated and exemplary tradition of striving for academic excellence, with standardized test scores that reflect a deep commitment to high achievement. St. Hugo of the Hills provides its students an outstanding program of nationally recognized excellence in an environment in which the teachings of the Catholic faith are instilled, nurtured and demonstrated. Since 1940, it is this combination that has enabled St. Hugo to count among its alumni scores of community leaders and dedicated, productive citizens.

Madam Speaker, I ask my colleagues to join my recognition of St. Hugo of the Hills on the honor of its outstanding achievement for being designated a 2009 National Blue Ribbon School.

CONGRESSMAN BOBBY L. RUSH DAY

HON. BARBARA LEE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. LEE of California. Madam Speaker, on behalf of the Congressional Black Caucus I rise today in honor of my colleague and fellow CBC member, the Honorable BOBBY L. RUSH. Throughout his distinguished career, Congressman RUSH has served as a determined leader for civil rights and a passionate advocate for our nation's least fortunate citizens and their communities. On Saturday, November 28th, Rev. Jesse Jackson and the RainbowPUSH Coalition will honor Congressman RUSH during "Bobby Rush Day," a celebration of his life and service.

Congressman RUSH was born in Albany, Georgia, in 1946 and spent his childhood growing up on the north and west sides of Chicago. As a child, his Boy Scout Master encouraged BOBBY to pursue public service. Congressman RUSH enlisted in the United States Army at the age of 17, which marked the beginning of what was to become a lifelong career in public service. After serving honorably for 5 years, he left the Army to attend Roosevelt University, where he graduated with honors in 1973.

It was during this time that Congressman RUSH began his passionate advocacy for the basic civil and human rights of minorities, as a member of the Civil Rights Movement. In addition to serving as a member of the Student Non-Violent Coordinating Committee, Congressman RUSH co-founded the Illinois Black Panther Party in 1968. With the Panther Party, Congressman RUSH organized the Free Breakfast for Children program and established a Free Medical Clinic, which gained renown as the nation's first to develop a mass sickle cell anemia testing program.

This commitment to the health and dignity of communities of color has been a remarkable trademark of Congressman RUSH's career in public service. After serving as an Alderman in the Chicago City Council for 8 years, Congressman RUSH was elected to the U.S. House of Representatives in 1993 to serve Illinois' First Congressional District. Congressman RUSH has been a strong leader and vocal proponent for issues such as health care reform, job creation, environmental protection, gun control and ending the embargo against Cuba. Most recently, as Chairman of the Energy and Commerce Subcommittee on Commerce, Trade and Consumer Protection, Congressman RUSH used his deft leadership to shepherd the bipartisan passage of the Consumer Product Safety Improvement Act of 2008 (H.R. 4040), which modernized the Consumer Product Safety Commission and established essential safety requirements for children's products.

An ordained Baptist minister, Congressman RUSH has remained true to the principles of truth and justice throughout his distinguished career. Today we rise in appreciation, not only of his contributions to date, but in anticipation of that which he will accomplish in the future. He is, and continues to be, an inspiring advocate for equality and a voice for the voiceless.

The Congressional Black Caucus is stronger because of Congressman RUSH's diligent work. His clarity of purpose and vision reinforces the CBC's role as the "Conscience of the Congress." For that we are deeply grateful. We salute and celebrate this great leader for freedom and justice.

To all, we wish you a very happy "Bobby Rush Day!"

THE DISTRICT OF COLUMBIA MEDICAID REIMBURSEMENT ACT OF 2009

HON. ELEANOR HOLMES NORTON

OF THE DISTRICT OF COLUMBIA
IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. NORTON. Madam Speaker, I introduce the District of Columbia Medicaid Reimbursement Act of 2009 today to raise the federal medical assistance percentage (FMAP), or contribution of the federal government from 70 percent to 75 percent, and to reduce the District's unique role as the only city, except for New York, that pays any portion of Medicaid, an expense that is carried by states and counties in our country. New York City, the jurisdiction that powers the economy of New York State, contributes a 25 percent local share to Medicaid, while the state pays 25 percent, less than the District's statutorily mandated 30 percent contribution. I introduce this bill because the District's continuing responsibility for the share of Medicaid costs typically borne by entire states is a major component of the District's structural deficit and a threat to the financial stability of the city itself, according to the District's Chief Financial Officer (CFO). Today, in the midst of an unprecedented recession and of structural change in the U.S. economy, this burden is not sustainable. Yet the District, unlike other cities which have lost significant populations, has no state economy to share this burden. More than 25 percent of District children and adults are enrolled in Medicaid, compared to 12 percent in Maryland and just 9 percent in Virginia. On average, the District spends over $7,000 per enrollee, while Maryland and Virginia spend $5,509 and $5,177, respectively, reflecting serious health conditions that are concentrated among big city residents in this majority African American city.

In 1997, as part of the Balanced Budget Act, Congress recognized that state costs were too high for any one city to shoulder. To alleviate the resulting financial crisis in the District, Congress increased the federal Medicaid contribution to the District from 50 to 70 percent, and took responsibility for some, but not all, state costs—prisons and courts—relieving the immediate burden, but the city continues to carry most state costs.

In 1997, a formulaic error in the Medicaid Disproportionate Share Hospital (DSH) allotment reduced the 70 percent FMAP share, and as a result, the District received only $23 million instead of the $49 million due. I was able to secure a technical correction to the Balanced Budget Act of 1999, partially increasing the annual allotment to $32 million from FY2000 forward. I appreciate that in 2005, Congress responded to my effort to get an additional annual increase of $20 million in the budget reconciliation bill, bringing DC's Medicaid reimbursement payments to $57 million as intended by the Balanced Budget Act. However, this amount did not reimburse the District for the years a federal error denied the city part of its federal contribution, and in any case, of course, was not intended to meet the structural problem this bill partially addresses. Now, with health care before the Congress, the time has come to close the loop on this leftover issue.

The District has taken important steps on its own to reduce Medicaid costs through greater efficiency, and to treat and prevent conditions that prove costly when hospitalization or expensive treatments become necessary. The District Medicaid agency won federal recognition as one of only two Medicaid programs nationwide to exceed the federal government's child immunization goal for school-age children at 95 percent, and improved its fraud surveillance, recovering $15 million in fraudulently billed funds. The city's novel DC Health Care Alliance, for which federal approval is pending, would allow coverage of residents and provide more early and preventative care, avoiding huge Medicaid costs when health conditions become severe and Medicaid becomes the only option.

The DC Medicaid Reimbursement Act of 2009 is the eighth in the "Free and Equal DC" series. This series of bills addresses inappropriate and often unequal restrictions placed only on the District and no other U.S. jurisdiction. Although today's bill cannot address the entire structural problem that the District faces because the city is not part of a state, the bill would at least make the city no worse off than the only other city that contributes to Medicaid.

I urge my colleagues to join me in supporting this increase that will help my city's most needy residents.

CHATHAM UNIVERSITY

HON. MICHAEL F. DOYLE

OF PENNSYLVANIA
IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. DOYLE. Madam Speaker, I rise today to inform my colleagues of an upcoming landmark event in Pennsylvania's 14th Congressional District—the 140th anniversary of Chatham University, one of the oldest women's colleges in the country.

On December 11, 1869, the Pennsylvania Female College was founded in the City of Pittsburgh by the Reverend William Trimble Beatty, the founder and pastor of the Shady Side Presbyterian Church. The college was originally housed in the Berry mansion on Woodland Road in Pittsburgh's Shadyside neighborhood. The college's original mission was to provide educational opportunities for women of comparable quality to those available at that time at the best colleges for men.

Chatham University is one of the outstanding institutions of higher learning that call the city of Pittsburgh home. For the past 140 years, this school has been committed to providing a high-quality education to young women. Chatham's motto is "Filiae nostrae sicut antarii lapides"—"That our daughters may be as cornerstones, polished after the similitude of a palace"—and for well over a century, the faculty and staff of this respected institution have labored hard to live up to that standard. Graduates have gone on to leadership roles in business, government, and academia locally and across the country. Chatham's most famous graduate so far is probably Rachel Carson, of the class of 1929—the individual almost single-handedly responsible for the birth of the environmental movement in this country.

Over the last 140 years, a number of traditions have become an important part of the school's identity—the Opening Convocation, the passing of the class colors from graduating seniors to the incoming first years, the song contest, May Day activities, and the Closing Convocation, to name a few. Needless to say, many alumnae retain treasured memories of these traditions for the rest of their lives—and while many wonderful traditions have been established and preserved, the school has changed and grown as well.

In 1890, the Pennsylvania Female College was renamed the Pennsylvania College for Women. Over the years, the student body grew and the school expanded into the buildings and grounds of several adjacent mansions, including those previously owned by Andrew Mellon, Edward Stanton Fickes, James Rea, and George M. Laughlin, Jr.

In 1955, the Pennsylvania College for Women was renamed Chatham College, in honor of William Pitt, the Elder—the first Earl of Chatham, the statesman who led Great Britain to victory in the Seven Years' War, and the man for whom Pittsburgh was named.

In 1992, Dr. Esther Barazzone became the school's 16th President, and under her leadership, the school has undergone substantial growth. New construction was undertaken, coeducational graduate programs were established, and the school's endowment was increased substantially.

On April 23, 2007, the school was granted university status by the Pennsylvania Department of Education, and it officially changed its name to Chatham University a year later on May 1st, 2008.

Today, the university is home to three colleges. Chatham College for Women continues the school's original mission of providing a high-quality undergraduate education for women. The College for Continuing and Professional Studies offers a number of certificate, masters, and doctoral programs, and online degree programs were begun in 2005. The College for Graduate Studies offers masters' and doctoral programs for both women and men in more than 20 fields, including art, architecture, business, health sciences, teaching, and creative writing. In 2007, Chatham University's Creative Writing M.F.A. program was singled out by The Atlantic Monthly as one of the top five innovative and unique programs in the country. Today, Chatham has more than 2,200 students enrolled. The university is home to several outreach centers as well, including the Center for Women's Entrepreneurship, the Pennsylvania Center for Women, Politics, and Public Policy, the Rachel Carson Institute, and the Pittsburgh Teachers Institute.

In 2008, Chatham University expanded dramatically to accommodate the growth in a number of academic programs.

On May 1, 2008, the Eden Hall Foundation gave Chatham University the Eden Hall Farm in Gibsonia, a suburban municipality near the city of Pittsburgh in Allegheny County. This 400-acre farm had been the summer home of philanthropist and H.J. Heinz Company Vice President Sebastian Mueller in the early

1900s. At Mr. Mueller's death in 1938, his entire estate, including Eden Hall Farm, was committed in his will to benefiting women. For the next 70 years, it was operated as a vacation and respite destination for the H.J. Heinz Company's working women. The Eden Hall Foundation was established in 1983 to further Mr. Mueller's goals of supporting other charitable efforts.

Chatham University's Eden Hall Farm Campus now is home to a number of educational, environmental, women's leadership, and community programs. It also provides a convenient campus for serving Chatham University certificate and degree program students who live in the suburban communities north of Pittsburgh as well as young participants in the school's Summer Music and Arts Day Camp.

In September of 2008, Chatham purchased a building in Pittsburgh's East Liberty neighborhood to hold its architecture and health science programs. The new facility is less than a mile from the university's main campus in nearby Shady Side. Establishment of this new facility, named Chatham Eastside, both benefited from and contributed to community efforts to redevelop and revitalize East Liberty.

Madam Speaker, Chatham University has grown from a college of 100 undergraduate students 140 years ago to a university with more than 2,000 undergraduate, graduate, and doctoral students today. It is a highly respected institution of higher learning that has faithfully carried out its mission of educating young women and promoting women's leadership for nearly 150 years. I want to congratulate the faculty, staff, students, alumnae, and friends and supporters of Chatham University on the 140th anniversary of its founding, to express the appreciation and deep respect that the residents of Pennsylvania have for this venerable local institution, and to wish Chatham University continued success in the years to come.

HONORING MR. AUSTIN LAYNE

HON. WM. LACY CLAY

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CLAY. Madam Speaker, I rise today to honor Mr. Austin Layne, a trail-blazing entrepreneur and valued member of the St. Louis community. For over 30 years Mr. Layne has served the residents of St. Louis with an admirable sense of compassion during their most difficult times.

Upon graduating from Vashon High School, Layne entered the U.S. Army where he studied to become a computer specialist. Layne was motivated to pursue a career as a funeral director after a family friend, Gilbert Wade Granberry, offered him a position working at his mortuary. This rewarding experience inspired him to earn his associate's degree in applied science from the School of Mortuary Science at Forest Park Community College.

Mr. Layne opened his first business in 1979, the Austin A. Layne Mortuary. He has since opened the Layne Renaissance Chapel and most recently, the Austin Layne Normandy Chapel. Mr. Layne independently owns and operates all of his businesses.

Mr. Layne is committed to providing people with the highest quality care possible and has remained dedicated to being available to his clients, both physically and emotionally during their times of grief. He is acutely aware that every family has different needs and strives to accommodate each family that he serves.

Throughout his career, Mr. Layne has been a supportive and gentle person, determined to do more for families than simply conduct a funeral. What makes Mr. Layne so extraordinary is his ability to empathize with each family. He puts himself in their position and works to ensure that arranging funerals for their loved ones goes smoothly as possible.

Madam Speaker, I am honored to pay tribute to Mr. Layne; a man who has made a difference in each life that he has touched. I urge my colleagues to join me in honoring Mr. Austin Layne.

IN MEMORY OF TOMMY JACQUETTE

HON. MAXINE WATERS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. WATERS. Madam Speaker, I rise in memory of Tommy Jacquette, my dear friend of over 40 years, who passed away this week. I know that the community of Watts and the greater Los Angeles area are grieving with me, because we've all lost a truly unique, larger-than-life friend and activist who had his finger on the pulse of the community.

Born in South Central Los Angeles in 1943, Tommy as a young man became part of the Black Power Movement of the 1960's and sharpened his leadership skills during his studies at Cal-Poly Pomona. He was acutely aware of the problems and issues facing the African-American community, and he wanted to make a difference.

Tommy especially loved Watts, and he dedicated his life's work to enriching the community. He was the founder of the Watts Summer Festival at Ted Watkins Memorial Park (formerly Will Rogers Park), which became an annual tradition in the community following the 1965 insurrection, which were riots that shook the Watts community and surrounding areas.

Tommy created the Festival to honor and celebrate our roots, our talents and our culture, and it subsequently helped to spark African-American festivals across the country: today it's known as the 'Grandfather' of all African-American cultural events.

Even in years when he struggled to get funding for the Festival, when traditional donors such as the business community and others wouldn't contribute, he always came through and was able to put on a Festival, using the resources he had and his amazing life skills, largely stemming from being a self-made man. Just this year, I joked with him that if he had two dimes to rub together, there would be a Watts Summer Festival.

I have no doubt, however, that in making the Festival possible each and every year for almost a half-century, Tommy knocked a few heads together. This tall, handsome and fatigue-wearing man made his presence known, often using his penchant for colorful language to drive home the point! His confrontations with City Hall, L.A. County, and other elected officials and community leaders are legendary. He spoke his mind, and was bold and uncompromising in his support of the Black community.

So when he was mad, you knew it. However when he was pleased and happy, you knew it too, because he had a smile that would light up a room and a hearty laugh that would resonate throughout an entire building.

The Watts Summer Festival is uniquely Tommy, bringing people together and focusing both on local and national talent, always with an Afro-centric theme.

Tommy was an inspiration to me and to so many other people. He was daring, fearless and bold, helping us to gain the courage to openly discuss and deal with race, discrimination and inequality in a way that few had been able to before.

I will truly miss his presence and the long conversations we would often have, which would usually start when he'd say "Hey Mac, what do you think about that?" He was an incredibly deep thinker. He was especially an inspiration to young people in the community, often speaking at high schools, colleges and universities to encourage them to succeed, to give back, and to hold their heads up high.

There will never be another Tommy Jacquette, and I know that the legacy he has left behind is enshrined not only in the Watts Summer Festival, but in the larger community. I look forward to working with his family and the Board of Directors to make sure that the Festival continues, though there will be a big hole that can never be filled.

I thank him for all that he was and all that he was not, for all the lives he reached, and for his friendship. I will miss him dearly, but am comforted because I know Tommy Jacquette's life was one of impact, purpose, and fulfillment.

RECOGNIZING JAY HARRINGTON FOR HIS 700TH CAREER VICTORY AS A MEN'S COLLEGE BASKETBALL COACH

HON. JERRY F. COSTELLO

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. COSTELLO. Madam Speaker, I rise today to ask my colleagues to join me in recognizing Jay Harrington, coach of the Southwestern Illinois College Blue Storm, who posted his 700th victory as a college men's basketball coach on November 13, 2009.

Jay Harrington began his coaching career as an assistant at Western Kentucky University for one year followed by a year as an assistant coach at the University of Arkansas at Little Rock. Jay's first position as head coach was at Wabash Valley College where he coached for three years. He next took over as head coach at Southwestern Illinois College, then Belleville Area College, where he has been for the past 30 years. Last season, Coach Harrington posted his 600th victory as the coach of Southwestern Illinois College.

Coach Harrington entered the 2009–2010 season with a career total of 696 wins. He posted his 700th victory with a 64–49 win over Highland College before the home crowd at the Blue Storm Basketball Classic at Southwestern Illinois College. With typical modesty, Jay deflected accolades over this milestone, preferring instead to discuss the good performance of his players.

Jay Harrington is enshrined in both the Illinois Coaches Hall of Fame and the National Junior College Athletic Association, NJCAA, Basketball Coach's Hall of Fame. He has been named the Junior College Athletic Director of the Year by the National Association of Collegiate Directors of Athletics and Co-Coach of the Year for Junior Colleges by the Illinois Basketball Coaches Association.

Madam Speaker, I ask my colleagues to join me in congratulating Jay Harrington on his milestone 700th victory as a men's college basketball coach.

TRIBUTE TO FRANK HALL

HON. KEN CALVERT

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. CALVERT. Madam Speaker, Norco, California has been fortunate to have dynamic and dedicated community leaders who willingly and unselfishly give their time and talent and make their communities a better place to live and work. I rise today to recognize and honor one of those individuals: outgoing Norco City Council Member, and former Mayor, Frank Hall.

Frank started his public service career in 1993 as a member of the Streets and Trails Commission in Norco, California. With that experience he was elected as a Norco City Councilmember in 1997. As member of the Norco City Council, Frank also served as Mayor in 2008, 2004 and 2000. In 2000, Frank received the Norco Chamber of Commerce Man of the Year Award.

Over his accomplished career, Frank served on a number of special committees which addressed a wide range of issues. He worked on transportation issues as a member of the Riverside County Transportation Commission, Riverside Transit Authority Board of Directors and the Transportation Uniform Mitigation Fee Northwest Zone Committee. He promoted education and learning in the community as a member of the Riverside Community College, Norco Friends of the Library, Norco Historical Society and the Corona/Norco Family YMCA. He also was successful in rallying support for NSWC, Corona and joined a regional effort to keep the base from being realigned to Port Hueneme during the last round of Base Realignment and Closure.

Frank Hall will leave the Norco City Council with many accomplishments; his legacy will serve as a shining example and constant reminder of what it means to be a public servant. I am proud to call Frank a fellow community member, American and friend. It has been an honor to work with him for the betterment of our community and I salute his service to the City of Norco.

GUISEPPE TAORMINA

HON. MICHAEL E. McMAHON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MCMAHON. Madam Speaker, I rise today to honor Giuseppe Taormina. His powerful voice, passion and talent make him the true "King of High C."

Mr. Taormina was born in Palermo, Sicily, Italy. He started voice training at a very young age and began performing in Sicily. When he arrived in the United States, he immediately auditioned for the Metropolitan Opera Company, where he was accepted into the Young Artist Program. Because of his beautiful voice, he received two scholarships as primo tenore while at Hunter College.

Most notably, Mr. Taormina is the only person in the United States who has received the prestigious honor of Necklace Knight, "Cavaliere di Collona" and the noble title of Saint George in Carinzia Supreme Military Order.

Mr. Taormina has had the honor to perform for the Kings of Yugoslavia and Bulgaria, as well as Imelda Marcos, the former First Lady of the Philippines. He has also traveled to the far corners of the world spreading his passion for music with the "Ambassadors of Opera."

On November 1st, Mr. Taormina performed at the 48th Annual Mario Lanza Ball, where he was the evening's special guest tenor. Mr. Taormina helped celebrate the life and career of Mario Lanza. His one of a kind tenor voice is a great tribute to a star that left us far to soon.

Madam Speaker, I ask that my colleagues join me in commending the talent and accomplishments of Giuseppe Taormina.

HONORING NORTON BUFFALO OF SONOMA COUNTY, CALIFORNIA

HON. MIKE THOMPSON

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. THOMPSON of California. Madam Speaker, I rise today to honor Norton Buffalo, a man of enormous musical talent, who passed away October 30, 2009, after a short battle with lung cancer. Although he is no longer with us, his music and his virtuosity as a harmonica player are gifts that will live on for generations to come.

Born 58 years ago in Oakland, California and raised in the blue collar streets of Richmond, California, Norton developed an appreciation for music from his father, a harmonica player in his own right, his mother, a nightclub singer, and his great-uncle, an Academy Award winning composer. He won his first talent contest in 1963 while in the 6th grade and he never looked back.

For decades he called Sonoma County home. His first solo album and tribute to his adopted home, "Lovin' in the Valley of the Moon," was released in 1977. In addition to his own albums, he played on more than 180 albums by other artists and was a member of the Steve Miller Band for 30 years. He was a master of all genres, from jazz to rock to blues to honky tonk. He toured with such notables as the Doobie Brothers, Kenny Loggins, Olivia Newton John, Commander Cody, Mickey Hart, Jerry Garcia and slide guitar player Roy Rogers, as well as his own bands.

I was honored and privileged to know Norton as a friend, long after I was a fan. I grew up on his music and sought out his performances at small clubs and venues throughout Northern California. When we became friends many years later, I was touched by his compassion and his dedication to making the world a better place. He was a man with a heart to match his talent.

Norton was a performer to the end. He was on tour with the Steve Miller Band in August when he received his diagnosis and was writing songs just days before his death.

He is survived by his wife, Lisa Flores, his children, Aisah and Elias, his stepchildren, Sierra Ruelas, and Bo Winterburn, his father, Ken Jackson, and five brothers and sisters.

Madam Speaker, Norton Buffalo touched millions of people with his music and his talent. It is therefore appropriate that we remember and honor him today.

INTRODUCTION OF THE RUNAWAY REPORTING IMPROVEMENT ACT OF 2009

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mrs. MALONEY. Madam Speker, today I am proud to introduce bipartisan legislation, the Runaway Reporting Improvement Act of 2009, along with my friends and colleagues Mr. SMITH of New Jersey, Mr. CONYERS of Michigan, and Mr. CARDOZA of California.

One of the few things more terrible than learning that a child was missing would be learning that everything possible wasn't being done to find him or her. Shockingly, the New York Times recently reported that many runaway children are missing not only from their homes, but also from the very database meant to help law enforcement officers find them.

If no one knows that a child is missing, that child is unlikely to be found. It is imperative that everyone—parents, communities, and especially law enforcement authorities—combine their resources and work together to find and protect missing children. The National Crime Information Center (NCIC) database is designed to help make information sharing easier. Virtually every law enforcement officer in the United States can access the NCIC database, which means that they can more easily cooperate in investigating and resolving multijurisdictional cases.

Every child reported to have run away is supposed to be listed in the NCIC database as a missing person. However, according to the New York Times' series "Running in the Shadows," as many as 16 percent of reported runaways are never entered into the NCIC database. Madam Speaker, this is outrageous and unacceptable. Without an NCIC entry, law enforcement officers will not share information

or resources, and are much less likely to find or protect a missing child.

The Runaway Reporting Improvement Act of 2009 would help solve this problem and protect missing children by making two small but useful changes to the current law. First, the bill would require law enforcement agencies to certify that they comply with federal law by entering all missing children into the NCIC database. Second, it would require that law enforcement officers provide someone who reports their child missing with information about the services of the National Center for Missing and Exploited Children and the National Runaway Switchboard, as well as 24-hour, toll-free contact information for those resources. NCMEC and NRS have a long and successful history of helping parents and law enforcement agencies work together to find and protect missing kids.

Madam Speaker, we simply must do better by our children. The necessary resources are already in place. The Runaway Reporting Improvement Act of 2009, will help ensure that those existing resources are used to find and protect the children who need them most.

EDUARDO PEÑA

HON. JOHN T. SALAZAR

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SALAZAR. Madam Speaker, I rise today to recognize a man who has dedicated his life to serving others. Mr. Eduardo Peña's lifelong commitment to public service and the Hispanic American community are to be commended.

Peña, a native of Laredo, Texas, is a 1957 graduate of the University of Texas in Austin with a Bachelor of Arts Degree in Marketing. He received his law degree in 1967 from Catholic University in Washington, D.C., while working full time for the Department of Labor.

Peña has a long and distinguished career in public service, working for the U.S. Department of Labor (DOL), the U.S. Senate, and the Equal Employment Opportunity Commission. He is a two time recipient, 1968 and 1969, of the DOL's award for meritorious achievement.

In 1979, he resigned from government service to enter private law practice. However, this did not prevent him from engaging in a number of community service activities.

In 1978 he was elected president of the League of United Latin American Citizens (LULAC), where he served for one year and used his expertise to ensure civil rights for Latinos. Today, Peña remains heavily involved in LULAC as a volunteer and his wife, Ada, serves as the State Director for the District of Columbia.

Earlier this year Eduardo Peña stepped down as General Counsel for the Congressional Hispanic Caucus Institute (CHCI), a pro bono post he held since March 1978.

In this role he committed his own time and energy to providing pro bono expert legal counsel and guidance to an organization that has grown dramatically since he began his work.

His efforts have assisted thousands of young Latinos to achieve a college education and take the first steps towards launching a successful career in public service and many other fields.

CHCI's growth and advancement as an organization have taken place thanks to the dedication Eduardo Peña has demonstrated for more than three decades.

Madam Speaker, I extend my sincere gratitude for more than 30 years of service to CHCI and a lifetime of contributions to the Hispanic American community and the nation.

RETIREMENT OF HERMOSA BEACH CITY COUNCILMAN J.R. REVICZKY

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Ms. HARMAN. Madam Speaker, I rise today to recognize a man of many abilities and talents, whose contributions to the City of Hermosa Beach enriched his community and contributed to the economic health of the region for the past 16 years.

A South Bay resident since childhood, my good friend and City Councilman J.R. Reviczky enlisted in the U.S. Naval Reserve after graduating from Bishop Montgomery High School in Torrance, California, also in my Congressional District. Following an honorable discharge from the Naval Reserve, he embarked on a career as an electrician. During his 37-year career, he worked his way up the ranks from apprentice to his current role as Training Director for one of the largest electrical contractors in the United States.

J.R. was first elected to the Hermosa Beach City Council in 1993, and has served four distinguished terms as Mayor. His lasting mark can be seen throughout the community. As a member of the Open Space People's Action Committee, he was instrumental in the development of Hermosa Beach's many acres of beautiful parks and recreation facilities, including the conversion of railways into a community treasure known as the Greenbelt. He was also one of the co-founders of the Beach Cities Holiday Toy Drive which, for the past 15 years, has collected and distributed thousands of toys to needy children throughout the 36th Congressional District and beyond.

I have personally benefited from J.R.'s counsel and encyclopedic knowledge of local issues and history.

On behalf of a grateful community, I thank Councilman J.R. Reviczky for his dedicated service to the people of Hermosa Beach and wish him continued success as he and his wife, Nancy, begin the next chapter of their life.

AARON THOMAS NEMELKA

HON. JIM MATHESON

OF UTAH

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MATHESON. Madam Speaker, Utah has lost a venerated hero with the passing of PFC. Aaron Thomas Nemelka of West Jordan, Utah.

Private First Class Nemelka was killed while serving his country at Fort Hood, Texas. On November 5, 2009, a lone gunman opened fire and caused the death of 12 soldiers, 1 civilian, while 30 more Americans were wounded.

Private First Class Nemelka is remembered for his dedication to both his family and his country. As a combat engineer in the 20th Infantry Battalion, 36th Engineering Brigade, he specialized in munitions diffusion.

Aaron was set to deploy on his first tour of the Middle East in January 2010. He will forever be remembered for having sacrificed his life in the defense of our great nation. His selfless devotion to those around him is a great tribute to his spirit.

Aaron grew up in West Jordan, Utah and was the youngest of four children. He earned the rank of Eagle Scout and through his efforts was able to help better his community by always extending a hand of service. Aaron graduated from West Jordan High School in Utah in 2008 and enlisted in the military shortly thereafter.

Private First Class Aaron Nemelka was very young, and he served his country honorably and heroically. Please join me in taking a moment to honor this Utahn for his service to our country. My thoughts are with Aaron's family during this difficult time.

DR. ALLAN B. PEREL

HON. MICHAEL E. McMAHON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MCMAHON. Madam Speaker, I rise today to honor Dr. Allan B. Perel, a dedicated physician, leader in the MS community and a true humanitarian. He is one of Staten Island's "everyday heroes."

Dr. Perel was educated in New York City schools, attending Brooklyn College, and obtaining his medical degree from the State University of New York Downstate Medical Center. He completed his residency at Columbia University—Presbyterian Hospital and interned at Staten Island University Hospital.

Dr. Perel is a great physician, and he gives back to his community. His has gone above and beyond by providing unprecedented care to those affected by Multiple Sclerosis and other life altering conditions. He has served as the Director of the Multiple Sclerosis Center of Staten Island/ Chapter Site NYCMS Society for the past 15 years.

He is also the Chairman of the Board of the Staten Island Heart Society for the past 5 years and was the only Neurologist to have served as President of the American Heart Association. Dr. Perel also founded and served as the director of the Staten Island University Hospital—NYS Department of Health Certified Stroke Center.

Throughout his career, Dr. Perel provided educational materials to the community and supported legislation that benefited both doctors and patients. He helps coordinate the Island-wide September 11 Memorial blood drive, and continuously supports charity walks for many causes.

Dr. Perel has been an active participant of the Richmond County Medical Society since 1989. In July of 2008, Dr. Perel was selected to be the organization's president. On Saturday, November 14th, the Richmond County Medical Society honored Dr. Allan Perel for his tireless dedication to his profession and the people of his community. I wish to join this organization in praising the accomplishments of one of Staten Island's finest physicians.

Madam Speaker, I ask that my colleagues join me in commending Dr. Allan B. Perel on his dedication to the citizens of Staten Island.

SUPPORTING S. 4073, THE RURAL VETERANS REIMBURSEMENT ACT

HON. WALT MINNICK

OF IDAHO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. MINNICK. Madam Speaker, I rise today to honor the brave men and women of our Nation's armed forces. As a U.S. Army veteran, I understand how important it is that we keep our promises and thank them for their commitment to freedom.

I'm pleased to announce the introduction of the Rural Veterans Reimbursement Act. This bill enjoys bipartisan support and has been endorsed by the Iraq and Afghanistan Veterans of America and the American Legion.

This legislation will allow rural veterans to receive reimbursement for their food and lodging any time they must travel to a VA medical facility to seek treatment for a service-connected injury. Many veterans living in backcountry Idaho and in other rural areas around the country must travel on narrow, winding roads for the better part of a day to reach the nearest Veterans Hospital or clinic. They deserve to be reimbursed for their travel expenses.

PROPERTY ASSESSED CLEAN ENERGY (PACE) TAX BENEFITS ACT

HON. JOHN P. SARBANES

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SARBANES. Madam Speaker, I rise today to introduce the Property Assessed Clean Energy, PACE, Tax Benefits Act. This legislation supports efforts by state and local governments to help homeowners and businesses install energy efficiency upgrades.

PACE projects are an innovative way to finance energy efficiency investments like insulation and home sealing projects, energy efficient appliances or renewable energy generation systems. These programs provide homeowners or businesses the upfront capital to pay for the improvements and allow them to finance repayment through the property assessment taxes they pay to state or local government. Because PACE financing offers real savings immediately and in the long term, homeowners and business owners are much more likely to pursue energy efficiency improvements.

The legislation I am introducing will make it easier for state and local governments to raise capital for PACE programs by making the interest earned on PACE-related bonds tax free. For example, under current law, when government bodies issue bonds for the construction of roads, schools, or other infrastructure, their investors receive tax free interest payments. The PACE Tax Benefits Act will ensure that energy efficiency projects are treated in the same manner—allowing state and local governments to raise adequate capital and providing the low cost financing to property owners that will make PACE programs more widespread.

This is an innovative and cost-free mechanism to encourage energy efficiency. The potential for economic growth and energy savings is vast if we establish a framework that allows for them to expand more broadly. By doing so, we will create thousands of new jobs; save billions of dollars in energy costs for consumers; and make significant progress in our efforts to reduce greenhouse gas emissions.

HONORING JAMES POPPELREITER

HON. GARY C. PETERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. PETERS. Madam Speaker, today I rise to honor James Poppelreiter, Fire Chief of West Bloomfield Township, for his 44 years of dedicated service to the safety and well-being of his community and its citizens.

Since beginning his career as a sergeant with the department in November 1965, Chief Poppelreiter has served West Bloomfield Township with the distinction, valor, and tenacity that have been essential in creating this vibrant and diverse suburban metropolis. In recognition of his 35 years of outstanding work and leadership with the West Bloomfield Fire Department and the greater community, Chief Poppelreiter was bestowed his current responsibilities as Chief in April 2000. Chief Poppelreiter's ascent to one of the top public safety offices in the township was a product of decades of perseverance and strong work ethic.

Chief Poppelreiter's career spans a transcendent period for the West Bloomfield community. At the start of Chief Poppelreiter's career the West Bloomfield Fire Department was a small volunteer force serving a mere 14,000 residents in a rural hamlet of Oakland County. The township has since grown to over 66,000 residents and is one of southeast Michigan's most economically and ethnically diverse communities. During the years spanning Chief Poppelreiter's career, the Fire Department grew to a full-time professional staff of over 100 that serve West Bloomfield and several of the surrounding communities. During his tenure, Chief Poppelreiter's commitment to excellence has ensured that the residents of West Bloomfield have received outstanding fire safety protection.

Chief Poppelreiter's career illustrates exemplary public service in its truest spirit and finest tradition. His absence in retirement will surely be felt by his colleagues and the residents of West Bloomfield. Madam Speaker I ask all of my colleagues to join me today in honoring the courageous work and unwavering commitment of Chief Poppelreiter to the community and citizens of West Bloomfield.

HONORING JOSYF SLIPYJ

HON. MIKE QUIGLEY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. QUIGLEY. Madam Speaker, I rise today to recognize the lifelong service and dedication of the Servant of God, Patriarch Josyf Slipyj to the Ukrainian Church and community. He died on September 7, 1984, and on November 22nd, 2009, a monument will be raised in his memory at the Sts. Volodymyr and Olha Ukrainian Catholic Parish.

Josyf Slipyj was born on February 17, 1892 in the village of Zazdrist, Ternopil region, Ukraine, into the Kobernytskyj-Slipyj and Anastasia Dychkovska families. He completed grammar school in his village and secondary school in Ternopil. He studied theology in Lviv, and completed his philosophical and theological studies in Innsbruck, Austria.

He was ordained to the priesthood by Metropolitan Andrej Sheptytsky on September 30, 1917.

He returned to Innsbruck to continue his post-graduate studies, attaining a doctorate in sacred theology. From there he traveled to Rome where he was bestowed with the title Magister Agregatus.

He began lecturing in 1922 on dogmatic theology at Lviv Theological Seminary. Toward the end of 1925 he was appointed rector of this institution, and in 1929 he was appointed rector of the newly created Theological Academy. In 1939 metropolitan Andrej consecrated him bishop with the right of succession. On November 1, 1944, he became head of the Ukrainian Greek Catholic Church.

On April 11, 1945 he was arrested by the Bolsheviks and given an eight year sentence of hard labor in Siberia. After this ended and without any cause, he was imprisoned a second time for an unspecified term. In 1957 he was given a third term—seven years of hard labor. Due to the efforts of Pope John XXIII and U.S. President John F. Kennedy he was freed in 1963 to take part in the sessions of the Second Vatican Council.

Sts. Volodymyr and Olha Ukrainian Catholic Parish in Chicago, Illinois was founded in 1968 by Patriarch Josyf Slipyj. Among the reasons for establishing this distinct parish was the desire to preserve and more intensely nurture the traditions of the Ukrainian Church. The elements contributing to the Ukrainian Church's distinctiveness within the Universal Catholic Church are the Julian Calendar, a traditional liturgy, as well as a unique spiritual heritage.

Members of the parish are proud of the fact that Patriarch Josyf Slipyj was involved in all significant events of the parish's development. Besides establishing the parish, Patriarch Josyf blessed the cornerstone of the church and subsequently, in 1973, blessed the church

itself. The reason for the parishioners' pride had to do with the Patriarch's position in the Catholic Church as a Confessor for the Faith.

Taking the lead from his predecessor Metropolitan Andrey Sheptytsky (+1944), as well as the decisions of the Second Vatican Council, Josyf Slipyj worked to restore self-government to the Ukrainian Catholic Church in the form of a Patriarchate. In 1965, he was made a cardinal by Pope Paul VI.

He died on September 7, 1984. In 1992 his remains were brought to Lviv, where they, in the presence of more than one million faithful, were re-interred in the crypt of St. George's Cathedral. Patriarch Josyf Slipyj has been proclaimed a Servant of God and the Ukrainian faithful pray for his beatification.

Madam Speaker, I ask my colleagues to join me in recognizing the great sacrifices and contributions Patriarch Josyf Slipyj made in his lifetime. His monument will stand as a reminder to all of his great achievements to future generations.

INTRODUCTION OF THE GRADUATION FOR ALL ACT OF 2009

HON. ROBERT C. "BOBBY" SCOTT

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 19, 2009

Mr. SCOTT of Virginia. Madam Speaker, I rise today in support of H.R. 4122, the Graduation for All Act of 2009 (GFA). I would like to thank Chairman GEORGE MILLER for introducing this comprehensive bill that creates a three-year grant to help turn around our nation's lowest performing schools. This bill will help address some of the problems facing our schools and ensure that they are moving toward a goal of graduating all of our children.

For far too long, schools have not been held accountable for ensuring that students graduate on time with a high school diploma. As a result, some students leave high school without a meaningful education that provides quality academic experiences sufficient for success in college or the workplace. Additionally, high school students are dropping out at an alarming rate. A recent study found that only 53 percent of all young people in the nation's 50 largest cities are graduating from high school on time. Regrettably, roughly 12 percent of all secondary schools in the United States produce approximately half of the nation's secondary school dropouts. In these secondary schools, known as "dropout factories," African American, Native American and Hispanic students have graduation rates that are 50 percent or below.

Recently, strong reform efforts have targeted dropout factories and other low performing high schools, but it is obvious we have to do more and start our efforts earlier. More of an emphasis must be placed on the lowest performing middle schools. Too many students leave middle school with significant deficiencies such as being behind on English and Math proficiency; this leaves them ill prepared for the rigors of high school.

Increasing graduation rates and improving academic achievement will enrich the lives of our children as well as strengthen our workforce and nation as a whole. A nation enjoys a competitive advantage in the global marketplace when it has a well educated and well trained workforce. If we expect to compete, we must ensure that all of our children receive a quality education.

The Graduation for All Act will make education a priority and invests significant funding to accomplish several goals. First, it provides funding for schools to increase teacher and leadership effectiveness, hire highly qualified teachers, restructure schools, and transition students out of low performing schools into higher achieving schools. Second, the bill will fund initiatives that increase college access and completion such as dual enrollment and early college programs. Finally, the legislation includes provisions from the Every Student Counts Act (ESCA, H.R. 1569), which I introduced on March 17, 2009, that will require consistent and accurate counting of high school dropouts, require the establishment of aggressive and attainable graduation rate goals, and provide incentives to meet these goals.

This bill will make significant strides toward improving student achievement, postsecondary readiness and graduation rates. It is my hope that Congress will move this legislation quickly and it will be signed into law. This will ensure that all of our nation's students will receive the kind of help and support required for them to obtain a quality education. Thank you.

SENATE—*Friday, November 20, 2009*

The Senate met at 9:45 a.m. and was called to order by the Honorable JEFF MERKLEY, a Senator from the State of Oregon.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

O Lord, Your Holy Word and our own good sense tell us that all we are and all we call our own belong to You. Help us to find ways of living and sharing with others that will reflect this truth.

Today, shower our lawmakers with Your blessings. Enable them to see and experience evidences of Your love. Give them the wisdom to walk humbly and to see everything with faith's eyes. Let them live with true thanksgiving, remembering Your love and presence which can turn deserts into paradise. Give them boldness to take stands for what You have revealed is the application of Your principles and justice for our Nation. We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable JEFF MERKLEY led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, November 20, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable JEFF MERKLEY, a Senator from the State of Oregon, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. MERKLEY thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. REID. Mr. President, at 10 o'clock this morning, the Senate will resume debate on H.R. 3590, the health care bill. The debate will be controlled in alternating, hour-long blocks until 10 p.m., from 10 until 10, with the majority controlling the first hour. The majority will control the time from 10 until 10:30 and the Republicans will control the time from 10:30 until 11 p.m.

There will be no rollcall votes during today's session of the Senate. The next vote will occur tomorrow night at 8 p.m., Saturday, November 21. That vote will be on the motion to invoke cloture on the motion to proceed to the health care legislation.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. McCONNELL. Mr. President, our good friends on the other side of the aisle have spent 6 weeks behind closed doors putting together this trillion-dollar experiment in health care that raises premiums, raises taxes, and makes drastic cuts to Medicare. We have now had less than 48 hours to look through this 2,074-page bill, but there are 10 things we know for sure that every American should begin to understand. There are 10 things about this bill we can begin to convey to the American people with certainty, starting this morning.

The Democratic bill includes nearly $½ trillion in new taxes that hit virtually every single American, including, most importantly, middle-class families who make less than $250,000 a year—almost $½ trillion dollars in new taxes, a substantial part of it hitting middle-class families who make under $250,000 a year.

The second thing we know about this massive 2074-page bill is it will raise insurance premiums for the 85 percent of Americans who already have health insurance in our country. So we know buried in this 2,074-page bill are higher insurance premiums for all Americans.

The third thing we know about this massive 2,074-page bill is there will be huge cuts in Medicare, $½ trillion in cuts in Medicare over 10 years, and it will limit many of the choices seniors now have.

Additionally, this monstrous 2,074-page bill, according to the Congressional Budget Office, will not lower health care costs. My recollection was that the principal reason we went down this path in the first place was to do something about the cost increases that are hitting American businesses and individuals. So we go through passing, presumably—I hope we don't, but if we pass this 2,074-page bill, we will actually increase costs. The true cost of this bill, which was not stated by the majority at the announcement of the bill—if you look at the 10-year period when everything is implemented, the true cost of the bill is $2.5 trillion. Certain gimmicks were employed to try to make the bill look like it actually was deficit neutral or even raised money for the Government over 10 years. The way that was done was to delay the implementation of parts of the bill. But once everything kicks in, if you look at a 10-year window after everything kicks in, in this monstrous 2,074-page bill, it would actually cost $2.5 trillion, a massive expansion of the Federal Government.

The sixth thing we know about this bill for sure is, if you like the health insurance you have, you may not be able to keep it. Buried in this 2,074-page bill are provisions that clearly indicate that if you like the health insurance you currently have, you may not be able to keep it. According to the Congressional Budget Office, the Democratic bill would force millions of Americans off the health insurance they currently have.

The seventh thing we know about this bill is it would let government bureaucrats dictate what kind of health plans Americans can buy. No longer would they have the option to buy whatever health care plan might make sense for their family. The Government will prescribe what kind of insurance plans Americans can buy and, thereby, of course, what benefits they can receive. Some bureaucrat in Washington is going to dictate the plans that are available for the American people. I suspect people who are young and healthy and have high deductibles may not have that option anymore. Those are the kinds of Americans for whom

the cost of insurance is going to go up dramatically.

What else do we know about this 2,074-page bill? It creates a government plan that the Congressional Budget Office has said would bring about higher premiums. The majority has said the whole point of the government plan, having the government, in effect, get into the insurance business, is to offer a lower cost alternative, but the only way to do that is to subsidize costs, ration care, and undermine private insurance, which could lead to a government takeover of health care.

In the Democratic plan, the Congressional Budget Office actually says the government insurance company would have higher premiums. So, clearly, the only way it could have a positive impact on the cost of insurance would be to subsidize costs, ration care, and undercut private insurers. Of course, that would be the first step toward what some of the more candid liberals in the House have said is a single-payer system. They are actually disappointed this bill doesn't go far enough to create a government insurance company, which then leads to a single-payer, European-type system.

What else do we know about this bill? The Democratic bill, for the first time in history, would allow Federal programs to pay for elective abortions. How do people out in America who feel strongly about that issue—what do they say about it? According to an AP story just this morning, a direct quote from the person with the Catholic bishops who work with this legislative issue here on the Hill—here is what he had to say. This is a quote from this individual who works for the Catholic bishops on legislative issues. ''This is the worst bill we have seen so far on the life issue.'' That is from a spokesman for the Catholic bishops on what is buried in this 2,074-page bill on the issue of whether the government will, for the first time, allow Federal programs to pay for elective abortions.

Another observation he made about it—and this is a direct quote, two words by the spokesman for the Catholic bishops: ''Completely unacceptable.'' Completely unacceptable, the abortion language in this 2,074-page bill. That is how the Catholic bishops apparently feel about this.

Finally, Americans should know this bill does not have the commonsense reforms they have been asking for all along. There is nothing in this massive bill about getting rid of junk lawsuits against doctors and hospitals that CBO said costs us $54 billion over a period of time. There is nothing in the bill about leveling the playing field when it comes to health care taxes. What the American people would like for us to do is to, step by step, address the cost issue—to them. This bill doesn't do that in any way.

Americans would like to have health care reform, but higher premiums, higher taxes, and cuts to Medicare that produce more government is not reform. Yet that is precisely what we would get were we to pass this 2,074-page bill sitting here beside my desk.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the motion to proceed to H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

Motion to Proceed to H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

The ACTING PRESIDENT pro tempore. Under the previous order, there will be debate until 10 p.m., the time controlled in alternating 1-hour blocks, the majority controlling the first hour.

The Senator from New Mexico is recognized.

Mr. BINGAMAN. Mr. President, I rise to speak for a few minutes about the health care legislation that has now been proposed by the majority leader and that we will be hopefully proceeding to for serious discussion, deliberation, and opportunity for amendment. Let me talk first about where we are today without health care legislation.

What are the circumstances faced by the average American family without enactment of health care legislation? The cost of medical care is rising. In fact, it is unaffordable for many individuals and businesses. In addition, there are 46 million who are uninsured in the country. That number continues to grow. I have been in the Senate and continued to watch that number grow for the last decade at least. Those most in need of health insurance often are denied coverage. Many others worry about whether they are one diagnosis away from financial ruin because of their lack of adequate coverage and their lack of ability to afford adequate coverage.

We are working in the Senate to craft a national health reform proposal that would remedy the situation and would do so by reducing the growth in the cost of health care. Let me be clear. We are not saying the cost of health care is going down substantially. We are talking about the growth in the cost of health care. That is what we are trying to moderate as part of this legislation.

We are also providing insurance to everyone in the country, regardless of their health status and medical condition. This health reform proposal is designed to lower health care costs, lower than what they otherwise will be in the future. This health reform legislation caps what insurance companies can force patients to pay in their out-of-pocket expenses and in their deductibles. The legislation would let small businesses and individuals join purchasing pools and give them the lower costs that benefit larger groups today. I have heard from hundreds of small business owners in my State over the years who have complained that the cost of health care to them and their employees is so much higher than the cost of health care to large employers and their employees. We would solve that. We would create a system that helps to prevent illness and disease instead of just treating it when it is too late and when the cost is excessive.

This health reform proposal will reduce health care fraud and waste and abuse and overpayment to insurance companies. It is estimated by most experts to be in the range of $60 billion per year under the current health care delivery system. This legislation would eliminate most of the cost of uncompensated care. This is a substantial part of the premium people with health insurance are required to pay. They are not only paying for their own health care when they pay their premium, they are paying for the uncompensated care that hospitals, physicians, and others are providing to people who don't have insurance. That is the 46 million uninsured figure I mentioned before.

This legislation reduces the growth in the cost of public programs such as Medicare and Medicaid and helps to rein in the Federal deficit. We have the unusual circumstance that many of the individuals who opposed the establishment of Medicare and claimed it was socialized medicine are now resisting any effort to put it on a sounder financial footing and doing so purportedly in the name of defending the beneficiaries of Medicare. We need to speak the truth to the American people and say: Medicare and Medicaid are going to continue. There are going to have to be reductions in the growth of those programs in the future, the growth of the cost of those programs, and some of those changes are incorporated in this legislation. That is a good thing for Medicare beneficiaries. That is a good thing for people who are going to be dependent upon Medicare in the future. They will know Medicare is there. They will know Medicare is solvent and will benefit accordingly.

Health reform will also ensure all Americans have access to quality and affordable insurance. We prevent insurance companies from the current practices in which they are engaged. One of

the worst of those practices is the practice of denying health coverage for preexisting medical conditions. If one has a preexisting medical condition and is able to buy a policy, perhaps, the policy in its own language will exclude them from getting medical treatment that might result from that preexisting medical condition. This legislation would end that. It would end the discrimination of charges that currently exist where the charge for health care is based on one's health status or gender.

During the course of this year and the last few years, while we have been studying the health care delivery system, I have come to a new understanding of what the word ''underwriting'' means. I used to think I knew what the word ''underwriting'' meant in insurance. What I have found it means is the screening out of people who might actually need the insurance that is being sold. So much of the effort of the health insurance industry today is not focused on assisting the patient or the policyholder; it is focused on screening out those individuals who might, in fact, wind up sick and might need health care. We try to end that in this legislation, and we do so effectively.

The legislation provides tax credits to middle-class families to make sure they can afford quality coverage. There are many middle-class families in my State who, frankly, cannot afford adequate and quality coverage for the parents and the children.

This legislation strengthens employer-based health care by offering small businesses a tax credit so that employers can offer competitive, affordable rates to their employees, if they choose to do so.

It creates incentives that reward doctors for healthy outcomes, not only for more and more procedures. We have the unfortunate circumstance today, for which this Congress and this administration and previous Congresses and previous administrations are responsible, where we have set up a system of payment, under Medicare in particular, where the amount the health care provider receives depends on how many procedures they perform, not on whether the patient gets better, not on whether they have done the right thing to assist that patient. We are trying to begin changing that with this legislation. This will result in better health care for all Americans.

Health reform is also designed to improve the choices people have when they go out to obtain coverage or to obtain health care itself. Most Americans get their insurance through an employer. Many are satisfied with the plans they currently have. They are satisfied with the physician or the doctor they currently have. It is clear in the legislation we are considering that this legislation does not require them to change that. This legislation says they can keep that policy. They can renew that policy. They can add family members to that policy if they choose to do so. But this health reform also provides security that ensures that families always will have guaranteed choices of quality, affordable health care. That is even when a person loses their job, when a person switches jobs, when a person gets sick, or a person decides to move from one community to another. This legislation will ensure that they have access to health care even in those circumstances.

It creates a health insurance exchange. This exchange would be a place where families and businesses could easily compare insurance plans and prices and make a judgment based on that comparison. This puts families, rather than insurance companies or government bureaucrats, in charge of their own health care. It helps people to decide which quality, affordable insurance option is right for them and for their family.

It keeps government and insurance bureaucrats, because there are bureaucrats working for insurance companies just as there are bureaucrats working for the government, both from coming between each individual and his or her doctor by simplifying insurance paperwork, by cutting out the pages of fine print, by eliminating all of the ''gotcha'' clauses people discover once they get sick. They find out they were not covered for whatever it is that now afflicts them.

By promoting computerized medical records, this legislation will dramatically improve efficiency in our health care system and, through that effort, also reduce cost.

Let me talk a little bit about the impact of this legislation on my State. I represent New Mexico. Frankly, this legislation is critically important to my State. This chart is a depiction of what is projected by the experts about the cost of health care in New Mexico. Without health care reform, my State is expected to experience the largest increase in health insurance premiums of any State in the Union. For example, the average employer-sponsored insurance premium for a family in New Mexico in the year 2000 was $6,000. By 2006, that had almost doubled to $11,000 for a family of four. By 2016, the expected increase goes to an astonishing $28,000.

In addition, this third chart highlights the health insurance premiums and the percentage those premiums represent of the income of the average New Mexico family. It is higher in my State, unfortunately, than in any other State in the Union. Today, 31 percent of a family's income is going to pay for health care. That is for the folks who have coverage today in New Mexico. That is expected to grow to an astounding 56 percent. Over 56 percent of a family's income is expected to be consumed just paying premiums for health care by 2016. That is totally unsustainable and unaffordable.

The health reform proposal that has been developed by the majority leader, based on the work of the Finance and HELP Committees, intends to slow the growth of health care costs around the Nation. The nonpartisan Congressional Budget Office forecasts that the legislation would not add to the Federal deficit. In fact, it would reduce the deficit by $130 billion by 2019 and by more than $400 billion by 2029.

Most experts believe these reductions also will drive down the cost in the private health insurance market. Thus this legislation is critically important to my State because it will help to curb increases in health care costs for all New Mexicans.

Let me show you a fourth chart. This one is a chart based on—I guess this is data from the Census Bureau. It is a chart that was developed by the Commonwealth Fund. It is the percent of adults ages 18 to 64 who are uninsured by State. It has two maps shown on it. The first is for 1999 through 2000 and the second is 2007 through 2008.

You can see what has happened just in that relatively short period. In 1999 to 2000, there were two States that had more than 23 percent of its population uninsured, and those two States were Texas and New Mexico. The only State in the Union that has a higher uninsured rate than we do in New Mexico is Texas. That was the case then, in 1999 through 2000. It is still the case today, I would point out.

But what you can see from this map on the right of the chart for 2007 to 2008 is that many other States—particularly the States shown in dark blue across the South and California—many other States have joined the ranks of States that have over 23 percent of their population uninsured. Their aged 18-to-64 population was uninsured. This is a very serious problem.

I think my State has the lowest rate of employer-sponsored insurance in the Nation. We also have the highest rate of uninsured among employed individuals in the Nation.

Let me show you this next chart, this fifth chart I have in the Chamber. This is a pie chart that shows what the current status of folks in New Mexico is. I know it is difficult to read from a distance, but let me explain what it is.

We generally think of most people having private health insurance coverage. In New Mexico, 38 percent of our population has private health insurance coverage. So it is not a majority; it is 38 percent. We have 14 percent who are covered by Medicare. We have 22 percent who are covered by Medicaid and the Children's Health Insurance Program. We have 4 percent who are undocumented immigrants in our State, estimated at about 80,000 individuals. They do not have coverage

today, and they will not have coverage once this legislation becomes law, if we are able to pass this legislation and the President is able to sign it.

Then this large red area shown down here at the bottom of the chart is 22 percent, and that represents individuals who have no coverage, excluding undocumented immigrants. So we have the undocumented immigrants, at 4 percent. Then we have 22 percent without coverage. These are folks who are here legally. Most of them are citizens. They do not have coverage. This gets back to the point I was making before about people's premiums today are covering not only the cost of their own health care needs, but they are covering the cost of the uncompensated care that is provided to this large red wedge of people shown down here on the chart. So it is a serious problem that needs attention.

New Mexico will benefit from this legislation in very important ways. The legislation will provide new Federal tax credits for private insurance, and it will also expand the Medicaid Program for individuals with incomes of up to 133 percent of poverty.

This is a very important provision for my State: It is projected that insurance market reform and Federal tax credits may reduce the cost of coverage in the individual/private market for the average family in my State by as much as 40 percent. So this last chart tries to take the previous information and say what would likely occur by 2019—10 years from now—if, in fact, we are able to enact this legislation.

You can see what the two biggest changes in the legislation are. The green wedge in the pie chart shows that we will have more people covered by Medicaid and CHIP. We would have 29 percent rather than the 22 percent we had before. It shows we will have many more people covered by private insurance. I believe for the first time in the history of our State, we will have over 50 percent of our population—exactly 53 percent is what is estimated—who will be covered by private insurance and have an insurance policy they can depend upon.

So this would still leave undocumented immigrants—which is still estimated to be 4 percent of the population—without any guaranteed source of coverage. But we would have about 124,000 New Mexicans newly eligible for Medicaid coverage, and covered by Medicaid, we would hope. We would have an additional 238,000 New Mexicans who would be eligible for private coverage through the exchange or from their employers if their employers chose to provide that coverage.

We will have a lot of opportunity over the next few weeks to debate particular parts of this legislation. I look forward to that debate. I think the more the American people understand what is in this legislation, the more wholeheartedly they will support us moving ahead and enacting this legislation.

This debate has been a long time in coming. In the 27 years I have been in the Senate, we have not gotten to this point previously, where we were beginning a serious debate that might actually result in the passage of legislation, major comprehensive reform legislation. But I think we are to that point.

This is legislation that is currently available for anyone to review on the Internet, and I encourage people to do that. I encourage people to study the issue and follow the debate. As I say, the more people do study the issue and follow the debate, the more people will conclude this is worth doing, this is important to do.

So I very much urge my colleagues to rally around this effort. I hope, frankly, we will get some Republican support for this legislation. I think it is very unfortunate we are going into this debate with reports that all Republicans are agreeing to oppose health care reform. That is not the way to move our country forward. If there are amendments they would like to offer, obviously, they will have every opportunity to offer those, and some of them may prevail.

That certainly was the case in the Finance Committee when we marked up the legislation. That certainly was the case in the HELP Committee when we marked up the legislation. Amendments were offered from Republican members, and some were adopted. But to just say no, to just say: We are opposed to reform, is not a good option. I think the American people deserve better than that. I hope we will have a serious, substantive discussion about what the elements of health care reform should be.

I compliment the majority leader for putting together a very credible proposal that will move this country very far toward meeting the health care needs of all Americans. I hope by the end of this year we are able to enact that legislation or pass it through the Senate and go to conference with the House of Representatives.

Mr. President, I see my colleague is in the Chamber to speak on this issue, and I will yield the floor at this time.

The ACTING PRESIDENT pro tempore. The Senator from Ohio.

Mr. BROWN. Mr. President, I appreciate following Senator BINGAMAN. Senator BINGAMAN perhaps knows more about this issue than anybody in the Senate. He was the only Democratic Senator to be on both committees that wrote this bill and did such great work both in the Finance Committee and the Health, Education, Labor, and Pensions Committee.

I would follow up his words by pointing out that this process—I was on a C–SPAN show this morning, and I heard the previous Senator who was on the show, a Republican, say this bill was written behind closed doors and that it is a partisan bill.

I went through this process, as did the Acting President pro tempore from Oregon, and we sat through 11 days of markup in the Health, Education, Labor, and Pensions Committee—all televised, all public, with hundreds of amendments. We accepted 160 Republican-sponsored amendments. The Senator from Oregon and I and Senator BINGAMAN and Senator MURRAY, also on that committee, voted for most of those 160 amendments. This bill had a lot of bipartisanship.

But on the big issues, the issues such as the public option, such as issues on how we are going to pay for it—some of the big issues—there is a clear philosophical disagreement. We can go back to 1965, when Medicare passed. Republicans opposed it in those days because they had a different view of the world. Their philosophy is government will never do anything right. Our philosophy is Medicare has been a pretty darn good program and has lifted a whole lot of seniors out of poverty, and so has Social Security. Medicare, in fact, has given people longer, healthier lives as a result.

So this issue is not so much partisan—although my friends on the other side of the aisle made it that—it really is a difference in philosophy. They wanted to continue—my friends on the other side of the aisle pretty typically do the bidding of the insurance industry. We cannot have health care reform and do it the insurance companies' way or there will be no health care reform.

We stood on the Senate floor—Senator MERKLEY and I, and Senator KAUFMAN and Senator WHITEHOUSE and Senator TOM UDALL and others—talking about some of the things insurance companies have done, such as having preexisting condition exclusions, where someone who has an illness cannot get insurance.

When I was on the C–SPAN show today, a gentleman from Indiana called. He is 63 years old. He has a preexisting condition, and he cannot get insurance. He has 2 years to wait to get on Medicare. But he knows when he is on Medicare, Medicare will not take away his coverage, exclude his coverage because of a preexisting condition. Neither will the public option exclude him from coverage because of a preexisting condition.

But you know Cigna does, you know Aetna does, you know WellPoint does, you know Blue Cross—the insurance industry so often excludes them because of a preexisting condition. That is why they can afford to pay their CEO at Aetna $24 million a year. That is why insurance company profits have gone up 400 percent over the last 7 years—because the insurance companies deny care for so many people, so

they cannot get covered, they cannot get insurance. Then they turn down so many claims. Thirty percent of insurance company claims are turned down initially by the insurer. So even if you eventually appeal and get your claim covered, get your claim paid for from the company that you have paid premiums to—if you ultimately get your claim paid for—why should you have to get on the phone day after day and call your insurance company and complain and complain and cajole and persuade and finally get it paid? That is not how our reform will work. That is not how the public option will work.

Mr. President, I know Senator MURRAY is here to speak in a moment. I just want to, as I have done many times on the Senate floor in the last 3 months, share three or four letters from Ohioans who have written me about this health insurance bill. What has come through in these letters I have gotten is a couple things—or maybe three things.

No. 1, I have found that most of the people who have written these letters—if I met them a year ago and asked them: Are you satisfied with your health insurance, most of them would have said: Yes. But then something happened. They lost their job or they got sick, and it was very expensive and they lost their insurance because they got cancer or they had a child born with a preexisting condition. They cannot get insurance. So they once were happy with their insurance—until they needed it. That has happened too many times.

The second thing I see over and over in these letters from the people—similar to the man from Indiana I mentioned earlier—is people who are 61, 62, 63 years old, maybe 59 years old, who are sick or they are not sure about their health and they cannot get insurance, they just say: I wish I was 65. I cannot wait until I am 65 so I can get covered because I know Medicare is stable and will not cut me off their plan.

What kind of health care system do we have when a 61-year-old writes a letter to their Senator saying: I cannot wait until I am 65 so I have health care protection, I have health care security? There is something wrong with that. We fix that too.

The third thing I hear in these letters—then I will read them briefly—is people call for the public option because they know a public option will help them, will help discipline insurance companies and make them behave, make them more honest. The public option will save money because they will compete.

In southwest Ohio, Cincinnati—in Hamilton and the three adjoining counties to Hamilton: Clermont, Warren, and Butler; those four counties—two insurance companies in those four counties control 85 percent of the insurance policies. Obviously, with that lack of competition, the quality is low and the cost is high for that insurance. Injecting a public option will inject confidence. The existence of a public option will inject competition and make those insurance companies work better.

This first letter is from Patricia from Hamilton County:

I am a senior who has been on Medicare for several years now. I also have a supplemental insurance plan with reasonable premiums and copays, but that has continued to rise over the last two years. Therefore, I don't have any problems accessing the care I need now. However, I have multiple sclerosis and when I was younger and living in another state, I was subjected to the preexisting condition exclusion. Fortunately, I was employed by the state which allowed me to obtain a reasonable health plan. But I know a lot of people are not as fortunate as I am. It is our responsibility as citizens to make sure all of our people have good health care coverage. A public option is essential to making sure this happens.

Patricia understands the public option will—again, whether you choose Aetna, whether you choose the public option, or a not-for-profit in Ohio called Medical Mutual, you have that option, and the public option is, in fact, an option that will give people that opportunity.

Joyce from Lawrence County, sort of straight southern Ohio along the Ohio River near the Ironton area of the State, writes:

I have been notified that any Medicare Part D monthly premiums will increase 25 percent in 2010. I simply cannot afford this increase and I need my medications. I am a senior, live on fixed income, and suffer from multiple sclerosis. I do not know how to handle this situation except give up my drug therapy and live with frequent episodes that require hospitalization. I support your efforts for health reform that includes a public option.

One of the things that will happen under our health care bill is that the doughnut hole that keeps people such as Joyce around Ohio and around the State and around the country who don't—it means people pay so much out of pocket for their prescription drugs coverage, we will close—initially, we will close it by half, and we are going to offer some four amendments to close the doughnut hole entirely so that people don't get hit so hard by drug costs.

Karen from Morrow County up near where I grew up in the Mount Gillian area, sort of north-central Ohio—Karen writes:

Please vote for health care reform for all that includes a public option. As a middle-aged female small business owner in rural Ohio, I am tired of seeing my community ravaged by the loss of affordable and accessible health care. With a preexisting condition, I have no option but to stay with my present provider and cross my fingers each year on my birthday that I won't be dropped.

This is a small business owner.

One of the things we knew right away and that Senator MURRAY and Senator MERKLEY and I worked on in the HELP Committee was to make sure there were good, strong incentives for small businesses to be able to afford health insurance for their employees. Whether it is in Olympia or Spokane or Portland or Eugene or Cleveland or Toledo, we have all been in similar situations where we have small business owners approach us all the time.

I have 20 employees. One of them got cancer. It costs so much for this one employee that they are either dropping my small business coverage or the cost has spiked so much that we can no longer afford it. What are we going to do?

Our bill will bend the cost curve for them and will give them tax credits so they can buy insurance and allow them to go into the exchange so they are in a larger pool. So 1 or 2 illnesses in a company of 20 or 30 people won't cause the price spikes that a larger pool of insurance will be able to blunt.

The last letter—and then I will turn it over to Senator MURRAY—is from Gail from Belmont County, which is eastern Ohio near St. Clairsville, Flushing, that area of the State. Gail writes:

I am a teacher and my husband is retired. In March 2009 I was diagnosed with cancer and began treatment soon after. I had surgeries, radiation therapy, and chemotherapy. I have an employer based plan, but it doesn't cover the entire costs of some of my expensive drugs which can cost thousands of dollars. How does someone without insurance afford such treatment? The fact is, they can't. I really didn't realize how expensive health care had gotten until I got sick.

Which is kind of the situation with all of us.

One of my sons is a veteran and has coverage that way. One son is in college and is still covered under my insurance. But my third son works seasonally and is not covered at all. He had an appendectomy several years ago and the resulting medical bills destroyed his credit. I don't know what will happen if he ever gets sick again. It is not right to leave the poor to flounder without proper medical coverage. It is time to end the greed of insurance and drug companies and have them face fair competition.

That is really all we are saying here. We want to create a system with consumer protections so that insurance companies can't drop people for preexisting conditions; can't put a limit on their coverage so that when they get sick they lose their insurance; can't discriminate against women, whom they usually charge more for premium costs for their insurance policies than they charge men; can't discriminate based on geography or disability. We want to give incentives to small businesses so they can insure more of their employees, and we want to bring competition into the system so insurance companies have to compete better than they have, driving prices down. That is what this legislation does, not to mention a lot in prevention and wellness. Prevention is in the bill, which really will help keep

people out of hospitals and live longer and healthier lives. That is our mission.

This Congress has tried to do this for seven decades. Tomorrow will be a historic moment when we vote in the evening to move this bill to the floor of the Senate so we can begin this process. It is the most important thing professionally I have ever done in my life. I feel privileged to have the opportunity to be a part of this and to fight for 11 million Ohioans. I know this isn't a bill just for uninsured Ohioans; it is a bill to make businesses more competitive, to help small businesses, to give consumer protections to those who are happy with their insurance and want to keep it, and to help Medicare beneficiaries by closing the doughnut hole and bringing some of their out-of-pocket costs down so they can live healthier, longer lives.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, I wish to thank the Senator from Ohio for sharing those stories. It tells the compelling reasons why tomorrow night's vote to move to this bill is so important, and we are all honored to be a part of that.

After a lot of hard work, it is amazing that our country really is now closer than we have been in decades to passing a real health insurance reform bill that will help provide our families and our businesses with affordable and stable health insurance coverage. There is a lot of debate and there is a lot of work still ahead of us, but it should not go unnoticed that this is a big moment for our country, and you know what. It couldn't come soon enough.

Our economy is hurting. Americans across the country are so worried about keeping their jobs and making their mortgage payments. The last stress people need today is to worry about the cost of getting sick or being dropped from their insurance plan or opening the mail and seeing yet another premium increase.

Health insurance premiums for families in my home State of Washington have more than doubled in the last 10 years, and they are rising at a rate that is five times faster than people's salaries. Families and small business owners are paying more and more for their coverage, and often they are getting less and less in return. These numbers demonstrate clearly what families and small business owners across my State of Washington understand all too well. The status quo in the health insurance system is unsustainable and the cost of inaction is just too high for them to bear.

The news we got back from the Congressional Budget Office on Wednesday is encouraging. It shows the American people that our bill, our legislation will save money while protecting Medicare, and it ensures that families and businesses can take back control over their own health care choices.

If we do not pass this bill, health insurance premiums are going to continue to skyrocket. If we fail to act, health insurance companies will continue to deny patients coverage simply because they are sick. And if we let another year go by without reform, more and more families are going to lose their coverage and more and more businesses are going to collapse under the growing burden of the cost of health insurance. It doesn't have to be this way. We have been talking about reforming our health insurance system for a very long time here. Now we owe it to the American people to give them more than just talk; to give them, finally, the stability and security of a health insurance system that will be there for them when they need it and that cannot be taken away from them if they get sick or if they lose their jobs.

Six months ago, I sent a letter to my constituents asking them for their stories and their thoughts on health insurance reform, and the response I got was overwhelming. I received over 10,000 letters and e-mails from people across Washington State sharing their health care stories with me. Those stories came from small business owners, from employees, from moms and dads who told me how they are struggling with the cost of care today. So many of them cannot afford the status quo and deserve health insurance reform that allows them to keep coverage if they like it, gives them additional options if they don't, makes their care more affordable, and guarantees, finally, stable coverage that cannot be taken away when it is needed the most.

I have come to the floor many times over the last several months as we have worked to put together our Senate bills and I have shared some of these stories on the floor. Now that we have a plan on the table, I wish to tell two of these stories once more to really demonstrate the desperate need for us to move quickly and to get this bill passed.

Chris Brandt, from Spokane, WA, told me a story about his problems finding coverage. Chris told me he is a healthy young man who works for a small business that cannot afford to provide coverage to its employees, so Chris, as do a lot of Americans, had to find coverage on his own through the individual market. He told me that after paying his mortgage, his car payment, and his student loans, the only insurance he could afford is a catastrophic plan that might keep him out of bankruptcy if he gets sick. But even the cost of that plan has doubled—has more than doubled in the last 2 years.

So here is a man named Chris who wants insurance. He doesn't want to be a burden to anybody else if he gets sick, but he cannot keep up with the rising cost. We have to have a system that encourages people such as Chris to get high-quality insurance that covers preventive care so that those small, inexpensive medical problems can be treated before they become large, expensive medical problems. That is what will keep our families healthy, and it will save money in the system in the long run.

I also received a very compelling story from a woman named Patricia Jackson who lives in Woodinville, WA. Like a lot of working families, the Jacksons told me they have insurance through their employer and they pay their premiums each month directly through Patricia's paycheck. But also like a lot of our families, the burden of those premium payments is rising too quickly. Patricia told me that to care for her family of four, she paid $840 a month in 2007—$840 a month. In 2008, her payments jumped to $900 a month. This year, Patricia paid $1,186 a month. Now, before this year is even over, she got a new bill and her rates have been hiked to $1,400 a month. That is an increase of over 66 percent for her premiums in just 3 years.

Patricia, not surprisingly, told me she and her family can no longer afford to pay this, and she is not alone. Family health care coverage rose over 86 percent between 2000 and 2007. That is an increase in my State of over $5,600 per family. Wages during that time period only grew 16 percent.

The largest private insurance company in my State sent out a letter in August to all of the people who get insurance through them and told them they were raising rates by 17 percent—17 percent. Some of my small business owners are telling me premium increases are going up 40 percent. This makes families and businesses have to make choices about what they can pay.

Families are really struggling today in this tough economic climate. It is the worst since the Great Depression. They cannot afford these cost increases. So the bill we are about to bring to the floor will finally—finally—make insurers compete for the business of the American people. That is what families and small business owners in my State and across the country want and need, and it is what they deserve.

The bill we are going to bring before the Senate will make health insurance more stable. It will end the unfair and deceptive insurance company practices such as cherry-picking and cancelling coverage because of preexisting conditions. It is going to reward what works in this system and change what doesn't. Finally, it will start reining in those costs so that health care can become more affordable. It is going to allow people such as Chris to get high-quality coverage, and it is going to rein in the costs for people such as Patricia.

This is more important now than ever before as our economy struggles and the cost of that care continues to rise.

We have been talking about health insurance reform for a long time, and while we were talking, families and small businesses have suffered. It is now time to end the politics and end the partisanship and come together to bring our families and our small business owners the health insurance reforms they deserve.

As we move forward in this debate, I am going to be working very hard to make sure that the needs and priorities of Washington State families and businesses are preserved and that we move forward in a way that ensures that the future health of our families and the strength of our economy is there. So I urge all of our colleagues to work with us now in a very constructive way over the next several weeks as we debate this bill. and to rise above the partisanship. Let's make health insurance work for our families, our economy, and for our country. That is what this debate is about.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. DURBIN. Mr. President, we gather on the floor today at a time that is historic. It is hard to imagine, to put it in the appropriate context, but this debate over health care reform is remarkably similar to the national debate over the creation of Social Security, or the creation of Medicare. It is that historic. It affects that many Americans and their futures. That is why it is important that all of us come forward to understand what this debate is about, the important issues that are before us.

The starting place for those who want to get into it is, of course, a Web site in today's technology and reality. The Web site is democrats.senate.gov/reform. If you visit that Web site, you will be able to see the bill that will be before Congress in its entirety. You will have your chance to read it, though it will be challenging. It is difficult not having all of the Federal statutes before you. But most of it is fairly clear in terms of what we are trying to achieve.

There have been critics of the bill who have come to the floor and argued that this bill should be defeated because it is too long, too many pages. They bring to the floor more than a copy of the Senate bill; they bring the House bill and the Senate bill and stack them up here to say how long this is. Well, of course, we are not going to vote on the House bill; it is the Senate bill. That is a bit of an exaggeration, but it is a long bill, over 2,000 pages. I won't talk about whether it is small or large print, but it is 2,000 pages plus.

You may ask, why does it take so many words to address this? But wait a minute, this is about health care in America. One out of every six dollars in our economy is spent on health care. It affects every single American citizen, and it will be challenged in court by the health insurance companies that want to stop this health care reform. We have to make sure this is carefully and well written, perhaps erring on the side of adding more language so there is no question as to our intent. But that is it.

The obvious question I ask back to the critics on the Republican side of the aisle, who say we should vote against this bill because there are too many pages in it, is: Where is your bill? Where is the Republican health care reform bill?

I know that in a few moments—in about 10 minutes—Republican Senators will come to the floor to talk about this important issue. I welcome that. I wish we could come to the floor at the same time. We might get close to something called ''debate,'' which would be an interesting phenomenon in the Senate, as it is something we have gotten away from. When they come to the floor, I hope the first Senator who stands up will do what I did. I hope the first Republican Senator will read a Web site where the American people can go to to read the Republican health care reform proposal. Again, ours is democrats.senate.gov/reform. What is the Republican Web site? Where can we find the Republican bill? I know the answer. There is no Web site where you can find the Republican health care reform bill—at least not today. I hope it will come soon. They have spent their time criticizing our efforts to change this system. That is healthy in a political system like ours, but at some point criticizing isn't enough. Stand and tell us what you are for, what you are going to propose.

If we start moving on this, as we expect to tomorrow, the procedures will take us to the consideration of the Senate Democratic amendment offered by Senator HARRY REID. I want to suggest and heartily recommend to the Republican side of the aisle—I see my friend, Senator JOHN BARRASSO, of Wyoming, who is here. He is a medical doctor, an orthopedic surgeon. We are friends. We may disagree on this issue, but we agree on many other issues. I hope he will encourage his leadership to produce a bill, show us what they believe. It would even be good if they send it to the CBO, as we did, and let us know what it would cost for the Republican plan for health care reform.

I will tell you what we have received from the Republican side of the aisle. It is three pages long. If you are looking for brevity, it is a very brief analysis of the health care reform issue in America. It is a press release from Senator MITCH MCCONNELL, where, as of yesterday, Senator MCCONNELL laid out everything—maybe not everything but most of the things he thought were wrong in the Senate Democratic approach. It is all negative. There is not one positive in here in terms of what the Republicans would do. Are they sensitive to the reality of health care in America today? Do they know the cost of health care insurance premiums have gone up three times faster than wages, that fewer businesses are offering health insurance coverage to their employees, and that more and more Americans have no health insurance protection because of unemployment and because of the cost of health insurance today? Are they aware that two out of three people filing for bankruptcy today are doing so because of medical bills—two out of three—and that 75 percent of them have health insurance that isn't any good? And they are in bankruptcy court. Are they aware of this cost challenge? If so, what will the Republicans do about it?

They will show us a stack of paper that Senator BARRASSO will show when he speaks, but they won't show us the Republican alternative. What is it? How much does it cost? How many people will it cover?

I hope my friend from Wyoming is the first Republican Senator who will come to the floor and join us in at least saying there is one thing we agree on—that health insurance companies are running roughshod over consumers and families of America. I hope this Senator from Wyoming, and other Republican Senators, will say there is one thing we can agree on with the Democrats: We should stop these abuses by health insurance companies. We should not allow these health insurance companies to turn you down for a preexisting condition when you get sick. We should demand that the health insurance companies cover our children beyond the age of 23.

My wife and I have been through this with our kids, and a lot of others have, too. Here comes your son or daughter, fresh out of college and looking for a job—oops, he or she is 23 years old, so now they need their own health insurance. Our bill moves that age to 26. Could the Republicans endorse that idea? It would be great if they did.

Would they endorse the idea that your health insurance would stay with you if you lose your job, and that we should not put caps on the coverage of a catastrophic illness so it won't wipe out a family? I hope they will join us in health care reform.

Of all the criticisms, I have yet to hear the first Republican Senator take

on the health insurance companies. That is what this battle is about. Who will win? Will it be the American people or the health insurance companies? I hope our friends on the Republican side of the aisle will join us in saying that it is clear it will be the American people.

Finally, this bill will expand coverage to 30 million more Americans. How many more Americans will be covered by the Republican health care reform plan? I am sorry to say I can't tell you. No one can tell you, because they have not produced a plan. We don't know what they are planning on doing.

This bill we are bringing before the Senate tomorrow for a procedural vote and to start the debate is a bill that is not perfect. I would have written it a lot differently. But it is a bill that we are working toward a working majority on. That means concessions. Some of these concessions are painful, from my personal point of view, but they are necessary. It would be great to have one Republican Senator cross the aisle tomorrow night and say, all right, I may not agree with everything in your bill, but I do believe this is an important national issue; the Senate should debate it, and this Republican Senator will join the Democrats in saying let's proceed to the issue, proceed to the debate. I don't think that is too much to ask. In fact, I think most Americans would say: Why wouldn't they want to debate it? Tomorrow night, they will have a chance to vote on that cloture motion on the motion to proceed to that debate. I hope they will join us at that point.

I will address one particular issue raised by one Republican Senator yesterday. Senator COBURN of Oklahoma, a medical doctor, said of the Democratic health care reform bill that there is a 5-percent tax on cosmetic surgery. He went on to say that this bill would cover breast reconstruction surgery after a mastectomy—in other words, imposing a tax on a surgery for breast reconstruction. I want to respond to him and say he is wrong and inaccurate. I want to make sure the record is clear. The bill we are proposing says the surgery is not a cosmetic surgery if it is ''necessary to ameliorate a deformity arising from, or directly related to . . . disfiguring disease.'' That is in the bill.

The bill points to the current definition for deductible medical expenses for the interpretation of this language. The IRS has already dealt with this. IRS publication 502 specifically states that breast reconstruction surgery following a mastectomy for cancer is deductible. It is clearly not taxable under our bill.

That statement on the floor by Senator COBURN was inaccurate. I wanted to make that clear. The Senator was mistaken. Breast reconstruction surgery is not elective cosmetic surgery for the purpose of this bill and is not subject to the bill's 5 percent excise tax on elective surgery.

I know we have a limited amount of time before the other side of the aisle has a chance to speak. I will save my remarks I had planned relating to some people in my home area back in Illinois, who are battling health insurance companies. On the Senate floor, I told the story of Danny Callahan, a baseball coach at Southern Illinois University who is fighting cancer. WellPoint has turned down the drug he was using, which his doctor recommended, to fight cancer and said they won't pay for it. It is a good drug for him, but it is expensive. It stopped the spread of cancer. His doctor said this drug works, but the health insurance company won't pay for it. The drug costs $12,000 a month. Danny Callahan cannot afford that. He will get a couple more treatments, but that is it. At the first of the year, the health insurance company is cutting him off from this lifesaving drug that is attacking the cancer in his body. They made that decision. His doctor said it was the wrong decision. He is another of many Americans who are at the mercy of the health insurance companies when you need help the most.

Can we change this? Can we give the American people a fighting chance when it comes to these situations? I think we can. But we won't do it by saying no. That is what we have heard from the other side of the aisle—no to everything. I hope that after 11 o'clock today, on Friday, November 20, the first Republican speaker will say: Here is the Republican health care reform bill. You can find it on the Web site. You can read it and compare it to the Democrats' bill. Again, the Democratic version is available at democrats.senate.gov/reform. Read it.

The ACTING PRESIDENT pro tempore. The majority's time has expired.

Mr. DURBIN. Mr. President, I am looking forward to reading their bill.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. ENZI. Mr. President, I ask unanimous consent that the Republican Senators, during their hour, be permitted to engage in a colloquy with fellow Republican colleagues.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. ENZI. Mr. President, I rise to talk about the health care reform bill. This country needs health care reform. The status quo in health care is unacceptable. Health care costs are skyrocketing, insurance premiums are increasing, and too many small businesses can no longer afford to offer health insurance to their workers. No one on either side of the aisle denies we need health care reform.

We need to enact reforms to bring down costs so everyone will have access to quality, affordable health care. We need to take a step-by-step approach to reduce health care costs and lower insurance premiums for individuals and employers. We need to eliminate discrimination based on preexisting conditions and ensure that people can take their insurance with them from job to job. I support commonsense reforms that would achieve all these goals.

Unfortunately, this 2,074-page Reid bill fails to address these issues. Instead, this bill would raise taxes by $493 billion. It would cut another $464 billion from the Medicare Program. The bill would reduce wages and eliminate the jobs of millions of Americans. It would actually drive up health insurance premiums for many more Americans and still leave 24 million people without insurance coverage. We need to do better than that, and I think we can.

Our country currently faces one of the worst economies in a generation. Our unemployment rate is 10.2 percent, which means there are 15.7 million Americans without jobs.

At the same time, the bill we are debating, or will be debating when we actually get to the real thing, would impose $28 billion in new taxes on employers. This new tax will eliminate millions of American jobs and reduce wages for millions of American workers.

When employers struggle with extra costs, workers and their families feel the impact. American workers depend on a strong economy to create jobs that help them feed their families and build their dreams. Unfortunately, the policies being pushed by the majority will only make it more difficult for America's businesses to hire workers or pay current employees more.

The Congressional Budget Office, health researchers, and nationally recognized economists all agree that Senator REID's new job-killing, employer tax will mean one thing: More Americans will be out of work if this bill becomes law.

As I mentioned, this bill will raise taxes by $½ trillion—$½ trillion. The authors of the bill truly believe the greatest problem in our health care system is that we do not pay enough taxes for our health care.

Under this flawed bill, if you take a prescription drug, you will pay a new tax. If you use any medical devices or equipment, ranging from walkers to wheelchairs, you will pay a new tax. If you do not have health insurance, you will pay a new tax. If you do have health insurance, you will also pay a new tax. If the government decides your health insurance is too expensive, there will be a new tax for that as well.

The problem with our current health system is not that we don't pay enough

taxes. Americans actually want to lower their health care costs—that is the message—not just pay more taxes to the Federal Government. All these taxes will only increase costs, making health care even more unaffordable.

The third major problem with this bill is it will actually increase the cost of health insurance for millions of Americans. The bill mandates that insurance premiums for younger, healthier workers be tightly tied to the costs for older, sicker individuals. This will immediately drive up costs for the young, healthy individuals who, coincidentally, make up a significant portion of our current uninsured population.

The bill also eliminates consumer choices, requiring Americans to buy richer types of plans that cover more of the deductibles and cover more out-of-pocket expenses. These plans typically have much higher premiums.

Taken together, these insurance changes will increase costs for millions of Americans. In looking at more modest provisions included in the Senate Finance bill, nationally recognized accounting and business consulting firms found these changes would increase insurance premiums by 20 to 50 percent.

The practical effect of this bill is, Washington could dictate to every single American, even those who have insurance they now like, the coverage they would need to purchase. Washington will tell you what is good enough coverage. The bill does not give people affordable options, and it penalizes those who do not purchase high-end, expensive plans, regardless of what they want, need or can afford.

Before I was a Senator, I was a small businessman. My wife and I owned three shoe stores. When I was showing someone a shoe and he said he did didn't like it or couldn't afford it, I didn't try another sales pitch. I knew it was time to find another shoe, one he liked and could afford. If the customer is complaining, get something else to show. The customers are complaining. The voices of August are still out there, and they know this bill is just more of the same.

There is a lesson in that story when it comes to reforming health care. It is time to listen to our customers and find an alternative they want and can afford. The intensity of the country's disapproval is apparent in townhall meetings, letters to newspaper editors, citizen protests, constituent calls, and letters from all across the Nation. I received some of those that said: My Senator is not listening but you are.

I wish to find solutions. Ask most of my colleagues and they will tell you, time and time again, I have been known to work across the aisle on commonsense reforms on all kinds of issues. I have fought for years to enact commonsense reforms that will help slow health care cost growth and make the insurance market work better for small businesses.

I worked closely with Senator BEN NELSON from Nebraska on a bill that would allow small businesses to combine their purchasing power across State lines, even nationwide, and collaboratively buy health insurance at discounted rates.

I worked closely with the late Senator Ted Kennedy on a bill to reform the drug approval process at the Food and Drug Administration.

I worked closely with then-Senator Clinton on a bill to save lives and decrease costs by promoting greater use of electronic medical records.

Time after time, I have advocated that we set partisan differences aside and work on the 80 percent of the issue that will make a difference for most people.

Unfortunately, rather than working with Republicans to develop a commonsense solution, the majority drafted a flawed bill that spends too much, does too little to cut health care costs, and puts seniors' benefits on the chopping block.

The White House and Democratic leaders should have responded to these concerns with alternative ideas that actually address the health care issues that most Americans care about—their cost. Unfortunately, they decided to simply try a more aggressive sales pitch. As a result, opposition to it will only continue to grow.

If this bill continues to move forward, in spite of what most Americans are telling us, I am going to keep offering amendments geared to bringing down health care costs for American families, scaling back total health care spending, and protecting seniors.

I yield the floor to my colleague from Wyoming who has copies of the bills.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. BARRASSO. Mr. President, in joining my colleague from Wyoming, he and I had a townhall meeting together in Gillette, WY, his hometown, a wonderful community. I was just there last week for a Veterans Day parade. What Senator ENZI knows and I know is when we talk to the people of Wyoming, they want commonsense solutions.

As I am here with the House-passed bill and the Senate bill we are now looking at, people of Wyoming are astonished at the amount of pages in this sort of thing, how to deal with this, how to comprehend it. What does it mean? What if I like something on page 208 but don't like something on page 1,200?

We ought to be using a step-by-step process. My colleague has a wonderful program, a 10-point plan to improve our health care, and any one of those would be a positive step to actually helping American families, helping them get the health care they would like and they need. But not these bills—one through the House, one through the Senate.

I don't know if my colleague wants to join me in discussing the townhall meetings, where people said: We want health care reform; we want things that are going to make life better but to help keep down our premiums, help keep down the cost of our care. Eighty-five percent of Americans have health care coverage. They are just not happy with the cost. What I heard for the last hour from my colleagues on the other side of the aisle is we need to cover more people; we need to cover more people. That is only part of it. We need to keep down the cost of care for the 85 percent of people who like the care they have.

That is what happens when we get together with groups of people from around the State of Wyoming who come out for our townhall meetings to discuss the issues, to listen. We are there mostly to listen; they are there mostly to talk.

I ask my colleague, is that not exactly what we heard: We need changes but not this?

Mr. ENZI. Absolutely and not just townhall meetings. That is how the letters, e-mails, and phone calls are coming in, greatly in response to what they anticipated they were going to get, which was going to be lower costs. They don't mind helping other people to have insurance and subsidizing that insurance or in some cases providing it for free. But they expected to get something out of it themselves. We miss the mark on this. You can tell they missed the mark. The bill that has been brought up to be voted on is just a little 2-page bill. Why didn't they put up the House bill? Because they couldn't get 60 votes for the House bill. They know that is wrong. This is a whole lot different from the House bill. It is different. I give them some credit for that. They couldn't put this bill up because they can't get 60 votes, and they have to get 60 votes to move on to debate.

They brought up the Service Members Home Ownership Tax Act of 2009, which is actually two pages and a summary. So there is not much to that bill. Their hope is they can get the 60 votes and people will not concentrate on the fact of what is in this bill.

I appreciate all the efforts of the Senator from Wyoming. He has been involved in the health care industry as a provider for a long time and a real student of what is in these bills. He has looked at these bills in detail, so he knows a lot of the flaws. I appreciate him taking the time to point those out.

Mr. BARRASSO. Mr. President, there are a lot of flaws in these bills because what Senator ENZI and I both hear when we go to townhall meetings—but also I had a telephone townhall meeting the other day—is: Don't cut my Medicare. Yet when we take a look at the details of these bills, it is going to cut $500 billion—$500 billion—from our

seniors who depend on Medicare for their health care.

They also say: Don't raise my taxes. But taxes are going to go up across the board. Every family is going to notice an increase in their costs, whether through taxes, premiums, an increase in the cost of their lives in terms of how it is going to impact the care they are going to receive. They say: Don't make my family pay more for health care. But across the board, people look at this and say they are going to end up having to pay more.

When Senator REID brought this bill out, he said: Of all the bills I have seen, it is the best. To me, it is the best of the worst bills I could ever see. It raises taxes. It is not just me speaking. If you read what the people who had a chance to read the bill say—the Associated Press, the Washington Post, the New York Times, others throughout the country, our e-mails from home—there are higher payroll taxes, companies would pay a fee, rely primarily on new taxes, new fees, and then cuts in Medicare. It is beyond me that this Senate—that this Senate, the Senate of the United States—is ready to tell the seniors of this country they are going to cut $500 billion from the care these seniors get from Medicare. That is a growing number of people. Year after year, more people are on Medicare but yet the cuts are going to be there.

The gimmicks, the budget gimmicks are astonishing. The advertised pricetag is an astonishingly large number, over $800 billion. To get down to that astonishingly high number, they have used quite a few gimmicks. You get taxes, you get Medicare cuts, and then you get the gimmicks.

I visited with Senator GREGG from the Budget Committee earlier today. He is going to be on the floor to discuss the gimmicks. One of the things they have done is basically hidden the true cost of the bill. The true cost of the bill is going to be close to $2.5 trillion over a 10-year span. They have done it by putting in a whole new program called the Community Living Assistant Services and Support Act. It is a new Federal long-term care program.

What happens in these long-term care programs? They take in the money early on and then they do not spend it until many years later. But in the way they count money around here—they do kind of a 10-year score, they call it. For the first 10 years they are going to be taking in all of this money, and then when it is time to pay the money out, that money is not going to be there anymore because they will have spent it on the increased cost of medical care because these bills do nothing to get the cost of care down.

KENT CONRAD, Democratic Senator from North Dakota, do you know what he called this part of the bill, the Democratic bill on which we are going to be asked to vote? He called it a Ponzi scheme of the first order. He said it is the kind of thing that Bernie Madoff would be proud of. That is a Democrat talking about what is in this bill.

What has the Washington Post said? ''It's a gimmick. These are not savings that can honestly be counted on the balance sheet of reform.''

Do we need reform? Yes. Do we need health care reform? Do we need to change the system? Absolutely. But this is not the way to go.

Senator ENZI is here. He has done a remarkable job as a member of both the Finance Committee and the HELP committee, and he has been part of the markups for both of the bills. He has focused relentlessly on trying to get the costs down so the premiums for the American people will not go up, and he has offered amendment after amendment, and they have been rejected time and time again.

Then Senator REID gets these two bills—one from the HELP committee, one from the Finance Committee—tries to stitch them together behind closed doors, and there is an amendment that Senator ENZI had put into the bill, one of the bills—it was voted on and approved—and then it magically disappeared without the knowledge of any members of the committee. It was something intended to help the American people, but that got taken out and thrown away in the dead of night.

I don't know if Senator ENZI would like to comment on that, but this is a Senator who was working to improve the lives and health and pocketbooks of the American people, and his great idea is thrown away.

Mr. ENZI. I would like to comment on that, in some way, unprecedented action by a committee. We agreed in committee on some amendments. Then when the bill was actually printed, which was not done for 2 months—which was, I think, so people couldn't actually look at it during the August recess, during that 2 months—when it was finally printed, some of the things that were agreed to were left out. One of the big ones was an actual wellness program, one that worked for Safeway, that helped cut their cost in the first year by 8 percent.

Have you heard of anybody cutting their costs in health care? Their program did. Since that time it has been held level because of what they were able to do with wellness programs. We got that wellness program approved. We didn't get much approved when we were doing that bill, but we got that approved.

But when the bill was printed, that was left out. Staff, without talking to any one of the Members, had taken it out. I think that is unprecedented around here. But that was not the only instance either. I would like to direct the attention of Senators to the costs on this bill, which the Senator from Wyoming has mentioned. As an accountant, I look at those. They say they are going to reduce the deficit in the first 10 years and even more in the second 10 years. There are two ways they can do that. One of them is to raise taxes. The other is to steal money from other people, which is what they are doing from Medicare. That, maybe, means they are overtaxing? So that might mean they want to stick in some other things that will be spending. Is there anybody out there who thinks you can do a $1 trillion new program and it will not cost a dime?

I hope people are taking a look at matters such as the Wednesday editorial by the president of Harvard who made some comments about how things are working. I hope everybody reads that. This is a good way for our Nation to go broke. We are not in very good shape right now, but that is a good way to go broke, and there are a lot of gimmicks in this bill too.

I appreciate the Senator from Wyoming pointing that out, and I assume the Senator from New Hampshire, who is the chairman—ranking member on the Budget Committee now—and has a handle on a lot of these gimmicks will share some of those too.

Mr. GREGG. If I could join this colloquy with my colleagues from Wyoming—what a great State to have two such exceptional Senators. First off, I want to make this point: Obviously, a lot of folks are pointing at this bill which I have right here—the Senator from Wyoming has one, and the other Senator from Wyoming has one—because it is real. Up until now most of the debate that has been occurring around here has been media. A lot of it has been theater. Some of it has been good theater, I hope, but it has been theater to a large degree.

Now we are dealing with something that is extremely real. Every page of this 2,074-page bill will have an impact on Americans. Every page of this bill will make a decision and direct a policy that will affect the health care of every American everywhere.

It is an extraordinarily intrusive and expensive bill. The Senators from Wyoming have been alluding to this, but it really is historic. The colleagues on the other side say this is a historic bill. It is historic. Never in my experience, and I don't think in any experience, has the Congress taken up a bill which is essentially going to restructure and fundamentally change the way that 16 to 20 percent of the national economy is going to be affected in such an immediate and intrusive way.

Essentially, the Federal Government will affect every decision that has to do with health care as a result of this legislation, every decision that has to do with health care.

The cost this is going to create in the area of increasing the size of the government is astronomical. We have heard this number, that this is a $890 billion bill. That is pretty big. I suspect that would run the State of Wyoming for a few years, maybe a century. I think the State of New Hampshire would probably run for pretty close to a century—in fact, more than a century, to be honest with you. I don't think our budget is $8 billion yet. So that is a lot of money, $800 billion plus. But that is not the real number. That is a phony number. That is a bait-and-switch number.

That number is arrived at by claiming, over a 10-year period, that the programs that are initiated in this bill—which is a massive new entitlement—will not start until the fourth and fifth year. In fact, the House bill was at least a little more honest than the Senate bill. It started in the fourth year. The Senate bill starts in the fifth year with most of the spending. But the taxes which the Senator from Wyoming, the senior Senator from Wyoming was just talking about, and the fees and the reductions in Medicare, they start pretty much in the first year.

So they have taken 10 years of taxes, fees, and cuts in Medicare, and they have matched them against 4 or 5 years of actual spending and claimed that they are in budget balance and that the bill only costs $890 billion—only.

In fact, CBO has scored this over the real period, when all the programs are in place. Over that period, over that 10-year window when all the programs are functioning that are created under this bill—all of them being Federal programs, brandnew entitlements, extraordinarily expensive initiatives—when that occurs, this bill costs, by CBO's estimate, $2.5 trillion. In order to pay for that we would have to cut Medicare by over $1 trillion. In order to pay for that we would have to raise taxes, fees, by over $1.5 trillion. This is a massive increase in the size of government, a massive increase in tax burden, a massive effect on Medicare.

The Senator from Wyoming mentioned there are a few gimmicks in here on top of the huge gimmick, that it is a bait-and-switch, that this is a $800 billion bill when in fact it is a $2.5 trillion bill. There are a lot of other games in here that deal with budgeting. I found one of the more entertaining ones: the fact they take credit in this bill for creating a new program, the CLASS Act, a massive new program, a long-term care program. They take credit in this bill as that being a budget surplus item. How do they figure that out? Because on a long-term care program, basically people in their twenties, their thirties, their forties, even into their fifties, pay into it. It is like buying insurance under this plan, so that money comes into the Federal Treasury.

What they do not account for is when those folks go into their long-term care facility and the money goes out, the money goes out at an incredibly fast rate, and the program balloons radically in its costs. They do not account for that. They just account for the years when people are paying in, and they claim that as surplus money they apply to try to reduce the cost of the bill. So they spend the money.

This is classic. First, they take in the money and claim it as an adjustment against the debt they are running up, and then they spend it so it will not even be available to pay for the program they claim they are going to fund with it. It is just inconceivable.

Bernie Madoff is in jail. Whoever thought up this program and scored it in this bill, Bernie Madoff would be proud of that person. He would say: My type of guy. That is the way you do accounting—fake it.

It is unbelievable. There are a whole series of these types of games in here. The States are going to be taken to the cleaners by this bill. The allegation that we are going to expand Medicaid by 20 to 30 million people, and the States are not going to end up paying a huge bill as a result of that? Absurd on its face. It is absolutely absurd on its face.

More importantly, when we expand Medicaid by 20 or 30 million people, the doctor will tell you, back here, the reason Medicaid is in such dire straits is because doctors will not see Medicaid patients. Why? Because they are reimbursed at 60 percent of the costs. Who pays the other 40 percent, by the way, for the present Medicaid recipients? Who pays the other 40 percent? I will tell you who pays. Mary and Joe Jones, who are working down at the local restaurant who have health insurance, they pay it with their premium. Bob and Marie Black, who are working over at the local software company, they pay it with their health care premium. The 40 percent of Medicaid that is not paid for by the government is paid for by people who are in private insurance. Their insurance premiums go up because they are subsidizing Medicaid reimbursements because the hospitals have to get paid for the cost, and they are only getting 60 percent of it from the government and the other 40 percent is being picked up by the private sector.

When we expand Medicaid by another 20 or 30 million people, we are inevitably going to drive up the costs of private insurance again. So the private insurance policies go up. What does that do? It does what this bill is basically intended to do: it will force employers to drop private insurance and move people over on to the public plan. That, when you get down to it, is what this is all about. This is an exercise in having the Federal Government get control over all health care. It is being done in an incremental way. They are setting up a scenario that will not be immediately apparent to people. But as we move through the years it will become apparent because what will happen is the costs of private health care will go up so much that private employers will start to drop their health care. They will take the penalty, which is not that high in this bill compared to what they have to pay in health care costs, and move their people, and say: Sorry, I am not going to give health care anymore—or never did—and go get this government plan.

Then down the road Congress will change this government plan a little bit, and they will start to put price controls in, just like they want to do in Medicaid. Basically, that will mean people will get fewer products because as you put price controls in you will have less innovation, fewer drugs. Fewer devices will be developed because people will not be getting a return on their investments because these will be price-controlled events.

You will find delays because that is what happens when you move to a government program that controls costs. The government can only control cost by controlling price. That creates delays in access which is what happens in England and Canada. So the quality of the health care system goes down.

I ask my colleague from Wyoming, who is uniquely qualified to comment on this because he is a doctor and he has experienced the problems of dealing with Medicaid, is this not a reasonably accurate reflection of what will happen if we move another 20 or 30 million people into the Medicaid Program? Doesn't that mean that private insurance policies have to go up, fewer doctors will see fewer people, and inevitably we will end up with a cost shift which forces private insurers to drop insurance?

Mr. BARRASSO. Mr. President, that is exactly what is going to happen. No. 1, we will get this huge push of an unfunded government mandate onto the States, a mandate that both Republican and Democratic Governors have called the mother of unfunded mandates, and they are across the board opposed. This is the way that Washington, with its wisdom, will say: We keep the price down, but what we will do is make the American people pay for it in a roundabout way. The more people you have on Medicaid, the program to aid the poor—and we have seen this in Massachusetts with their health care plan; there are not enough doctors to take care of everyone so the system is swamped, which is why it is taking now up to 9 weeks to get an appointment to see a doctor in Massachusetts, but also about 40 percent of doctors do not see Medicaid patients because the reimbursement rate is so low.

What you said, 60 percent of the cost, that is exactly right. It doesn't cover

the cost of seeing the patient. We are talking about hiring a nurse, turning the lights on, paying the rent on the office, doing all of those things, the medical charts, the liability insurance, the whole list of the costs of having an office opened. You cannot keep the office open if all of your patients are Medicaid patients. As a result, physicians—and I saw every Medicaid patient who wanted to see me. My partners and I have the same program where anyone can call and get an appointment, regardless of the ability to pay. But we know 40 percent of the doctors don't see patients on Medicaid.

Mr. GREGG. If I may ask a question on that point, this is an important point. As a practicing physician, if all your patients had been Medicaid, would you have been able to pay your bills?

Mr. BARRASSO. The answer is no. Doctors' offices cannot stay open at the rate that Medicaid reimburses, and no hospital in the country can stay open if they are getting paid across the board at Medicaid rates. You have to have other people who are paying more to make up for the underpayment by the government on Medicaid.

Mr. GREGG. If I might follow up, doesn't that inevitably mean that the people who are paying more are in the private sector, which means premiums for people in the private sector go up, which means fewer people are willing to give that type of coverage because the cost is too high for the business to cover; right?

Mr. BARRASSO. The people who have private insurance end up paying more for their insurance premiums to help make up the difference because the government has across the board been the greatest deadbeat payer. Washington is a deadbeat when it comes to paying for health care costs, both for Medicare as well as Medicaid across the board. That has been the long tradition of Washington and health care. The other people who are penalized under this situation are people who have no health insurance, because they are being charged at a higher rate. The person who works hard and says, I will kind of self-insure in case something happens, I get sick and I have to pay the full bill, they pay the full bill to cover themselves as well as more to help for the underpayment done by Washington.

That is how, when you have more and more people on the Medicaid rolls, more and more people forced onto that through Washington's wisdom, it is going to be harder on people who have insurance through their jobs. Insurance premiums, for people who have insurance and like their insurance, those rates are going to go up. It is going to make it harder for American families and for small businesses that want to hire someone, because the rates of insurance will go higher. It will make it harder for small businesses to provide health insurance for their workers, and those who continue to provide health insurance will not be able to give raises because the costs are going to go up.

This whole approach to health care reform was supposed to be designed to help keep the cost of care down. That is what the President and the Senate promised all through the year. But it does not. It drives prices up.

When I hear my colleague from New Hampshire talk about all of the gimmicks being used in an effort to claim this is a good bill, I refer to this morning's column ''Health Bill Hoax.'' Only Bernie Madoff could believe the Senate's health care bill will expand coverage to 31 million while cutting the deficit by $127 billion over 10 years. It would be the first profitable entitlement. Kind of like when the President of the Senate, at an AARP townhall meeting this year, said: We have to spend money to keep from going bankrupt. On its face, we know how absolutely ridiculous that sounds. You can't do that. This is an incredible expense: taxes galore, all over the place. The word ''tax'' is used in the Senate bill 183 times; ''taxable,'' 164 times; ''taxes,'' 17 times; ''fee,'' 152 times; ''penalty,'' 115 times.

For people who believe this will keep down the cost of care, it will not. As my colleague from Wyoming said earlier, I advise Members to take a look at an editorial by the dean of Harvard Medical School, living in a State where they have the Massachusetts health care plan, which is government-forced insurance, government-mandated care, government-run care. According to the dean of Harvard Medical School in an editorial this week, the health debate deserves a failing grade. The plan is wrong and those who support it are living in collective denial. This is what is wrong with this. This will markedly accelerate national health care spending rather than restrain it. It will do nothing or little to improve the quality of care.

That is what we started with at the beginning—to improve quality, improve access, and lessen the cost. What we have is a bill which, if passed into law and signed by the President, will decrease quality, increase cost, and lessen the access of Americans to health care providers.

I appreciate my colleague's comments. The numbers are so high. These are staggering figures. How do you communicate to the folks back home how astonishingly large these numbers are? Because people say: We do want you to fix things, but don't cut Medicare, don't raise our taxes. Drive down the cost of medical care. Improve access to providers. Create more choices. As I look at this, to me this is going to mean higher health insurance costs, higher taxes, Medicare cuts and then, unfortunately, more government control over health care decisions.

Mr. GREGG. I thank the Senator from Wyoming. He has a unique perspective which we should listen to, as a practicing physician for how many years?

Mr. BARRASSO. I have 24 years practicing orthopedic surgery, taking care of the families of Wyoming.

Mr. GREGG. That is impressive. He understands this whole issue and the point on cost. It is very hard to conceptualize that this is a $2.5 trillion bill when honestly scored. When honestly scored, it is a $2.5 trillion bill.

This page right here, page No. 1, cost the American people $2 billion. You could pick almost any page in this bill. And I don't think they are worth $2 billion a page. This page here, what does that say? I don't know. I am just picking this out: Transfer to the Secretary of Treasury a list of individuals who are issued a certification under subparagraph (h), including the name and taxpayer identification number for each individual, the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36(b) of the Internal Revenue Code of 1986 because, A, the employer did not provide essential coverage, and B, the employer provided such minimum essential coverage, but it was determined under section—and on it goes—section 36 (b)(c)(2)(c).

I don't understand what that said. We now will have about 72 hours to figure it out. But I know this much: When a bill costs $2 billion a page and when it includes language such as that, it is something we should spend some time on. This bill is being rushed. It should not be rushed. This vote that will occur tomorrow at 8 o'clock at night, after having this size of a bill on our desks for less than 2, 3 days, is very serious. We are firing real bullets here. This is no longer theater. It is no longer political media. This is the passage of a piece of legislation, the potential passage of a piece of legislation. Tomorrow's vote is a critical vote because it basically will mean we are on the road to passage. In fact, 97 percent of the bills that come to the floor of the Senate under a motion to proceed pass.

So this piece of legislation is serious. It is real bullets at $2 billion a page. Tomorrow's vote is something we need to look at as a vote that is not some sort of a procedural vote. It is a substantive vote on whether we are going to fundamentally change the way health care is delivered, cause the size of this government to grow by trillions and trillions of dollars, and put the Federal Government virtually into every decision that has anything to do with health care. With the way you choose a doctor, the way you get your insurance, with the type of procedures you get, with the type of drugs you can obtain—the Federal Government will

be involved. How much it costs, the Federal Government will be involved. And with the type of debt that will be passed on to our children. This bill will play a major role.

Remember something about the Federal Government: Once you give the Federal Government power, you don't get it back. This bill is all about moving power here to Washington. That is what this legislation is about, about centralizing the decision process, the national decision process on health care. In the end, the goal, as openly stated by some of my colleagues on the other side of the aisle—and I appreciate the fact that they are forthright—is to have a single-payer system where the government essentially runs health care top to bottom, much as it does in Canada and England. I believe that fundamentally undermines quality and is fundamentally unaffordable. It passes on debt to our kids which we obviously don't want. In the process, it will take Medicare, which is already in serious trouble—there is already a $55 trillion unfunded liability in Medicare—it will take Medicare's problems and aggravate them dramatically. To the extent savings are taken out of Medicare and used to create this new entitlement, which has nothing to do with Medicare or Medicare recipients but is going to be funded by Medicare both on the tax side with the HI tax in here and in the cuts in Medicare benefits with the elimination basically of Medicare Advantage, all of that is Medicare money that should be going, if you are going to do those things, to making Medicare more solvent for seniors, not to creating a new entitlement.

I see the Senator from North Carolina wants to jump in here.

Mr. BURR. I thank my colleagues from New Hampshire and Wyoming. Let me say on the same note, an $800 billion-plus bill, when you ask anybody in America, do you think this will increase the deficit, everybody's hand goes up. But the claim is that this is deficit neutral, that there is no no continuation of increasing the debt. Let me pick three areas, one you were just talking about, Medicare. This bill proposes that we shift $464 billion over 10 years to pay for this new program.

Mr. GREGG. Fully phased in, it is a trillion dollars.

Mr. BURR. But in that 10-year period, if you took Medicare, the proposal to shift over, if you face the reality that we will not cut doctor reimbursements 23 percent, which is another $246 billion worth of revenue, and the creation of a new program called the CLASS Act actually has people paying in for 20 years before the first person might take out a benefit, those three items alone come to $700 billion of the $800 billion we are paying for it with. Most Members would agree there are cuts that probably will never happen. On the face, it says it is going to contribute to the deficit. It will continue to add to the deficit at greater numbers, as the ranking member of the Budget Committee has stated.

But let me try to point out something I know my colleagues understand. This is a bill about coverage expansion. This is not a bill about health care reform. There are very few reforms, if any, in this bill. The Senator from Wyoming was talking earlier about Medicaid. One of the fundamental reforms that has to be made in health care is that we have to eliminate cost shifting where an individual who is uninsured goes in, receives a service, does not pay, and the cost is shifted to the private side, with people who pay out of pocket, people who have insurance. For the underinsured, the person goes in and receives a service, but the reimbursement is less than the cost of the service, and what is left over is shifted. Usually that is where the debate stops.

But under Medicaid, the current system, we reimburse 72 cents of every $1 provided, meaning 28 cents is shifted to the private pay side, out-of-pocket and insured side. In this reform package, we are increasing the rolls of Medicaid by 15 million Americans. We are taking a program today where, if the attempt is to eliminate cost shift—which it should be in health care reform—we would be eliminating Medicaid and we would be putting the Medicaid beneficiaries in a program that actually provided them a medical home, provided them an opportunity at prevention, wellness, and chronic disease management.

But, no, we are keeping Medicaid intact. And in the bill it says to the States: You cannot change your program. You have a maintenance of effort. You may find a more efficient way to do it, but if that efficiency means you are cutting any benefit, you are asking them to select where they choose health care differently, you cannot do that, States. We are locking you in for 10 years. And we are going to increase the rolls in Medicaid by 15 million Americans. We are actually exacerbating the problem we are trying to solve, which is, either shifting from people who do not pay or where there are reimbursements that underreimburse for a service. We are increasing the rolls by 15 million Americans.

Forget the fact, as the good doctor from Wyoming knows, that when you lock them into Medicaid, you have locked them out of having a medical home. You have locked them into a system that is there to treat them when they get sick and not to spend a dime on trying to keep them well. The truth is, health care reform, in large measure, is about our ability to change the lifestyles of the American people so we make healthier choices.

In part, you do that by creating a medical home. It is the reason most of us, if not all of us, have argued that everybody should be covered in some fashion. Health care should be accessible and affordable. The debate is over: where and what type. And, more importantly, should the American people have the ability to have choice? Should the American people have the ability to construct a health care plan that meets their age, their income, and their health conditions?

What we are doing is, we are taking on a one-size-fits-all government approach to say: If you do not like what is out there, we are not going to let what is out there change. We will give you an option, and it is to be insured and to be managed and to be run by the Federal Government.

I am not sure how others in other States have found it. In North Carolina, it has been overwhelmingly rejected by the population. I daresay, I think we have the greatest health care delivery system in North Carolina, both public and private, some based in academia. I think what North Carolina says is: Do not hurt my quality of care. If we are going to talk about reforms, let's talk about how we increase the quality of care, not decrease it.

Unfortunately, this misses the boat on reform. It is the most expensive approach to coverage expansion that anybody could ever imagine. The question is, if we took some time, if we worked in a bipartisan way, could we find a way to do this more efficiently and more effectively for quality of care, where the outcome was different?

This is a town obsessed with process, as my colleagues know. This is a product where we should be focused on outcome, not process. Because at the end of the day, there is an American family who is going to be the recipient of the rules, the regulations, and also the outcome of what this produces.

Mr. GREGG. The Senator has made a very good point, which is how you do health care correctly. You do not create a massive new Federal entitlement. You do not spend $2.5 trillion we do not have. There are a couple things you could do, though, on a step-by-step basis.

One of them—and I would be interested to know if the Senator understands why it is not in here—one of them is to correct lawsuit abuse. It is estimated $250 billion a year of medical expenditure is defensive medicine which doctors order and hospitals undertake simply to avoid the potential of a lawsuit being filed. CBO estimates it would be a $50 billion savings if we would adopt the proposals they use in Texas, California. That is one approach.

Another approach would be to allow employers to pay employees more who live healthy lifestyles, such as employees who stop smoking or employees who get the tests they need—whether it is mammograms or colonoscopies—

when they should have them or employers who live healthy lifestyles and lose weight. Under the bill that is not allowed, other than what present law is, which is very restrictive. That would save a lot of money, by the way.

The first proposal, as I understand, was opposed by the trial lawyers. Do you think that is why it is not in this bill—saving $54 billion on abusive lawsuits?

The second proposal—allowing employers to pay a differential and pay employees who are living a healthy lifestyle more—is opposed by the big labor unions here in Washington. Do you think that is why it is not in this bill?

I wonder whether maybe the Senator from North Carolina has some thoughts on those two approaches as to whether they would help the health care system in this country, and why they did not find their way into a 2,000-page bill, since we seem to have a lot of room in this bill for things.

Mr. BURR. I think the Senator makes a good point. I think many in the Congress who have worked on health care for a period of time have seen private businesses across this country reach new efficiencies in health care. Why? Because they have self-insured their employees. Where have they focused? They have focused on exactly what the Senator has talked about: prevention, wellness, chronic disease management, paying employees to enroll in chronic disease management courses, working with dietitians to make sure they lose weight, having cessation programs that are offered for free.

The things we have seen in private companies across the country that have brought down health care costs are absent in this piece of legislation. It is as though they have come to Washington and shared their tremendous experience, and we have ignored it when we sat down to write the bill.

Mr. GREGG. That is because we would have to change something called HIPAA.

Mr. BURR. That is exactly right.

Mr. GREGG. It is a technical term, but it basically allows companies to pay an employee who lives a healthy lifestyle more than other employees, and that is opposed, as I understand it. It was originally in one draft, and it got dropped somewhere.

Mr. BURR. Well, the Senator makes a tremendous point about the rational, reasonable reforms that the American people are looking for, and saying: Why can't we purchase insurance across State lines if that creates competition? Why can't we have insurance reform that allows us to construct the products? Why does the Federal Government have to mandate: Here is what the structure is?

Many Americans have chosen over the past several years to have flexible spending accounts, to have the ability to put their money in to take care of their health care needs. What does this bill do? It basically reduces the ability to fund flexible spending accounts at the amounts that are sufficient to let them continue to access their health care, in many cases with their own money. In fact, that is going backwards from what we have learned.

The Senator from New Hampshire mentioned earlier this shift of money from Medicare to this new program. Think about our Nation's seniors, those who are relying on Medicare for their health care, and the next generation that is getting ready to go in—some of us in this room. Well, when you shift $464 billion, you are shifting $1,063 per senior per year. Over the 10-year life of this score, we are going to shift $10,363 per senior, per beneficiary on Medicare today.

Is that fair to our country's seniors who have paid a lifetime of premiums into Medicare to receive a benefit, that because of fiscal irresponsibility that benefit may be cut in the future or the premium may go up for the next generation? And, thank goodness, the current beneficiaries in Medicare are screaming as loud as anybody because they understand the ramifications of what we are getting ready to do.

As the Senator from New Hampshire said, this is all going to happen tomorrow. This is going to happen at 8 o'clock Saturday night. People are going to come to the floor and they are going to vote on a bill, 2,074 pages—one that, at best, takes a team of people reading and a computer searching words in hopes you can identify everything of importance that is in the bill.

Mr. BARRASSO. The Senator from North Carolina, who has been a champion of early detection, early treatment, and prevention of disease, did see a preview of rationing this past week when this Preventive Services Task Force made a decision and recommendation about breast cancer.

The Senator talked about our seniors. I worry about rationing of care, delaying care, denying care. They said for women under 50 they should not have mammograms anymore. They should not do a breast self-exam. They said for women over 75, they should not have a mammogram anymore.

I will tell you that my wife is a breast cancer survivor, and she was diagnosed by a mammogram under the age of 50. And they cannot say that mammograms are not helpful. What they are saying is that the number of mammograms done per life saved is not cost effective.

I know both of the Senators who are on the floor, from New Hampshire as well as from North Carolina, have talked about early detection, early treatment, not using cost as the issue on comparative effectiveness research. We say let's use some clinical judgment. Let's see what we can learn. But, no, because for women under 50, they have to do 1,900 mammograms to save a life. For women over 50, it drops down to 1,300 mammograms to save a life. So that is what they are putting the cost of a life at: a 600-mammogram difference.

But for my wife—who is alive today, after three operations, and two full bouts of chemotherapy, and is now 6 years cancer free—having that mammogram under the age of 50 meant the difference between life and death.

That is what this bill has to do with. It is the difference between life and death for people. If you get into rationing care, delayed care—that is why people come to the United States for their care. It is the best care in the world. That is why Canadians and Europeans come here, because they have to wait too long. That is why our techniques and our treatments and our survival for cancer is so much better in the United States than these other countries. Because the Senator from North Carolina knows it is that early treatment that makes a big difference.

Mr. BURR. I think the Senator from Wyoming, being a medical professional, would probably agree with this: that every disease that can be detected at an early stage provides, one, more treatment options, greater survivability and, in the long run, less expensive cost to treat that disease.

It troubles me we have these determinations being made on cost that are not true costs because they are not putting into the calculation the treatment cost. But, more importantly, incorporated in this bill we are putting fees on medical device companies, we are putting fees on pharmaceutical companies, we are putting fees on health care equipment companies. Why? Because they have to pay for them.

We are replicating the same thing. We are disregarding the fact that when an innovative drug comes off the research bench, there is a likelihood we could cure disease versus maintaining, that we might have a new treatment option that cuts down on the cost.

As the Senator knows, even though he is an orthopedic surgeon, we have cholesterol-busting drugs that now people take who would have been in line for bypass surgery. And after that, we got stents that we put in, in place of bypass surgery, and that bypasses the last resort.

Sure, the creation of those blockbuster drugs was expensive. As they go off patent, generic competition comes in, and they become very inexpensive. But when compared to the $70,000-plus of bypass surgery, those drugs all of a sudden look inexpensive. But, more importantly, when you look at the quality of the care, where a patient did not have their chest cracked, they did not have rehab time, they did not have a

hospital cost, we save a tremendous amount of money in the health care system.

Mr. GREGG. If I could jump in at this point.

I think the Senator has touched on something that is important; that is, when you start putting these major fees on things such as medical devices and drugs, you reduce the willingness of people to invest in creating the next device, and not only do you end up with a device being priced out of the market or maybe not being produced, but——

The ACTING PRESIDENT pro tempore. The Republican time has expired.

Mr. GREGG. Then I will yield the floor.

Mr. President, I ask unanimous consent we be allowed to speak for an additional minute each, so we may wrap up our time.

The ACTING PRESIDENT pro tempore. Is there objection?

The Chair hears none, and it is so ordered.

Mr. GREGG. My point is, this bill fundamentally undermines innovation, and innovation has been at the essence of what has made American medicine better than the rest of the medicine in the world. We are the most innovative country in the world in the areas of drugs and medical devices and procedures. I think this bill undermines that.

Mr. BURR. I might add, that level of innovation is what makes the U.S. health care system unique to the rest of the world. We may not do primary care very well, and I think we have all admitted that, but if you get sick, where do you want to be treated? Right here in the United States of America because of the innovation that takes place.

Mr. BARRASSO. Mr. President, there are improvements that need to be done to the system. There are simple things we can do to keep down the cost of care, such as allowing people to buy insurance across State lines as well as giving individuals the same tax breaks big companies get, ending lawsuit abuse and dealing with what is needed to be done in terms of incentives to help people stay healthy so they have opportunities to save money themselves, and allowing small businesses to join together.

The bill we are looking at here is going to raise premiums for people who already have insurance. It is going to raise taxes on all Americans. It is going to cut Medicare—cut Medicare—for our seniors who depend upon Medicare for their health care needs. And while they are doing it, they are going to fund a whole new program rather than save Medicare—a system we know is going to go bankrupt.

Thank you, Mr. President. I yield the floor and note the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. KAUFMAN). Without objection, it is so ordered.

Ms. STABENOW. Mr. President, I am very proud to be here with colleagues of mine who have today joined me on the floor. Senator MERKLEY from Oregon and Senator MARK BEGICH from Alaska are such strong, passionate voices for people in this health care debate, for what we need to do to stop the insurance abuses and to save lives and save money. I am so pleased they are both here with me. Let me take a moment before turning it over to them to talk about what this is really all about for us.

Right now, the bill in front of us basically saves lives and saves money. We save lives through making sure that the 47,000 people who lost their lives last year because they couldn't find affordable health insurance to be able to see a doctor—making sure we change that; by focusing on prevention, also, so people have early detection and people can find out earlier when they have cancer and get the treatments they need to save their lives. There are so many ways in which this bill in front of us literally will save lives.

We save money. We save money for individuals and small businesses that are currently having a difficult time finding affordable insurance. If you have your insurance through an employer, as do about 60 percent of the people in my State, and if you are a large employer, then you can get a better rate because you have a large group plan. If you are a small business, you don't get that same treatment today. If you are an individual, if you are, like many people today, operating out of your home as a businessperson, a single entrepreneur, or maybe you are creating that next great invention in your garage and you are trying to find health insurance as a single individual for yourself and your family, you can't do that right now in a very affordable way.

So we want to fill in the gaps in a system that has worked well for many people with employer insurance and certainly for people in Medicare and our veterans with the VA and our military personnel and others. But we have a little less than 20 percent of the public right now that is left out there without a way to get affordable insurance, so we want to bring down their costs. We want to bring down the costs for our bigger businesses as well.

We want to make sure we are stopping people from using emergency rooms inappropriately and raising the cost on everybody with insurance and instead give everyone the opportunity to see their own doctor, their family doctor, and make sure their children and their families get the care they deserve.

We know this also saves money for the Federal Government, for States, for our economy as a whole, and we know what the numbers are in terms of inaction, the fact that we need to bring down costs across the board.

This bill protects Medicare. We know we would not have the AARP endorsing the House plan and hopefully supporting ours as well—I know they are still looking through the specifics, but they certainly support health care reform, and we welcome their support. They want health care reform. They have said certain things that I think are very important that debunk what we have heard from the other side of the aisle.

We have heard over and over that health care reform will hurt Medicare. The AARP Web site has up on its site: Myth: Health care reform will hurt Medicare. And then it says—not from us but from the AARP, a champion for senior citizens in this country—Fact: None of the health care reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services. None of the proposals we have introduced as the Democratic majority, supported by President Obama, would do that.

Fact: Health care reform will lower prescription drug costs for people in the Medicare Part D coverage gap, or what has now been dubbed the ''doughnut hole,'' so that they can get the better, affordable drugs they need.

Fact: Rather than weaken Medicare, health care reform will strengthen the financial status of the Medicare Program—strengthen it for the future.

We know Medicare has been a great American success story, and we want to make sure it is on strong financial footing to go forward for all of us who are baby boomers and beyond, to our children. This comes from the AARP Web site. So we strengthen Medicare. We protect Medicare.

Then we focus like a laser on stopping insurance abuses. We have heard so many times, unfortunately, story after story about families who cannot find insurance because someone in the family has a preexisting condition of some kind—a child who has leukemia, someone who is a diabetic. Even for women, pregnancy has been used as a preexisting condition. We want to make sure all Americans have the opportunity to find affordable insurance. We want to make sure that if you have insurance you have paid for your whole life, you have paid the premiums, you feel confident that because you have health insurance, when somebody in the family gets sick, the companies can't drop you on a technicality.

So we have a number of areas in which we want to stop abuses and,

frankly, strengthen the system. We want your children to be able to stay on your policy until age 26 if they need that. That is something I have often said that I wish had been in place a couple of years ago because I know what it is like to have a son or daughter come out of college and that first job doesn't have health insurance.

We want to make sure early retirees get the health care they need and are able to afford their health insurance with the Federal reinsurance plan, to help businesses keep costs down for people who—frankly, many have been forced to retire at age 55 or age 60 and don't yet qualify for Medicare.

So this is the bottom line: We are saving lives, we are saving money, we protect Medicare, and we stop insurance abuses.

I wish to focus for a moment on something else we are doing that is absolutely critical to me and, I know, to colleagues across the country, because this plan will also save jobs. Folks have said to us: Well, don't talk about health care; let's talk about jobs. Lowering the cost of health care is about jobs. It is about jobs. We lose jobs overseas to other countries that have lower health care costs than we do. We have seen plants—in fact, in Michigan—go across a river that you could swim across, the Detroit River, from Michigan into Canada, everything else being equal—a unionized labor force, environmental standards—everything else equal but one thing: the health care costs are less. So this is about jobs, and it is about keeping jobs in America.

We know our plan will allow big employers to save $9 billion over the next 10 years—$9 billion. What will they do with that? They will put that back in, reinvesting in equipment, building other plants, hiring more people.

Health care reform is about jobs.

Small businesses are estimated to save 25 percent in their costs over the next 10 years with the tax credits we have in the bill—the ways we create the ability to buy through a large pool, to be able to lower costs, and with the tax cuts in the bill to small business. There are tax credits to help all the companies that don't have insurance to be able to find affordable insurance.

The bottom line is, it is estimated that if we do nothing, the costs to businesses will double, and we will lose 3.5 million jobs. We can turn this ship around and begin to bring down costs. It is estimated we can save 3.5 million jobs.

People in America understand we have to focus on jobs and the economy. They also know the one-two punch is that when you lose your job, you lose your health care. So in our bill, we specifically create policies that make sure that if you lose your job, you don't lose your health care.

We want businesses, large and small, to be able to redirect the spending on ballooning health care costs and premiums, to be able to redirect that on hiring people and doing what we know how to do best, which is making things in America and putting people to work.

This is about jobs. It is saving lives and saving money and saving jobs in this country. I will conclude by saying that what are we hearing from our colleagues on the other side is the same kind of tactics that were argued in the 1960s before Medicare. You can take some of the same arguments and lift them right from the pages of the CONGRESSIONAL RECORD and you would think it was today's debate, but it was actually back in 1964, 1965, with Medicare. We know the arguments they used then about destroying the economy, about costs going up, about people losing access to doctors, and about how this would hurt businesses—it didn't happen then. We know it will not happen now. But what we are hearing is: Just wait, wait, wait, wait—that is all we heard in the Finance Committee. Don't do it now. What is the rush?

Well, if you are not getting those premium increases in the mail, maybe you don't feel the rush. If you are not losing your job and health care, maybe you don't feel the rush. But we have been talking about this for 100 years. We are tired of waiting. The American people are tired of waiting. They are saying business as usual for insurance companies: Let the insurance companies decide whether we are going to have maternity care covered under basic insurance. That is not necessary. It is an option. Let them decide whether we are going to focus on prenatal care.

We are 29th in the world in the number of babies who live through the first year of life—below Third World countries. Right now, 70 percent of the insurance companies in the individual market don't offer maternity care as basic health care. They say let the insurance companies decide. Let them be the ones between you and your doctor. When a doctor says what he wants to do when you are sick, what is the first call they make? To the insurance company. They say that is OK, let the insurance companies be the ones deciding what you are going to pay or get, whether you are going to be able to find coverage. Let them stand between you and your doctor. We say: No, we have had enough of that.

Finally, they say higher costs for middle-class families and small businesses are OK. Higher costs are OK because they are willing to allow this craziness to continue. Mr. President, we are not.

Let me emphasize, again, the bottom line: This is about saving lives, about saving money, and it is about protecting Medicare and stopping insurance abuses. We are committed to doing those things, getting through all the misinformation. All those who make so much money off the current system are just flailing and saying anything right now to try to stop us from getting control of the system and bringing costs down and making health care available. We are committed to getting this done for the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. BEGICH. Mr. President, I thank Senator STABENOW for her leadership. Last night, I had the honor of presiding while she spoke. I heard her first comment after she heard the other side describe the bill, saying it is so big they cannot read it, but they had great detail, for some reason. She even said she wouldn't support a bill as they described it. I agree with her. After hearing the last hour and what they described, I wouldn't support it either.

But that is not what this bill is about. This bill is about saving lives and saving money, protecting Medicare and stopping insurance companies and their abuse. I sat here for a few days—and I preside quite a bit, and I enjoy the opportunity to watch. I see the props brought out by our opponents. They always bring out the bill. It is almost always taller than they are. It is interesting that the prop is not realistic. The American public should know that. They make it look like it is such a large bill that they are incapable of studying it and reading it in a fashion—something that drives one-sixth of our economy. I learned one thing. In the last 11 months, I have gotten so many different books on different issues, and it is amazing. I took the bill—one of the pages out, page 114, and I was curious and thought, if we converted this into a regular book page similar to the ones we read on a regular basis—or all the books I get that people want me to read—I said, how big would it be? Well, it is just about as big as the book I have here. It is not hard. If you want to do it—and former Senator Martinez, who left us recently, I took his book, and it is an easy read. Maybe you would have to read it twice. It is not as they describe—like it is some complicated, huge document that is bigger and taller than they are. It is not a fair representation of what we are doing.

As you know, we have lots of pages here who work hard every day. I know they were surprised when I grabbed one of their textbooks for just one subject matter that they are required to study in order to be proficient. If you converted it into bill language, it would be four times the size of that document that they stack next to them. We ask our young people to be well educated, to learn the topics, and understand what they are referring to when they are tested. It is a simple thing.

I encourage our colleagues on the other side to not be so extreme in the

way they display the bill. It is not accurate. I think it is important to recognize that. This book is short. Probably people cannot see this book because it is so low on this table.

The other thing, as a new Member, I am learning the elements of the process here. I heard some colleagues on the other side talk about the process. The motion to proceed is a simple issue. It is an issue of are we going to debate this in earnest. Are we going to put ideas on the table rather than just talk about it and talk about it? We tried this a few weeks ago on the Medicare fix. The idea was a motion to proceed so we could move forward and debate how we were going to pay for it. The Medicare fix is critical to Alaskans. We have Alaskan seniors who want to make sure the reimbursement rate is the right one to ensure long-term coverage. But they didn't want to move on the motion to proceed. Therefore, we never debated how to pay for it. We couldn't get there with the amendments that many of my colleagues on the Democratic side were anxious to put forward. That is where it is.

To the American public and for folks listening to this forum here, it is important we keep to the facts, and they are very simple. This bill saves lives, money, protects Medicare, and stops insurance abuses. It is proconsumer, pro-patient. It creates more affordable access to health care. It strengthens Medicare, as I said. It is fiscally responsible. We have a long way to go. I hear, again, my colleagues on the other side say rush, rush, rush or, as the Senator from Michigan said, they always want to wait, wait, wait. The fact is, we are going to have weeks of debate, and there are items I will bring forward to improve this, similar to many of my colleagues on both sides who will bring forth amendments. That is what we should let happen in the process—debate it, discuss it, and end up with a product that will improve the health care system of this country. That is the goal.

When I hear, on the other side, that somehow this bill will be rationing, delaying, and denying care—I don't know about you, but I get letters every single day about people who have been denied care by their insurance company, who have been rationed out because they have preexisting conditions. They cannot get coverage because of the delay of the private insurance companies and the techniques being utilized.

It is important to know the debate on this side of the aisle on this bill is about ensuring that we will no longer have insurance companies denying or dropping coverage. We are asking insurance companies in this bill not to place limits on your coverage and ration your care. As I said, there will be no discrimination for preexisting conditions, and there will be preventive care, making sure people can access their health care and their insurance.

As was said by Senator STABENOW, who clearly understands the job issues because of the struggle in her State, there is a report—I will cite a few things, and I know Senator MERKLEY from Oregon has many items, because as we have sat here as freshmen talking about health care, I know he has more to share from the small business perspective.

My wife has been a small businessperson for many decades. A report was done by the Small Business Majority, working with MIT. Here is the basic data. The largest employers in this country are small businesspeople. Small businesses will pay $2.4 trillion over the next 10 years for health care costs for their workers. With minor reform, I believe that is what we are offering, at minimum. It will save them as much as $855 billion. That is not me or a bunch of politicians coming up with this; it is people in the small business community working with folks to do the research who determined this. That means more small business can employ people and raise capital, expand employment, create new jobs. As described earlier, it saves real money for small businesspeople.

I can tell you my brother-in-law who owns and manages one of my wife's operations has diabetes, a preexisting condition, and he has a $15,000 deductible. He pays an enormous amount each month, with no preventive care or chronic maintenance. It is a program that will not do much for him until he ends up in a hospital in a severe condition.

This bill is not just about making sure the insurance companies are held accountable and do the right thing for people who buy and have insurance today; it is also about creating jobs and making sure the private sector continues to grow.

The last thing I will mention right now—and we talked about this—is protecting Medicare. This bill protects Medicare. Why I know this is because I have looked at that component of the bill and, most recently, I had to explain this to my mother who is on Medicare; she is 71 years old. She discussed this with me just this week, as I visited her at her home in Carson City, NV. She described her sister, my Aunt Audrey, who has a disease. She is in the doughnut hole, where she has to pay for prescription drugs that she had no idea she would have to pay for. Today, this bill is trying to rectify and fix that problem and make sure seniors who are struggling out there don't end up having enormous out-of-pocket expenses. This issue around Medicare is not real. What we are trying to do is solve the problem and make sure to extend its length of stability but making sure seniors get more. They have earned it and they deserve it. This bill moves it forward.

Again, I wish to reemphasize the point that this bill reduces the deficit. It has a positive impact for this generation and future generations—$127 billion in the first 10 years, $650 billion in the next 10 years. That is what it does.

You will hear all kinds of numbers—and I am sure people who watch this get confused, as I do at times, listening to all these numbers they throw out. But that is the fact. That is not decided by us as Democrats or Republicans; that is the independent office of CBO that made that determination. They determined that is the positive impact to the deficit.

We need to push aside all the debate and rhetoric that is out there that is not factual and focus on what is right. Again, as we move forward on health care and insurance reform, there will be a lot of stuff put on the table. There will be items I will put on the table to work to improve health care and to protect Alaskans—yes, I will be parochial at times—but also look to the greater picture for America. This will be a great debate. It won't end Saturday at 8 o'clock; it will continue on and on, probably to some folks' dismay because it will be longer than people want.

The fact is, we will debate this issue. We will struggle with it. We will struggle with it within our own caucus of what the right decision is. But when done, our focus is the American people, improving the system—the status quo is not acceptable—and ensuring that we save lives, save money, improve Medicare, and hold our insurance companies accountable for their actions.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. MERKLEY. Mr. President, it has been a pleasure to listen to the comments of my colleagues from Michigan and Alaska, Senators STABENOW and BEGICH.

The bill before us saves lives, saves money, saves jobs, strengthens Medicare, and ends insurance abuse. You wouldn't have known that is the case if you were tuning in earlier to the Republican discussion in the last hour because what we had were a series of interesting arguments ranging from the plain silly to the flat wrong.

On the plain-silly end, we had a stack of paper about the complexity of a bill that addresses one-sixth of our economy and quality of life for every single American. My friend from Alaska has pointed out that if you put it in a normal size print, that is about equal to a normal book. I think we ought to realize that with a topic as serious as health care reform, which is touching the lives of every American, you are going to want to be thoughtful enough to address it in that detail.

We also had in the last hour a conversation about how much does the bill cost per page. Senator GREGG from New

Hampshire said the bill is going to cost $2 trillion and there are 2,000 pages, so it costs $2 billion a page. Last I checked with my schoolchildren, 2 divided by 2 is 1, not 2 divided by 2 is 2. But that is not the point. The point is, health care reform is not an issue to be played with hysterics, to be played with phony visuals, to be played with phony math. This is about our future, a future in which our businesses can compete around the world and in which our small businesses are able to provide health care. In fact, this is about quality of life for every single American.

In the course of my colleagues from across the aisle discussing the bill, they actually made a pretty good case for it. Let me start with Senator BURR.

Senator BURR said health care reform should be about choice but this bill takes one-size-fits-all. Boy, I thought, he is absolutely right. Health care reform should be about choice, and this bill before us is about choice.

Right now in America, we have one dominant player in most major health care markets. Even if we have more than one, we have antitrust exemptions that enable the health care companies to collaborate and cooperate. So you don't have real choice in the marketplace today.

What does this bill do? This bill says we are going to give every American the same type of choice Federal employees have. I became a Federal employee in January after I was elected and sworn in. I was told to go to a Web site and look at all the choices I had. My wife and I sat down and looked at the situation facing our family, and we chose the health care plan we thought would be best for us. We had that choice. What this bill does is it creates a health care exchange or health care marketplace that creates those choices and puts them in front of every family.

I will tell you that right now it is very hard for an insurance company to go into a new market. Why is that the case? Because in health care, unlike in life insurance, you have to do contracts with the providers. You cannot sell health insurance if you don't have arrangements with the hospitals and the doctors. It is very expensive to do. You don't yet have any customers. So it is very hard to break into a new market. But now, if you have a computer marketplace that citizens who go to the exchange are going to see and have a chance to change plans every year, you have automatic access to the customers and you can then afford to make contracts with the hospitals and physicians. It encourages competition across State lines. Take Oregon. You may have a company operating in Washington, Idaho, or California now say: Yes, we want to be on that exchange in Oregon.

I say to my colleague from North Carolina, he is right, reform should be about choice, and this bill is about choice.

My colleague, Senator BARRASSO, told a poignant story. He told a story about his wife having breast cancer and how fortunate he was and she was and their family was that it was detected by a mammogram and how important that type of preventive care is. I couldn't agree with him more. But millions of Americans—45 million, 47 million, one report says 50 million—do not have health care, and therefore they cannot get those preventive tests. They cannot get that mammogram if they are a woman. They cannot get that prostate checked if they are a man.

Senator BARRASSO makes a very good point about why we need to expand health care coverage throughout this Nation. The bill Senator REID has put before us will reach between 94 to 98 percent of all Americans.

The question came up: Why not 100 percent? Because Americans move a lot. Americans have crises and may not be paying attention when they are supposed to sign up. There will always be a small part of the population that is not signed up for health care. That is why it is a few percentage points. Let's put it this way: 100 percent of Americans will have the opportunity to have affordable, accessible health care. That is what this bill is about.

Returning to my colleague from North Carolina, he made the point that the bill before us is not about reform and that it should be about reform, about insurance reform. I have good news, good tidings for my colleague from North Carolina. Embedded in this bill are all kinds of reforms that are important for every person who has insurance in the United States of America.

First of all, guaranteed issue. You cannot be turned down because you have a preexisting condition if we pass this bill. I cannot tell you how many Oregonians—and I am sure it is true in North Carolina—have been turned down for health care insurance because of some health care problem they had in the past, maybe in the far past of their life.

This bill says you cannot have a lifetime limit. What kind of insurance do you really have if you have a $50,000 or $100,000 lifetime limit? After 20 years of paying your premiums, you get sick and, as you all know, you can wipe out $50,000 or $100,000 in a week or two. And now you are informed—you paid health care insurance for 20 years, you have been in the hospital for 2 weeks—sorry, you are on your own now. What kind of insurance is that when it is not there when you need it? This bill reforms that.

This bill adds nondiscrimination for gender, which is a fundamental value I think all Americans share.

This bill says you cannot be dumped off your insurance when you get sick or you have an accident. How many Americans have paid health care insurance premiums for years, paid those premiums month after month, are very healthy, rarely go to the hospital, rarely go to the doctor, but then they have a car accident and are seriously injured or they have bad news and have gotten a serious disease and they get that letter from their insurance company saying: Sorry, we are not renewing your insurance; you are on your own. So now, because preexisting conditions are not allowed, they cannot get insurance from anybody else either. They truly are on their own. This bill reforms that.

I am glad to let my colleague from North Carolina know that this bill is about reform.

Senator ENZI noted the story of selling shoes, that he had three shoestores and that when a customer came in and he showed him a shoe and that customer said that shoe is too expensive, he knew he shouldn't keep pushing the same shoe, he should not keep trying to sell it. No, he should show him a different shoe. That is exactly what the public option does in this bill.

Those who are in support of the status quo and don't want reform, they want to keep sending the same shoe, keep saying: Americans, you have only one choice or maybe a couple choices. But within a situation where there are no antitrust provisions, you just have to keep going back to that private company—no new shoe for you; no different product for you. But this bill says: No, if you are not happy with that, there is another alternative. In fact, this bill not only gives you one new shoe, it gives you two. Nonprofit co-ops can be set up—a provision that came to us through the Finance Committee—and it gives you a strong public option, a plan dedicated to healing, not dedicated to profits. So if you are not satisfied with the insurance you have, you have some alternative choices.

I think my colleagues across the aisle made a very good case—maybe better than the case I could make—for the fact that we need health care reform. We need it for large businesses so they can compete around the world, and we need it for our small businesses so they can afford to provide health care to their employees. We need it for our families because health care is about the biggest stress families face in America. If you have health care, you are worried about losing it, and if you don't have it, you are worried about getting sick. We need health care reform today.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I wish to take a few moments and continue this discussion and then turn it over to the distinguished Senator from New Mexico, Mr. UDALL. We are so

pleased to have him. We served together in the House. We are pleased to have him as a colleague in the Senate. They are a terrific team of people who are so smart, who care so much and have such great experience. Our previous speaker, coming from Oregon as the leader in the State legislature, and Senator BEGICH, as a leader, as a mayor—we bring a wealth of experience of people who have been serving, problem-solving, trying to make government work, make the right decisions at various levels of government. It is wonderful to be working with them today.

I wish to take a moment because I understand that the Republican leadership, our colleagues, are currently holding a press conference talking about what we are doing is somehow rationing care. This is the same argument, by the way, used back in the sixties with Medicare. Somehow seniors would not be able to get care, it would be rationed, which, of course, is the exact opposite of what happened.

Now people hold their breath if they retire early and don't have insurance, just waiting to turn 65 so they can get Medicare and they can see whatever doctor they want, not the one the insurance company says they can see but the doctor they believe they need to see, the specialist they believe they need to see.

We know that for too many people in this country, there is the ultimate in rationing. Over 45,000 people lost their lives last year because of the ultimate rationing. They couldn't find affordable health insurance. They couldn't see a doctor. They couldn't get the care they needed. Mr. President, 45,000 people in the greatest country in the world paid the ultimate price. Shame on us. We want to stop that. This legislation will head us in the direction to stop that, to say as a matter of principle in this country that it is not acceptable that any American would lose their life, any mom or dad would lose their child because they could not find affordable insurance in this great country.

We also know that every year we push as hard as we can to increase the amount of money going to the National Institutes of Health to gather information, to do research to save lives—to save lives through research, through information. In this legislation we want to make sure as the NIH is doing more research, as we are looking at better prescription drugs or new cures, that we are giving physicians and patients the very best information.

I am not scared of information. I want information for my family, for myself. I have been in a situation—I am sure that we all have—talking to my physicians, where they said according to the latest data we now think a little bit differently about a particular procedure or a particular medicine. And they make a different recommendation. I want my doctor to have that information. That is not rationing. In fact, we specifically say in this bill, we specifically prohibit the Secretary of Health and Human Services from denying coverage of treatment solely based on research, solely based on information. But we certainly want the information.

I think it is kind of silly to even argue about whether we want medical research and information so our doctors have the very best information to be able to treat us. Right now, less than 1 percent of our health care spending goes to examining what treatments are most effective. We want to make sure the information is there for physicians. Physicians support that, by the way. This is something in the House bill, endorsed by the AMA, endorsed by medical professionals all across the country. We want our doctors to have more information to do a better job for us, not less.

We are hearing, over and over, scare tactics. We know we are going to continue to hear that until we get to the end and pass this bill. But none of the groups—doctors, nurses, family groups, consumer groups, business groups—none of those who currently support this legislation would be doing so if they thought it was in fact doing the things the other side is claiming it is doing, and certainly not if it was rationing care. The ultimate rationing right now occurs when people arbitrarily get dropped because the insurance company doesn't want to pay the bill; when people cannot get the coverage they need because of a preexisting condition; or when they lose their life because they can't find affordable insurance. Our legislation is about saving lives and saving money.

I wish now to turn the floor to my colleague from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico is recognized.

Mr. UDALL of New Mexico. Mr. President, I thank Senator STABENOW for that very good statement on what I think is a very important issue. As we speak, and as I have watched the floor, I hear my Republican friends talking, as Senator STABENOW said, about rationing. They are seeming to imply this legislation somehow would do that. They also look at this administration and see that a prevention task force report of some of the key experts in the country, trying to give us the very best science, the very best medicine—that somehow that could be rationing.

My advice to women, listening to this debate, is that they should be consulting their doctors when it comes to things such as this. They should be listening to their doctors. Their doctors are up on the best research, they are up on the best science, they are up on the best medicine and get on top of it.

I would say to the women of America: Listen to your doctors, not to Rush Limbaugh.

Senator BEGICH from Alaska is on the floor. I am happy to join with him and Senator MERKLEY and DEBBIE STABENOW—with all these great Senators down here—to talk about this bill. But there is something that—I look on the other side and I see these huge stacks of paper. We should be a little bit truthful and talk to people in a truthful way about these stacks of paper. First of all, they are one-sided, so you only have print on one side, which is not even the way we print them up around here. I have had mine printed up on both sides so I use both sides of the paper. They have made an attempt here to make it look a lot higher than it is, as Senator BEGICH pointed out here earlier today, and if you take the type and reduce it to the regular type of a book, you come out with an average size book.

We are doing a piece of health care legislation that is very important to this Nation, a significant part of our economy, and we want it to be something that will rein in these insurance companies, bring in competition, bring in more choices, so we have to be careful about what we put in it. I think we should focus on the substance rather than focus on the gimmicks. We are getting a lot of gimmicks from our friends on the Republican side with these big stacks of paper. Let's talk about the substance.

I hope we are going to see someday in this debate an actual Republican bill and proposal so we can debate it back and forth. We have not seen that yet. We have just heard an awful lot of rhetoric.

One of the things I want to talk about today is what is a very important part of this bill and that is the public option section. A public option would bring to the Nation more competition. What we want more than anything is to have more choices when it comes to insurance. We want to see as many choices out there in the marketplace.

Sometimes I don't understand, when my Republican friends talk about this, because we are talking on their terms—about competition, about choice in the marketplace, giving people more choices. I don't understand why they are opposed to those kinds of solid principles that are the backing of this particular bill.

The other thing a public option would do is keep insurance companies honest. That is tremendously important. We have these insurance companies out there, we know they are doing very well in terms of their profit making. I am going to be talking about that in a little bit. We know they have very high administrative costs. If you have a public option that is actually dedicated to providing health care

rather than to making a profit, then you are going to have something going on in the marketplace that will keep everybody honest.

As you can see here, keeping the insurance companies honest, inserting competition into the market, and giving the uninsured access to affordable coverage—that is what we are talking about here. When we say a ''public option,'' we are not talking about subsidized by the government. This is going to be fully financed by premiums. The public option is not going to make a profit for its shareholders, it is going to focus on health care. It would have low administrative costs since it operates as a nonprofit. It would exert bargaining power to obtain discounts from providers. It would offer savings to its subscribers with lower premiums, greater benefits, or lower out-of-pocket expenses. It should follow the same insurance requirements as private plans. What you are going to see is the public option offering low cost and high value.

I think at this point what I wish to talk a little bit about is what has happened with some of our major health care insurance companies in the last couple of months. We have reached the end of a quarter. You see Wall Street has completed its third quarter earnings. Two of the big health care companies, Humana and Cigna, released their reports a couple of weeks ago. Let's just say that both companies did very well last quarter.

How well, you ask. Humana reported a 65-percent jump in profits over the same period. That is a big number. But, ironically, Humana's earnings seem positively restrained compared to Cigna's report. That is because Cigna reported a 92-percent increase in third quarter profits—92 percent.

Many companies right now are just getting back on their feet after the worst recession since the Great Depression. Although the economy is improving, times are still tough. When you take that into consideration, an earnings report with a 65-percent jump or a 92-percent jump in profits makes you wonder how Humana and Cigna are doing so well in such tough economic times.

I will tell you how they do it. They do it by putting profits above people. While Humana and Cigna touted earnings that are incomprehensible to the average person, or the average business for that matter—the average businesses, the business people I talk to say, are making 10 percent, 15 percent profit if they are doing well. Yet here these folks are making these huge profits.

While these health insurance companies are doing that, 47 million Americans continue to struggle without health insurance. While Humana's total revenue jumped 8 percent to almost $8 billion, and Cigna predicted profits of more than $1 billion this year, small businesses began reporting that their premiums are expected to jump more than 15 percent next year.

Unfortunately, Humana and Cigna are not alone in their ''profits above people'' business model. Over the past 7 years, publicly traded health insurance companies, companies that include Humana and Cigna, saw a 428-percent increase in profits—428 percent increase in profits. While the companies were raking in the cash, so were their CEOs, who in 2007 alone made $118 million between 10 of them. That is why health insurance premiums more than doubled over 9 years. Health insurance premiums doubling over 9 years, three times faster than wages increased.

Giant insurance companies are happy with the status quo. For them it means little competition, skyrocketing profits and the ability to do just about whatever they want to do to boost their bottom lines. A public option would change all of this. It would keep insurance companies honest by putting much needed competition back into the market. It would provide real choice for Americans by giving them another option that best meets their needs. And it would help small businesses and the self-employed by making health insurance for their employees more affordable.

I urge my colleagues on both sides of the aisle to pay close attention to these earnings reports. I urge them to take a hard look at the skyrocketing profits these health insurance companies have reported and ask themselves: Whose side am I on? The insurance companies that continue to put profits above people, or the people I was sent to Washington to represent?

I know which side I am on. I know a public option is the right thing for Americans and the right thing for this country.

One of the things we hear in this debate—all of us, as Senators, stay in constant contact with our constituents. We get mail, we get telephone calls, we get e-mails. My constituents in New Mexico have talked to me a lot about their health care problems. They have talked to me about their rising premiums. They have talked to me about losing their insurance. And they send me some very powerful stories I want to share.

Here is a story from a woman in Placitas, NM. Here is what she wrote me in an e-mail.

> Dear Senator Udall: I own a small business—just me and my secretary. I just got my notice from my insurer about the rate increase for next year, which is between 9 and 10 percent. For two people I will now be asked to pay $2,300 per month in premiums.
>
> We can't afford it. I am now faced with the likelihood of having to drop insurance, which for two cancer survivors is not the right answer.
>
> I know you support the public option and that you are a reliable vote for reform. But if anyone on the Hill is keeping a record of how the inanity of this debate is actually affecting real people, please include this e-mail in the log.

How would a public option help in that circumstance the woman just wrote in about? A public option would provide another, more affordable choice for small businesspeople such as this lady from Placitas, people who own their own businesses, who are doing the right thing, pursuing their own American dream. These folks cannot achieve that dream when they are paying outrageous costs for health coverage for themselves and their employees. A public option would help small businesses succeed by giving them another, more affordable choice in the insurance market.

This is something we need to focus on. As we flip through the bill, as the American people look at this bill, ask themselves: Are you for the status quo, are you for keeping these premiums going up, are you for the insurance companies dominating the market or are you for competition? When it finally comes down and we look at the overall package, it is going to be clear.

The PRESIDING OFFICER. The time of the majority has expired.

The Senator from Florida.

Mr. NELSON of Florida. Mr. President, I will vote for the motion to proceed. That gets us to the point at which we can have the bill before the Senate in order to debate and to amend the legislation. It is a debate we must have. It is a debate we cannot afford not to have.

The PRESIDING OFFICER. The time of the majority has expired.

Mr. NELSON of Florida. I ask unanimous consent that I be able to proceed for 2 minutes.

Mr. ALEXANDER. That is OK as long as it is taken from the Democratic time.

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

Mr. NELSON of Florida. I will vote for the motion to proceed to bring the legislation before the Senate. This is a debate we must have. It is a debate we cannot afford not to have. What is before us is to make health insurance available and affordable. The legislation that will come before us will prevent someone from being denied insurance because they have a preexisting condition. It will not allow the insurance companies to cancel policies because someone is sick. It will bring in millions of uninsured people who will then be able to have insurance and can afford it. By the way, that brings down the cost of all the rest of our premiums because they get health care at the emergency room, and guess who pays. All the rest of us do, to the tune of a national average of about $1,000 per policy. This legislation will reduce the deficit, $130 billion over the next 10 years and over $650 billion in the second 10-year period. There is room for

improvement. That is why we need to debate it. That is why we need to amend it. I will be offering an amendment that will produce savings to the taxpayers of another $100 billion by lowering the cost of drugs to Medicare recipients. Let the debate begin. I look forward to it.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, the Republican side should now have 60 minutes; correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. ALEXANDER. That will extend until about 2:05.

The PRESIDING OFFICER. The Senator is correct.

Mr. ALEXANDER. Mr. President, the debate has begun. The debate is about reducing health care costs—the cost of premiums every American has or the cost to the government that every American has to be responsible for. The bill we have been presented goes in the opposite direction. It raises taxes. It means higher premiums. It cuts Medicare. It transfers major new costs to States which, in turn, will damage higher education and/or increase taxes or both.

Our purpose on the Republican side is to take this next hour, as we intend to take several hours, all the hours allocated to us today and tomorrow, and help the American people have a chance to read the bill section by section, to understand what it costs and to understand how it affects them.

In this next hour, the Senators from Georgia, Mr. CHAMBLISS and Mr. ISAKSON, and the Senator from Kansas Mr. BROWNBACK, will be focusing on tax increases. We will be referring specifically to page 348, title I, subtitle (f), part 2 of this 2,074-page bill, which has to do with the tax on employers. We believe a great many employers will look at this big bill, look at the tax on them, if they don't pay insurance, look at the new government program and say: It is going to be a lot easier for me to pay the fine and write a letter to the employees and say: Congratulations, I have written a check to the government. You are on the government plan.

Then we will go to page 2,040 of the bill, which is the new Medicare payroll tax. That is a tax on hiring. You heard that right, a tax on hiring in the middle of a 10-percent unemployment situation. How is that going to create any jobs? We don't think it will.

Then Senator CHAMBLISS, especially, and Senator ISAKSON, because of his background as a small businessperson, will talk about what Republicans want to accomplish. If you are waiting for the Republican leader to roll in a wheelbarrow with a 2,074-page Republican version of health care reform, you will never see it. We don't believe in that. What we do believe in is identifying a goal—reducing the cost of your premium, reducing the cost to the government, and then going step by step toward that goal; for example, by reducing junk lawsuits, by allowing small businesses to pool their resources to purchase insurance, which we have offered but the Democrats will not allow to come forward, and by allowing people to purchase health insurance across State lines. Senator CHAMBLISS and others of us will talk about this during the next hour.

That is the Republican plan, to do what most Americans want done, to reduce the cost of premiums, and to not increase premiums and taxes, or cut Medicare.

There is one hidden tax I wish to talk about because it is in the bill, and it is in the news. Most Americans may have seen that the University of California yesterday raised tuition 32 percent. There are, in our country, around 18 million students who are in higher education. What I wish to say to them is, if this bill passes, their tuition is going up. California's tuition is going up again. It is going up in Tennessee. It is going up in North Dakota, in Nebraska, in Georgia, everywhere there is a public college, university, or community college there are going to be new taxes or higher tuition or both.

In California right now, they are pointing fingers at each other about the 32-percent tuition increase. But they should be pointing the finger at us, Washington, DC, Congress, because it is we who have allowed the Medicaid Program, the largest government-run program we have in the country, to go year after year with increases of 7 or 8 percent. We require every State, if it opts in, to have a government-approved Medicaid Program. In our State, it is called TennCare. That Medicaid Program is helping bankrupt the States.

Here is a State of Tennessee headline: ''State looks at $1 billion in cuts.'' Part of that is from the recession. But part of that is because of the increased cost of Medicaid. What does this bill do? It sends to the States another $25 billion in increased Medicaid costs. What will that mean? Higher tuition rates, higher taxes, or both. The University of California has the reputation as the best public university in the world. It will not be that very long if the Congress of the United States doesn't rein in Medicaid and reduce its cost so Californians can afford to have both a health program and a fine university system. The Governor of Tennessee has said the same thing. He has been outspoken about this. He has talked about exactly the dollars it will cost us. In the House bill, it is $1.4 billion over 5 years. In my view, I don't see how the State of Tennessee can pay that without a big State tax increase or without damaging higher education or both.

Someone might look at this and say: What does health care have to do with a 32-percent tuition increase in California? It has everything to do with it. Instead of reining in Medicaid, we are expanding Medicaid. By doing that, we are making it impossible for virtually every State to properly support higher education. The only choice they have, other than taxes, is raising tuition for 18 or 20 million students across the country. Californians, if this bill passes, your tuition is going up one more time.

I call on the Senator from Georgia, Mr. ISAKSON. He spent a number of years as the leader of the Republicans in the Senate. He dealt with the Medicaid question. He dealt with the question of taxes. As a small businessman for most of his life, he understands well the impact of new taxes on hiring and mandates on businesses.

Mr. ISAKSON. I thank the Senator from Tennessee.

Mr. President, I am delighted to be a part of the debate for all the right reasons, to talk about things we can do but also talk about things that the proposed legislation, in fact, does do to the American people, to small business, and to our future.

When I end my speeches in Georgia, I always end with the same line. I say: I am 65 years old. I have nine grandchildren; in fact, No. 9 was just born. His name is Hunter. He is 5 weeks old. I always say my life is about their lives. The rest of my life is about making their lives as rich, as prosperous, as safe, and as free as the one my parents left to me.

Legislation such as this severely threatens that. I wish to talk about two ways in which it does.

The heart and soul of America is the small businessman, as 73 percent of our employees are employed by small business. I ran one. I had 200 employees and 800 independent contractors. By law, I could provide health insurance to the 200 employees, and I did. But contractors, because they are independent, the IRS will not let an employer provide that benefit. That is one of the reasons you have a large number of uninsured who are actually working—real estate agents, sole proprietors, contractors. The Senator from Tennessee and I and the Senator from Wyoming, Mr. ENZI, then as chairman of the HELP Committee, proposed a small business health care reform act, a Republican act proposed in this body to cover one-third of the uninsured without raising rates or without raising premiums or without raising taxes. We had to get to a cloture vote of 60, and we only got to 57. So 3 years ago we missed a chance to cover one-third of the uninsured by a change in our law which would make it more affordable and accessible for independent contractors. That is what we were for.

Let me tell you what this bill does to a small businessperson. No. 1, if you have more than 50 employees and you

do not offer them health insurance, you have to pay a fine of $750 per employee for ad infinitum. If it is 500 or 51, you have to pay a $750 fine. I ran a company for 20 years. When I ran that company, I did provide insurance to 200 employees. I paid about $3,200 a year for the company's expense of their group health insurance. They paid the balance. If this offer were before me as a small businessman, then I would have said: Well, I have a $750 fine if I don't insure them and a $3,200 cost if I do. What should I do? Well, as a businessman, you are going to elect not to provide insurance, to pay the less expensive cost, which is the $750-per-person fine, and drive them into a public option.

This is not about a public option, it is about a public ultimatum, because as you look at the revenue-raising procedures, the tax-raising procedures, and the policy procedures, it basically drives people to a public option and drives small business away from providing that insurance.

There is another way it hurts small business. It also says, if you do provide health insurance to an employee and the cost of their part of the premium exceeds 9.8 percent of their annual income, then you have to move them to the public option, and they get subsidized. But you get fined $3,000 a year for the rest of the number of years that person works for you because their cost to their insurance was more than 9.8 percent of their income. You might say: Well, whose insurance would be more than that? Well, if you take a receptionist or someone like that today in a business, who may be making $25,000 or $30,000—an entry-level job—9.8 percent of that is only $2,800, $2,900. It would be more than easy for their share of their premium to exceed 9.8 percent. So the company gets fined, the employee gets driven to a public plan, and more revenue goes to the government through an indirect tax of a fine.

Mr. ALEXANDER. I wonder if the Senator would yield for a question?

Mr. ISAKSON. Absolutely.

Mr. ALEXANDER. If the employee were eligible for the Medicaid Program in Georgia and lost employer insurance and went into the Medicaid Program, isn't it true that the employee who went into the new government plan under this bill is likely to pay a higher premium and have a harder time finding a doctor?

Mr. ISAKSON. There is no question. I say to the Senator, you are exactly right. To think that it actually benefits the employee by doing that is wrong. They will have fewer doctors providing the coverage, and their cost might, in fact, be higher.

But I want to talk about one other thing on the small businessman before I yield to one of my other colleagues.

There is another tax—and we have heard the business about taxing the rich. This bill provides a surtax on payroll—a payroll Medicare tax on any employer who makes more than $200,000 if they are an individual or $250,000 if they are a couple. The Medicare tax goes from 1.25 percent—your share; the company matches it—to 1.95 percent.

Now, $200,000 is a lot of money, and so is $250,000. But to a small business incorporated as an LLC, a sub S, or something like that, that pays taxes as an individual, that is 1.95 percent doubled, which will increase the tax to 3.9-percent on every dollar that company makes on gross, not profit, if they're above $200,000. It is a tax on their business for Medicare to pay for a public option, not for Medicare. And Medicare goes broke in 2017.

So we are raising taxes on Medicare for the alleged rich, which really is most small businesspersons, all to pay for a program that does not benefit Medicare. The unintended consequences of this legislation are disastrous to small business, it is inappropriate in the way they are handled, and it is directed to drive people to an inevitable option to where there is no option at all.

I thank the Senator from Tennessee for giving me the time. I know my colleague from Georgia, Senator CHAMBLISS, has a few facts to add as well.

Mr. CHAMBLISS. Mr. President, I thank both my colleagues from Tennessee and Georgia.

I want to talk just for a minute about what Republicans are for. We have been criticized by the folks on the other side of the aisle for being just against what they are for, and that is not at all true. There are actually four other plans that were filed in both the HELP Committee and the Finance Committee, three of which were strictly Republican plans, one was a bipartisan plan, that never saw the light of day, simply because the folks on the other side of the aisle had their minds made up that they were going to have their plan with a government option, and they were going to do whatever they could to move us toward universal health care coverage.

I want to say to those folks on the other side of the aisle who have stood up and said on the floor of this Senate: Yes, by putting a government option in place, our intention is for the government to take over health care—some of them have been very straightforward about that, and they have been honest. There have been others who have been not so honest about that. But that truly is the reason there is a government option in the plan we have up for a vote tomorrow night.

But what are Republicans for? First of all, everybody in this body is in agreement that we want to drive down the cost of health care and we want to drive down the cost of insurance, and those are integrally linked. If you drive down the cost of health delivery, then you will drive down the cost of health insurance.

There are a number of ways we can agree today to enact legislation that will help drive down the cost of health care. What are those things?

Preventive health care. Well, there is some mention of preventive health care in Senator REID's bill somewhere in these 2,074 pages. There is the mention of preventive health care, but there is not the incentive in place to encourage people to move toward preventive health care as was done in the private sector with Safeway, a grocery store chain where the CEO has visited both Republicans and Democrats and talked about the way Safeway was successful in doing that.

We all want to make sure those who do not have insurance today are covered. We want to cover preexisting conditions. We want to make sure we put competition into the insurance market by allowing policies to be sold across State lines. All of those things will work in concert to drive down the cost of delivery, as well as the cost of insurance policies per se.

There is another measure that will significantly improve the cost of delivery; that is, putting in some measure of tort reform. In this bill, with these 2,074 pages, that seeks to totally reform the health care industry in America today, there is not one mention of reforming the tort system in this country, the malpractice reform area. If you go to any doctor and you ask him what is the No. 1 issue on his mind when it comes to reducing the costs in his office, I bet in 99 percent of the cases—maybe 100 percent—they are going to tell you that tort reform must be implemented if we are ever going to hope to drive down the cost of the delivery of health insurance in this country.

Senator GRAHAM and I have an amendment we will be talking about that is a tort reform measure that is a loser-pays style of tort reform. It does not take away the right from anybody who is injured. Anybody who is injured ought to have the right to have their day in court. But it does eliminate the potential for the extensive, frivolous lawsuits that our docs and our hospitals have to deal with every single day that drive up the cost of health care.

I want to talk, too, about one other measure we are for that has been talked about a lot today; that is, covering the uninsured. I think, without question, if you want to drive down the cost of delivery and the cost of health insurance, you need to cover those people in this country who need to be covered.

We have a little disagreement with folks on the other side of the aisle as to the exact number they seek to cover with this 2,074-page bill. But there is

one area where we do agree; that is, there are somewhere between 47 million and 50 million people in America today who are truly in that uninsured category whom we all, as a body of 100, would like to see have affordable insurance available to them.

Now, who are these uninsured? First of all, there are about 6 million people in this country today who are uninsured who are here illegally, and they are illegal, undocumented aliens.

Folks on the other side—and there is some question about this when you look at the language in this 2,074-page bill, whether they cover those illegal aliens, but let's assume we all agree they ought not to be covered. There are another 14 million people in America today who have health insurance available to them from the Federal Government in one form or another. Either they are Medicaid eligible or they are eligible for some form of SCHIP, the State Children's Health Insurance Program. In Georgia, it is called PeachCare. For whatever reason, these 14 million people have not taken the initiative to go out and sign up, for example, in Georgia, at the Department of Family and Children Services. I do not know what it is in Tennessee, I say to Senator ALEXANDER, but there is a comparable office in all 50 States for that to be done. What do these 2,074 pages seek to promote as to the 14 million people who have insurance available to them today to go in and take that insurance? Nothing. So these 14 million people are not even addressed.

Then there are another 15 million people to whom Senator ISAKSON just referred. They are people who are either those independent contractors or they are employees who work for employers who do not provide health insurance, but all of them are gainfully employed, and they have the ability to purchase health insurance. Some of these people are dealt with in this 2,074-page bill. Some of them are not because if you are an employer with 50 or fewer employees, then you are exempt, you would not be covered, still, as a part of that 15 million.

Then there are about another 12 million to 15 million whom I refer to as the hard-core uninsured. Those are the folks whom we really ought to try to reach, and those are the folks to whom the bulk of the $2.5 trillion this bill is going to cost during the 10 years when it becomes fully implemented seeks to reach.

I would simply say, if we are going to truly have a health reform bill, we need to start and take it step by step. If the folks on the other side of the aisle are serious about health care reform, we can get the appropriate committee chairmen together this afternoon, tomorrow, or whenever, and begin work on these issues I have just laid out about which there should be no disagreement. We could move forward with developing a true and meaningful health insurance reform package.

I want to come back in a minute and talk about Medicare taxes and the way Medicare is going to be dealt with here. But I would simply throw it back to the Senator from Tennessee, as well as to my colleague from Georgia, because they have both been involved in a very honorable way at the State level. Senator ALEXANDER is a former Governor of Tennessee. Senator ISAKSON was an elected member of our State house, as well as our State senate.

I say to the Senators, you gentlemen have experience dealing with Medicaid, and you know what the taxation side of Medicaid does from a State level. I would like to ask for your thoughts on what this 2,074-page bill is going to do to Medicaid in this country as we know it today.

Mr. ALEXANDER. Mr. President, I thank the Senator from Georgia. I am going to throw the question right back to Senator ISAKSON in just a minute.

I appreciate Senator CHAMBLISS taking time to point out what Republicans are for because it seems as if no matter how many times a day we say it, our Democratic friends do not hear it.

Let me put it this way: Let's say Senator ISAKSON, who has been a small businessman, buys a new small business. He takes it over, and he sees that generally it is working pretty well but it has some problems with it. I wonder if the first thing he would do is come in and say, I tell you what, let's just turn it all upside down and change it all, or would he say, let's identify the problem, and let's take a few steps in the direction of fixing that problem.

What Republicans are saying is, we have a big health care system that in general works pretty well. Mr. President, 250 million of us have health insurance plans; 47 million do not. Senator CHAMBLISS has just pointed out who those people are. Thirteen million or 14 million are already eligible for plans and for one reason or another do not sign up. A few million are illegally here. Some others are young and think they are invulnerable and do not sign up. But we are saying the problem is the cost, people cannot afford to buy their own insurance, the government cannot afford its health care costs, and people are going broke over this. So we want to reduce the cost.

Senator CHAMBLISS identified this step-by-step approach. He mentioned reducing junk lawsuits against doctors. We have proposals for that. Combating waste, fraud, and abuse—we have introduced legislation for that. Senator ISAKSON talked about allowing small businesses to pool their resources. Additional ways to reduce cost is allowing people to purchase insurance across State lines, so you can shop for more insurance and reduce your cost through competition, and amending the health savings account laws so you can withdraw your money in a tax-free way to pay for your insurance premium, and encouraging wellness and prevention. We could take those six steps, reduce costs, and then take six more.

I wonder, Senator ISAKSON, with your experience in business, if you think it makes any sense for us to just come in here and say: OK, we are really smart here in the U.S. Congress. This is a big country, with 300 million people. We are just going to turn the whole health care system upside down, write a 2,074-page bill, change the premiums, raise the taxes—do all these things—or would you go step by step in the right direction and try to re-earn the confidence of the American people who have lost a lot of confidence in Washington, DC?

Mr. ISAKSON. I think it is an excellent question, because every year in my company we had an annual planning retreat at the end of the year for the next year, and ironically—and I didn't know we were going to get into this discussion—but our No. 1 topic that I would send out to all of my management team is: What is the No. 1 thing we need to correct or do in our company? We would spend the entire retreat talking about that one thing. If that one thing was the uninsured, then what we would have talked about is what do you do to insure that 14 to 15 percent who don't have coverage.

Senator CHAMBLISS hit the nail on the head: Small businesses with health plans that allow independent contractors and contractors to be covered; that is one. Have an immediate identification and registration system for people who are eligible for Medicare, Medicaid, or SCHIP so that when they come to a provider or a doctor they end up getting covered. Then, third, come up with a program that meets that last third, which Senator CHAMBLISS referred to as hard core, those who by choice or by chance are not covered.

The last thing I would have done is said, We are going to throw out the 85 percent of this that works in order to fix the 15 percent that doesn't, and that, in effect, is what this bill does.

Mr. ALEXANDER. I say to Senator CHAMBLISS, one of the most difficult issues I think for many Americans who are watching what we are doing is the plan to cut Medicare. The new bill goes a step further. The way I read it—and I indicated the sections in the bill a moment ago—we are not only cutting Medicare, we are going to tax Medicare. Then we are not even going to spend the money on Medicare. In other words, we are going to cut grandma's Medicare, tax grandma's Medicare, then spend grandma's money on somebody else, and grandma's Medicare is going broke in 3 or 4 years, according to the Medicare trustees.

Mr. CHAMBLISS. In addition to that, we are going to continue to tax young

people who are in the workplace for additional Medicare taxes that are intended to be used by them in what is called the CLASS Act, which is another part of this monstrous bill, and chances are those people are never going to see those benefits. There is one tax after another in this bill that applies to Medicare.

One other aspect of Medicare that is of such critical importance here is that they have an $850 billion pricetag, according to the Democrats. According to the numbers and the figures of Senator GREGG, the ranking member of the Budget Committee, who came down here this morning and talked about it, that $850 billion is for the first 10 years. The taxes begin next year. The benefits don't begin until 2014. When you look at 2014 to 2025, the first 10 years of full implementation, the cost of this bill is actually $2.5 trillion, not $849 billion.

Why is it $2.5 trillion? Well, it is because the scope of government has broadened to such an extent that the expense of providing the services is going to be greater. We are going to have more people coming onto Medicare. We know now, as Senator ALEXANDER said, according to the bipartisan Medicare Commission, we will be paying out more in Medicare benefits than we receive in Medicare taxes in the year 2017. There are only two ways to fix that: either raise taxes or decrease benefits. The majority that is in power in Congress today has a habit of not seeing a tax they don't love, so my guess is that is the direction in which they are going to want to go: Raise taxes on Medicare beneficiaries and those in the workplace again to ultimately pay for Medicare benefits down the road.

The other part of this I wish to address with respect to Medicare is the Senator from Florida got up as we were coming on the floor and talked about this so-called deficit reduction. What do they mean when they say we are going to have a $32 billion deficit reduction over 10 years? Well, here is how it works. The deficit reduction is brought about primarily by the addition of a program in this bill to Medicare, what is called the CLASS Act. The CLASS Act is a long-term policy of insurance to take care of long-term health care needs. Young people are going to be required—young people in the 20, 30, 40-year age bracket will pay into the so-called Medicare trust fund that will be used to pay benefits for long-term care for those individuals when they start reaching the age where they need long-term care. So CBO has said that because these folks are 20, 30, and 40 years old and they are going to be buying these policies, they are not going to be getting any benefits for another 20, 30, or 40 years. So we are going to take the position that all of those premiums, which go into the general fund, by coincidence, will go to reduce the deficit. But guess what is going to happen, even according to CBO, when all of these young people who have been paying into the CLASS Act start getting benefits. All of a sudden we are going to start seeing deficits in the outyears, and our children and our grandchildren are going to have an additional debt put on them because of the way this particular provision is scored—and it is being touted as a deficit-reducing provision right now—that truly is going to be a provision that adds to the deficit and the debt our children and grandchildren are going to have to pay.

Mr. ALEXANDER. It must be a little confusing to the American people. I mean, one day Senator REID comes out and, a big hurrah, we are going to reduce the deficit and we are only going to spend $800 billion, and then the next day Republicans come out and say, No, when the program gets going, it is $2.5 trillion over 10 years. I wonder if I could say to the Senator from Georgia, while we have heard you talk about these projections, the senior Republican on the Joint Economic Committee has come to the floor, the Senator from Kansas.

How do you explain this to people in Kansas, Senator BROWNBACK, who must be very confused by this back and forth?

Mr. BROWNBACK. I don't think they are particularly confused. I think they smell a rat in this and they know if you are going to add this big of a program, somebody is going to tax me somewhere here.

The interesting way this is actually scored in the bill is the government uses the old heavy hand of inflation. As we have heard, many economists have spoken in the past about how inflation is the most cruel tax of all, particularly for the people on a fixed income, because then the base dollars they have do not go as far as they used to. What is scored in this bill—and we have seen this time and time again—is what you have as an inflation factor that is not indexed. It is not indexed.

I wish to show these charts here to prove it. At the end of how this is scored, we will end up having people who have subsidized insurance when they start out, but that in the outyears in the scoring will be taxed for having subsidized insurance. So we will be both taxing them at the same time as we are subsidizing their insurance. And we are also—and I will show a chart here in a minute—taxing their insurance plan that we are subsidizing at the same time, and that is built into the base score. So then that is how you get to a CBO score that, presto chango, the budget is balanced; we are even producing a surplus. It is this cruelty of inflation.

People can remember back to the Jimmy Carter days with 10 percent inflation. They know what that did to them. Look at this. This is all in the CBO scoring. This is from the Joint Economic Committee staff who have been working through these calculations to see, How do you come up with adding a multitrillion-dollar entitlement program and come to a budget deficit-neutral facet to it? What we see here is surtax levels—and this is kind of a busy chart—but this red line is 100 percent of poverty in 2009 and 100 percent of poverty built out over 100 years, which is also part of the scoring system, and then the median income of married households. What you see is families receiving subsidies beginning to pay the surtax in the scoring of this. That is all due to the cruelty of inflation.

Mr. ALEXANDER. I wonder if I could ask the Senator from Kansas, haven't we heard this story somewhere before? As I remember, back in the late 1960s there was a so-called millionaires' tax. We were going after 155 very rich people in America who weren't paying any taxes and now we call it the alternative minimum tax, and if we don't fix it every year more and more people will end up paying this tax. I think last year there were 28 million Americans who would have had to pay the tax.

Mr. BROWNBACK. That is absolutely correct, and it is the same technique. This is the alternative minimum tax on steroids in the insurance industry and in the insurance field. It is the same thing. We fix it every year. That is why this is such a fraud. Do you really think we are going to tax people for their health insurance at the same time we are subsidizing their purchase of health insurance? That isn't going to happen, so those dollars aren't going to arrive. So where are those dollars going to come from? It will be from deficit and debt, or you are going to have this cruelty of inflation taking place.

The bill funds health care reform with increased Medicare taxes. We are going to see that taking place in this as well.

Here is the chart I like that I will show. It demonstrates how we are going to have these Chevrolet plans—you have heard of these health insurance plans. Let me put this chart up. We are going to tax the Cadillac plans, all right? Well, it turns out under this bill, the Chevy becomes a Cadillac. So you are going to tax the Cadillac when it is still a Chevy. That is because of inflation.

Most people know their health insurance premiums have been going up pretty consistently over time. Well, it turns out that the Chevy will metamorphose into a Cadillac and it gets taxed and that is in the CBO scoring of this bill, and that is how you come out with balancing the cost of the bill.

None of this is going to happen. You will have some sort of AMT-type fix

that will take place on an annual basis, and at the end of the day you get a big debt and deficit you are going to have with it or horribly cruel high levels of inflation or maybe both.

Mr. CHAMBLISS. I would ask the Senator from Kansas if he would yield for a question. The question is: The Senator from Kansas and I were elected to Congress in the same year. This is our 15th year, I believe, of serving. You have been over here longer than any of us have, and you were involved in State government as well.

Have you ever seen a Federal program that was projected to be at X number of dollars of expenditure which came in on time and on budget?

Mr. BROWNBACK. No, I haven't seen that take place.

Mr. CHAMBLISS. Do you think that when Senator REID comes down here and says this bill is going to cost $849 billion over 10 years, that is a correct figure for a massive reform of health care?

Mr. BROWNBACK. No, and I don't know that there would be 5 percent of the public in my State who would believe that, because their experience tells them differently. Their experience tells them: Look, I know you guys make these great promises and everything, but I also know the further out you make this promise, the less reliable your data, and I have seen that whenever the government gets into things, it always costs a lot more and it seems as though our debt and deficit always keeps growing and it is way too big.

What is troubling is that this is built into the base of how we get to the numbers of getting this as a budget-neutral matter. This isn't going to happen. On top of all of that, you say we are going to save $400 billion in Medicare. We have now voted four times for the so-called doctor fix, which was a slight reduction in Medicare spending for providers, and I voted for it three times, to fix it, on an annual basis. Do you possibly think—possibly think—that the Congress is going to cut Medicare $400 billion, that people are going to come back here and say, You can't do that, you are going to be ruining Medicare and that Congress will fix it? I said this to Treasury Secretary Geithner yesterday: Our experience has never been to do something like that. So where does the money go? It goes right on the deficit and the debt and you are going to add to that $12 trillion estimate. We are hemorrhaging Federal money and, at the same time, the global community is saying, you have to get your fiscal house in order.

We just had our President over in China, hat in hand, with our bankers saying, OK, we think human rights is pretty important, but we need that loan. What we are going to see take place, because this is a fiscally irresponsible package, I think we are going to see the international community saying words are one thing but action is what talks, and we are going to start pulling capital out of the U.S. marketplace. It is going to drive up interest rates, it is going to drive up inflation.

So maybe this scenario happens, but it is cruelly done through inflation, and it is not fair to the American public.

Mr. ALEXANDER. I wonder if I might ask Senator ISAKSON from Georgia, we talked a little bit about his experience as a small businessman. Senator BROWNBACK has talked about taxes and how they are going to go up. According to the Republican Budget Committee analysis, the new taxes in this bill that we have on our desks would be about $850 billion over a 10-year period of time. Senator ISAKSON has been a small businessperson. Some of those taxes would be on you. Who is going to pay the taxes?

Mr. ISAKSON. My customer. The thing is, business is the collector of taxes for the government. Government imposes a fee, a fine, a cost to business, and it rolls into the base of what that business has to pay to produce its product and it is upon that which they make a profit. So this business of taxing business, they are getting business to collect a tax from the ultimate consumer. That is all it is.

I want to throw something else in. I appreciate Senator BROWNBACK very much. I was in Georgia a few weeks ago, Albany, near where Senator CHAMBLISS raised his family, at a Rotary Club. I was asked by a fellow: You keep talking about a trillion. How much is that? I babbled and fumbled. Have you ever tried to explain that number and quantify that? It is a huge number. We are talking about $2.5 trillion in the first full 10 years. I got so frustrated that I got on the calculator to figure out an analogy as to how much it is. I decided, I wonder how many years would go by for a trillion seconds to pass. I got on the calculator and worked it out. It is 31,709 years for a trillion seconds to go by. That gives you some proportion of the volume of dollars we are talking about in taxes and costs and, as the Senator said so rightly, debt. That is a lot of money, and the American taxpayer ultimately is on the bill for every dime of it.

Mr. CHAMBLISS. I ask my colleague from Georgia, we talked about this, and he has had extensive experience at the State level with respect to Medicaid. Take our State—and I think we are representative of all 50 States. We have a Medicaid Program now that provides for coverage or eligibility at 100 percent of the poverty level. This bill takes that to 133 percent of the poverty level. Talk for a minute about the impact of going from 100 to 133 percent to cover some of those uninsured I referred to earlier. What is the impact on our State?

Mr. ISAKSON. Right now, Georgia's current year budget for the cost of Medicaid is $2.15 billion, or about 12 percent of the State appropriations. This bill, as currently configured, raises that eligibility by 33 percent. But the Feds hold harmless the States for the first 3 years of that increase, and then it is a 90/10 split for the next 7 years, and then it is silent. To give everybody the benefit of the doubt, say States only have to pay 10 percent more. That is one-quarter of $1 billion more in Georgia—from $2.15 billion to $2.4 billion in the State budget.

We all know what is going to happen—what happened with the original Medicaid program. The State will eventually have to pay the full 35 percent match, which would mean that over time, at the end of the 10 years, using today's numbers without inflation, Medicaid costs in Georgia for about 12 percent of the population would go from $2.15 billion to $3.4 billion a year for Medicaid.

Mr. CHAMBLISS. Whether it is paid by the Federal Government after that 3 years or by the State of Georgia, whose pocket will it come out of?

Mr. ISAKSON. The taxpayers of the United States of America.

Mr. ALEXANDER. As we were discussing earlier, it could be paid out of the pockets of the 18 million or 20 million students who go to, for instance, the University of Kansas and Kansas State. We began this discussion by pointing out that California raised tuition yesterday 32 percent for its students. They are pointing fingers at each other, but they should be pointing at us for not reining in Medicaid because over time that is the biggest reason.

Mr. BROWNBACK. In my State of Kansas, a huge budget debate is going on about where we are going to come up with the shortfall this year in the State budget. People can save in some places, but you have to do this on Medicaid. It ends up, in all probability, that a disproportionate share will come out of the schools for the schoolchildren. Is that what we at the Federal level want to see take place? No. That is one of the reasons I am voting against this bill. You are dictating a State budget. Initially the Feds are putting in the full amount, but I have seen this before too. You start with the Federal Government wiggling the carrot, saying: Take a bite. You can do it. Then once you get hooked, you say: OK, we are going to reel it in now, and you will pay more of it. It will be the Federal Government dictating the State budget, putting it into Medicaid and taking it away from schools. That is what will take place. That is what is happening in my State now.

It is not fair to do that. It is not right for us to do that. Most of the people across Kansas think this whole issue is fiscal insanity—literally fiscal

insanity—what we are looking at doing with that level of debt, $12 trillion a year. With my State having the level of debt it has, making this requirement—a multi-trillion-dollar entitlement expansion when the Federal Government is hemorrhaging money, as well as State governments—is fiscal insanity. The world community is saying: Get your fiscal house in order. This makes no sense.

Mr. CHAMBLISS. I don't think we can overstate what the Senator has said. Not only is the Federal Government looking at the largest deficit we have ever seen in the history of our country—just this past year, $1.3 trillion—but every State is having the same problem. That deficit is trickling down.

In Georgia, for example, we have one county that has run into these education reductions that Senator ALEXANDER is talking about, which universities are facing. That one school system reduced the days the children are going to school from 5 to 4 days to save the cost of buses running and other bills, for heating and whatnot, for that extra day. That is not what we need to be doing as Americans. We need to figure out a way to struggle through this.

Instead of struggling through it, we are now in the toughest times we have ever seen, as Senator BROWNBACK said, we are adding these huge taxes that will stifle the small business community on top of the debt that we have seen created in this country just in the past 12 months.

Mr. ALEXANDER. I have a question I will ask any of the Senators who want to comment. Someone asked me yesterday: Where is all this opposition to these health care bills coming from? We have seen the Gallup poll and the Pew poll. These are not Republican Polls. They are well-respected polls in this country that are showing that independent voters, by 2 to 1, say they don't want this bill.

I have been in and out of politics for many years. I have never had as many people stop me on the street or in the airport or wherever, and say, ''Please don't do this.'' Somebody asked me yesterday: Why is there that much opposition?

My answer was—and this is what I would appreciate comments on—this is not just about health care. This is, as President Obama said one time, a proxy for a national debate about the role of government in Washington and in everyday American life. This is about the stimulus package, about the Washington takeover of car companies. This is about the growing debt; this is about the takeover of student loans; this is about every Washington takeover, and every increase in debt. That is what this debate is about. I think that is why we are seeing such intensive opposition. I wonder if you have any reflection?

Mr. BROWNBACK. I certainly think it is. What I observe, too, is people coming up to me in large numbers and very passionately saying they are both mad and scared. They are mad about this taking place, and they are scared it is going to actually happen to them. They feel like, how can this happen to them in this country? They look at that huge debt and at our President over in China talking as if he is going to see the banker, and they don't like it. This isn't their country the way they want it to be. They want our country to be fiscally sound instead of going to beg hat-in-hand to the ''banker'' in a foreign country. Then you are going to add another big entitlement on top of that? They are saying: Don't ask me, the taxpayer, for more money because I don't have it. They are mad and scared about this. It is very disconcerting for people in the country.

Mr. ISAKSON. I agree with Senator BROWNBACK. I guess I could sum it up in four phrases. There will be less access, seniors fear, because of cuts in Medicare. They will have less access. There will be higher costs because of the bending of the way in which they calculate premiums and the additional taxes. Everybody knows that will be a higher cost. There is a great fear of rationing, which is a component part of almost every plan to get from where we are to where they want to take us.

Lastly, I hear a lot from young people who are considering a medical career either in research or in applied medicine. They fear that medicine will not be the practice in this country in the future that it has been in the past. If that is true, if they leave and go to other fields, we will have less innovation and research and development and, in the end, less quality health care for the American people.

Mr. CHAMBLISS. These are not people who are on the extreme right or extreme left who are bombarding us with phone calls, e-mails, and letters as all of us get on airplanes, as I did Monday. I had people come up as I walked through the airport, and as I was on the airplane, and when I got off the airplane, saying: Please stop this bill. Don't pass this foolish bill that you all are talking about up there now. It is amazing, the type of folks who will come up and say that.

I have two quick anecdotes I would like to read. One is a letter I got from a doctor. It reads:

> Dear Senator:
>
> I am a vascular surgeon in Rome, GA, with a patient population that is 70 percent Medicare. I am deeply concerned about the proposed Medicare cuts. After 8 years of college and medical school, and 7 years of training, I have accumulated a large debt in loans and interest. Plus there is the huge administrative burden of a large Medicare population in my practice. I don't know how I and other physicians are going to be able to afford to continue to see Medicare patients if these cuts go through. As it stands now, I am paid only 23 cents on every dollar charged. I would appreciate help in staving off these cuts.

The other one is an e-mail I got in the last few days about a good friend of Senator ISAKSON and mine, Bob Lovein, a funeral director in Nashville, GA, which is close to my hometown. It says this:

> A lady walked into the funeral home and gave him a letter from the VA. The letter stated that they (the VA) owed her $307 on her husband's death benefits. Bob pulls her husband's file and he had buried him 10 years ago . . . and we trust the government to run health care?

That is how ridiculous it is in the minds of people in this country who are calling and writing our offices—certainly the offices of every one of the Members of this body—because they don't understand why we are mortgaging and sacrificing our children's future, or why, as Senator BROWNBACK says, when the President goes to China to see their banker—China owns almost $1 trillion worth of our debt—the Chinese Premier asked the President about the health care bill because he is concerned about the way we are spending money here.

I can never remember any foreign leader ever asking the President of our country about anything to do with the financial condition, particularly a program like this, which would affect us.

Mr. ALEXANDER. I am afraid our time is almost up.

Mr. BROWNBACK. Yes, our President got lectured by the Chinese regulator about our financial system. This is unbelievable. This exacerbates it, if we pass this bill.

Mr. ALEXANDER. I thank Senators BROWNBACK, CHAMBLISS, and ISAKSON. I think all four of us want the American people to know above all that we have repeatedly said that instead of 2,000-page bills that raise taxes, raise premiums, cut Medicare, and transfer costs to States, we would rather identify the goal of reducing costs and go step by step toward that goal. We have introduced specific legislation to take those steps, which could be bipartisan, such as allowing small businesses to pool their resources to purchase insurance, that Senator ISAKSON talked about, and reducing junk lawsuits, as Senator CHAMBLISS talked about, and allowing competition across State lines. We have our step-by-step plan.

We believe the American people have lost confidence in Washington and that they would prefer that we go step by step in the right direction to reduce costs and re-earn their trust rather than pass a 2,074-page bill that will bankrupt the country.

I yield the floor.

Mr. BROWNBACK. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. HARKIN. Mr. President, the debate has now begun on the bill we call our health care reform bill. It has taken us a long time to get here. After a lot of hearings, a lot of markup, a lot of public discussion, a lot of town meetings around the country, now we are at the final pivotal moment, a historic moment in the long march to pass meaningful health care reform.

I say long march because it started with Theodore Roosevelt and continued on through the New Deal, continued on to Harry Truman's administration, and on to this time. Every time we have been turned back by the status quo forces, those who want to stick with what we have, those who are afraid of making changes. This time they are not going to stop us. This time it is unstoppable. We have come this far, and we are not going to turn back.

Just listening to a little bit of the discussion on the Republican side today and listening to what the Republicans have had to say about health care reform in the last few months and anticipating what we will hear from Republicans in the next few weeks, it will be a message of fear that somehow by changing the status quo, the American people are going to be worse off than they are now, that somehow we are going to take away something they have, that somehow if we just stick with what we have, everything will be fine. But you will hear a lot of words and messages from the Republican side meant to frighten people, to put a pall of fear over what we are trying to do.

The frightening thing for the American people is if we do nothing, if we stick with the status quo. Too many people in this country have no health insurance whatsoever. Thousands every day in this country, every single day thousands of people lose health care insurance coverage. So many people who have preexisting conditions cannot get coverage at all. People who are beginning to retire but they are not quite 65 and cannot get on Medicare are left in a state of limbo, where they cannot get health care coverage.

So many people in this country are being discriminated against in health insurance because—well, because they are a woman or perhaps because they are older, perhaps they are a person with a disability. For a variety of reasons, they are being discriminated against in health insurance coverage.

We have to make these changes. We cannot continue to spend over the $2 trillion a year and still be so lacking in the essential health care services for the people of this country. We spend twice as much in this country on health care as Europe. Yet we have twice as many people sick with chronic illnesses. That does not seem to make sense.

We have some of the highest of high-tech medical devices and procedures and interventions anywhere in the world and, of course, people who have a lot of money in other countries—we always see kings and princes and wealthy people from other countries come here. They come here for the very high-tech, high-cost interventions. We are very good at that. We are the best. We are unequaled in that. But where we fall short is helping the very broad mass of American people to have the peace of mind knowing that if something happens to them, if they do get ill, they are not going to lose everything.

The single biggest cause of bankruptcy—I know in my State of Iowa and I think most of the country, the single biggest cause of bankruptcy is because of medical expenses because people bump up against lifetime caps or annual caps, they cannot make it, and they declare bankruptcy. In no other country in the world is this allowed to happen. It is incumbent upon us to get this bill through.

At the beginning, I wish to salute our majority leader HARRY REID for what he has done. We had our bill that came out of the committee that I am now privileged to chair after the untimely death of our esteemed colleague and friend, Senator Ted Kennedy. Our HELP Committee bill came through under the great leadership of Senator CHRIS DODD. We passed it on July 15. Then the Finance Committee, under the able leadership of my friend and classmate Senator MAX BAUCUS of Montana, did their work. Then the two bills had to be put together and that was done by the majority leader and he did a masterful job of putting the two bills together and getting it down to the Congressional Budget Office and getting a score on what it would cost, what it would cover. When we saw the bill come back—the bill we now have in front of us, the so-called merged bill—it truly is a work of genius by the majority leader.

I said the other day that he has the patience of Job, the wisdom of Solomon, and the stamina of Sampson to get this job done.

I also salute all the Senators—Democrats and Republicans—whose ideas are incorporated in this bill. It is a robust bill. It went through a long, bipartisan process. In our committee, we had proceedings that spanned 13 days, 54 hours. Republicans were full-fledged participants. They offered 210 amendments. We accepted 161, many of them making substantive changes in the bill.

A similar open and inclusive process was followed in the Finance Committee. I daresay, when we got our bill through, after all that, after all the amendments offered, accepted or adopted, not one Republican would vote for our bill—not one. It is truly unfortunate now that we have put these bills together, we have gone through this long process that has taken most of this year, that Republicans have now chosen the path of delay and filibuster and obstruction.

Why are we even here today? We are here because the Republicans are trying to prevent us from even bringing the bill to the floor for debate. How many people in America know that? The reason we are here is because the Republicans do not even want to bring the bill to the floor for debate and amendment. That is their right under the rules of the Senate. It is their right. They can filibuster. They can delay. They can obstruct. They can say no. But just as surely as that is their right, it is our responsibility, as Democrats, to move this bill forward.

I remind my colleagues on the other side of the aisle that last year voters overwhelmingly voted for Barack Obama to make changes, and one of the changes he campaigned so hard on was changes in the health care system and, just as surely, voters elected Democrats to majorities—big majorities—in the House and the Senate to do the same thing. So it is our responsibility to lead, and that is what we are doing now by bringing this bill to the floor. We are taking another giant step toward fulfilling the mandate—the mandate—the people of this country gave to President Obama and the Democratic Party last November to undertake a comprehensive reform of America's health care system.

As not only the long debate has made clear to the American people, but innately the American people know and they understand the current system is hugely dysfunctional, it is wasteful, and it is abusive. People are aware of the abuses that have become standard practice in the health insurance industry: denied coverage because of preexisting conditions; health insurance being dropped because they get sick; their insurance premiums jacked up 100 percent, 200 percent in a year simply because they had an illness.

People know they can be charged higher rates simply because they are a woman. We know, we have the data. Woman, man, same age, same occupation, same status—a woman is charged more than a man for the same policy or they are charged more if they are older. We know about annual caps and lifetime caps I just mentioned that cause people to go into bankruptcy.

The bottom line is this: Every American family knows that in many cases, they are one illness away from financial catastrophe. If you want to talk about fear, that is what people are afraid of, not so much of getting sick—that is part of life—but the fact that illness will drive them to financial ruin, that they will not have enough money to take care of their kids, to send them to college, or to take care of

themselves in their old age to supplement their Social Security because the money will be used for an illness.

As I said earlier, 62 percent of U.S. bankruptcies are linked to medical bills. What is the kicker in this is that 80 percent of those were people who actually had health insurance, but they ran up against their lifetime cap. Abuses, abuses by the health insurance industry because they can do it and they can get by with it.

Think about it this way: Health insurance companies employ armies of claims adjustors who routinely deny requests for medical tests and procedures. Why do they do that? Because they get bonuses by saying no to the policyholder. Think about that. An insurance company says to their claims adjustors: We will pay you more the more people you deny. What a system. It is outrageous. It is intolerable, and we cannot afford to let it go on any longer.

One of the many things we do in this bill is to crack down on these health insurance companies' abuses in a very strong and robust way. Again, I deeply regret that our Republican colleagues refuse to join us in this reform effort. They have chosen to defend the status quo, protect the insurance companies and their profits over the health of the American people.

Indeed, my friends on the Republican side and the health insurance companies are now joined at the hip—same talking points, same distortions, same untruths about this bill, same bogus, cooked-up studies, the same determination to obstruct and kill any health care reform effort.

As I said earlier, this time they will not succeed. The more the American people learn about this bill and what is in this bill, the more they like it and the more they are demanding that we get the job done.

President Obama pledged that we would do health reform and not add to the deficit. We have done that with this bill. The Congressional Budget Office says this bill will actually reduce the deficit by $130 billion next year and by $650 billion in the next decade—$650 billion—and it will reduce the deficit continually every decade thereafter. All the budget concerns have been put to rest. Now we can focus on what is in the bill.

The Congressional Budget Office says our bill will cover 94 percent of the American people; 94 percent will now be able to have the peace of mind to know they have health insurance coverage.

Our bill says if you have a health care plan that you like and that you want to keep, nothing will disturb that—nothing. You can keep whatever plan you want if you like it.

A lot of people say this plan doesn't go into effect until 2014. It does take some time to get these exchanges and things set up, but there are some immediate things that will happen next year, and the American people ought to know what that means. For example, our bill right now would ban lifetime and excessive annual limits on coverage next year—not 2014 or 2015, next year. Think about that in your own policy. Your policy, I guarantee, has some kind of lifetime cap or annual caps. Next year, they will not be able to do that any longer.

Our bill bans rescissions. What that means is that right now so many people don't know that their health insurance policy can drop them. There is a clause in it that says that when you are up for renewal, they can drop you for any reason. The reason they use is, if you get sick. Think about that.

I can't tell you how many people I have talked to in my State of Iowa who have come up to me, especially during the town meetings we have had this summer, and have said: I like my health insurance policy. I have a good policy, and I would like to keep it.

My rejoinder is: That is fine, but I want to ask you a couple of questions. What is your lifetime or annual cap?

Most often, people say: I don't know.

I say: Do you have a lifetime or annual cap in your policy?

They aren't certain.

I say: Do you have a rescission clause in your policy?

I can tell you 100 percent of the people I have talked to said: What does that mean?

I said: What it means is, if you get sick, if you have to have a kidney transplant or if you have cancer or heart disease, can your insurance company drop you when your policy comes due, with no explanation whatsoever?

They don't know.

I said: You have to look at your policy and find out, because most policies have those rescission clauses.

I daresay, when a lot of people say they have a good health insurance policy, they answer yes, they do have a good health insurance policy, as long as they are healthy. As long as you are healthy. Once you get sick, out the window it goes because you have a cap, either a lifetime or an annual, or you have a rescission clause.

The other thing I hear from a lot of families: You know, my kids were covered when they were in school. They are now out of school, they have not quite gotten a job yet, and I can't keep them on my policy and it costs a lot of money to put them on a different policy.

Our bill says that now these young people can stay on their family policy until they are age 26. This is a huge benefit to working families.

I have said many times that the two biggest winners under our health care reform bill are small businesses and the self-employed. Small businesses—we are in a deep recession. If we want to get out of that recession, we better start focusing on small businesses because it is small businesses that create over 65 percent of the jobs in this country. Yet small businesses are thwarted in their effort to expand and grow. One of the biggest reasons is because of the cost of health care for their employees. So many small businesses now have dropped health care coverage for their employees because they simply cannot afford it or the premiums have gone up, the deductibles are huge, and basically what it has gotten to be is basically catastrophic coverage for their employees. Small businesses need help in order to grow and expand and get us out of this recession. This bill will provide immediately, next year, up to a 35-percent tax credit for health insurance policies for their workers. That is a big deal. It is not just for small businesses, it is for my farmers and for those who are self-employed—for so many self-employed in this country, next year, a tax credit of up to 35 percent.

Next year, we are going to have a new policy option for people who have preexisting conditions. So if you had an illness in the past, if you have been living with cancer and you have it under control, you have a chronic illness, next year we are going to provide a new policy option to put people like that into a high-risk pool and provide that they can get insurance coverage at prices they can afford. When the exchanges come on in 3 years, all of that will go by the wayside. They will not be able to discriminate because of preexisting conditions. But next year, right away, people who have preexisting conditions can get policies at prices they can afford.

How many times do I hear people tell me: Here I am, I have been working hard, I have been a construction worker, or something like that, that is hard work. I am 55. I have had some accidents. I have a bum leg and my back is bad. I can't work until I am 65. But what am I going to do about my health insurance?

We have in here, starting next year, if you are an early retiree, we have a program to protect your coverage and at the same time reduce your premiums, both for you and your employer, until the time you get to be age 65. This is a big deal for so many people in this country.

Last, in whatever time I have left—parliamentary inquiry: How much time does the Senator from Iowa have left?

The PRESIDING OFFICER (Ms. KLOBUCHAR). The Senator has 37 minutes 13 seconds.

Mr. HARKIN. Madam President, I understand my friend from North Dakota wishes to speak. I will wrap this up by saying there is one other part of this bill that is so important that doesn't get much play but I consider to be one of the most significant parts of this

bill, and that is an emphasis on prevention and wellness, keeping people healthy in the first place.

There is a lot of talk about bending the cost curve and how we are going to bend that curve and get costs down. I submit that not only the best way but perhaps the only way we are going to do this is by keeping people healthy in the first place, putting more emphasis on prevention.

I have often said that we don't have a health care system in America, we have a sick care system. If you get sick, you get care. Almost all of our expenditures go for interventions and patching and fixing and mending once somebody gets sick. Very little goes for prevention. About 96, 97 cents of every dollar goes for taking care of you after you get sick. Only about 3 or 4 cents goes to prevention. It is time to do more for that, time to do more for prevention and wellness, keeping people healthy in the first place.

In this bill, we have a provision that says that if you want to go in for your annual checkup and your annual screening, no copay, no deductions, and for certain other screenings, such as colonoscopies, breast cancer screenings, and things like that, no copays, no deductibles.

In the ensuing days and weeks when we debate that, I will be talking a lot more about the prevention and wellness part of this bill. It is big. It is the first time we have ever done anything like this, to begin to move the paradigm in this country away from sick care to health care. Our goal in this bill with this provision is to change America into a wellness society, where it is easier to be healthy and harder to be unhealthy—just the opposite of what it is today. It is easy to be unhealthy in America today. It is hard to be healthy. We are going to change that around, and we are going to start with this bill.

One of the most important parts of this bill is the massive change we are going to make in prevention and wellness.

I note the presence on the floor of my distinguished colleague from North Dakota. I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from North Dakota is recognized.

Mr. CONRAD. Mr. President, I thank the Senator from Iowa, Mr. HARKIN, and I commend him for the outstanding work he did on the HELP Committee, especially on the prevention provision. I don't think there is anyone in the Senate who has been more dedicated to moving us from a sickness system to a wellness system than the Senator from Iowa. He did outstanding work on the prevention provisions in the Health Committee bill, many of which now are in the bill before us. I applaud him for his leadership because in many ways those are the most important provisions. If we can encourage people to lead healthy lifestyles and have an emphasis on wellness, we can change the quality of millions of people's lives.

I personally think the provisions Senator HARKIN authored that are part of this legislation are in many ways the most important pieces of this bill. What is interesting is they have received very little attention in the public debate. In fact, many of the most important provisions in this bill have very little attention in the public debate. Hopefully, over the next weeks that will change and people will learn what is really in this bill versus the rumors of what is in this bill. They are very different things.

I again thank the Senator from Iowa for his leadership. It made a real difference to the quality of this bill.

Why are we here? We are here because we face a completely unsustainable situation in health care in this country. Medicare is going broke, premiums are rising 3 times as fast as wages, 46 million people have no health insurance, spending is twice as much per person in our country as in almost any other country in the world, and the outcomes of our system for our people are not as good as they should be. So it is very clear: The status quo is unacceptable. Doing nothing is not an option. Failure is not an option. It is critically important that we reform the health care system in this country. If we do not, our families' budgets will be threatened, our businesses will be threatened, and the Government itself is threatened. That is the reality.

I want to praise Leader REID for putting together a responsible package and a really very good first step. I also want to praise Senator BAUCUS for his leadership in the Finance Committee. He did an outstanding job. I have never seen, in my 23 years, any committee chairman have as diligent and focused an effort as Senator BAUCUS gave this in the Senate Finance Committee over a 2-year period. Our group of 6 alone met 61 times, and there were dozens and dozens of other hearings, meetings, forums, roundtables. Senator BAUCUS organized a health care summit last year, and that was a model of how Congress ought to approach an issue. So I give high praise to Senator BAUCUS.

Senator DODD, who was called in at the eleventh hour to replace Senator Kennedy because of Senator Kennedy's illness, deserves enormous credit, enormous praise for picking up the ball at a critical juncture and carrying it across the line in the HELP Committee as well.

Senator REID had the very difficult task of bringing together the Finance Committee bill and the HELP Committee bill, combining them into a vehicle for consideration here.

This bill is not perfect. No work of humans ever is. Certainly more needs to be done to control cost. That is what I believe. But this is a very good beginning. This bill makes an important contribution to improving health care. Those who labored for months and months to produce it deserve our thanks and praise.

I am somewhat taken aback by speeches I have heard from colleagues over the last several days acting as though this vote tomorrow is the end of the story. Anybody who understands Senate procedure even a little bit knows this is the beginning of the story. This is the beginning of the debate. This is the beginning of a process to amend and improve the bill. This is the beginning of the discussion on the floor of the Senate about legislation to reform the health care system. I don't know of a single credible reason to vote against going to consideration of legislation to reform the health care system in this country. This isn't about the final result. This is about beginning the discussion and the debate. Who would want to prevent a discussion and debate? Who would want to prevent Senators from being able to offer amendments to improve the legislation?

If people are dissatisfied with the product at the end of the process, that is when they can vote no. They can vote no against cloture. They can vote no against the package. There are lots of opportunities to oppose it if you are unhappy with the final result. But being unwilling to even discuss the subject strikes me as a preposterous position.

This plan meets key health care reform benchmarks. It is fully paid for. In fact, according to the Congressional Budget Office—not controlled by Republicans or Democrats; it is strictly nonpartisan—this measure reduces the deficit by $130 billion over the first 10 years. That is their judgment. In the second 10 years, they say this legislation will reduce the deficit by $650 billion. When people come out here and say this increases the deficit, this increases the debt, I don't know what legislation they are talking about. It is not the legislation before us. They are, of course, free to make up whatever numbers they want, but the official evaluation of this legislation by the nonpartisan CBO, the Congressional Budget Office, is that this bill reduces the deficit in both the short and long terms.

It also expands coverage, according to the CBO, to 94 percent of Americans. It contains critical insurance market reforms and, perhaps even more important, delivery reforms. We will get into those in a minute.

Let's talk about the need for action. This chart shows what is happening to premiums for health insurance coverage. Premiums are projected to continue to rise on American families. In 1999, premiums averaged $6,050. In 2009,

they increased by 117 percent. What the experts are telling us is, from 2009 to 2019, they will go up another 71 percent to average premiums in 2019 of $22,440 to an American family for health care premiums. How many families will be able to afford premiums of $22,440?

At the same time we see employer-based health care coverage—and the vast majority of our people receive coverage at their place of employment—is in decline, from 68 percent to 62 percent in 2008. In 2000, 68 percent of companies were offering health care coverage. That is down to 62 percent in 2008.

At the same time we know 46 million fellow citizens do not have health insurance. That is projected to increase, by 2019, to 54 million who will not have health insurance. It is interesting because every other industrialized country in the world has universal coverage. They have figured out a way to provide health insurance to every family in their countries. France, Germany, Great Britain, Japan, every other major industrialized country has figured out a way to provide health insurance for every one of their citizens. It is time for America to do the same. That is a moral issue. That is not just a financial issue; it is a moral issue. What kind of country are we going to be?

This is a letter I received from a constituent in September. I wanted to share it with my colleagues.

Dear Senator Conrad, I am 51 years old and have never given much thought to writing a Senator until now. Three days ago, we received some of the worst news a person can get. My husband has been diagnosed with bladder cancer. He does not have health insurance. We are self-employed. Our income is low but we do own some property which makes us ineligible for most assistance programs. A few years ago we both dropped our Blue Cross Blue Shield because the premiums were too high. I re-applied and got my insurance back but my husband was denied due to his weight. (He quit smoking 4 years ago and put on weight gradually since then.)

We are stunned by the diagnosis and are terrified by the uncertainties of his prognosis. We already owe $2,000 just for emergency room costs and he has surgery scheduled for September 22 with at least an overnight stay in the hospital. The medical bills will be astronomical. If the cancer is not localized, he will be referred to oncology and will begin chemotherapy/radiation treatment and possibly even more surgery. We will have to sell almost everything we own to pay [the] bills.

Please, sir, consider our story when thinking about health care reform. Any change will happen too slowly to help us but others will benefit. Don't give up. We are counting on you to make a difference.

To that woman, I make this pledge: I am not going to give up. I think enough of my colleagues will not be giving up so that we can at least begin the debate on whether there should be health care reform in this country. I repeat, I can't think of a single credible reason why somebody would vote against beginning the debate, to have a chance to amend. If you don't like the product as it has come to the floor, that is what legislating is about, the opportunity to amend, the opportunity to improve, the opportunity to convince colleagues that we need to move in a different direction. I don't know what could be more clear than that we have to move in a different direction on health care.

We are now spending 17 percent of our gross domestic product on health care. That is $1 in every $6 in this economy. The experts tell us by 2050, we will be spending 38 percent of our gross domestic product on health care, if we stay on the current trend line. That would be more than $1 in every $3 in this economy on health care. That would be a disaster for the American economy, a disaster for the budgets of families and businesses. That simply cannot be the result for our Nation.

On Medicare and Medicaid spending, in 1980, if you put the two together, Medicare and Medicaid consumed 2 percent of our gross domestic product; $1 in every $50 in this economy was going to Medicare and Medicaid. In 2010, we are up to almost 6 percent of GDP for Medicare and Medicaid, three times as much as a share of our economy. But look where we are headed. By 2050, again on the current trend line, we would be spending 12.7 percent of gross domestic product just on Medicare and Medicaid, six times as much as back in 1980. If we look at the indebtedness of the country, there is no bigger contributor than Medicare. It is the 800-pound gorilla: $37.8 trillion of unfunded liability in Medicare. The comparable number for Social Security is $5.3 trillion. We can see the unfunded liability in Medicare is seven times the unfunded liability in Social Security.

For those who say, let's not even go to a debate, let's not even go to a discussion on reforming health care, what is their proposal? Are they afraid to offer one? Do they not have one? Is their answer do nothing? Is their answer really to do nothing in the face of a crisis of this magnitude? Their answer is: Let's not even debate it; let's not have even have a chance to amend it?

That is not a credible position. It is not a responsible position. It is not a serious position. That is a position of obstruction, pure and simple.

If we look at our system, we have had a review by Dartmouth Medical School. They concluded:

Although many Americans believe more medical care is better care, evidence indicates otherwise. Evidence suggests that states with higher Medicare spending levels actually provide lower quality care.

They went on to say:

We may be wasting perhaps 30% of U.S. health care spending on medical care that does not appear to improve our health.

As a country, we are spending almost $2.5 trillion a year on health care. If 30 percent of that money is being wasted, is not contributing to better health, 30 percent of $2.5 trillion is $750 billion a year. The answer by some of our colleagues is, let's not even debate it. Let's not even discuss it. Let's not even attempt to address it.

That is a remarkable position to take.

If we look at our country versus others around the world, we see we are spending far more as a share of our income than they are. If we look country by country: Japan is spending 8 percent of GDP; the United Kingdom, 8.4; Belgium, 10 percent; Germany, about 10; Switzerland, almost 11; France, 11; and we are at 16 percent. That is as of 2007. We have gone up to 17 percent of GDP in 2009 on health care. We are spending as a share of the economy almost twice as much as any other major industrialized country in the world. Yet we still have 46 million people without any health insurance.

Under the British model, they have universal coverage. Under the so-called Bismarck model, countries of Germany, France, Japan, Switzerland, and Belgium have universal coverage. Yet if we remember their costs, we see even though they are providing universal coverage in these other countries, their costs are much lower than ours.

If we look further at the quality of health care outcomes, quite an interesting story emerges. Those countries have universal care, lower costs. And if we look at quality outcomes, they do better than we do. On preventable deaths, the Commonwealth Fund, which is very distinguished and nonpartisan, looked at preventable deaths around the world. They found the United States came in nineteenth. But other countries that have much lower costs and have universal coverage, for example France and Japan, are ranked 1 and 2. With much lower costs and universal coverage, they are getting better results. And some do not even want to debate going to health care? They are going to have a tall order to explain why they do not even want to discuss it.

On infant mortality, the United States is ranked 22nd, again, according to the Commonwealth Fund. Again, these are countries that have universal coverage, with much lower costs than we do. Ranked No. 1 was Japan. France was No. 5. Germany was No. 9. From my earlier chart, you will remember each of those countries has universal coverage and much lower costs than we do, and yet they are getting, on these metrics, better outcomes than we are.

It does not stop there. Here is life expectancy, as shown on this chart. The United States is ranked 24th. This is according to the OECD, the international scorekeeper. Again, Japan, Switzerland, France—universal coverage, much lower costs—still ranked

much higher than we do on that metric.

Japan, with universal coverage, much lower cost than we have—in fact, half as much as ours—yet they were No. 1. Switzerland, No. 2—they have universal coverage, with much lower cost than we have, and yet they rank No. 2. France, with universal coverage, much lower cost, is ranked sixth in the world.

It would seem to me we ought to look to evidence, and evidence shows us there is a better way, and that is what this legislation seeks to find. It seeks to find a better way to expand coverage, to improve quality, and to contain exploding costs.

The key elements of this Senate health care reform plan are these: One, it reduces both short- and long-term deficits. I noticed in one of the newspapers circulated on the Hill today a full-page ad asking: How can Senator CONRAD, who is a deficit hawk, be for this bill? Well, because I have read the CBO analysis, the Congressional Budget Office analysis, that says clearly and unequivocally this bill lowers the deficit. It lowers it by $130 billion over the first 10 years. It lowers it by $650 billion over the second 10 years, according to the Congressional Budget Office.

So when somebody asks, How can a deficit hawk like Senator CONRAD be for this bill? It is because this bill lowers the deficit. That is not my analysis. That is the official analysis of the Congressional Budget Office which is nonpartisan.

This bill also expands coverage to 94 percent of the American people. It promotes choice and competition. It reforms the insurance market. It improves the quality of care. All of these issues are at the heart of what reform must be.

The Senate health plan reduces short- and long-term deficits. It extends Medicare solvency. Medicare is going to go broke in 8 years. This bill extends the life of Medicare by 4 to 5 years. It extends the solvency of Medicare by 4 to 5 years. It includes reforms to improve delivery of care and reduces costs.

It curbs overpayments to Medicare Advantage plans. Some Medicare Advantage plans are now costing 150 percent of traditional fee-for-service Medicare. Medicare Advantage was started on the basis it would save money. In fact, it was initially capped at 97 percent of traditional fee-for-service Medicare. It was supposed to save money. Now there are Medicare Advantage plans that cost 150 percent of traditional fee-for-service Medicare. It is not saving money, it is costing much more money. And it will break Medicare if we do not reform it. That is clear.

This bill also creates an Independent Medicare Advisory Board to make recommendations on how we can have further savings to extend further the solvency of Medicare. It also includes an excise tax on insurers offering Cadillac plans. Virtually every analyst who came before the Finance Committee said one of the most important things we could do was to start with a levy on Cadillac health insurance plans to reduce overutilization and to begin to control the exploding costs.

When I say this bill reduces the deficit, that is not my assertion or the work of the Senate Budget Committee. That is the judgment of the official scorekeeper here, the nonpartisan Congressional Budget Office. Here is a page from their report, and it shows very clearly, from 2010 to 2019, this legislation reduces the deficit by $130 billion.

I have heard colleagues come to the floor and give all kinds of speeches about how this increases the deficit. They have every right to come here and make up any numbers they want to make up. They can make any claim they want. But let's be clear, the official analysis of this bill by the agency we have all empowered to give us objective analysis has concluded that this bill reduces the deficit by $130 billion over the first 10 years, and $650 billion over the second 10 years.

The Congressional Budget Office on the Senate health plan and reducing long-term deficits:

> . . . CBO expects that the bill, if enacted, would reduce federal budget deficits over the ensuing decade [beyond 2019] relative to those projected under current law—with a total effect during that decade that is in a broad range around one-quarter percent of gross domestic product.

Gross domestic product over that second 10-year period is forecast to be $260 trillion. One-quarter of 1 percent of $260 trillion is $650 billion.

> . . . CBO anticipates that the legislation would probably continue to reduce budget deficits relative to those under current law in subsequent decades. . . .

In other words, it would continue to reduce deficits beyond the first 20 years.

The excise tax, which virtually every analyst has said needs to be part of a package if you are going to be serious about controlling the explosion of costs, will target plans that have a value of more than $23,000 a year. The average premium in 2013 is projected to be $15,740. So these Cadillac plans are plans that would have a value of more than $23,000 a year. There are very few people in the country who have plans of that value today, and there will be very few who will have plans of that value in 2013.

The Senate health care plan also expands coverage. According to the Congressional Budget Office, it covers 94 percent of the American people by building on our existing employer-based system. It creates State-based exchanges for individuals and small businesses.

It provides tax credits to help individuals and small businesses buy insurance. In fact, there is more than $400 billion of tax credits here. Somebody said: Well, this is a big tax increase. It is a big tax increase. Well, they must have left out the $400 billion of tax credits. They must not have gotten to that page in the bill.

It expands Medicaid eligibility with assistance to States so they are able to afford it.

The Senate health plan also promotes choice and competition. It creates a public option to compete with private plans, but not one based on Medicare levels of reimbursement. I think many of my colleagues know I strongly resisted a public option tied to Medicare levels of reimbursement because that would work a real hardship in my State. But in this plan, there is no tie of a public option to Medicare levels of reimbursement. And States can opt out. It also provides seed money for nonprofit cooperatives—member-run, member-controlled cooperatives—to compete with private plans.

This chart shows the Medicare reimbursement per enrollee for 2006. You can see, New York was getting nearly $10,000; North Dakota, though, $6,000. That is the kind of disparity that exists in Medicare reimbursement. It is even more dramatic if you look at institution to institution. In fact, for many years, I was shown a hospital in Devils Lake, ND—Mercy Hospital—that would get one-half as much as Lady of Mercy Hospital in New York City to treat the exact same illnesses—one-half as much. That is all based on formulas based on historic costs. That is why many of us believe it would be unfair to tie a public option to Medicare levels of reimbursements. That disparity across the country would work an extreme hardship on low reimbursement States such as mine.

The cooperative plan allows for not-for-profit co-ops to provide an affordable, accountable, transparent alternative to private insurance. The mission is to provide the best value for consumer members. It could operate at a State, regional, or national level. They are self-governed by members with an elected board—not controlled by the Federal Government—subject to the same State and Federal rules and regulations as private plans. There would be $6 billion in startup funding for capitalization by the Federal Government. And that would be the end of the Federal Government role.

The Senate plan also reforms the insurance market. It prohibits insurers from denying coverage for preexisting conditions. It prohibits insurers from rescinding coverage when people become sick after they have paid premiums for years. It bans insurers from lifetime caps and unreasonable annual limits on health care benefits. And it

prevents insurers from charging more based on health status.

This plan also improves the quality of care. It covers preventive services. It provides incentives for healthy lifestyles. It promotes adoption of best practices in comparative effectiveness research, and includes delivery system reforms to encourage quality over quantity of care.

When we look at the major reforms that are in this bill on the delivery system and compare them to the House bill, we see that the Senate has accountable care organizations; the House a pilot. Both have primary care payment bonuses. Both have readmissions reforms. Only the Senate has hospital value-based purchasing. Both have comparative effectiveness research. Both have CMS innovation centers. Only the Senate has an Independent Medicare Advisory Board. And only the Senate has a full platform for bundling. The House just has a pilot.

Debunking the myths: There is no government takeover of health care here. The public option, according to CBO, would get 2 percent of the American people—2 percent. That is hardly a government takeover. And there is no tying of the public option to Medicare levels of reimbursements. There is no cut in the guaranteed benefits for seniors. There is no coverage for illegal immigrants. There are no ''death panels.'' And there is no expansion of Federal funding for abortion services.

To conclude, if we look at the Senate Democratic plan and the only Republican plan, and compare them, the Senate Democratic plan contains delivery system reforms. There are none in the Republican proposal. The Senate Democratic proposal reduces the number of uninsured by 31 million people. The Republican plan makes no progress on that front. The Senate Democratic plan reforms the insurance industry, banning preexisting conditions and rescissions of coverage and health status ratings and lifetime benefit limits. The Republican plan has no similar provisions.

The Senate Democratic plan improves rural Medicare reimbursement. The Republican plan does not.

The PRESIDING OFFICER. The Democrats' hour has expired.

Mr. CONRAD. Mr. President, I ask unanimous consent for 30 seconds.

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

Mr. CONRAD. The Senate Democratic plan extends Medicare solvency by 4 to 5 years. The House Republican plan has no extension of Medicare solvency. And, finally, the Senate Democratic plan reduces the deficit, according to CBO, by $130 billion—twice as much as the Republican plan from the House.

I thank the Chair. I thank my colleagues.

The PRESIDING OFFICER. The Republican deputy leader.

Mr. KYL. Thank you. Mr. President, we are going to focus for the next hour on perhaps one of the most pernicious aspects of Leader REID's bill: the fact that it cuts Medicare by almost $½ trillion—almost $500 billion in Medicare cuts.

There are a lot of seniors in my State of Arizona and in the States represented by my other Republican colleagues. Those seniors are scared of these cuts. It is not because of anything Republicans have said to try to scare them; they have simply become aware of what is in these bills. By ''these bills,'' I am talking about both the Senate bill offered by the majority leader and the House bill, which are the two bills that would presumably try to be reconciled in conference. Our seniors have been told that under both bills, their benefits are going to be cut by about $500 billion, and that is enough to scare them.

In fact, all of America is concerned about this. A recent USA TODAY Gallup Poll shows that an overwhelming number of Americans—61 percent—oppose cutting Medicare to pay for health care reform. Yet, despite that overwhelming opposition, Democratic leaders in Congress have moved ahead with this bill to slash, as I said, nearly $½ trillion from Medicare to pay for the new health insurance programs. They are simply not listening to what Americans have to say about this.

If Democratic leaders have their way, hundreds of billions of dollars will be slashed from hospitals that treat seniors, from the Medicare Advantage Program, which we will talk about in a minute, from nursing home care, home health care, and hospice care. Medicare already faces a severe challenge, including a whopping $38 trillion in unfunded liabilities and insolvency by the year 2017. That is almost incomprehensible—in just a few short years, $38 trillion in unfunded liabilities and insolvency. Obviously, seniors want us to fix that problem rather than raiding Medicare to pay for a new health care program, and they want to preserve Medicare Advantage.

I receive letters from worried seniors every day about this Democratic plan to cut Medicare Advantage, which is a very popular program in Arizona. Medicare Advantage is the opportunity we have given seniors to enroll in a private insurance company to help them receive Medicare benefits. What these private insurance companies do is make a more attractive program by adding some additional benefits to the basic set of benefits that are promised under Medicare. What our seniors are telling us is, these are very important benefits to them, things such as vision care and hearing. Now that I am getting a little bit older, I can tell you that both my vision and hearing is starting to go, and I would like to have that kind of benefit. Dental benefits, preventive screenings, free flu shots, home care for chronic illnesses, prescription drug management tools, wellness programs, personal care, and durable medical equipment, all very important for seniors. By the way, physical fitness programs, one of which has a great name—it is called the SilverSneakers Program, and the seniors are very supportive of this because it keeps them physically fit which is, of course, what we should be doing.

I get letters and phone calls from my constituents, and they are sharing their anxieties about losing these benefits, losing prescription drug coverage; about the overall decline in the quality of care that they understand will occur when their doctors' payments are cut, when all these other cuts under Medicare that my colleagues are going to discuss in a moment finally hit. They know it is going to impact their care. They don't like this interference from government bureaucrats, in effect, getting between them and their physicians when it comes to their health care.

Let me read portions of three letters from constituents and then I will yield to my colleagues.

A constituent from Surprise, AZ, writes:

Dear Senator Kyl:

Please fight the cuts to Medicare Advantage. I am on Social Security disability and on a fixed income. The Medicare Advantage insurance I have has literally been a lifesaver for me. I cannot afford to lose the coverage that includes prescription drugs. I need your help on this.

Two Medicare beneficiaries, a husband and wife from Mesa, AZ, write:

We believe that our health is our responsibility and that we have a right to make all the decisions regarding our health. We do not need permission from our government to take actions that will protect and preserve our health. We do not need a third party who has never met us and who is not acting in our best interests in making decisions about our medical care and we do not want to lose our Medicare HMOs.

That is the Medicare Advantage about which I spoke.

Then, a constituent from Sun City West, AZ, who incidentally is a World War II veteran, wrote a very powerful letter about how Medicare Advantage improved his life and his wife's life. He said:

As a B–17 pilot I flew 50 combat missions out of England and I earned five air medals after flying B–24s on coastal submarine patrol. When we moved to Arizona to be near our children I visited a local VA hospital to find out that I had a $50 copay for each visit and I never saw a physician, just an assistant. In desperation, I purchased a Medicare supplement for my wife and myself. The cost was almost $600 per year and I only receive $833 a month on Social Security. Fortunately, here in Arizona, my wife and I were both able to sign up for MediSun, an Advantage plan, with no monthly payment and simple $10 or $20 copays. That made it possible for us to purchase a home. With the health care reform being considered, we understand that Advantage plans will be reduced or eliminated. What happened to ''if I like my insurance, I can keep it''?

Well, it is a good question from my constituent. Of course, he is exactly right. When the promise was made: If you like your insurance you get to keep it, unfortunately, that is not the way this legislation works. As a result, a lot of the benefits they are currently receiving, for example, from Medicare Advantage, would be cut or eliminated.

My constituents are right to be wary of cuts to their Medicare Advantage. They depend on it. They realize you can't cut $½ trillion from Medicare without adversely affecting your health care.

Mr. WICKER. Mr. President, I wonder, before the Senator closes, if he would yield.

Mr. KYL. I am happy to yield to my friend.

Mr. WICKER. Mr. President, I think it is important for us to understand that there are some differences between the bills—the HELP bill, the Finance Committee bill, and the bill that has come out of the House of Representatives—but in each and every case the proposals put forward by the Democrats do have this $½ trillion cut in Medicare. Indeed, as the Senator pointed out, these involve cuts to hospitals, to Medicare Advantage, Medicare cuts to nursing homes, to home health, and to hospice. There is no question about that. I appreciate the Senator bringing some information to the public and to the Senate about the concerns of his constituents.

In the previous hour, I heard a Senator from the other side of the aisle talk about scare tactics Republicans will be putting forward during the coming weeks of this debate. Of course, you have read letters from your constituents outlining why the people of Arizona are legitimately fearful for the coverage they have enjoyed. I would tell my colleagues that the opposition to these Medicare cuts has come in a bipartisan way. We heard a great deal about that from our friends at the other end of the building when the House of Representatives was talking about this.

The president of the Blue Dog Democrats, MIKE ROSS, a senior Democrat from Arkansas who has worked to try to make this palatable to people in his constituency, had this to say about these Medicare cuts:

> With more than $400 billion in cuts to Medicare, it would force many of our rural hospitals to close, providing less access to care for our seniors.

Less than 12 days ago, Representative ROSS from Arkansas said this. His constituency in Mississippi is very much like mine, and I can assure my colleagues that a great number of our hospitals in Mississippi and throughout the country are rural and no doubt they are in Arizona too. So there is a very real concern. The gentleman from Arkansas flatly says it can force many of these hospitals to close.

Representative LARRY KISSELL from North Carolina said this:

> From the day I announced my candidacy for this office, I promised to protect Medicare. I gave my word I wouldn't cut it and I intend to keep that promise.

Representative KISSELL from North Carolina concluded that in his judgment, the only way he could keep that promise was to vote no on this legislation.

Representative MICHAEL MCMAHON of New York said:

> Medicare Advantage, which serves approximately 40 percent of my seniors on Medicare, would be cut dramatically.

This is not a Republican scare tactic; this is a flat statement by an elected Democrat from the State of New York in the Northeastern part of our country, one of the larger States. But he said flatly that Medicare Advantage would be cut for 40 percent of his seniors and he voted no on that basis.

Representative IKE SKELTON, the chairman of the Armed Services Committee, said:

> The proposed reductions to Medicare reimbursement could further squeeze the budgets of rural health care providers.

Chairman SKELTON goes on to say:

> I also oppose the creation of a new government-run public option and continue to have serious concerns about its potential unintended consequences for Missourians who have private insurance plans they like and, of course, we know that this Reid bill also has the government-run option.

Finally, to quote Representative RICK BOUCHER, another senior Democrat from Virginia, he said:

> I also intend to oppose the bill because of my concern that a government-operated health insurance plan could place at risk the survival of our region's hospitals.

I am concerned, and I am determined to protect the rural health care we have in the State of Mississippi and that we have in these districts that are represented by these comments.

So I wanted to jump in now, before the Senator from Arizona concludes his portion of the initial remarks, and say that the concerns are not only coming from Republicans, they are coming from actuaries, they are coming from people who have analyzed this bill, and they are coming from Democrats who have read the bill, who understand its meaning and who understand that these cuts to Medicare are real and they are hurtful.

I yield back to the Senator.

Mr. KYL. Mr. President, the Senator from Mississippi is exactly right. It is not just Members of the House and Members of the Senate, Republicans and Democrats and senior citizens in the State of Arizona. Here are some other third-party sources. I will just cite three: The Centers for Medicare and Medicaid Services; that is, CMS. That is the outfit that runs Medicare. They confirm that cuts will indeed compromise the services seniors now receive.

The Washington Post—how about that for a third-party source—summarizes a report in a November 13 article entitled ''Bill Would Reduce Senior Care.'' That is a fairly specific headline. It says:

> A plan to slash more than $500 billion from future Medicare spending, one of the biggest sources of funding for President Obama's proposed overhaul for the Nation's health care system, would sharply reduce benefits for some senior citizens and could jeopardize access to care for millions of others.

Then Politico, which is a Capitol Hill newspaper, reported that, by 2014, enrollment in Medicare Advantage would drop from 13.2 million to 4.7 million because of less generous benefit packages. That is a 64-percent decrease.

Looking at my colleague's chart there, Medicare Advantage, which I spoke about and which my constituents wrote to me about, the concern there is that people now enrolled—13.2 million—are going to be reduced down to 4.7 million because the reductions in the benefits are simply no longer sufficient incentive for them to enroll in that program.

Of course, that is what the pro-government-run health care folks want to happen. They are all for a public company competing with private insurance companies in the market for folks, but when it comes to Medicare, they don't want the private companies that provide Medicare Advantage care competing with the government program. Under this bill, they will get their way. It is going to go from 13.2 million down to 4.7 million. That is a lot of senior citizens who will lose their Medicare Advantage coverage.

I will conclude by confirming what the Senator from Mississippi said. It is not just Representatives in the House or Senators who have sworn to help protect our constituents, but it is third-party sources as well in the government and in the media that have confirmed that this bill will cut benefits. They will certainly do it for senior citizens.

We will talk later about the Republican ideas. Republicans have suggested a step-by-step approach to target specific solutions to specific problems, including things such as medical liability reform; allowing Americans to purchase insurance across State lines, which would expand competition for patient business; association health plans to help reduce costs. Most of our ideas are cost-free; they won't cost a dime. They wouldn't cut Medicare or diminish the quality of care for anybody. They have been rejected by our Democratic colleagues.

I hope my colleagues will agree that a place to start in this legislation is not to cut Medicare. Why would you want to cut Medicare if the whole idea here is to provide greater opportunity for affordable and quality health care for American citizens? It makes no sense to me.

I yield the floor to my colleague from Idaho.

Mr. CRAPO. Mr. President, I appreciate the opportunity to be here with my colleagues from Arizona, Mississippi, and Florida.

When the people of the United States talk about health care reform, they are seeking some way to control the punishing and skyrocketing increases, year after year, in health care insurance costs and medical costs and better access and quality of health care. Yet when this 2,074-page bill, which was crafted in secret for the last 2 or 3 weeks, was finally revealed, that is hardly what we got. In fact, the reality is that this bill will drive up the cost of health care insurance and medical care in this country. It will increase taxes by hundreds of billions of dollars. It will cut Medicare by hundreds of billions of dollars. It will grow the Federal Government by $2.4 trillion of new spending over a 10-year period. It will push the needy uninsured not into subsidized health care insurance but into a failing entitlement program, Medicaid. It will impose a damaging unfunded mandate on States that are already strapped financially. It will leave millions of Americans uninsured, while probably creating the most enormous and massive government extension of Federal control over our economy that we have seen in our country, starting with creation of a new federally owned and managed insurance company.

As the Senator from Arizona indicated, today we are here to focus on the Medicare cut aspect of this legislation. The Senate bill contains something in the neighborhood of $500 billion of cuts in Medicare. The first one I want to focus on is the one the Senator from Arizona already identified; that is, the Medicare Advantage cuts.

The Senate bill contains $118 billion in cuts to the Medicare Advantage Program. Let me talk about that program for a minute. Currently, there are nearly 11 million seniors, as has been indicated, enrolled in Medicare Advantage. That represents about one out of four of all Medicare beneficiaries in the United States. In my State of Idaho, there are more than 60,000 Medicare Advantage beneficiaries, which is about 27 percent of the population in Idaho.

In addition, this is an extremely popular program. A 2007 study reported very high overall satisfaction with the Medicare Advantage Program. Eighty-four percent of the Medicare respondents said they were happy with their coverage and 75 percent would recommend Medicare Advantage to their friends or family members. Yet, despite this, there are massive cuts coming forward in the bill. Why would that be the case?

I don't think most Americans who are not on Medicare recognize the difference between Medicare generally and Medicare Advantage. Medicare Advantage was a modification of the traditional Medicare Program that, frankly, was put into place—I ask my colleague from Arizona to comment. Wasn't it put into place when the Republicans were in control of the Congress to try to help get market forces more engaged and involved in the administration of Medicare benefits?

Mr. KYL. Mr. President, the answer to that is yes. The idea was that seniors were complaining about the existing program. One thing was that a lot of folks in rural areas were not receiving good, efficient, and quick care because they had to drive long distances and couldn't find a doctor to serve them and hospitals couldn't take care of them.

Republicans tried to figure out, how could we incent the insurance companies to put together pools of physicians and hospitals to go into rural areas and take care of citizens who live there. The Medicare Advantage Program was one of the ways in which that was done. It has proved to be very successful.

Mr. CRAPO. If you look at the Federal entitlement program Medicare, the portion of Medicare that truly does have some private sector involvement, where private sector companies can come in and contract to provide the government's responsibilities under Medicare, it is the most popular of all Medicare programs, the one that was growing and letting the private sector deliver the benefits.

One of the aspects of the Medicare Advantage Program is that senior citizens on Medicare Advantage actually get additional benefits beyond those traditional Medicare benefits that those in the normal or standard Medicare Program get because the private sector options have been able to identify ways to enhance and create opportunities for greater and stronger benefits.

Yet those who don't want to have anything but a single-payer system, those who want to make sure the government-provided health care is provided only by the government, do not like the Medicare Advantage Program. So it is not surprising that we see this level of cuts in this program.

During the Finance Committee markup, CBO estimated that the value of extra benefits that Medicare Advantage plans provide will drop from $135 a month to $42 a month of extra benefits. The CBO Director, Mr. Elmendorf, confirmed this during the markup. I asked him:

> So approximately half of the additional benefit would be lost to those current Medicare Advantage policyholders.

His answer was:

> For those who would be enrolled otherwise under current law, yes.

In other words, compared to current law, if these cuts are put into place, about half of the benefits would be lost to these Medicare Advantage beneficiaries.

We now have more detail on that. I am sorry we don't have a bigger chart. We will have one in the future. If you can see the United States here, the States in the deep red are those that have cuts in excess of 50 percent to their Medicare Advantage beneficiaries; those in the lighter red are between 25 and 50 percent. In the white, there are only five States; they are the ones that don't have a negative impact. So 45 of the 50 States will see significant reductions in the Medicare Advantage benefits that are provided to their constituencies. You just have to look at the map to see it is a large percentage of those 45 States that are getting cuts in excess of 50 percent of their benefits.

Mr. LEMIEUX. Will the Senator yield for a question?

Mr. CRAPO. Yes.

Mr. LEMIEUX. The Senator is saying that seniors who have Medicare Advantage now will have big reductions in the benefits they receive. My understanding is that includes flu shots, eyeglasses, and hearing aids—as the Senator from Arizona said, programs to keep seniors healthy. My folks in Florida very much appreciate the Medicare Advantage Program. We have more than 900,000 Floridians who are on Medicare Advantage.

I want to make sure I understand this correctly—that under the proposal put forward by Senator REID, we are going to make substantial cuts to Medicare Advantage and the benefits Medicare Advantage provides.

Mr. CRAPO. The Senator is right. The way I look at it is that it is the extras. Some say Medicare benefits aren't being cut by these proposals, but that is a real stretch. When you look at Medicare Advantage, it is an outright misrepresentation. The benefits are vision benefits, dental benefits, and the kinds of preventive medicine, such as the mammograms, the PSA tests, and other types of things we have found that help you to dramatically increase your health, if you pursue these kinds of preventive medicine options. They are the ones that will be deprived through these benefits.

Mr. WICKER. Will the Senator yield?

Mr. CRAPO. Yes.

Mr. WICKER. I notice that in Florida that reduction, according to the CBO map, would be 81 percent. That is an unthinkable, drastic change in Medicare Advantage. In my area of the country, over in Arkansas, for example, it has a 40-percent reduction. My State, Mississippi, has a 41-percent reduction. Our neighboring State of Louisiana—these are some examples—has an 81-percent reduction, the same as the proposed reduction this legislation would cause for the State of Florida. I

think it is important for our constituents to understand the magnitude of these Medicare Advantage reductions.

Mr. CRAPO. That is absolutely true. Taking a couple of other States, California is 68 percent; Arkansas, 40 percent; New York, 69 percent; New Mexico, 65 percent. The list goes on. The point here is this: The CBO Director made it clear that these will be benefits Medicare Advantage holders will be losing.

I want to move on to some of the other reductions in Medicare. The argument being made by the proponents of this bill is that we can cut $500 billion out of Medicaid and not impact anybody's benefits or the quality of the medical care they are receiving. That is not true. Where are the other cuts, non-Medicare Advantage cuts, coming from? They come from home health agencies, hospice, skilled nursing facilities, hospitals that provide care to seniors, and other Medicare providers in what is called the market basket.

You might say we can just continue to cut the compensation or the allocation of return for procedures and health care provided in these medical providers' services and not have any impact. The reality is far from that. What will happen is this. I will give a couple of specific examples. In general, what happens is, when a home health agency or a skilled nursing facility or a hospital receives these massive reductions of over $100 billion worth of cuts in these areas, they have to adjust somehow. Let me give you some examples. The adjustment is this: In some cases, providers simply stop taking Medicare patients because they can no longer make a profit. In that case, the Medicare population loses access because they have fewer providers from which to choose. In other cases, they reduce services or reduce employees. Again, both the quality and the quantity of health care services to seniors is reduced.

Let me give some examples. A few weeks ago, I spoke to Gary Thietten of Idaho Home Health and Hospice about the impact of Medicare cuts to home health and hospice providers, which is his business. He described to me just how bad the fiscal situation has already become for home health, hospice, and other Medicare providers in Idaho.

Idaho has already lost nearly 30 percent of its home care providers. Let me repeat that. Already, it has lost nearly 30 percent of its home health care providers. They are going out of business because we are squeezing them down so tight. And that included Idaho's largest provider. The providers that are still in business are working under the same Medicare reimbursement levels they received in 2001—8 years ago. If the kinds of cuts contemplated by this legislation go into effect, on top of the current reimbursement issues, the situation will get worse.

Gary said that he compared this situation for home health and hospice providers to the farmers in Idaho. He said that most farmers don't grow just one crop. Similarly, home health agencies do more than just provide home health; they provide hospice and private-duty care along with medical supplies and equipment. All of this will get reduced.

Let me give another example. Robert Vande Merwe of the Idaho Health Care Association talked to me about the impact of these cuts on skilled nursing facilities.

Skilled nursing facilities, such as the hospice facilities, already face a budget challenge under recent CMS rules restricting their compensation for the services they provide. The cuts they have already received, not counting what will come at them in this bill a hundredfold more, have already caused a reduction in reimbursement in Idaho by over $4 million per year to skilled nursing facilities.

He pointed out to me that in the nursing home world, more than 70 percent of the expenses they have are labor, primarily nurses and nursing assistants. He said when payment cuts like these occur, they cannot go to their buildings and take bricks out of it. What they have to do is reduce their employment. That cuts employees. That cuts benefits and services to those who are there.

Let me make this clear. First of all, these cuts are going to reduce jobs and, secondly, they are going to directly tie to the quality and number of staff there to provide care for those in the Medicare system.

Mr. KYL. Mr. President, I ask if my colleague will yield for a quick question.

Mr. CRAPO. Yes.

Mr. KYL. We talked a lot about the rationing of health care that is the inevitable result of these cuts in this bill; that when you reduce the amount of money you compensate hospitals, doctors, nurses, and others, they cannot provide as many services. Some leave the business altogether. As the Senator from Idaho pointed out, some businesses go out of business. So there are fewer entities providing the care. That means it takes longer for patients to obtain the care where it is available, and frequently they do not get as good of care because folks cannot take that much time to take care of them in that sense.

Will my colleague please talk about his concerns about the overall problem of rationing that comes from the reductions in the benefits to providers? By the way, the Senator's chart says ''other Medicare cuts to providers.'' We use that term ''providers'' as a shortcut term. Will my colleague explain what it means to a 70-year-old woman in Idaho who is a provider and how important is that, what happens when you don't pay that provider so that provider is no longer available to take care of her?

Mr. CRAPO. Mr. President, I appreciate that question, who are the providers. If this Medicare beneficiary is in a skilled nursing facility, the provider is the facility itself, which I said we already lost 30 percent of our facilities. It is the nurses and the nurse assistants who are there to assist them and care for them.

The bottom line is, you simply cannot cut hundreds of billions of dollars out of these services and expect to provide the same level of access and quality and available health care.

The same would be true if the care were being provided in a home setting, which a lot of the home care services are compensated by Medicare or in a hospital which is there to provide care in some of the most serious types of circumstances. Whatever it is, whether it is home hospice care, skilled nursing facility, a hospital or what have you, what we see is a reduction in the number of facilities and personnel available, and that is nothing other than rationing.

It is a different kind of rationing than will occur under some other parts of this bill where the government will actually get in the business of saying what kind of health care you can get and at what time in your life you can get it. But it is a kind of rationing that simply forces the availability of health care down so far that the system itself rations it out.

Mr. LEMIEUX. Will the Senator yield?

Mr. CRAPO. Yes.

Mr. LEMIEUX. I wanted to follow up on my colleague's point. With all these cuts to Medicare, $464 billion in this proposal, $192 billion in reductions to most services, $118 billion in cuts to Medicare Advantage, $21 billion cuts to hospitals serving low-income patients, $23 billion from other sources, it seems inevitable that seniors are going to have a lower quality of health care. We were told by the President that if you liked your health care, you were going to be able to keep it. But it seems to me that we need to change that a little bit because under this proposal, you might be able to keep it unless you are a senior and that seniors are going to have a diminished quality of health care under this proposal; is that correct?

Mr. CRAPO. The Senator is absolutely correct. I will comment on that and then conclude and turn the floor over to my colleagues from Mississippi and Florida for their comments. That is exactly right. In fact, one of the most clear and obvious places in which this legislation violates the President's pledge—that if you like what you have you can keep it—is in Medicare Advantage because one out of four Medicare beneficiaries in America will not be able to keep what they have and will see their benefits cut.

There are also other parts of this bill that impact people outside of Medicare in terms of the kind and quality and extent of health care insurance coverage they have and expect that will be impacted. It would impact beyond this. This is about as clear a case there is of violating that promise.

Mr. WICKER. Mr. President, before the Senator leaves that subject matter, I wonder if I could interject. My friend from Idaho also has listed specific cuts under this legislation: hospitals, Medicare Advantage, cuts to nursing homes, cuts to home health, and hospice. But also I think Senators and Americans need to understand that the Reid bill also establishes a permanent board of unelected members appointed by the administration which, in this case, initially at least would be the Obama administration, and they would dictate further savings under Medicare.

This gets to the question of my friend from Arizona about rationing. It would dictate annual Medicare cuts geared toward reducing Medicare spending. These people are not going to be like us—accountable. They will not have to go back to their district every 2 years or their States every 6 years. But they will have the unbelievable power under this legislation to dictate additional cuts that we know not. The Wall Street Journal called this a rationing commission. This ties right in with the concerns that Americans have had over the last 2 or 3 days about these recommendations with regard to mammograms.

I realize I am intruding on the Senator's time, but I have a letter from a physician in Mississippi who is fearful that this sort of rationing board is going to impose the requirement that mammograms not be given until after age 50. He says:

My wife and I have two daughters who had breast cancer in their 40s. One daughter was age 42 and it was picked up on a routine yearly mammogram. The other daughter was age 49 and she found an abnormality by self breast exam and it was confirmed by a mammogram. . . .

Now we have a group of unelected people coming forth and saying you are not supposed to get a mammogram, you are not entitled to a mammogram, and we learned that some insurance companies have already decided to follow that dictate. This gentleman, a physician, says my two daughters would be dead from breast cancer if that were imposed.

I am afraid that in addition to these very definite cuts, this permanent board of unelected members would impose the very type of requirement that we are fearful might come forward on mammograms.

Mr. CRAPO. The Senator is correct. I will conclude with this. I think we have all seen folks are almost falling over themselves backing away from the news on the mammograms that came out. But it is a very clear example in a way a study can come out from a government source or otherwise to say we don't need to have this kind of health care in the United States, it is a cost saving. What do you think is the potential for this commission to say: We are charged with saving costs in these programs, and we are going to do that.

I suspect that the mammogram issue is one they would not do it on today because of the reaction to it. Somewhere this commission is going to save tens of billions of dollars, in addition to these kinds of cuts, by reducing services. Color it as you want, you cannot make this kind of reduction of health care services, personnel, and infrastructure without reducing the access to and the quality of care that Americans receive.

I will conclude by saying these issues face every State in America. We are going to see in this arena a dramatic reduction of the quality and content and quantity of health care that our Medicare beneficiaries today see because of these proposals, and they are being done not in order to make the Medicare system more solvent but to finance yet another major Federal entitlement program that will cost hundreds of billions of dollars. As a matter of fact, if you look at the true numbers, the cost will be over $2 trillion in a full 10-year period of time.

There is a lot more we could say, but I know my colleagues from Mississippi and Florida have some remarks they wish to make. I yield to them at this time.

Mr. LEMIEUX. Mr. President, I thank the Senator from Idaho for his great remarks today. I want to follow up on what he started to discuss and continue also with the comments from my colleague from Arizona about Medicare Advantage because it seems to me, being a Senator from Florida where we have the second highest senior population in the country, the highest per capita senior population, we have 3 million people on Medicare, more than 900,000 on Medicare Advantage, that Florida is going to receive the worst impact perhaps of any State in the country because of this proposal.

I am here today to talk about this not just as an American but as a Floridian because I want my fellow Floridians to know, especially seniors, what is in this bill and what it means to them. That is our job. It is our responsibility to read through this document, this 2,074-page bill that we received a day and a half ago and to talk about what it means for the average American and, in my case, the average Floridian.

We find out today this Medicare Advantage Program that 900,000-plus Floridians enjoy is going to have a substantial cut to the benefits. This is not just extras or fringe benefits. These are things people need to stay healthy—eye doctors, hearing aids, programs to make sure folks stay in shape, all sorts of things that contribute to the health and wellness of seniors. Our seniors enjoy this program. The popularity of this program is sky high.

But we are finding out today—and I am looking at this map—that Florida is getting the worst impact of any State in America. Only Louisiana is going to get it as badly as Florida. We get the hurricanes, and now we are going to get the Medicare Advantage cuts—an 81-percent reduction in the benefits to our seniors.

What is that going to mean? It means they are not going to have the health care they enjoy now, which is what the President promised.

Right now this bill says the benefits offered will drop from $135 a month to $42 a month. Florida seniors will lose 81 percent of this additional coverage. I have some constituents who have written to me because they have been hearing about these problems. I want to read one or two of these letters from Floridians who are concerned about losing Medicare Advantage. This one is from Dennis Shelton in Plant City, FL, which is in central Florida. He writes to me:

Senator LeMieux, I am writing this letter to express my deep concern about the proposed cuts in Medicare Advantage funding. I am currently enrolled in an advantage program that is crucial for me to get medical attention. The plan provides doctors, medicines, urgent care and my diabetic supplies. The plan does this significantly better than traditional Medicare at a reduced cost.

By regular visits . . . I have been able to maintain reasonable health. If the cuts reduce services then my health will suffer along with other seniors that are in the Advantage program.

This is distressing and I sincerely hope that you will strongly advise fellow congressmen how important Medicare Advantage programs are to seniors all across the United States.

I am new to this body. I have only had the honor of serving here for a couple of months, so I am still learning the ways of Washington. But my understanding of this health care process and this health care bill is we were going to maintain quality, we were going to try to cut costs for people who have experienced the high cost of insurance, and we were going to try to provide more access.

But what I am finding out from this proposal is that we are going to cut quality for seniors, and we are not going to reduce the costs of health care for the 170 million people who actually have insurance.

It occurs to me that the goals that were set are not being achieved by this plan. Worse still, we are taking a program that seniors rely on and that seniors paid into their whole life through their wages and we are going to cut $½ trillion out of it, a program that in 7 or 8 years is going to run a deficit and be in tremendous trouble.

The question I have—and maybe my colleague from Mississippi can help me with this since I am new to the Chamber—is why are we going down this path? This doesn't seem good for seniors. It doesn't seem good for people in any walk of life in America, especially in light of what my colleague from Mississippi pointed out with the mammogram issue that came out and the self breast exam issue that came out this week. Why are we going down this path?

Mr. WICKER. I appreciate the Senator asking that question. The answer is there is no reason for us to go down that path.

Early in our hour, the Republican whip pointed out that there are many proposals the Republicans have that do not require the huge expenditure, the huge expansion of Federal power and actually are relatively simple and relatively inexpensive. For example, we have a proposal:

To reduce junk lawsuits against doctors, by Senator ENSIGN, the Medical Care Access Protection Act. It is only 28 pages, compared to these huge pieces of legislation in front of us. That would not cost anything. It certainly would not require any reduction in Medicare.

To combat waste, fraud, and abuse, by my friend from Florida, and I congratulate him for that. It is only 21 pages, something Republicans have been begging for and arguing for for years and have been stymied on.

To allow small businesses to pool resources to purchase health insurance for employees. Small business people in restaurants and realty companies, small motels, ought to be able to pool together and have the same purchasing power the huge corporations have. But that would only take 8 pages, it would not involve a cost to the Federal Government, and certainly not involve these draconian cuts of $½ trillion to Medicare and Medicare Advantage.

Further, we could purchase health insurance across State lines. We certainly agree there is not enough competition in health care purchasing. I would love to see a commercial someday with someone coming in saying, ‘‘I have great news, I just saved a ton of money on my health insurance by switching to XYZ Company.'' We see that in car insurance and life insurance. There is vibrant competition. But if we opened competition across State lines to the 50 States and if I could buy insurance from Idaho, I might find a company that gives me better service, that provides better care or reduced premiums. Or if I could look at a Florida insurance company, the Senator from Florida might look at a Mississippi company. We would use good old American competition that has worked in our market society for years but has not been allowed to work in the area of health insurance.

Then, of course, health savings accounts—a one-page bill by my friend from Arizona and our colleague Senator DEMINT. And then wellness and prevention, again only a simple 14 pages.

None of these would require cuts to Medicare. None of these would involve the $2.5 trillion that this spends per decade, once it is fully implemented. So the answer to the question of why we are doing it is, it is not necessary. I guess the reason people might be doing it is that they believe that big government works well. I have a different view on that.

I see, as the Senator pointed out, all of these Federal programs that are not exactly working as efficiently as they were projected to be. My dad is on Medicare. We are going to protect Medicare. Republican and Democrat, we are going to do that. But as the Senator pointed out, it goes broke in the year 2017. We certainly do not need to be taking from Medicare to pay for a new entitlement.

Medicaid, as has been pointed out—many doctors will not take Medicaid payments anymore because it is broke and it doesn't reimburse at a market rate. So we see in my home State of Mississippi, 60 percent of the doctors will not take Medicaid. Yet there are some people in this building, there are some people in this country within the sound of my voice, who believe that somehow a huge $2.5 trillion takeover of one-sixth of our economy can work and will not be like the Census and Fannie and Freddy, like the post office and the highway trust fund, and will not be broke.

It comes down to a difference in philosophy. But certainly we ought to all agree that savings we find in Medicare ought to be used to shore up Medicare, to make sure it is there for people such as my dad and people who are going to rely on that program for years to come.

Mr. LEMIEUX. I thank the Senator for that explanation. That is very helpful to me. What is disconcerting about the path it seems we are on is we are going to have this government-run health care system and if already now people cannot go see their doctor if they are on Medicaid because doctors won't take Medicaid, and if it is growing more and more the case that you cannot see a doctor if you are on Medicare—I have some information here about 29 percent of beneficiaries surveyed saying they are having a problem finding a doctor who will take Medicare.

There is a senior from Sanford, FL, Earl Bean, who was interviewed this week and he said:

> I called about 15 doctors and was told repeatedly that they were not accepting Medicare patients. . . .

They wouldn't even take his name when he called. So what I am worried about is we are going to enter into a system where 5 years from now, 10 years from now when everybody in the country is basically on a government-run health care program—Medicare, Medicaid, or this new program which unfortunately we all think will push the private insurers out of the business eventually and we all have government health care—is we will be going places, there will be 100 people waiting in the room if we can get a doctor at all, they will be rationing the care, they won't be providing mammograms such as this recommendation that came out this week by the Government task force, for women in their forties to be discouraged from self-breast exams, and we will all have very poor health care unless you are wealthy.

What is already happening now is that those folks who are wealthy—there are doctors now who are not taking Medicaid, they are not taking Medicare, and they are not even taking insurance. So what concerns me—maybe the Senator from Mississippi can comment on that—if we enter on this path, we are going to a world where the majority, the vast majority of Americans are going to have poor quality government-run health care and only the very rich will have access to good doctors and all the best quality of health care. That does not seem to me like an America we want to live in.

Mr. WICKER. I think this constituent of mine, from Brandon, MS, said it very well in a recent e-mail I received. Obviously she is dependent upon home health care.

> I support the goal of health care for all. However, that goal should not come at the expense of frail, elderly and disabled homebound Medicare beneficiaries receiving care in their homes and communities. . .

She points out what this legislation would do to home health care.

Truly, this bill before us and the one from the House and the one from the two committees takes money from America's seniors to the tune of $½ trillion, and instead of shoring up the system that needs to be enhanced and protected, it puts that money in the new government entitlement program we have exhibited here. I certainly believe we can do better.

Mr. KYL. Mr. President, I want to interrupt my colleague from Mississippi for a moment and ask him—or I think the Senator from Idaho has some experience with this as well—we have been talking about $½ trillion in cuts to Medicare. But we have not even talked about the biggest one yet. We have talked about cuts to Medicare Advantage, we have talked about the cuts that will be ordered by this new Medicare Commission. But I guess I would ask my colleague from Idaho, isn't it true that the biggest dollar cuts to Medicare are going to come because we are going to pay the doctors and the hospitals and the nurses a lot less money?

Of course, every one of my constituents who has talked to me about it said

wait a minute, if you are going to pay them a lot less money—I am having a hard time finding a doctor who will take Medicare patients. Isn't that going to result in delay of care for me and denial of care, in effect rationing of care? There will not be enough doctors and nurses to take care of me because they are not being paid enough to even keep their doors open.

Mr. CRAPO. The Senator is right. As a matter of fact, if I understand the legislation correctly, it assumes the current projected cuts for physicians are going to happen. That is how it says it is not going to increase the deficit. You and I both know this Congress will not let that happen.

But even today, 29 percent of Medicare beneficiaries looking for a primary care doctor had a problem finding one because, both with regard to Medicaid and Medicare, because of the problems we have been discussing here, there are fewer and fewer providers who will take patients in those programs.

Mr. LEMIEUX. Mr. President, I was wondering if I could ask my colleague, the leader from Arizona, a question because we are about at the end of our time. My understanding is we are going to have a vote tomorrow at 8 o'clock. Again I am new here. I was hoping the Senator could explain this for me. My understanding is we are going to vote whether to proceed on this bill. It is not going to be this bill, it is going to be some kind of shell bill or something, which hopefully can be cleared up for me. But I am told by folks who work with me that the Congressional Research Service has said when there is a vote to proceed on a bill, that 97 percent of the time that bill passes. So it seems to me if we are voting tomorrow to proceed, that is really a vote on this bill.

Do I understand that correctly?

Mr. KYL. Mr. President, I would say to my colleague from Florida that is exactly right. I was interested in that Congressional Research Service report, a totally nonpartisan report, which essentially makes the point if you vote to proceed to the bill, 97 percent of the time you are voting to approve the bill because they end up passing. Those of our colleagues who say they have problems with this bill, serious problems with the bill, are enablers if they vote to proceed to the debate of this bill. They are enabling those who want to pass a bad bill to do so because that is exactly what will happen.

In order for them to try to fix the bill it would take 60 votes to get an amendment agreed to and that is a very tall order around here.

The second part of the question, yes, this may be a little confusing, but what the majority leader has asked is that we vote on a cloture motion to proceed to a House bill that has to do with bonuses for AIG people. You say, What does that have to do with this? The answer is it has nothing to do with this. The leader ordinarily would have taken the House bill, which is the bottom half of this stack here, would have taken the House-passed health care bill and asked to proceed to that bill. If we then agree to proceed to that health care bill, he would then substitute his own version, which is the second half of the stack here, and then you would have a Senate version that we would begin to amend or act on or at least debate.

I don't think the majority leader wants those on his side of the aisle to have to vote on the House-passed health care bill. It doesn't appear to be very popular out in America. In fact, by about 2 to 1 the American people say they don't want to have anything to do with that bill. So, instead, we are going to a shell bill that has nothing to do with health care and then the leader will simply shift to his substitute health care bill. As my colleague from Florida knows, once you vote to begin the debate on this bill, you have put in motion the process by which it could, and in 97 percent of the cases does, end up getting passed into law.

For those colleagues who say I am not sure I like this bill but you know I will move the process along by at least going to it, the time to stop it and to say let's fix it before is the time right now, not after you get on the bill. It is too late.

Mr. WICKER. Will my colleague yield? This Reid substitute that will be substituted for the shell bill contains taxpayer funding of abortions and it contains a government-run company to compete with the private sector. So Senators who vote to proceed on that bill, in my opinion, are playing with fire and very much risking that type of legislation might come out of the closed room that will be the House-Senate conference.

Mr. KYL. The point is this: Unless they have a way to get 60 votes to get those provisions out they are in effect endorsing them by voting to proceed to the bill because they can't get them out. My colleague is exactly right.

The PRESIDING OFFICER (Ms. KLOBUCHAR). The time of the Republicans has expired.

The Senator from Florida.

Mr. NELSON of Florida. Mr. President, I rise to support the majority leader and his motion for cloture to cut off debate to allow us to vote on the motion to proceed which will allow us, then, to get the bill to the floor so that we can debate and start amending this bill. I wish to use the next several minutes to lay out a comprehensive reason of why this Senator supports moving to take up this legislation.

I look forward to the amending process, and there will be vigorous attempts to amend it. I had offered a number of amendments in the Finance Committee. Most of those amendments were, in fact, adopted, but there was one in particular that was not adopted on a vote of 13 to 3. It would save the American taxpayers $109 billion by having the price of drugs that are sold to Medicare recipients under the Medicare Part D who also are eligible for Medicaid but get their drugs under Medicare, it would cause those drugs to be sold at the same discounts that they get the drugs under Medicaid. There have been discounts for a couple decades because of the bulk purchases of millions and millions. It is close to 50 million people who get drugs under Medicaid. There are about 43 million people who get their drugs under Medicare.

Let me correct that. There are 43 million people on Medicare. There is some number less than that who are now getting their drugs under Medicare Part D. But, in fact, they don't get the same discounts that those very same people in Medicaid would get, even though they are eligible for those discounts. Those people are called dual eligibles because they are eligible because they are poor to get it under Medicaid, but they are also over 65. Therefore, dual eligibles should be able to get cheaper drugs. No, we can't do that. Because in the Medicare prescription drug benefit passed 6 years ago, those kinds of discounts were not allowed.

That is a huge additional cost to the taxpayers. The overall amount of Medicare drugs being sold, if you got those discounts, would be something in excess of saving the American taxpayer $200 to $250 billion. For those who are dual eligible—they qualify for Medicaid but get their drugs under Medicare—the savings would be $109 billion.

This Senator is going to offer that amendment. It is a high threshold of 60 votes that we have to get but, indeed, we will see and on down the line.

Why am I insisting on continuing to offer this? Well, it is interesting that just recently an AARP study has come out, along with another study called IMS. They have noted that the cost of drugs, brand name drugs, their wholesale prices have increased, in the year 2008, 9.3 percent. Contrast that to the rate of inflation, which was about zero percent. So you see that the cost of drugs is continuing to go up. It is time to give our people some relief.

We could do a lot with that extra $109 billion. First, we could lower the deficit by $109 billion. So whereas this bill brought forth by the majority leader saves the Treasury money over the 10-year period and reduces the deficit by $130 billion, we could add another $100 billion to that. We could be lowering the deficit $230 billion. But we could take part of that money that we would save the taxpayers and use that to fill the doughnut hole.

That is the strange creature in statute that gives senior citizens under

Medicare some reasonable compensation for their drugs, up to a certain level. That level is, generally, between about $2,500 and $4,500 of total drug purchases within a year. But once they get into that zone, that doughnut hole, in fact, they get no assistance from Medicare. That is called the doughnut hole. We could help senior citizens fill that doughnut hole so they are not bearing the full cost of those drugs when they get hit with huge drug expenses in a particular year.

We will see what the will of the Senate is as we come out here and start to vote.

The reason it is important, tomorrow night at 8, for us to get 60 votes to shut off debate is so we can go to the motion to proceed to get this bill to the floor. The reason is we need a debate. We can't afford not to have a debate. In what is known as the world's most deliberative body, that is what we do—debate and amend and try to perfect. Is anyone denying that health care, the cost of health care, the availability of health care, the availability of health insurance, the availability of health insurance at a reasonable price, is anybody disagreeing that is not a problem? Our people are hurting.

One of the main purposes of bringing this legislation out here and trying to find a reasonable solution is to make health insurance and health care available and affordable.

For example, what about if you have a preexisting condition. You can't get health insurance. We are going to change that in this legislation.

What about if you are sick and your insurance company suddenly comes and says: We are going to take away your insurance, we are going to cancel your health insurance. Is that a good outcome? There is nobody in America who thinks that is a good outcome. That is what we are trying to change. By the way, that is what the bill proposed by the majority leader will, in fact, do.

What about all those 46 million people who don't have health insurance? First of all, a lot of those folks do get health care, but where do they get it? They get it at the most expensive place at the most expensive time. They go to the emergency room, after what could have been very possibly prevented becomes an emergency. So it is at the most expensive place at the most expensive time. By the way, guess who pays. Do you think all those costs suddenly evaporate in the ether? No. They are costs in a hospital that are ultimately borne by all the people who support the health insurance system; that is, those who have health insurance policies and pay premiums. It is no small amount that we pay. As a matter of fact, nationwide, the additional cost to a family health insurance policy to take care of uninsured people is between $900 and $1,000 per year extra. It is a hidden tax on all the rest of the people who are paying their health insurance premiums.

In my State of Florida, it is even higher. It is estimated to be $1,400 per family policy per year, a hidden tax. That is a hidden tax that will disappear, if we can bring in those 46 million people nationally who are uninsured, 4 million of whom are in Florida, if we can bring them into the system. Will we bring them into the system? The bill the majority leader has put on the table will cover 98 percent of all Americans with health insurance. That is the entire spectrum of Americans who receive health care. Is that worthwhile doing? I certainly think it is.

I said at the outset this bill also tries to approach this in a responsible financial way. The actual cost of the bill is about $848 billion over 10 years. But that $848 billion is more than paid for because, at the end of that 10 years, there is an additional $130 billion that is left over. That is surplus that will go directly to lower the deficit. The projection by the Congressional Budget Office for the second 10-year period is at least a $650 billion reduction of the budget deficit in that 10-year period and possibly as high as $1 trillion in lowering the deficit.

What does that tell us? What it tells us is that one of the reasons we need a bill coming out on the floor is that not only do our individual Americans have difficulty paying for the cost of health care, the U.S. Government is having difficulty paying for the cost explosion of Medicare.

Unless we start getting those costs under control, then, in fact, we are going to be in an unsustainable proposition with Medicare. A system of revising health delivery capabilities so people are not being canceled, no preexisting conditions, people can get health insurance at affordable rates but at the same time starts lowering the overall cost to not only individuals but to the U.S. Government, it seems to me that is desirable.

So you will hear and we have just heard comments about how Medicare is going to be cut. Well, there are clearly inefficiencies in Medicare that need to be wrung out. Let me give you an example. Right now, we have what is known as Medicare fee for service. It basically pays the doctor's bill that is submitted for the person who is eligible for Medicare. But what happens is, the Medicare patient goes to this specialist, that specialist, that specialist, and all of them are not talking to each other. This one orders this particular set of tests, and that one, because he does not know what the other one is doing, is ordering the same test, but Medicare is getting all of the same bills. This bill, in reforming health care delivery, is going to try to get at that. It is going to set up accountable care organizations. It is going to set up electronic records so there is no more of this shifting around and, oh, I didn't get the report. It is going to be there available immediately. These are obvious technology increases we have to do. That is Medicare fee for service.

How about a program called Medicare Advantage? Let me tell you what Medicare Advantage is. Medicare Advantage is a fancy word for a Medicare HMO. Do you know what an HMO is? An HMO is an insurance company. It was originally designed in the late 1990s that you could deliver health care cheaper to senior citizens in Medicare through an HMO. So when it was first set up, Medicare HMOs were given 95 percent of fee for service because they were going to save costs. They were going to save costs to the individual, they were going to save costs to the government—95 percent.

But, lo and behold, in 2003, in the Medicare prescription drug benefit, it not only set up what I described a while ago as this unusual doughnut hole and drugs that cannot be discounted to the Federal Government when it is buying drugs in bulk for millions of Medicare recipients, it also set up that we are going to give a cushy arrangement to insurance companies where insurance companies that want to sign up Medicare recipients are going to get 14 percent more per patient—114 percent instead of 100 percent of Medicare fee for service. Is it any wonder costs are exploding in Medicare if suddenly a program gets 14 percent more per patient than what the standard baseline ought to be, which is Medicare fee for service? It does not take a rocket scientist to figure that out.

Because insurance companies—Medicare HMOs; the fancy name is ''Medicare Advantage''—because they get more, 14 percent more, then they can offer additional things to the senior citizens, and this has proved to be quite popular. Basically, 30 percent of all Medicare recipients in my State of Florida have signed up for Medicare Advantage. Indeed, the biggest thing they have that is desirable—you hear about eyeglasses and hearing assistance and so forth, but the biggest thing that is the most popular is that because the insurance company is getting paid so much more per person, it can then use part of that money to pay the copays on Medicare, such as Medicare hospital insurance, Part A and part B, as well as Part D, the drugs. So it is very popular.

So what I said in the Finance Committee is—obviously, we ought to reform the system. And I can tell you, this Senator did not vote for it 6 years ago, which set up this system, which was a cushy system for insurance companies as well as the drug companies. But the fact is, we have not.

So this Senator said, in the Finance Committee: All right, what I want to

do is I want to grandfather the people who have it in Florida so that, on a going-forward basis, when this takes effect—in this bill, it takes effect in 2013—when it takes effect, it is only those new people signing up who will operate under the new system that will make it more streamlined but that those who have the existing benefits from Medicare Advantage will not be cut. I offered that amendment along with other Senators in the Senate Finance Committee, and that amendment was adopted.

So the statements that have been made on this floor about Florida Medicare Advantage recipients being cut in Florida is not accurate on this bill. I fought for that. Everybody knew I fought for that. And of the 949,000 Medicare Advantage recipients in Florida, at least 800,000 are operative under the formula we put in and the remaining 149,000 virtually would not be affected anyway. I cannot speak for the other States, but I can sure speak for Florida. That is in this bill. Those other Senators who offered the amendment with me in the Finance Committee had things that tended to their States, as well, that were part of that amendment. But that is what the situation is with regard to this legislation.

Let me say that if we can get this legislation out of the Senate and get it to a conference committee with the House, the House has a whole different approach. The House works on streamlining Medicare Advantage from the basis of not something known as competitive bid, which is in the Senate bill, but what is known as fee for service, as the target benchmark. That does not have the Draconian cuts, in my opinion, to many of our Medicare Advantage recipients.

But I want the record clear here that with regard to Florida, Florida Medicare Advantage people have been grandfathered in of those who are in existence and those who still will be in existence having signed up for Medicare Advantage until the date at which the new system would start.

I see we have changed Presiding Officers, and it is such a pleasure to have the esteemed Senator from Minnesota in the chair. Madam President, there is room for improvement. We spent 2 full weeks in the Senate Finance Committee on amending this legislation. We had spent 3 months prior to that discussing it. You can imagine, in a nation as diverse and complicated as ours and a health care industry where everybody and his brother and sister have their fingers in the pie, how complicated this is. But that is the reason for the amendatory process: to improve, to perfect.

I want to wind up my remarks by giving a picture of the totality. We have had so much of the debate, ever since summer, dominate on the concept of a public plan. Many organizations have now come out and said that a public plan, at max, is going to affect 4 million or 6 million people. If it affects 6 million people who sign up for a public plan—if there is one in existence. And, of course, the majority leader has in here not one that is mandatory. He has it as an option where a State can withdraw from having a public plan. But if the max of 6 million people signed up on a public plan, that is 2 percent of the entire country. Yet you would think that was the only thing when you listen to the arguments—and sometimes we watched fights in these townhall meetings back in the summer—you would think that was the only thing this whole health care reform was about. In the max, it is going to affect 2 percent.

Why is that? Why is it that it only affects 2 percent? Well, look at the whole population to whom we want to give health care delivery.

Take my State of Florida. Approximately—and I am rounding these numbers—approximately 50 percent of our people in Florida get their health insurance from their employer and they are in a group policy. Another 16 percent in my State get their health care from Medicare because they are eligible at their age. Another 10 percent in my State get their health care from Medicaid because they are either qualified under the income level or they are disabled. Now add that up. That is 76 percent right there of all the people of Florida. That includes children. OK. What about the remaining 24 percent? About 4 or 5 percent of our people also have health insurance but they pay through the nose because they are buying it as individuals as opposed to a group policy. If you are buying it individually, where all the health risk is on one life, the cost of those premiums is very high. The remaining 19 percent are the uninsured. That is as to the population of my State of Florida. That will vary with different States. Obviously, in Florida we have more people aged 65 and older and therefore eligible for Medicare than most States.

But you can see now that what we are going to do is, over here for this remaining 24 percent, we are going to set up a health insurance exchange. In the case of Florida, it is going to have potentially 4 million people in it. It is going to be the uninsured who are now going to have access to health insurance with no preconditions, and they cannot cancel their policies, and it is affordable. It is also going to be available to those people who, in fact, have policies they cannot afford, usually the individual policies. There will be some small business employers—for example, those with 50 employees or fewer—who will not be offering health insurance, and their employees will, for the first time, be able to go to the health insurance exchange and be able to get health insurance.

All right. The competition in that health insurance exchange is going to have a public plan, if a State approves. That is why it comes down to such a small percentage. That is why an issue has dominated the debate but is not the main issue. The main issue of this legislation is to provide health insurance and health care to our people that is available and affordable.

I will close with this: We have all heard these stories because people have been coming to us in our townhall meetings, on the phone, in the airport, back during the parades, at the meetings, and they have been telling us these very tragic stories: the woman who is in the middle of chemotherapy and suddenly gets a cancellation notice from her health insurance company; the person who desperately needs health insurance and can't get it and who has had it for some period of time; the person who is hanging on for dear life to that job because that job they have is not only their means of financial remuneration but is also their ticket to having health insurance.

These are the tragic stories we want to change. We want to make people's lives better. We have to start somewhere. That point of starting is going to be at 8 o'clock tomorrow night, Saturday night, because the Senators are going to parade on this floor and indicate yea or nay on whether we are going to shut off the filibuster in order to get to the motion to proceed which will then allow us to get to the bill after Thanksgiving.

It is absolutely essential for the sake of our people that we bring this legislation to the floor and that ultimately we get a product we can pass and get it on to a conference with the House and have an agreement that the President can then sign into law.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

Mr. KAUFMAN. Madam President, I rise this afternoon to talk about the topic that is on the mind of each and every Senator today: health care reform. First off, I wish to congratulate our majority leader, Senator REID. He has accomplished something that has not been done in years. He has the Senate on the precipice of debating a major health reform bill on the Senate floor.

I agree with the Senator from Florida. Tomorrow night at 8 o'clock we should come to the floor and we should move this bill. It is essential that we pass health care reform this year. The present system lets down all Americans and we need a new, reformed health care system. We should move this bill and then we can debate, we can amend, as the Senator from Florida said, and we can deal with this bill then. But it is essential that we move this bill.

Senator REID has melded the good work of the Finance Committee and

the Health, Education, Labor, and Pensions Committee into one bill that we stand ready to bring to the Senate floor. If people don't acknowledge that accomplishment, they are forgetting history. For all the efforts to reform our health care system back in 1994, the Senate never came close to bringing a bill to the floor to debate. Because of the searing experience the Congress went through back then, it took another 15 years to pass before Congress attempted another major reform of our present dysfunctional health care system.

I believe if we don't get it done this year, it might take another 15 years or more before we will bring it up again, and Lord only knows what will happen to the health care system in this country in the interim. But thanks to Senator REID and Chairmen BAUCUS, DODD, and HARKIN, as well as the tremendous efforts of their members, the committee staffs, all the long hours, weekends in the office and time spent away from their families, we stand here this afternoon literally a day away from the first procedural vote on the Patient Protection and Affordable Care Act. Make no mistake. We cannot afford to wait another day to fix our health care system.

We need to pass health care reform because the trajectory of our national health care expenditures is out of control. In 1979 we spent approximately $220 billion as a nation on health care—$220 billion. By 1992 we spent close to $850 billion. And in 2009 we will spend $2.5 trillion on health care—from $220 billion in 1979 to $2.5 trillion in 2009. The trajectory clearly is absolutely unsustainable.

We need to pass health care reform because premium costs for middle-class Americans are rising at an astronomical rate. Take my home State of Delaware, for example. In 2000, the average premium for family health coverage was just over $7,500. In 2008, that number had jumped to $14,900, almost doubling in just 8 years. If we do nothing and allow the current health care system to continue, the same premium for family coverage is expected to reach $29,000 in 2016, another doubling of the price. Think about it. Every 8 years, our premiums doubling in size. That is simply unaffordable.

We need to pass health care reform because failure to do so will drive more and more Americans into bankruptcy. Today, bankruptcies involving medical bills account for more than 60 percent of U.S. personal bankruptcies, a rate 1½ times that of just 6 years ago. Keep in mind, keep in mind, 75 percent of families entering bankruptcy because of health care costs actually have health insurance. To repeat: More than two-thirds of all bankruptcies due to medical expenses are of Americans who have health care insurance. That number is simply appalling.

We need to pass health care reform because small business owners and their employees are desperate for relief from the cost of health insurance. Right now small business owners and their employees pay much higher premiums than their counterparts in large corporations. In fact, during the past 5 years, one in five small businesses reported premium increases of 20 percent annually. Add that up and that is 100 percent over 5 years. Imagine paying a 100-percent increase.

Largely because of the increase in premium rates, fewer and fewer small businesses offer coverage to their employees. For example, in 2000, 68 percent of small businesses were able to offer health insurance coverage to their employees. By 2007, just 59 percent of small businesses offered health benefits. That is a reduction from 68 percent to 59 percent in just 7 years.

Small businesses are the engine of our economy and will be the catalyst to get us out of this recession. It is time to make it easier for small business owners to provide health insurance for their employees so they can retain the workers they have and hire more to help lift us out of this economic distress.

We need to pass health care reform because failure to do so could bankrupt the country. Just look at Medicare and Medicaid. One of the biggest driving forces—in fact, the biggest driving force—behind our Federal deficit is the skyrocketing cost of Medicare as well as Medicaid. In 1966, Medicare and Medicaid accounted for only 1 percent of all government expenditures. They now account for 20 percent. If we do nothing to start bending the cost curve down for health care costs for Medicare and Medicaid, we will eventually spend more on these two programs than all other Federal programs combined.

I am pleased the Patient Protection and Affordable Care Act begins to tackle these problems and begins to reform our health care system. It is passed time.

This bill is fiscally responsible. Anyone who is concerned about our budget deficits should embrace this bill. According to the Congressional Budget Office, the bill will reduce deficits by an estimated $130 billion over the first 10 years from 2010 to 2019, and by more than one-quarter percent of GDP in the decade after. This amounts to about $55 billion in 2020 and several hundred billion dollars over the next 9 years. This is not chump change. This is real, effective deficit reduction that will help our economy over the next 10 to 20 years.

In addition to reducing the deficit, the bill strengthens the Medicare Program. Contrary to claims of the bill's critics that we hear on the Senate floor, the Patient Protection and Affordable Care Act adds coverage for Medicare beneficiaries. It doesn't cut a single service. Let me repeat: It doesn't cut a single service.

For instance, the bill provides seniors with three annual wellness visits under Medicare where they can develop personalized prevention plans with their doctors to address their health conditions and other risk factors for disease, making the conditions easier and less costly to treat. The bill also eliminates out-of-pocket costs for recommended preventive care and screenings such as mammograms. In terms of restrictions on drug coverage, the bill helps seniors manage the cost of the doughnut hole in Medicare Part D coverage by giving a 50-percent discount on brand-name drugs and biologics to low- and middle-income seniors.

Most importantly, the act helps ensure the sustainability of the Medicare Program for years to come. In the past year, Medicare spending has increased by roughly 8 percent a year. According to the CBO, under this bill, the annual growth rate for Medicare dropped substantially to 6 percent for the next several decades. Adjusted for inflation, CBO estimates that Medicare spending per beneficiary under this bill will increase the annual average rate of growth of roughly 2 percent during the next two decades, much less than the roughly 4 percent annual growth rate of the past 20 years.

Right now, the Medicare Hospital Insurance Trust Fund is projected to become insolvent in 2017. But with the measures to strengthen the Medicare Program contained in this bill, the date of insolvency of the trust fund is put back by at least 4 to 5 years. Simply put, this bill is good for seniors and Medicare and good for the Federal budget.

As I mentioned earlier, small business owners struggle to provide their employees with affordable health insurance. This bill will help small business in this quest. The bill will provide a sliding scale tax credit based on the number of employees and annual average wages of these employees to help these small employers pay for health insurance for their employees. This tax credit is estimated to reach more than 3.6 million small businesses nationwide. In addition, small businesses will be able to purchase insurance through the new State-based exchanges. These exchanges would allow small businesses to expand their risk pool and thereby lower premiums. The bill is a win for small business.

The bill helps protect middle-class Americans against the worst abuses of the insurance industry. No longer will Americans be denied coverage because of preexisting conditions. Let me repeat that: No longer, if we pass this bill, will Americans be denied coverage because of preexisting conditions. No longer will insurers be able to rescind people's coverage once they get sick

and they actually need the insurance they have been paying premiums on. No longer will insurers be able to charge people more based on their health status or gender.

The bill helps protect the finances of middle-class Americans and helps reduce the number of medical-related bankruptcies by placing a cap on what insurance companies can require families to pay out of pocket. It also restricts the use of annual limits and prohibits the lifetime limits on insurance benefits, which is especially important for Americans with high-cost conditions to treat. It creates a health insurance exchange that provides a public insurance option to compete with private insurers to provide consumers with more choice.

This will make a great difference in States where one or two insurance providers dominate the marketplace and where there is no true competition.

These are good, strong provisions that will help provide health security and stability to all Americans.

The bill is strong in two other areas as well: promoting prevention and wellness and cracking down on waste, fraud, and abuse. On the prevention front, the bill recognizes that we have to move away from a system that encourages people to wait until they are sick to seek treatment. Instead, it encourages prevention and early treatment of diseases which can help lower the cost of treating patients.

The bill recognizes the need to shift this emphasis by eliminating any copayments or deductibles for recommended preventive care and screenings, such as cancer screenings, colonoscopies, and mammograms. The bill would allow employers to offer premium discounts and other awards for up to 30 percent of the total premium for individuals who quit smoking, lose weight, lower their cholesterol or blood pressure, or take other steps to improve their health status.

We have already seen how successful this type of program can work at companies such as Safeway. All of these measures will help increase the use of preventive measures and reduce the need of costly new treatments as a result of waiting too long to treat a condition or disease.

Finally, I wish to highlight the measures contained to reduce the waste, fraud, and abuse that exist in our current system. Each year, health care fraud drains between $72 billion and $220 billion from doctors, patients, private insurers, and State and Federal Government. Left unchecked, fraud drives up the cost of care while reducing public trust in our health care system. I am pleased this bill will increase the funding for the Health Care Fraud and Abuse Control Fund to fight fraud in public programs. In fact, CBO estimates that every $1 invested to fight fraud results in approximately $1.75 in savings.

In fact, CBO estimates that every $1 invested to fight fraud results in approximately $1.75 savings.

The bill will also establish new penalties for submitting false data on applications, false claims for payment, or for obstructing audit investigations related to Medicare, Medicaid and the State Children's Health Insurance Program.

By reducing the amount of waste, fraud and abuse tolerated in the health care system, we will be able to bring health care costs down for everyone.

Mr. President, this is a good bill.

I have only touched on parts of the bill, as time does not allow me to discuss every provision—including the fact that the bill will extend insurance coverage for an additional 31 million Americans.

But it is a good bill. It is fully paid for. It reduces short and long term deficits. It strengthens the Medicare program. It provides security and stability for the middle class. It provides Americans with greater insurance choices. It promotes prevention and wellness. It cracks down on waste, fraud and abuse. I applaud the hard work that went into the drafting of this bill.

As I have said many times, it is time to gather our collective will and do the right thing during this historic opportunity by passing health care reform.

We can't afford to wait another 15 years. We need to act now. We can do no less.

The American people deserve no less.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. KOHL). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Ms. KLOBUCHAR. Mr. President, I am going to focus for the next 10 minutes on the issue of costs. I know many people are focused on important issues like the fact that this bill will finally eliminate the limitations on preexisting conditions, so if your kid gets sick, you don't have to lose your health care; and the fact that people will be able to keep their kids on their health care until they are 26. These are very important parts of the bill. It is very important to people of my State.

The other facet that is very important to people in my State is something I heard about all over the last few months: the issue of more affordable health care. This is why: At $2.4 trillion per year, health care spending represents close to 17 percent of the American economy. It will exceed 20 percent by 2018 if the current trend continues.

Hospitals and clinics are providing an estimated $56 billion in uncompensated care. In fact, today, Peter Orszag, the Budget Director for the President, wrote an opinion piece for the Washington Post that highlights the fiscal importance of passing health care reform. One of the things he said is, looking forward, if we do nothing to slow the skyrocketing costs of health care, the Federal Government will eventually be spending more on Medicare and Medicaid than all other government programs combined. He notes that it is time to move toward the high-quality, lower cost health care system of the future.

As you know, Mr. President, coming from Wisconsin, we know how to deliver high-quality, highly efficient care. They do it in Wisconsin and in Minnesota. They also do it in Washington State. A number of States have figured out how to do this. Those are the models we need to see all across the country. We need to make health care affordable for everybody, and we need to reduce the waste and fraud that plagues the current system in this country.

In 2008, employer health insurance premiums increased by 5 percent, two times the rate of inflation, and the annual premium for an employer health plan covering a family of four averaged nearly $12,000.

In fact, I tell people around me that they have to know 3 numbers: 6, 12, and 24. Ten years ago, the average family was paying $6,000 for their health care premiums. Now it is $12,000. That is average. A lot of small companies in Minnesota—the owners of companies are paying more than that. But right now the average nationally is $12,000. If we do nothing to bend the cost curve, the average family will be paying, on an annual basis, $24,000 for their health care 10 years from now.

Meanwhile, a new study found that small businesses pay up to 18 percent more to provide health insurance for their employees. We are talking about a backpack company up in Two Harbors, MN. A guy started that small company, and it is now up to 15 employees. He has a family of four and is paying $24,000—in Two Harbors, MN—for his family to make sure they have health insurance. He said if he knew it would have cost that much, he might not have started that company. Now they are providing beautiful, great backpacks for our troops who are serving us—high-quality backpacks. Those backpacks wouldn't have existed if he knew what was happening. Those jobs would not have existed. He could be working at a big company and paying less. But he was an entrepreneur, and we should reward that.

The American people know inaction is not an option. If we don't act, costs will continue to skyrocket, and 14,000 Americans will continue to lose their health insurance every single day. We must keep what works and fix what is broken.

Let me tell you about some good news. It is encouraging news that the Senate will start considering the bill that will reduce the Federal deficit by $127 billion in 10 years. If we go out 20 years, it is a $650 billion reduction in the deficit. That is good news. We achieve these long-term savings by making our health care system more efficient, rewarding quality, and improving patient outcomes, and reducing administrative spending and waste.

Most health care is purchased on a fee-for-service basis. So more tests and more surgery mean more money—quantity not quality pays.

According to researchers at Dartmouth Medical School, nearly $700 billion per year is wasted on unnecessary or ineffective health care. That is 30 percent of total health care spending. One study showed if the hospitals in some of these inefficient areas would follow the high-quality protocol the Mayo Clinic uses—and a lot of people would like to have that kind of health care—we would save $50 billion in taxpayer money every 5 years for chronically ill patients—$50 billion. That is just one example for one set of patients.

That is what we do in Minnesota. We want that same kind of health care, the same kind of high-quality care, the incentives on the Federal level that aren't there now, and that is what we are seeing in this reform package.

I am pleased the ''value index'' I proposed, which was cosponsored by Senator CANTWELL of Washington and Senator GREGG of New Hampshire, was included in the Senate bill. This indexing will help reduce unnecessary procedures because those who produce more volume will need to also improve care or the increased volume will negatively impact their fees. Doctors will have a financial incentive to maximize the value and quality of their service instead of the quantity. This is supported by doctors in my State.

Linking rewards to the outcomes for the entire payment area creates an incentive for doctors and hospitals to work together to improve quality and efficiency. In too many places patients struggle against a fragmented delivery system, running all over with x rays in the back of the car, seeing specialists, and not having someone in charge, or a quarterback running the team, having 20 wide receivers running this way and that way. That is why we need the integrated care that is rewarded in the bill—bundling of services. What you pay for is the result, the combination of services that gives you good results. That is what bundling is about.

There is another good thing about the bill. In 1 year, hospital readmissions cost Medicare $17.4 billion. A study found that Medicare paid an average of $7,200 per readmission that was likely preventable. Who wants to go back in the hospital if you don't need to? One of the problems, if we don't have quality indexes in place—my State has one of the lowest hospital readmission rates in the country. If we don't have that index in place, we are rewarding bad practice. We want to reward high quality and put the patient in the driver's seat. That is what we do with the provisions in the bill.

I am encouraged the Senate bill includes a provision that calls for reduced payments to hospitals if they have preventable readmissions.

In this bill, we also work to better reward integrated health care systems. At places such as Mayo Clinic or Health Partners in Duluth, a patient's overall care is managed by a primary care doctor in coordination with specialists, nurses, and other care providers, as needed—one-stop shopping.

In our rural communities, critical access hospitals utilize this model and provide quality health care for residents in their communities with a team of providers.

To better reward and encourage collaboration, we encourage the creation of accountable care organizations. This is what I hear from the people in my State and across the country: We want more accountability in this health care system.

Do you know what else accountability means? It means better enforcement of Medicare fraud. When the dollars are so tight and people are having so much trouble affording health care, why do we want to waste $60 billion a year on fraud? Think what that money could be spent for to make it easier to go to the hospital or doctor instead of $60 billion wasted on fraud.

This bill and some of the amendments we are going to propose in the next month will bring us much closer to reducing that fraud, bringing that fraud down, and will hold the perpetrators accountable, including criminal penalties—that is important—making sure we have direct deposit, a bill that Senator SNOWE and I have, so nobody can make out false checks and try to get the money that way; giving our law enforcement officers more tools to go after Medicare fraud. We can save $60 billion a year.

In today's Washington Post, Peter Orszag writes:

> As we enter the homestretch, the greatest risk we run is not completing health reform and letting this chance to lay a new foundation for our economy and our country pass us by.

I argue one of the most important things we can do—and I know everybody is focusing on who pays and what the provision means—is to change the delivery system in this country, reward that kind of high-quality, highly efficient care, so that our big companies are able to compete with companies in other countries that have more highly efficient delivery systems so our small companies are able to exist and multiply and keep their employees on health care, so that individuals in this country aren't cut off just because their child gets sick. That is what this reform is about. Thank you. I look forward to the vote tomorrow.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, the whole point of health care reform is to bring down costs and to make health care more affordable for American families. So why have Democratic leaders produced a health care bill loaded with provisions that will increase premiums?

Independent studies from the nonpartisan Congressional Budget Office and the Joint Committee on Taxation and even a study by the chief actuary at the Department of Health and Human Services confirmed this: that the Democrats' plan will drive up premiums and overall health care spending faster than in the absence of these so-called reforms.

How is this so? Let me mention five specific ways.

First, new insurance mandates and new taxes on the insurance industry. New insurance requirements and new taxes on the insurance industry will force premiums to rise for many Americans, particularly the young and healthy. According to an independent analysis that studied the effect of the new insurance reforms and new taxes on the insurance industry, insurance premiums in my home State of Arizona could skyrocket by as much as $2,619 for individuals and $7,426 for families.

Think of that, an increase of $7,426 for families in my State. That is outrageous.

What can $7,426 buy an Arizona family? A lot of things. It could pay for a year's tuition at the University of Arizona. It could pay for a year and a half of groceries or nearly 2 years of utility bills or it could pay for 2 years' worth of gasoline. Families have a lot of expenses and a lot of ways to spend $7,426. They don't need the Federal Government intruding on them and dictating that money has to go somewhere else.

Our friends on the other side of the aisle will say they could provide subsidies. In fact, the legislation will provide subsidies to help with this increased cost. But not every family will qualify, and the subsidies may not even cover the total cost of the increase.

Moreover, what is the point of raising the cost of health insurance and then subsidizing a portion of the increase? You are still raising premiums. It is nonsensical to have a health care reform that makes families worse off and then gives them a government subsidy to help make up for part of the cost.

Second, new mandated benefits will increase costs. Under the Reid bill, the government will require insurers to

cover a broad range of new medical benefits determined by Washington, regardless of whether those benefits are actually needed by each individual patient.

These additional benefits might help some patients, of course, but the government cannot provide them to everyone for free. So the cost will be shared by everyone in the insurance pool, and that means increased premiums for many Americans.

In fact, the Council for Affordable Health Insurance estimates the new mandated benefits would increase the cost of basic health coverage between 20 and 50 percent. That is the second way insurance premiums are increased.

Here is the third way: limits on plan types. Under this Reid bill, insurers are limited to offering a total of only four specific kinds of insurance plans. So the low-cost, high-deductible plans that currently families and individuals enjoy will be virtually eliminated. They will have to buy more expensive plans, again paying more in premiums. Whatever happened to getting to keep what you have? Just as one size do not fit all, in this case, four sizes do not fit all either.

Here is the fourth way premiums increase: New taxes are imposed on groups such as medical device makers. According to the Congressional Budget Office and the Joint Committee on Taxation, a new tax on medical devices will increase premiums and increase the price of everything from wheelchairs to diabetes testing supplies, to pacemakers, and it will be paid entirely by the patients.

Its cost, according to the Joint Committee on Taxation? It is $19.3 billion over 10 years. This tax will hit cutting-edge technology such as CT scanners, replacement joints, and the arterial stents that doctors use during angioplasty. This tax will clearly stifle innovation.

As the Wall Street Journal editorialized:

> This new tax will eventually be passed through to patients, increasing healthcare costs. It will also harm innovation, taking a big bite out of the research and development that leads to medical advancements.

The fifth way in which this legislation will increase costs for the insured is it actually taxes the insurance plans themselves for the first time. You buy insurance, you get taxed. The Reid bill, for the first time, directly accomplishes this. As the independent Joint Committee on Taxation told us, this new tax will increase the cost of health insurance for everyone, since insurers will pass the costs along to their patients.

This tax alone could raise some Americans' premiums by $487 per year. Because this tax is indexed to regular inflation rather than to health care inflation, just as with the alternative minimum tax, it could soon start hitting middle-income families.

According to former Congressional Budget Office Director Douglas Holtz-Eakin, half of all families making less than $100,000 per year could end up paying this tax.

Those are five specific ways in which this bill will increase your costs, increase the premiums you pay for health insurance once this bill is in effect. We believe there are better ideas. Republicans have proposed a variety of solutions to target specific problems and, in particular, the problem of cost.

I, specifically, want to conclude by mentioning the Republican health care alternative in the House of Representatives. The majority voted it down, but the truth is, it would, in fact, lower premiums for individuals, families, and small businesses. Contrast the House-passed bill which increases premiums, the Reid bill which increases premiums, but the Republican House bill which would actually decrease premiums and you will see Republicans in the Senate proposing similar ideas.

According to the Congressional Budget Office, under the Republican plan, premiums would be $5,000 lower than the cheapest plan under the Pelosi bill.

Small businesses, too, would see their premiums decrease by as much as 10 percent, again according to the Congressional Budget Office.

Those in the small group market would also see a 10-percent decrease under the House Republican bill, again according to the nonpartisan CBO.

The House Republican bill included such reforms as allowing States to sell policies across State lines. You have heard a lot of Senators on the Republican side talk about that point. That would have enabled 1,000 companies to compete nationally, and that helps to drive down the costs. Medical liability reform, a proven way to cut costs. My State of Arizona, Texas, and Missouri have all seen premiums go down because of medical malpractice reform. Health savings accounts, which put patients in charge of their own health care by allowing them to save their health care dollars to spend as they choose, this, too, would have been strengthened by the House bill, and you heard Republican Senators talk about that as a reform. There are many other ideas we have. We will be talking more about those ideas as we go forward.

I wish to conclude my remarks about the Reid bill, loaded with provisions that increase insurance premiums, and to make the point that since, as I said at the beginning, the whole point of the exercise is to reduce health care premiums, the last thing we should be doing is adopting the provisions in the Reid bill, which will actually increase health care premiums.

Let's keep in mind that health care reform is all about making things better for Americans, and this bill does not meet that test by a long shot.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I rise to discuss the health care bill that the Senate will begin voting on tomorrow evening. Let me begin by making clear that I believe our health care system needs fundamental reform.

One of my top priorities as a Senator has been to work to expand access to affordable health care. The fact is, however, that the greatest barrier to health care coverage today is the exploding cost. Monthly health insurance premiums in Maine have risen at an alarming rate. They now often exceed a family's mortgage payment. Whether I am talking to a self-employed fisherman, a displaced mill worker, the owner of a struggling small business, or the human resource manager of a large company, the soaring cost of health insurance is a vital concern.

Much of the health care reform debate so far in this Congress has centered around the need to expand coverage to the uninsured, a goal I embrace. The fact is, however, it will be difficult to achieve our goal of universal coverage until we find a way to control health care costs that have driven up the cost of insurance coverage for families, employers, and governments alike.

While I agree that our health care system is broken and in need of major reform, the bill we are about to consider falls far short when it comes to reining in health care costs. This is a critical issue because the high cost of health care is the biggest barrier for those who lack insurance. The high cost of health care is what is driving up the cost of insurance premiums, causing many middle-income families and small businesses to struggle to meet these rising costs.

I am concerned that this bill takes us in the wrong direction and that it will actually drive up costs and reduce choices for many middle-income Americans and small businesses.

Health care reform should give Americans more, not fewer, choices of affordable health insurance options. Under this bill, many Americans will be required to purchase health insurance that is more expensive, not less expensive, than the coverage they currently have.

Under the majority leader's bill, all individual and small group policies sold in our country must fit into one of four categories: bronze, silver, gold, or platinum, and they must have an actuarial value of at least 60 percent. Post reform—if this bill becomes law—it will be illegal to issue new policies in the individual or small group markets that do not meet those standards.

Moreover, unless they are grandfathered, most Americans who are not enrolled in at least a bronze plan will face a new $750 fine.

Let's look at what this means. In my home State of Maine, 87.5 percent of

those purchasing coverage in the individual market today have policies with an actuarial value of less than 60 percent. In other words, they have policies that do not qualify under the standards that would be established by this bill.

The most popular individual market policy sold in Maine costs a 40-year-old about $185 a month. Under Senator REID's bill, that 40-year-old would have to pay at least $420 a month, more than twice as much, for a policy that would meet the new minimum standard, or pay the $750 penalty.

I believe Americans should have the choice to purchase more affordable coverage if that is what works best for them. Health care reform should be about expanding affordable choices, not constricting them. It should not be about forcing millions of Americans to buy coverage that is richer than they want, need, or can afford. Yet under this bill, even an individual who does not qualify for any taxpayer assistance, for any subsidy, would have to buy a prescribed plan rather than, for example, a low-cost, high-deductible policy that, when combined with a health savings account, may best meet his needs.

Moreover, the very tight rating bands in this bill will increase costs for young people.

Why does that matter, when we are trying to expand coverage for those who are uninsured? For this reason: More than 40 percent of uninsured Americans are between the ages of 18 and 34. Extreme price increases for the young and healthy will simply force them out of the market because most young people, I fear, will just do the math. They will decide to pay the new $750-a-year fine, rather than paying $5,000 a year or more for health insurance. This is particularly true because under the bill, if they do get sick later, they can still buy insurance with no penalty, no increased cost. That is why the National Association of Insurance Commissioners—keep in mind, this is the association of State officials which regulates insurance; these are public officials—according to the NAIC, these provisions will lead to severe adverse selection that will drive up the cost of premiums for everyone else who is in the insurance pool.

Proponents of this legislation contend that the subsidies included in the bill for low- and moderate-income Americans will compensate for any premium increases. Let's take a look at that. First of all, it is important to know that the subsidies do not go into effect until the year 2014 yet a lot of the taxes which I am going to discuss later, which are also going to drive up the cost of premiums, go into effect next year. So that is a problem as well.

Moreover, these subsidies are going to be available, it is estimated, to fewer than 8 percent of Americans. Moreover, if you receive your health insurance from your employer, as the vast majority of Americans now do, you are not eligible for a subsidy under this plan. But your premiums are still going to go up because of the increased taxes and fees imposed by the bill.

When Americans understandably are so upset about the high cost of health care, and when health insurance premiums are going up by double digits, making it so difficult for most Americans to afford health insurance, the last thing we should be doing is to make the situation worse. I can't help but think of the Hippocratic Oath, "do no harm." Should not that be our first rule?

Americans who are already shouldering the burden of too high health care costs would hardly consider a bill to be "reform" if it drives those costs up further. Yet I fear that is exactly what will happen if this bill becomes law as written.

In light of this, I think it is a legitimate question to ask whether this bill may actually increase the number of uninsured Americans by driving up the cost of health insurance for years before the subsidies go into effect?

Let me take a further look at some of the increased taxes that are in this bill. Americans will face at least a dozen new or increased taxes and fees amounting to $73 billion before the subsidies go into effect in 2014. What kind of new taxes are we talking about? This chart shows just some of the taxes that will hit Americans when the bill goes into effect—and there are many more. Here are a few.

There is a tax on pharmaceutical manufacturers, a tax on health insurance providers, a tax on medical devices. Think of what we are talking about taxing here: We are talking about insulin pumps, artificial hips and knees, stents put into hearts—all sorts of medical devices. If a new fee is put on these devices, that is going to be passed on to consumers and reflected in insurance premiums.

All in all, as I mentioned, these taxes will cost $73 billion before 2014. These taxes will be paid right away by Americans in the form of higher health insurance premiums. That is not just my opinion, that is the view of the Congressional Budget Office, which evaluated the impact of several of these taxes. For example, here is what the CBO said about the $6.7 billion increased tax on insurers:

> We expect a very large portion of the proposed insurance industry fee to be borne by purchasers of insurance in the form of higher premiums.

The problem is, the way these taxes are structured, they are going to be passed on to consumers, and it is not only the taxes on insurers that will be passed on. Here is what the CBO Director said about new fees on the pharmaceutical industry and also on medical devices. The CBO said:

> Those fees would increase costs for the affected firms, which would be passed on to purchasers and would ultimately raise insurance premiums by a corresponding amount.

The Joint Committee on Taxation looked at the tax on the so-called Cadillac plans, the 40-percent excise tax. Here is what it said:

> As insurers pass along the cost to consumers by increasing the price, the cost of employer-provided insurance will increase.

I do not believe that the American people have sent us to Washington to raise their taxes and call it health reform—especially now, in the midst of a recession, with unemployment above 10 percent.

This leads me to another point. I am so concerned about the impact of this bill on our small businesses. They are the job creators in our economy, and the rising cost of health care has been particularly burdensome for them. A small business owner in Maine recently e-mailed me to say the following:

> I just received our renewal proposals for our small business. The plans are all up anywhere from 12 to 32 percent on the three plans that we offer. . . . You are right when you say we need to address the cost of health insurance, not create another vehicle to deliver the services. The current legislation, as I understand it, totally misses the mark.

How does this bill help small business? On balance, it doesn't. That, again, is not just my opinion; that is the opinion of our Nation's largest small business group, the NFIB. In a statement on the bill released yesterday, the NFIB said:

> This kind of reform is not what we need. New taxes . . . new mandates . . . new entitlement programs . . . paid for on the backs of small business.

In fact, NFIB described the bill as "a disaster."

I ask unanimous consent a copy of the NFIB statement be printed in the RECORD.

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

[From NFIB—Small Business News, Nov. 19, 2009]

SENATE BILL FAILS SMALL BUSINESS

(By Stephanie Cathcart)

WASHINGTON, DC.—Susan Eckerly, senior vice president of the National Federation of Independent Business, the nation's leading small business association, issued the following statement in reaction to the Patient Protection and Affordable Care Act:

"Small business can't support a proposal that does not address their No. 1 problem: the unsustainable cost of healthcare. With unemployment at a 26-year high and small business owners struggling to simply keep their doors open, this kind of reform is not what we need to encourage small businesses to thrive.

"We oppose the Patient Protection and Affordable Care Act due to the amount of new taxes, the creation of new mandates, and the establishment of new entitlement programs. There is no doubt all these burdens will be paid for on the backs of small business. It's clear to us that, at the end of the day, the costs to small business more than outweigh the benefits they may have realized.

''Small businesses have been clear about their needs in health reform; they have been working for solutions for more than two decades. They have a unique place in this debate because of the exceptional challenges they face. They experience the most volatile premium increases, are the most cost-shifted market, see the most tax increases and have the least competitive marketplace. For all these reasons, they especially need reform, but these reforms can't add to their cost of doing business. The impact from these new taxes, a rich benefit package that is more costly than what they can afford today, a new government entitlement program, and a hard employer mandate equals disaster for small business.

''We are disappointed that, after so many months of discussion, small business could be left with the status quo or something even worse. Unless extreme measures are taken to reverse the course Congress is on, small business will have no choice but to hope for another chance at real reform down the road.

''Congress is running out of opportunities to prove to small business that they are serious about helping our nation's job creators. We are hopeful that a robust bipartisan debate will produce a bill that small businesses see as a solution and not another government burden.''

Ms. COLLINS. Mr. President, there are some provisions in the bill that are intended to try to help small business but again they miss the mark. I support and have long proposed the idea of tax credits for small businesses to help them afford to provide health insurance for their employees. But the credits for small businesses in this bill are poorly structured. Only businesses with no more than 10 workers, paid an average of $20,000, can get the full tax credit. So if a small business hires additional employees or pays more, its credit begins to decline and it is eventually phased out. Businesses with more than 25 workers, or paying average wages of above $40,000 get no tax credit whatsoever.

Take a look at this. I realize this chart is a bit busy, but stay with me. Under the Finance Committee bill, if you have 10 employees and you pay them on average $20,000, you get a 50-percent tax credit applied to the cost of the insurance. But if you give them a raise, the tax credit begins to decline. For example, if you have 10 employees and you pay them $25,000 on average, you only get a tax credit of 38 percent.

Let's say you are trying to improve their quality of living. They have done a great job for you, so you give all your employees a raise, bringing their average wage to $30,000. Now the tax credit is only half as much as when you paid them $20,000.

If you pay them $40,000 on average—zero. You lose the tax credit altogether.

What we have here is a tax credit that is structured in such a way that it discourages small businesses from adding employees and paying them better. That doesn't make any sense at all. That makes no sense at all.

This legislation would have enormous consequences for our economy and for our society. We have to remember that this bill would affect every single American, every small and large employer, every health care provider. It affects 17 percent of our economy.

There are many reforms, such as allowing small businesses to pool together to have better bargaining clout, that I support and that have strong bipartisan support, that could have been the basis for further debate and amendments. So it disappoints me greatly that we are about to proceed to a divisive, partisan bill. I continue to believe that the American people would be better served by a bipartisan bill that brings together the best ideas on both sides of the aisle, and I pledge to continue to work with Members on both sides of the aisle to develop alternatives that will bring about true health care reform.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. BARRASSO. Mr. President, I find it fascinating, listening to the comments from the Senator from Maine. Maine and Wyoming are similar in a number of ways. One is that the engine that drives our economy is small businesses. What we heard is that this bill right here, this large bill which is the bill the Senate is considering right now, over 2,000 pages—underneath it is the bill that passed the House—I hear these are actually going to penalize the small businesses of Maine and the small businesses of Wyoming when those businesses try to hire another employee.

We are looking at 10.2 percent unemployment right now. People in our States are well aware of those numbers. I don't know if that number is being neglected by others, but for small businesses trying to hire people, this health care bill makes it much tougher. It will certainly make it tougher for them to provide insurance, and it will make it tougher for those small businesses to give raises to people.

It is, indeed, unfortunate that we are here in the Senate Chamber looking at a bill that is going to raise premiums for the American people who have insurance and who like the insurance they have. Their big concern isn't cost. We are looking at a bill that is going to cut Medicare for seniors who depend on Medicare, and the numbers are huge, almost $500 billion. And we are looking at a bill that is going to raise taxes on the American people.

I heard the Senator from Maine, and she can jump in and correct me if I am wrong. What I heard her say is that it is not just a tax on the rich; it is a tax on people all across the board because the taxes are going to be passed on. I see the Senator nodding her head in the affirmative. When taxes are raised on medical devices or on medication, on one thing after another after another, those are costs that will get passed on to all the consumers of health care.

Right before this party took the floor, we had the senior Senator from Minnesota talking about the Mayo Clinic and the wonderful care that is given there. It is wonderful care. But the Mayo Clinic has also said they don't want any part of this bill, nothing to do with it, to the point that they have sent doctors in my home State and States surrounding the Mayo Clinic who refer patients—and I practiced medicine in Wyoming for 25 years, have taken care of families there as a physician, and we sent patients to the Mayo Clinic—they just said: Stop sending patients on Medicare or Medicaid. We want nothing to do with it because the government is the biggest deadbeat payer. The Mayo Clinic said: Every time we get one of those patients, we have to charge the people who pay their own way, the people who have insurance. We have to charge them more. We don't want to take any more patients on Medicare and Medicaid. Hospitals and the communities in Maine, South Dakota, and Nevada, hospitals in those States have to take all those patients.

So what happens to people who pay their own way because they buy insurance themselves or they get it through work is the hospitals have to charge them more to make up for the biggest deadbeat payer of all time—the Federal Government.

I see the Senator from Nevada rising to his feet. I imagine the exact same thing is happening to hospitals in Nevada. Premiums are going up on the 85 percent of the people who have insurance they like. Yet we in the Senate tomorrow night are going to vote on a bill which, to me, the people of America don't like. Do you know who doesn't like it the most? Seniors. They are concerned. They know Medicare is going broke. And by the year 2017, there will be $500 billion of cuts in Medicare. Yet the money that is being cut from Medicare isn't being used to save Medicare; it is to start a whole new program that will cause Americans who have insurance to pay more. It will cause people who don't have any insurance to make it harder to get or if they go to an emergency room and have to pay a bill, that bill will be higher, all because of what I believe is an irresponsible piece of legislation that is going to be a huge weight on the American economy at a time when we have 10.2 percent unemployment.

I see the Senator from Nevada. He has a similar copy of the bills next to him. He may want to chime in on what he sees in his home State and what he is hearing from people who live in Nevada, from small businesses as well as hospitals and providers.

Mr. ENSIGN. Mr. President, these pieces of legislation were put on our

desks to show the American people what we are dealing with. We have only just started going through these bills. Already we have found major problems with the legislation.

What we are going to talk about over the next few minutes is the premium increases for the American people. If you have insurance now, your premiums are going to go up because of this legislation we have before us. Probably in other ways we don't even know about yet, we will discover in the future, but we at least know some ways that are going to cause the premiums to go up.

Let me first talk generally about the bill and what some of the problems are and just briefly on some alternative ideas Republicans have come up with in more of a step-by-step type approach.

We know this bill cuts Medicare by $465 billion, including $118 billion in Medicare Advantage cuts. That means millions of seniors who are on Medicare Advantage today will lose the plan they have. Medicare Advantage plans in my State are incredibly popular among senior citizens. I know they are across the country. We know taxes are going to go up by almost $500 billion. We know premiums are going to go up for millions of Americans.

This bill was supposed to bend the cost curve. Because it is actually deficit neutral, maybe it helps the deficit a little bit because of the smoke and mirrors they play with it. They say that bends the cost curve, but when we look at the American people and the actual cost they will be paying for health care, their cost curve continues to go up and up and up into the future.

This bill will also lead to rationing. We saw this week a Federal board that talked about mammograms, and it caused an outrage in women across America. That is the sort of thing that is going to happen because of this legislation. Federal bureaucrats are going to be in charge of your health care, not your doctor and you. We need to have legislation that focuses on that doctor-patient relationship that should be so sacred in our health care system today.

Republicans have come up with the idea of medical liability reform to start driving down the cost of all of this defensive medicine that is practiced. We all know doctors order all kinds of unnecessary tests to prevent themselves from being sued in all these frivolous lawsuits.

Both sides agree, let's eliminate the preexisting conditions. That is kind of a given. That is something on which we all agree. That is part of the step-by-step approach this side of the aisle would certainly be willing to do.

I also believe we need to encourage healthier behavior in America because 75 percent of all health care costs are because of people's behavioral choices—smoking, people who are overweight. We know obesity contributes to every kind of cancer, to heart disease, diabetes. It is epidemic in this country. Look at our young people. If we don't turn around people's behavior, get them to exercise more, eat right, quit smoking, I don't care what health care reform you pass, we are not going to do anything about driving down the cost. And the high cost of health care is the No. 1 problem with our system.

We believe we should have small business health plans where small businesses can join together to buy health insurance, take advantage of purchasing power that larger businesses have. We believe individuals should be able to buy across State lines the way you do with car insurance. If your State is too high on insurance, buy it in another State where it is cheaper, where maybe they don't have as many mandates. Doesn't that make sense?

We also believe we should have transparency on cost and quality. When you walk into your doctor's office, you should be able to get a written estimate of what it is going to cost. You should be able to shop that estimate so that we have more consumers making more intelligent choices on health care. When was the last time you went into your doctor's office and got a written estimate or knew how much something was going to cost? I practiced veterinary medicine for many years. When you walk into my practice, you get a written estimate. We have you sign that written estimate because we have to give that. That is part of our general practice. We need to bring that into human medicine, whether it is hospitals or doctors' practices. We need to have transparency for cost and quality.

How does this bill drive up premiums for Americans?

First, there are nine new taxes put in by the Democratic majority: a 40-percent insurance plan tax for what are called Cadillac plans; another tax on insurance companies; an employer tax; a drug tax; a lab tax; a medical device tax; a failure to buy insurance tax; a cosmetic surgery tax, brand new in this bill; and also an increased employee Medicare tax, a brandnew tax structure on Medicare taxes. Who pays for these kinds of taxes? It isn't just insurance. On the failure to buy insurance, 71 percent of that tax is going to be paid for by people who make less than $120,000 a year.

Almost every one of the taxes I just put up of those nine new taxes—the vast majority of them are paid by people who President Obama, when he was campaigning, said would not pay one dime more in new taxes. He repeated that promise time after time. He said: No new fees, no new taxes, capital gains. He went through the whole litany of types of taxes that would not be raised. Yet in this plan approximately 80 percent of all of the new taxes are paid by people making less than $250,000 a year.

Another way this massive piece of legislation raises premiums is this thing known as cost-shifting. The doctor from Wyoming practiced medicine. He was talking about the Mayo Clinic and why the Mayo Clinic, the Cleveland Clinic, and other places and other doctors don't want to take Medicaid and Medicare patients anymore. Why? Because the government pays 20 to 30 percent less than private health insurance in reimbursement to doctors; isn't that correct?

Mr. BARRASSO. Plus, when you read this bill, one of their so-called solutions is they will put more people on the Medicaid rolls.

Mr. ENSIGN. How many more people are going to go on the Medicaid rolls?

Mr. BARRASSO. It is millions and millions of people, with the cost to the States. You say we will take it out of here. You won't see it in this bill because they are going to make the States pay over $20 billion in money because it is a matching program, so they get it off the Washington books. But it is still the taxpayers and the States, and we all come from States. That is going to drive up the cost for individuals as well as increase taxes around the country.

Mr. ENSIGN. Because you were in the practice of medicine, I ask the Senator from Wyoming, I have heard numbers as high as 15 million new people on Medicaid, plus we have a new public option, so there will be more people on another government plan. What will happen as far as cost shifting to those of us who have private insurance? For those tens of millions of Americans who have private health insurance, what will happen to their cost of insurance when more people are on government plans?

Mr. BARRASSO. Those costs will have to go up. Premiums will go up for all people who have insurance, private insurance. The Senator from Nevada is correct. Some people think the number is 15 million more who will go onto the Medicaid rolls because there is a difference between the Senate bill and the House bill as to how many more folks they move onto the Medicaid rolls. But either way, we are talking tens and tens of billions of dollars that will come out of the taxpayers' pockets around the States. But that is still for a government-run program that doesn't reimburse, doesn't pay the hospitals, doesn't pay the doctors even what the cost of delivering the care is.

Across the board, hospitals will tell you they cannot keep their doors open if everyone is paid at Medicaid or Medicare rates. The only way they can pay the nurses, keep the lights on, take the food in the trays around to the patients, do all the things a hospital has to do, or keep a doctor's office open, the only way they can do it is because

they charge more to people who have private insurance than they get paid for people on Medicare or Medicaid. And Medicaid is worse than Medicare in terms of the payment.

So it is this cost shifting that occurs. Who pays that? The people who have regular insurance. It is the hard-working men and women of America through their jobs who pay for that. We just heard from the Senator from Maine. Anytime we try to help that individual—I see the Senator from South Dakota is in the Chamber as well, and he may want to jump in as well because South Dakota is a State like mine where we have lots of small businesses that are going to be hit specifically hard as they try to continue to provide insurance. This does not even allow small businesses to group together to get better deals.

The Senator from Nevada talked about buying insurance across State lines to help people get the costs down. This bill prevents that. It also prevents small business groups from getting together, which would be a great help.

I know the Senator from South Dakota is interested in getting into the discussion. I invite him to discuss this very aspect and the impact of all these increasing premiums on the folks in his State.

Mr. THUNE. Mr. President, Wyoming is not a lot unlike the States of South Dakota or Nevada, as the Senator knows, although they have a few larger businesses in Nevada. But the people who get hit hardest under this bill are small businesses.

We heard the Senator from Maine, Ms. COLLINS, point out the impacts on small businesses. The ironic thing about that is a lot of small businesses, where you would want to encourage them to offer health insurance to their employees, will be discouraged from doing so under this bill. In fact, what most of them are probably going to do is pay the $750 penalty and then push everybody off into the government plan.

The assumption that is being made in here is that the government plan—it will grow over time, obviously. I think 5 million people will lose their private insurance, according to CBO. My guess is that number is going to be much higher because I think what is going to happen is small businesses that are impacted the most by these tax increases are going to find themselves less and less able to provide health insurance coverage to their employees.

The other thing I want to point out, as to what my colleagues from Wyoming and Nevada have said, is that I would be somewhat, I guess, interested in what is being proposed by the other side if it did anything to impact cost. But it does not. The whole purpose of this exercise, at least in the minds of most Americans, is to drive the cost curve down. I heard my colleagues on the other side get up and talk about, well, their plan is going to decrease costs for people in this country.

Well, here is the cost curve, as shown on this chart. The blue represents the cost curve; that is, what would happen if we do nothing. That is the expected increase in health care costs in this country if we do nothing.

What is ironic is, the red represents what happens under this bill. So instead of bending the cost curve down, it actually increases the cost curve. So we are going to spend $160 billion more on health care in this country by enacting this bill, this monstrosity of a bill right here, which, as my colleagues have pointed out, is 2,074 pages. The Senators from Nevada and Wyoming both also have the House version, which is 2,200 pages. But look at this thing. You would think somewhere in here, in all this volume of paper, there would be a way to actually do something to actually bend the cost curve down. But all that represents more spending.

In fact, if you look at the amount of spending in the bill when it is fully implemented, it is much more than what the CBO estimated it would cost. There was all the publicity when they unveiled this health care plan a couple days ago that it is going to be under $1 trillion. Well, in fact, we all know they have used a lot of accounting gimmicks, a lot of scoring tricks, a lot of ways to obscure the true cost. In fact, even in the first 10 years it understates the cost, which is over $1 trillion. But the 10-year fully implemented cost of this bill is $2.5 trillion—a $2.5 trillion expansion in the size of the Federal Government.

If you look at how that plays out and how it is paid for over the fully implemented phase—we all talked about $½ trillion in Medicare cuts. For 10 years, fully implemented, it is over $1 trillion they have to cut Medicare to pay for this thing, and then to raise taxes by another $1 trillion. So you are talking about not only cutting Medicare to senior citizens, as the Senators have talked about, but also raising taxes substantially on small businesses. But at the end of the day, after all is said and done, what do you end up with? You end up with an increase in cost above and beyond what we would see if we did nothing. Tell me how you can call that reform.

The other point I will make before I yield back to my colleagues is, if you are someone who already has insurance—and 182 million people in this country have insurance—you are not going to be able to participate in the exchange.

You get no more options out of this. There are 19 million Americans who would, perhaps, benefit from being part of an exchange. But if you are one of the 182 million people in this country who currently have insurance, you cannot get into an exchange and you cannot get any subsidy. What you get are big fat tax increases and increases in your insurance premiums, for all the reasons that have been mentioned. Because when you tax the health insurance companies—as this bill does—when you tax the medical device manufacturers—as this bill does—when you tax the pharmaceutical companies—as this bill does—and create all new kinds of mandates on insurance companies, including changing these age band ratings, going to a 3-to-1 age band rating, you are going to raise premiums for a lot of people in this country, and you are going to raise them the most for people who are age 18 to 34. The people who are age 18 to 34 do not realize what is coming at them today, but it is about a 69-percent increase in their insurance premiums. They are the ones who get stuck the hardest.

But if you are any of these 182 million people, your taxes are going to go up, your insurance premiums are going to go up, and you are not going to see any benefit from being able to participate in any sort of an exchange. These are the cold, hard facts.

I have heard countless Democratic colleagues come down here and talk about bending the cost curve down and reducing premiums for people in this country. As shown on this chart, this is the Congressional Budget Office number. This is not anything the Republicans put together. This is the CBO cost estimate of what it would do to the cost curve. As I said before, the red represents the increase: a $160 billion increase in health care spending over 10 years—all of which is going to be borne by those 182 million Americans in this country who already have insurance.

Mr. ENSIGN. If the Senator from South Dakota would yield, I wish to get your comments—maybe from both of my colleagues—on a couple of quotes from the Congressional Budget Office as well as the Joint Committee on Taxation dealing with these premium increases and who is actually going to bear the taxes. Because a lot of people think that: Well, let's tax the insurance companies. Let's tax the medical device companies. Let's tax somebody else. Well, this is what the Congressional Budget Office says. Let me read a couple quotes. One quote is:

> Although the surcharges would be imposed on the firms, workers in those firms would ultimately bear the burden of those fees, just as they would with pay-or-play requirements. . . . Many of those workers are more likely to have earnings at or near the minimum wage.

So it is the low-income people who are going to end up paying when you actually put some of these taxes that we have talked about in.

Here is another quote from the Congressional Budget Office. Let's remind folks, the Congressional Budget Office is nonpartisan. It is not Republican,

not Democratic. They are kind of the objective scorekeeper around here. They say, these taxes ''would increase costs for the affected firms, which would be passed on to purchasers and would ultimately raise insurance premiums by a corresponding amount.''

The last economic quote is this. This is by the Joint Tax Committee:

Generally, we expect the insurer to pass along the cost of the excise tax to consumers by increasing the price of health coverage.

I say to the Senator, this is what you are talking about on that other chart you have up. I wish to hear your comments on that.

Mr. THUNE. Well, the Senator is absolutely right. I think what the CBO has pointed out is—and I have the Joint Tax Committee there; the data they produced is very similar to what CBO said—84 percent of the tax burden is going to fall on people making less than $200,000 a year. And half of the families making under $100,000 a year are going to get hit with new taxes under this bill. So it is going to fall on those people in this country. And I think they like to think they are taxing medical device manufacturers and everybody else, but at the end of the day, a lot of this gets passed on. And the taxes in the bill, the premium increases in the bill, are all going to be borne by the people who are probably least able to absorb that and take that, and it is going to be the people in the lower income categories.

So the Senator from Nevada is absolutely right. I again come back to the basic premise of this whole purpose of health care reform, which should be to get health care costs down, not raise them. The Senator from Wyoming has alluded to a number of things we believe would do that, that actually do put downward pressure on health care costs in this country. It is done in a step-by-step way. It is done in a way that does not call for throwing out everything that is good about the health care system in this country, creating this massive new expansion of the Federal Government here in Washington, DC, with $2.5 trillion in costs over a 10-year period when it is fully implemented.

And probably—who knows—if a lot of these things do not happen, if the tax increases, for some reason, do not happen, if the Medicare cuts do not occur, it means borrowing from future generations. They talk about reducing the deficit by $130 billion only because they did not include the physician fee fix in this, only because they added $72 billion in revenue from something called the CLASS Act, which we know is never going to become law—and even if it does, it is a huge money loser in the outyears.

So you have all these things that they did, including delaying the implementation date by 5 years so it understates the true cost of this thing—all these things that have been done to try to make this turkey look like something other than what it is, which is a massive increase in spending, massive tax increases on the American people, and increased premiums for Americans, particularly those 182 million Americans who already have health insurance who are going to get hit the hardest by this.

Mr. ENSIGN. Maybe we could have the Senator from Wyoming comment. One of the big things Republicans have been talking about—instead of driving premiums up, which this bill does—is driving premiums down. Maybe the Senator can discuss medical liability reform, which the Congressional Budget Office, which is a very conservative estimate, has said would save about $100 billion in medical costs in this country.

As a practicing physician, maybe the Senator could talk about the unnecessary tests that are ordered, the huge increases in medical liability insurance costs that physicians face today.

Mr. BARRASSO. Mr. President, if you do a poll of doctors, with the question: Have you ever ordered a test that was not going to help that person get better, that patient get better, but you were doing it because you did not want to miss something for fear of a malpractice suit, every hand will go up of every physician. The Massachusetts Medical Society did a poll and 87 percent of doctors said that. Massachusetts has their new health care plan.

As an aside, the dean of the Harvard Medical School had an editorial in one of the major national publications this week, and he gave this whole thing—he said: I give this whole thing a failing grade. He said people who support this—the legislation that is being proposed—are engaged in collective denial. We need to do some things that will help with cost, with access, with quality. All this bill is going to do is drive up the cost, with no improvement at all in quality.

So there are step-by-step things we can do: letting people buy insurance across State lines, getting the same tax breaks as others. The Senator talked about helping people stay healthy—exercising, getting down the cost of their care by getting their cholesterol down.

But also you have to deal with lawsuit abuse. It is out there. You could do a thing as easy as loser pays. Obviously, there are great objections to trying to do that. There are people who would oppose that all the way. But it would help eliminate—eliminate—a lot of the unnecessary tests and certainly a lot of the costs of the system. Because two-thirds of the cost of that whole liability system goes to the system, it does not even go to the injured person. If somebody is injured, you want to take care of them. But this does not do it at all.

One of the things the Senator from South Dakota mentioned, fairly quickly in passing, was age band ratings, which flies in the face of the things we have been talking about: individual responsibility, opportunities for people to stay healthy. The big problem is that we know 50 percent of all the money we spend on health care on this country is on 5 percent of the people—the people who eat too much, exercise too little, and smoke. But yet under this government-forced insurance, where people are going to be forced to buy insurance—and if young people do not buy it, they are going to be listed as either tax cheats or criminals because they are going to get fined or they are going to get taxed an amount for not buying the insurance—they are going to have to buy insurance.

As the Senator from South Dakota talked about a 3-to-1 ratio—and the Senator from Maine mentioned the same thing—what that means is for the youngest, healthiest person buying insurance—that kid out of college who is staying healthy or might be working construction, who is in good shape, going to the gym—what they are doing on a 3-to-1 ratio is that person has to pay a lot of insurance compared to the person who does eat too much, exercises too little, and smokes. The ratio of their insurance premiums—this person can pay no less than one-third of what this person pays, when you might have 100 young people where their total health care bills for a year would be equal to that one person who exercises too little, eats too much, and smokes.

So these young people are going to end up paying the cost. And it is their premiums—and I think we heard that from the Senator from South Dakota—their premiums are going to go up—did I hear 69 percent?

Mr. THUNE. Mr. President, 69 percent. If you are 18 to 34, that is what you are looking at in the form of premium increases, not to mention the fact that future generations are going to deal with all of the debt we continue to pile on them, which I think bears heavily on this debate right now, when you are looking at trillion-dollar deficits as far as the eye can see. This is not a good deal if you are a young person in America.

Mr. BARRASSO. It is the wrong prescription for America.

I am going to continue to speak on the floor about the things that I think are problems with this bill. I think it is the wrong approach. I think it costs way too much. I think it raises taxes on all Americans. It cuts Medicare. What we have heard now, and what we know for sure, is it is going to raise premiums for people who have insurance, who like the insurance they have, who want to keep the insurance they have; and their costs are going to continue to go up if this becomes law, at a rate faster than, as we saw from the graph, if nothing was passed at all.

The PRESIDING OFFICER (Mr. BENNET). The time has expired.

The Senator from California.

Mrs. BOXER. Mr. President, what is the order?

The PRESIDING OFFICER. The Democrats control the next hour.

Mrs. BOXER. Thank you very much, Mr. President.

I have listened to several of my Republican colleagues and I wish to note that they have the bill in front of them and they are attacking this health care bill, but nowhere on their desks do we see their bill. They have no answers, no solutions.

Mr. THUNE. Will the Senator from California yield?

Mrs. BOXER. I can't yield.

They have no solutions at all on an issue that affects every single American.

What we have before us is the Reid bill which I think is an excellent piece of legislation that will make life better for every single American. I will spell that out in the course of my remarks.

We all know change isn't easy. It is easy to come down here and demagog and pound your fists and complain. It is human nature to resist change. But every once in a while a situation cries out for change, and that is the case today with our health care system.

The status quo is not benign. It is hurting our people. I wish to share the story of Nikki White as brought to us in the book ''The Healing of America'' by T.R. Reid. He talks about Nikki in the prologue where he poses it as a moral question: What we do about health care? This is what he writes:

If Nikki White had been a resident of any other rich country, she would be alive today. Around the time she graduated from college, Nikki White contracted Lupus. That is a serious disease, but one that modern medicine knows how to manage. If this bright, feisty, dazzling young woman had lived in say, Japan, the world's second richest Nation, or Germany, the third richest, or Britain, France, Italy, Spain, Canada, et cetera, the health care systems there would have given her the standard treatment for Lupus and she could have lived a normal life span. But Nikki White was a citizen of the world's richest country—the United States of America. Once she was sick, she couldn't get health insurance. Like tens of millions of her fellow Americans, she had too much money to qualify for health care under welfare, but too little money to pay for the drugs and the doctors she needed to stay alive. She spent the last months of her life frantically writing letters and filling out forms pleading for help. When she died, Nikki White was 32 years old.

That is a story that should move every one of us, move every one of us to action.

Look, we have spent years studying and analyzing what is working in our health care system and what is not working. What it comes down to is this: Too many of our fellow citizens are suffering because of the broken promises of a health insurance system that abandoned them when they needed it the most. Too many cannot afford health insurance. Too many are getting sick after praying to God that they wouldn't because they knew that sickness could leave them in economic ruin. Praying is not a health care insurance plan.

Americans will spend over $2.5 trillion on health care next year; $2.5 trillion. In all, we spend twice as much per person on health care as other advanced nations. Yet, the United States of America, out great Nation, ranks near the bottom of the 30 leading industrialized nations in basic measures of health, such as infant mortality rate and life expectancy—the bottom of the list. That is where we are. So we spend twice as much and the results are not anywhere near where they should be. It is clear why. Too many people don't have affordable health insurance, and they wait too long before they get the help they need. Or, they are like Nikki and they never get the help they need.

Health care premiums have more than doubled in the last 9 years—more than doubled in the last 9 years—and one respected nonpartisan study says if we fail to act, the average American family will have to spend 45 percent of their income on health insurance premiums alone, and that is by 2016. By 2016, 45 percent of their income, the average family, by 2016, if we do nothing. My friends on the other side stand there with the bill and downgrade what we are doing and never address that issue.

It is time for change. When we know that two-thirds of all bankruptcies are due to a health care crisis, it is time for change. When we know that every day—every day—another 14,000 Americans lose their health care coverage, that tells me it is time for change.

I know there are many people listening who think the uninsured are not their problem, that it doesn't affect their health care. They are flat wrong. Right now, every one of us with insurance is paying $1,100 a year—each of our families—for those who are uninsured. Why? Because we have to pay for the emergency room services they get when they are rushed into the hospital because they have neglected a health care problem and it is very expensive, and we are paying for it. That tells me it is time for change.

When family after family tells us they paid for insurance for years, but when they had a crisis their insurance company walked away from them—in T.R. Reid's book, we learn about a man who paid all his life for insurance and he got struck by an automobile and he was in the hospital with a terrible situation, and the insurance company knew it was going to cost them a lot. You know what they did? They rescinded his insurance. They told him that he weighed more than he should have, and they walked away from him. Story after story. Good, hard-working people unable to get health insurance, knowing that their future is dark. It is time for a change.

Today, I want to say to America's families: Change is definitely on the way. It won't be easy. It is going to be tough. But all these things I have said are truths. Everybody here has to be moved by that. I believe we will finally bring change. I am hopeful. I am hopeful because of the work of so many of our colleagues and the work of Senator HARRY REID. He has put a bill before us that, as I said, will make life better for every single American. It is called the Patient Protection and Affordable Care Act. First and foremost, if you have health insurance you like, this bill gives you the security of knowing it will be there for you when you need it. And if you don't have health insurance, you will be able to get affordable coverage through a new exchange which includes the public option.

Ultimately, under this bill, we are expanding health care to cover more than 94 percent of the American people, and all the while we are cutting the Federal deficit by an estimated $130 billion over 10 years, because there are real savings and real revenues in this bill to offset the new important programs.

When this bill is signed into law, America's families will see immediate improvements to their health care. They won't have to wait.

For example, right away, when President Obama signs this bill, your insurance company won't be able to kick you off your plan for some made-up reason because they no longer want to cover you. They will no longer be able to cap your coverage. I can't tell my colleagues how many people think they are safe because they had a $500,000 cap on their insurance. They never dreamed they would use it up. But one difficult and terrible illness can use it up, and then they are out of luck. No more rescissions, no more caps.

Parents will be able to keep their children on their health care policy up to the age of 26. Small businesses will have immediate access to tax credits to make covering their employees more affordable. And seniors will have a more generous benefit through their prescription drug coverage. We all hear about that doughnut hole that affects seniors as soon as they need to buy more pharmaceuticals. This will give them another $500 before they reach that point. Those are just a few of the immediate benefits of the Patient Protection and Affordable Care Act.

Here is a sample of other major provisions. This is a very important one. In this bill, no family of four making less than $88,200 a year will have to pay more than 9.8 percent of their income for health insurance premiums. Let me say that again. No family of four making less than $88,200 a year will have to

pay more than 9.8 percent of their income for health care premiums. So if you make anything between say the poverty rate all the way up to $88,200, you never have to pay more than 9.8 percent of your income for health care premiums, and if you are on the lower end, it is even less. It goes down to about 2 percent. So it ranges from 2 percent to 9.8 percent at $88,200. That means that more than 62 percent of all of our families will be able to be assured that they will not have to go broke to buy health insurance.

Remember what I said. A respected study has already stated that if we do nothing, by 2016 people will be paying 45 percent of their income on premiums. In this bill, we ensure that our middle class down to our working poor do not have to worry about those kinds of premium increases.

For the rest of our Nation's families who are more affluent, there is the security of knowing that the insurance company reforms in this bill are going to help you. The insurance company can't walk away from you. If you have a preexisting condition, they can't turn you down. If you have a child you want to keep on until age 26, you can. If you are a small business, you will get tax credits to help you pay for your employees. There are many other benefits, including some free prevention coverage that kicks in right away. So no more discrimination against those with a preexisting condition.

By the way, no longer will insurance companies be able to discriminate based on gender. Right now, women in my home State of California are paying almost 40 percent more for the same insurance as men. There is gender discrimination. That will end when this bill becomes law.

In this bill we increase competition, which is perhaps one of the most important things we can do to bring down costs to our families. We have the health care exchange which includes a public option that will compete on a level playing field with insurance companies to keep them honest. In other words, there will be a government option, but there won't be anything different about the government plan in terms of the way it negotiates with the insurance companies.

There has been a lot of shouting from my colleagues about the public option. Why shouldn't the American people have access to a public option?

I ask that question. I don't hear my Republican friends coming down to the floor and saying they are going to give up their public option. More than 90 percent of us have a public option right now—the Federal Employee Health Benefits Program. I don't see one of my colleagues who have been trashing the public option coming to the floor and saying I wish to get rid of mine. Oh, no. They like it. But they don't want it for the rest of the people. I don't understand it.

There are lots of public options we have here. Medicare is a public option, run by the government. I don't hear my Republican friends coming here and saying we should end Medicare. They used to say that. They don't say it anymore. Now they say they depend on it. It is a public option; 45 million Americans are covered by it. Not one of them said get rid of Medicare.

I don't hear any of my Republican friends coming to the floor saying we should get rid of another public option called Medicaid. That is for the poor. It works well. It is tough, and there are problems with it, but it works and it covers 60 million Americans. So you have 45 million Americans in a public option called Medicare, 60 million Americans in a public option called Medicaid.

How about the veterans health care program? I don't hear them pounding the table and saying get rid of the public option for our veterans. I will tell you, maybe they want to, but they would not say it because the veterans would be at their door because that public option covers 7.9 million veterans. Not one of my Republican colleagues say they want to end it.

I don't hear my Republican friends coming to the floor to say we should end our TRICARE program for our military. That is a public option for 9.5 million people. I don't hear them saying stop that public option.

Again, their own health care, brought to them by FEHBP, Federal Employees Health Benefits Program, that is a public option that covers 8 million people, including them, and they don't seem to want to end that. But when it comes to everybody else, they come down here and basically say: a government takeover of health care. False.

The public option is just one option in the exchange. It has to run by the rules of all the other insurance companies. I say if it is good enough for a Republican Member of the Senate and a Democratic Member of the Senate, a public option ought to be an option for the people whom we represent.

Small business needs help here. I don't know if everybody is aware of this, but small businesses pay as much as 18 percent more for the same health insurance as large businesses. In California, we have seen increased premiums to small businesses that have meant a choice between laying off employees or not providing health insurance at all. More and more of these businesses are dropping health care coverage. If you are in the position where you work for a small business, you don't have health care coverage, and you want to stay there, when this bill goes into effect, you can go into the exchange and then you will have some buying power or your small business can go into the exchange.

This bill will protect our seniors, and it will strengthen Medicare. Medicare is a success story. Before Medicare became law, half our senior citizens went without health insurance. Now, 98 percent of our seniors are covered by Medicare. They believe in the program and they want it to continue. Those of us supporting this bill want to make Medicare stronger, and we do. This bill will ensure a stronger, more sustainable Medicare Program. It lowers prescription drug costs, as I mentioned before. It increases access to preventive services for our seniors, and it extends the solvency of the Medicare Program by 4 to 5 years.

My Republican colleagues are standing here saying that Democrats want to hurt Medicare—by the way, Medicare is a public option. They are saying the Democrats want to hurt Medicare, a public option. Honestly, who could believe that?

In 1964, George H. W. Bush called Medicare ''socialized medicine.''

Newt Gingrich, when he was Speaker of the House, said he wanted to see Medicare ''wither on the vine.''

In 1995, while seeking the Republican nomination for President, Senator Bob Dole bragged that he voted against creating Medicare in 1965. He bragged about it and said: ''I was there fighting the fight, voting against Medicare . . . because we knew it wouldn't work in 1965.''

The Republicans are saying the Democrats want to destroy Medicare in this bill. That is beyond ridiculous. The American people know who is on their side when it comes to protecting Medicare. We didn't just wake up this morning. We know who brought us Medicare.

This bill expands Medicaid. That is for the poor to ensure that the poorest and sickest among us can get into the program. We are going to get those with incomes below 133 percent of the poverty level into the program. That means that more than 1.5 million Californians who are uninsured or are struggling with the cost of health care, that will allow them to be covered.

I thank the majority leader for working with us to ensure that California receives increased Federal support as we expand Medicaid. For the first 3 years of this expansion, the Federal Government will fully cover the cost of expanding Medicaid.

I talked a little bit about prevention. Today, only 4 cents of every $1 we spend on health care is on prevention. Yet more than half our people live with one or more chronic conditions.

Five chronic diseases—heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes—are responsible for more than two-thirds of the deaths in America.

This bill will eliminate copays and deductibles for preventive care so people don't get to that serious illness. Those preventive services go into effect immediately.

That is an overview of the Patient Protection and Affordable Care Act. My friends on the other side have already come out against this bill. They say it is too long, too complex. One of them said it is ''holy war.'' This bill will cause them to fight a ''holy war,'' for some reason. Where is their bill? They don't have one. After all the things we know are wrong with the system—and you don't have to agree with us on everything, but where is your bill?

It seems like my Republican friends care more about playing politics than about protecting our families. That is what it feels like. They seem to care more about bringing down our President than bringing down the cost of health care.

They seem to care more about all that than Tim and Josie Jentes, of Los Angeles, CA. Tim is retired from Raytheon. He gets his health care through his retirement plan. During 2007, the first year of his retirement, their monthly health care premium was $460. During 2008, it rose to $630. In 2009, it rose to $850. That is an 85-percent increase in 2 years for this retiree.

Tim wrote to me and said:

> I understand that compared to many we are fortunate to have good health care and insurance. But we look forward to you, Senator Boxer, the Senate, and the House . . . addressing the seemingly unbounded increase in health care cost.

We do it in this bill. People such as Tim will be protected. But my friends across the aisle say: No, we are not going to help Tim.

What about Madeleine Foote of Costa Mesa, California? She turned 25 and lost the health care coverage she had under her parents. She tried to get coverage, but because she is taking medicine, she was denied. They said it was a preexisting condition. They said you can have health care, but you have to have a $3,000 deductible and premiums of $300 a month. She wrote:

> As a young person working in a restaurant, repaying student loans and trying to make it on my own, this is a huge financial burden. I cannot afford insurance that charges me so much. . . . For now, I am forced to hope that nothing extremely bad befalls me.

She is another one who prays not to get sick. That is not a health care plan. My friends on the other side say: No, sorry, we are not going to help you, Madeleine.

I have so many other stories. There is Douglas Ingoldsby, a small business owner in Santa Barbara, CA. He has 11 employees, and soon he will not be able to afford to get them insurance anymore. He asked that I support a public option, and I do. My Republican colleagues are saying: Douglas, no, we are not going to help you. It goes on. The stories go on.

One of the stories is from a doctor, a retired pediatrician in Sacramento, Robert Meagher, who wrote and said that some parents begged him not to write on the form—after he saw a child with asthma, they asked: Please don't write down asthma. Say it was bronchitis. If you write down that my child has asthma, they will have a preexisting condition and when they go out on their own, they cannot get insurance.

Can you imagine a doctor having to face a parent like that? My Republican friends don't want to think about that. They seem to be thinking about politics and the next election.

We all know the bill before us isn't perfect. They should vote to start debate. They can try to make it better. There are many issues I am working on for California. There is the Disproportionate Share Hospital Program. I am working to get better prevention for women.

At the end of the day, this is where we are. Health care coverage for all of America's families has been an elusive goal since Teddy Roosevelt first proposed it nearly a century ago. Our dear friend, Senator Ted Kennedy, whom we miss so much, fought for health care right here on this Senate floor from the moment he arrived in the Senate in 1962 to the moment he died. Today, I am proud to say we are moving closer to fulfilling this promise of health care for all.

Robert Kennedy once said:

> Few will have the greatness to bend history itself; but each of us can work to change a small portion of events, and in the total of all those acts will be written the history of this generation.

This is our time. This is our moment. This is the moment for us to come together as a nation and make sure our people never again have to face what Nikki White faced in her last days—filling out forms, praying to God she could get health care, not being able to get it, and dying at age 32. That is immoral. It is not necessary. We can fix it, and we should.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

Mr. DORGAN. Mr. President, I note that this has been a lengthy discussion already. My guess is that because this is merely a motion to proceed to a subject on the floor of the Senate—my guess is that were this motion to be approved, we will have weeks on the floor of the Senate talking specifically about amendments, about approaches that will strengthen and improve some portions of the legislation that will be before us. The subject is health care.

Frankly, health care is personal to everybody—from senior citizens on Medicare to people who get their health care policy from their employment, to families who are struggling to pay for increasing costs of health care year after year. So the question before the Senate tomorrow evening is: Should we debate and vote on these matters? It is not should we approve a health care bill but should we proceed to the bill to have a discussion and have some amendments.

Health care has changed dramatically in a very short period of time. My background is from a town of 300 people. In my little town, as was the case many decades ago, we had a town doctor in a town of 300 people. It doesn't happen much anymore. We had a doctor, Doc Hill. He came when he was a young man, and he stayed until he died. He delivered probably 1,500 babies. They had a Doc Hill Day once, and all the babies he birthed came to march in the parade in my little hometown.

As times changed, medicine changed, things changed. Doc Hill used to go on house calls to the farms, yes, to deliver babies and to deal with illness, house calls all around the region. Times changed and those practices changed as well.

The big debates in the last half century or perhaps century about health care have, in most cases, advanced health care. I was not here, of course, nor were most of my colleagues—I guess a couple of them were perhaps here—during the debate on Medicare. I remember vividly as a very young boy the old folks in my hometown, some of whom had nothing, lived in little shacks, certainly had no health care, no health care coverage, because when you got old, back in those days, no insurance company wanted to cover you, even if you could pay for insurance. Nobody was chasing old folks to say: Now that you are 70, 80 years old, can't we sell you a health insurance policy? They couldn't find health insurance.

Half the senior citizens in this country couldn't get health insurance. So the Congress came together and said: What do we do about the people in their sunset years, those who helped build this country, went to war, built the roads, built communities? What do we do about that? So they passed Medicare.

Medicare has been an unbelievable success. Yes, there are financial strains on Medicare, but that is born of success. People are living longer and over a period of a longer life, they often need more health care. But that is a success, not a failure. We have changed medicine in our country in many ways. Medicare is one example.

Miracle medicines, medicines that did not exist some decades ago now can be used to keep people out of acute care hospital beds. Vaccines can now prevent people from getting sick. Polio was cured. Smallpox was cured. Think of the changes over all of these years. And, yes, it is the case that if you have a very serious illness, in most cases you want to be in this country.

It is the case, however, that many in this country cannot afford to access the health care that exists. But people come here, not elsewhere, for good health care. We have terrific clinics

and opportunities for people to get good health care in this country. The problem is, the cost is relentlessly increasing every single year and pricing health care out of the reach of too many Americans. Too many families cannot figure out how to pay for health care. They cannot pay for the increased insurance premium that is going up double digits every year. They have to go to the grocery store and stop in the pharmacy to figure out what a prescription drug is going to cost. They buy their medication first and see what they have left for groceries.

The fact is, prices of health care are marching relentlessly upward, so too many people do not have coverage. Families often cannot afford it. Small businesses cannot afford the price increases for health care. So what do we do about that?

If there is a sick child, should a sick child who is crying because of pain be told: Your visit to a doctor depends on how much money your parents have? I don't think so. So we passed legislation dealing with that, providing health care opportunities for children who come from families of meager means.

The question for us now is, Is there a way for us to extend health care coverage and also to put the brakes on these relentlessly increasing costs? If at the end of the day legislation that is considered here does not put the brakes on price or cost increases, I don't want to be a part of that. I am not going to be supporting things that really do not put the brakes on these relentless increases in health care costs. That is the purpose of all of this, is to try to get a handle on costs somehow.

There was an author named Barbara Ehrenreich who described visiting with a friend of hers from a European country. She told her friend that she had breast cancer and had difficulty getting insurance because she had breast cancer. She said: But isn't that when you would most need insurance? Not understanding, of course, in our country you are least likely able to get what you need when you need it the most.

That is another question in this set of issues, preexisting conditions. Is there a way for us to make it easier for people to access health insurance when they really need health insurance because they have a debilitating illness? I would hope so.

What should happen when you pay an insurance company premiums for 10 or 15 years? You pay every month and all of a sudden the insurance company says: We are going to terminate you. What should happen? Is that fair? I don't think so.

Shouldn't there be some opportunities to address those kinds of things—the denial of coverage, the termination of coverage? I think so.

Let me also say as we discuss these policies, there is another element that is not very often discussed that I want to amplify, and that is the issue of personal responsibility—personal responsibility that goes well outside legislative activities.

Two-thirds of the people in this country are overweight. One-third are obese, according to statistics. I invited someone from Safeway Corporation to meet with our caucus. The CEO of Safeway, Steve Burd, has met with folks in both caucuses in the Senate. He told of a very interesting program at Safeway.

I think there were about 45,000 employees in this group, and he did the following. He said: Here is your health insurance plan. Here is the amount the Safeway company will pay, and here is the amount that you pay. So that amount the employee pays is X. But the company said to the employees, you can reduce the amount you pay if you do four things. You can reduce it in four steps: Do you have high blood pressure? You have to be on medicine to control it, and we will pay for the medicine.

Do you have high cholesterol? You have to be on medicine to control it, and we will pay for it.

Are you overweight? Then you have to be on some sort of weight reduction program, and we will pay for that.

Are you smoking? Then you have to stop or be in a smoking cessation program, and we will pay for that.

If you don't do any of those things, you don't want to do those things, you have high cholesterol, high blood pressure, smoke, and are well overweight, that is all right, here is your copay. It will be higher. But if you do all four of those things, and the company will pay in each instance for the cost of it, you will pay four steps below, less money every single month.

He says with that program, they have had flat health costs for 5 straight years. Think of that: 5 years flat cost. While the rest of the country is seeing these relentlessly increasing costs, that program provided flat costs, no cost increases. Why? Because they incentivized personal behavior in the right way: Do this, improve your health, we will pay the cost of it and save yourself some money. That is exactly the right thing to do.

I hope as we have this discussion, a fair amount of that impulse can be a part of what we are trying to do—incentivize the right behavior, personal responsibility. That makes a great deal of sense to me.

One of the things I have always supported is the issue of health care coverage at the workplace. That is where most Americans get their health care coverage. I don't want to do anything to disincentivize that. I want, whether it is small, medium, or large businesses, for us to say: You know what, good for you. You are providing health care to your employees. We support that. I don't want to disincentivize that; I want to incentivize that.

I know it is hard for small businesses during tough economic times to pay 10 percent more this year than last year and 10 percent more next year than this year. That is what they are seeing in health care costs. That is why it is important for us to put the brakes on these cost increases, for small businesses, medium-size businesses and large businesses as well, to help them be competitive.

We have to find a way to do that. I am not talking about diminishing the quality of health care. I am saying let's put the brakes on the price increases year after year. Let's find out what is causing it—and I have some ideas about that—and let's put the brakes on it. That is what this debate needs to be about.

I want to talk about an amendment I intend to offer as soon as we are able to offer amendments. It is an amendment, by the way, that is bipartisan, unlike a lot of things in this Chamber. My amendment was cosponsored by the late Ted Kennedy. It is also cosponsored by Senator OLYMPIA SNOWE, Senator JOHN MCCAIN, Senator CHUCK GRASSLEY, Senator DEBBIE STABENOW, and the list goes on including Republicans and Democrats. The amendment is about prescription drug prices, and I want to describe it.

It says let's give the American people the freedom to access the identical FDA-approved drugs when they are sold for a fraction of the price everywhere else in the world. The American consumer is charged the highest prices in the world for brand-name drugs.

By the way, here is what is happening to price increases for prescription drugs. We see the rate of inflation in this country. That is the yellow line. Take a look at drug prices, the red line. By the way, this past year, there was a 9 percent increase in prescription drug pricing.

This issue is not some irrelevant issue. There are a whole lot of folks who use prescription drugs to manage their disease and keep them out of a hospital. I understand many of these drugs are miracle drugs. I don't want to slow the ability of companies to create drugs, do research and so on.

A substantial amount of the research goes on at the National Institutes of Health, which is publicly funded. The knowledge from that research is made available to the drug companies, and that knowledge leads to a product. Good for them.

But what I don't like is the fact that those same pharmaceutical companies charge the American consumers the highest prices in the world. They will say: If you offer an amendment, you Senators, Republicans and Democrats, that tries to give the American people the freedom to access the same identical FDA-approved drug when it is

sold in Spain or Italy or Canada—name the country—when it is sold in a number of countries for a fraction of the price, then somehow it will harm research and development on new drugs.

That is not true at all. Those name-brand drugs are sold for a much lower price in Europe, and they do more research in Europe—at least that was a couple years ago. I haven't seen recent data. The fact is, they have lower prices and they have done more research.

In any event, there is more money spent on advertising, promotion, and marketing than there is on research. Watch television tonight and see when you see the next commercial that says: Shouldn't you be taking some Flomax—whatever that is. Shouldn't you ask the doctor whether the purple pill is right for you? Go find a doctor and say: I don't have any aches and pains, there is nothing wrong with me, but isn't the purple pill right for me? That is what the commercial tells you to do.

I haven't the foggiest idea what the purple pill is used for, but they relentlessly push this advertising. Knock it off. Maybe they should use some of that money for a little more research and development, I say.

To put a finer point on it, if I might, this is the price of Lipitor. This is the new price, by the way—$4.78 in the United States for a 20-milligram tablet and $2.05 in Canada.

By the way, here is what the two bottles look like. The same pill is put in these bottles, made by the same company—Lipitor. It is the same manufacturing plant in Ireland. They put the same pill in these two bottles. This one goes to the United States; this one goes to Canada. The American consumer has the privilege of paying $4.78 per tablet, and the Canadian buys it for $2.05. That was June 4, 2009, when I priced it.

It is not just Lipitor, although Lipitor is the most popular cholesterol-lowering drug. But Zocor, a 20-milligram tablet, the same thing, $5.16, $2.45, U.S. price versus Canadian price. I used Canada because it is a close neighbor. I could have used Spain, Italy, France, Germany.

By the way, some folks on the floor of the Senate will support the pharmaceutical industry's pricing policies of pricing their brand-name drugs the highest in the United States—I don't support that. Some will. They will say you can't really import drugs safely. The fact is, in Europe they have been importing drugs for 20 years. They have something called parallel trading. If you are in Germany and want to buy a prescription drug from Spain, no problem. If you are in Italy and want to buy it from France, no problem. You have parallel trading of prescription drugs. The consumers have the freedom to buy it where it is least expensive.

In our country, consumers don't have that freedom, and our amendment gives the American consumer the freedom to shop for those prescription drugs where they are sold for the most reasonable prices. I am not interested in having consumers buy their drugs from other countries. I am interested in the opportunity to buy drugs at a fraction of the price, forcing the pharmaceutical to reprice their drugs in this country.

I sat on a straw bale once at a farm where we had a town meeting. We all sat around on these bales and talked. An old codger there, about 80 years old, said to me: My missus—he meant his wife—my wife has been fighting breast cancer for 3 years. Every 3 months, we have driven to Canada to buy Tamoxifen. That is the medicine my wife has taken to fight breast cancer. Every 3 months, we drive to Canada to buy Tamoxifen.

I said: Why do you drive to Canada?

He said: Because it costs me 20 cents for what I would pay a dollar in the United States. I can't afford it in the United States, so we drive to Canada.

The fact is, they will allow someone like that to drive across with 90 days of use. But most Americans do not have that opportunity and most Americans could not access that drug from Canada because it would be against the law at this point.

I want to give the American people the freedom to be able to access FDA-approved drugs, and the legislation I will introduce with my colleagues has the most substantial safety provisions, including batch lots and pedigrees on these drugs that will make the entire drug supply much safer than it is now.

Price increases in 2009. The paper this week described what is happening with the pharmaceutical industry in pricing drugs. Enbrel, an arthritis drug, increased 12 percent this year. Nexium, for ulcers, increased 7 percent this year. Lipitor is up 5 percent this year. Singulair is up 12 present this year. Plavix's price increased 8 percent this year; that is an anticoagulant. Osteoporosis—if you are taking Boniva, there was an 18-percent increase this year. What is the deal? Does anybody understand what the reason for this is, these kinds of unbelievable price increases?

I am going to offer this amendment with my colleagues. My expectation is if you want to say at the end of the day that you have really done something to address the issue of skyrocketing prices in health care—you can't say that if you decide you are not going to do something to put the brakes on prescription drug pricing, because the American people should no longer pay the highest prices for brand-name drugs in the world. That is not something that should be allowed. It is certainly not something that is fair to the American people and not something that we ought to turn a blind eye to when we are talking about legislation here.

My legislation will be about giving the American people freedom—the freedom to access those drugs from a number of other countries named in our bill that have an identical chain of custody to our country, where it will be safe and secure for the American consumer to access those drugs at a fraction of the cost.

I want to say that some are pointing out that the issue of health care is also a jobs issue because the fact is, this is a significant burden on employers; that is, those who hire workers and who are covering them with benefits, as part of their compensation including health care. So it is a jobs issue, and when the burden becomes too great, it destroys jobs. That is just a fact. So I want to talk about jobs for a moment because even as we describe these issues, which I think are very important, they relate to jobs. But I want to go further to talk about jobs just because I have a bit of time today.

I have seen some things in the press recently that have bothered me, some stories. I want to describe them.

First of all, Senator DURBIN and I are leading a task force to talk about how we put together a new effort to try to create jobs. What kinds of incentives will allow small- and medium-size businesses to create new jobs? What are the things that will get the economic engine restarted, not just in GDP but putting people back on payrolls, putting people back to work?

I noticed that small- and medium-size businesses are having great difficulty in this country, even those that want to expand, because they can't find the financing to do it. I saw a report this week about the large financial institutions that got TARP funds, the bailout funds. The 22 banks that got the most help from the Treasury's bailout programs cut their small business loan balances by a collective $10.5 billion over the past six months. And the fact is that Wells Fargo got $73.8 billion in TARP funds, and in the last 4 months they have cut the amount of financing of small business loans by 3.9 percent. Think of that—a company gets $73.8 billion in TARP funds and cuts lending needed by small businesses by 3.9 percent. Bank of America, $41.9 billion in TARP funds, and they cut small business lending by 5 percent. I am quoting from a Treasury Department report, by the way, comparing 4/30/90 to 9/30/09. JPMorgan Chase, $25.4 billion in TARP funds, and they cut lending to small business 2.9 percent. American Express—the list goes on. I don't understand this at all.

So the question is, How do we try to give some help to small- and medium-size businesses and see if we can restart this economic engine so that they can put people back to work? They are the job generators in this country. And we are looking for a mix of ideas. What are the best ideas we can use to try to put people back on payrolls?

But what I want to talk about just for a moment is something I saw in the Washington Post this week when the President was in Asia. It talks about:

[Folks from the] 21 Pacific Rim Nations at an annual event that this year has put some of America's policies in the line of fire.

A chorus of complaints about U.S. trade policies . . . in the hour before the President's arrival [in Singapore]. Leaders of Mexico, China and Russia broadly condemned protectionism . . . endorsing free trade as the best engine of growth—

And so on.

The bluntest criticism . . . [said] America is moving in the opposite sense of free trade.

China and others have said the same.

Let me just say, it takes an unbelievable amount of gall to suggest that we are moving in the opposite direction of free trade. We have an unbelievable trade deficit, and this is a trade deficit with China. It is a sea of red ink that has gotten worse and worse—a $266 billion deficit last year, a $266 billion trade deficit with China, and China is telling us we have a problem with free trade? They are the ones that have closed markets. We are the sponge for all the goods China wants to send us, only to find out we can't get into their markets. This is about jobs. This is about jobs that leave our country and go there. When we start talking about how to create jobs, maybe we ought to straighten out this trade mess.

Let me say, there is a discussion in the same story about Korea and the trade agreement with Korea. I think it is pretty interesting. This is what happened with Korea last year. They sent us about 600,000 cars. They put them on ships and sent them to America to be sold. We were able to sell them 100,000 cars. Why? They don't want American cars on the streets of Korea. Ninety-eight percent of the cars on their roads are made in Korea because that is what they insist and that is what they want. They are criticizing us about the lack of free trade? That is unbelievable.

Let me describe the Cash for Clunkers Program in this country. We did a Cash for Clunkers Program. Yes, it put people in some showrooms and sold some cars. The Chinese and the Koreans had cash for clunkers programs. A lot of us would have liked to have said: You know what, if you are going to spend some money on cars, maybe at least spend it on cars that are made in manufacturing plants in this country. But that was not a requirement because it was so-called illegal under the WTO rules.

For example, when Japan and Korea decided, for their own economy, on a cash for clunkers program, they figured out a way to favor their domestically produced cars.

In Japan, only 5 percent of the cars were imports and 95 percent were made in Japan because that is the way they wanted it in 2007. After the cash for clunkers program, even fewer cars came from imports. Why? Because Japan had what was called a certification requirement that was open to only a small number of foreign vehicles. For example, they would allow the sale of a Toyota Land Cruiser, but you couldn't buy a Ford Explorer in Japan under the cash for clunkers program.

Yet we have these folks saying to us that we are not for free trade? Excuse me? How much gall do you have to suggest that a country with a $600-plus billion annual trade deficit, $260 billion of which is from China—to have our President go overseas and have others suggest that somehow we are not owning up to our responsibilities in trade?

The reason I make this point is this is about jobs. I think restarting the economic engine is an unbelievable priority in this country. A good job that pays well makes almost everything else possible. There is no social program in America as important as a good job that pays well. That is what makes everything possible for you and your family.

When we see the millions of people who have been laid off as a result of the deepest recession since the Great Depression, we need to get about our business. Senator REID and Senator DURBIN and I are working on that need, to address it. One of the ways to address it is with this trade issue as well.

Let me conclude as I started, talking about the bill that is before us. The legislation we are dealing with is health care, and the vote that will occur is on the motion to proceed. There is a lot of hyperbole about these issues. This is a motion to proceed to a piece of legislation that we will then debate for weeks and we will amend, I expect.

I just described one of my amendments that I feel very strongly about. It will be bipartisan. I fully expect it to pass. I have a couple of other amendments as well that I will offer.

I don't want health care to be concluded by the Congress in some way or another without the Indian Health Care Improvement Act, which has been languishing for many years here in the Congress, being a part of it. These are the first Americans, and too often these days the first Americans have second-class health care despite the fact that we signed the treaties on the dotted line and we owned up to the trust obligations that we have, that we have never quite delivered in health care, housing, and education. I have spent a lot of time, as have some of my colleagues, on the subject of the Indian Health Care Improvement Act. I hope very much that in this discussion—and I certainly will raise it as an amendment—we will have the opportunity to do what we need to do with respect to Indian health care.

I know there will be a lot of opportunity in the coming weeks to describe virtually all the things people want to describe about every single issue. I want to come back to something I mentioned in the middle of my presentation; that is, personal responsibility.

We can do all we want to do. We can have all kinds of legislation. But there also has to be some personal responsibility with respect to health care. I hope, whatever we do legislatively, if, in fact, at the end of the day the legislation moves forward, I hope we remember the lessons we have learned from some companies around the country that are deciding that personal responsibility and the incentives for that kind of personal behavior is the right way to address some of these rising costs of health care. Certainly the Safeway example I described is in that genre.

Our time is about up. I want to say again that we will vote tomorrow night, come back after Thanksgiving, and my guess is that for 3 or 4 weeks we will have a substantial, generous amount of discussion about how best to put the brakes on health care costs. This has to be done in a way that is fiscally responsible. It has to be done in a way that is effective. If not, there ought not be legislation passed, in my judgment. If so, if we can do this in a way that is fiscally responsible, in a way that helps the American people and begins to put the brakes on the skyrocketing health care costs, then I would want to be part of that.

I yield the floor.

Mr. WYDEN. Mr. President, transforming American health care so that more Americans get good health care at home, instead of only in a doctor's office, is an idea whose time has come.

Quality, affordable home-based care makes sense for patients. It generates good-paying jobs for our people and sparks development of exciting technologies through research that will pay even bigger dividends in the years ahead. Care at home is an idea that Democrats and Republicans, conservatives and progressives, can all come together on and get behind.

Right now, getting to see a doctor in their office can be an onerous process. You start by calling the doctor's office and testing your patience while you sit through menu after menu of options just to get past the doctor's voicemail system. You are in trouble if you don't listen carefully and miss the option you wanted. You might get sent to records or accounting and have to start all over again. After you have run that gauntlet, you have to match your schedule up to whatever days the doctor's in. With doctors having other obligations like surgeries or teaching, you could be up against a schedule where the doctor only has office hours a few days a week. That will lead to your getting an appointment two months from now. That won't do much good if you are sick today.

Once you have won that prized appointment, you have to navigate to the doctor's office on the day in question. In rural areas, you might end up driving yourself and your family long distances to get there. In urban areas, workers lose a big part of their day getting themselves, or maybe their elderly parent, to and from the doctor's office or hospital. That can be a difficult task if your parents have a hard time getting around at home—never mind getting them from the car to the doctor's office safely. By the time you get to the doctor's waiting room, you feel like you have run a marathon. It's the opposite of the well-oiled machine you would expect from a country that leads the world in health care innovation.

Our current health care system seems modern, but it is actually based on a 19th century model of institutionalized health care. It is like riding a horse-drawn wagon all the way from here to Oregon. Just because the Pioneers did it and found the beauty of Oregon at the end, it doesn't mean that is the best way to get there in 2009. Likewise, just because the majority of American health care is delivered in a doctor's office or hospital doesn't mean that is the best way either.

There is a lot of wasted time and effort spent on services that could be done more easily—and in some cases, more effectively—done from home thanks to something called ''telehealth technologies.'' Telehealth technologies are simple-to-use, home-based systems that use tools, such as home security sensors and the internet to connect patients to their medical providers. Home telehealth has already been used by the Veterans' Administration and has lowered costs for treating patients with multiple chronic diseases like diabetes and high blood pressure.

Here's how it works. Some systems help patients with chronic conditions like diabetes or high blood pressure send their daily blood sugar or blood pressure readings straight to their medical professional. There, the readings can be checked and monitored for signs that the patient's care needs to be adjusted. Sudden weight gains, which can be a sign that someone's about to go into congestive heart failure, can also be noted and addressed right away, so that the patient can be treated and avoid that outcome.

These are just a few of the ways that telehealth technologies can help patients better manage their health issues from home, instead of waiting for their occasional checkup in a doctor's office, when it might be too late to correct their health problems. Telehealth technologies give medical professionals a new tool by increasing the amount of data they can collect on their patients over a long period of time. That aggregated information improves the quality of care that the patient then receives when they do visit the doctor's office.

Some of these telehealth technologies are so advanced they sound like science fiction, but they are real, they are here today and they need to be part of building our new health care system. They offer more than just unique, time-saving solutions. Telehealth technologies also open a new world of jobs and services that will shore up our economy with good-paying work right here at home.

Researchers from around the country are working to tap the potential of these technologies, and I am proud to report that much of the cutting edge work is being done in the Pacific Northwest. Their discoveries address everything from depression to neurological disorders. For example, new technologies can help isolated seniors stay connected to the world through a variety of social networking sites. This would be a simple, high-tech fix that can help cure the loneliness that so many seniors suffer from, and that often leads to depression. Some seniors with cognitive issues are being taught how to use personal computers to play games that exercise the brain, like Sudoku puzzles. Neurologists can then analyze the changes in patients' success at the games over time and to understand how and when their cognitive abilities start to deteriorate.

Technologies like this give us the chance to learn about devastating diseases like Alzheimer's so that, hopefully, we can one day find new drugs and treatments for those who suffer from it.

Other technologies are moving forward to help those with memory loss and help to improve the quality of life for our seniors. ''Caller ID on Steroids'' is what one technology has been called that would be life-changing, and give them more confidence as they age, despite possible memory loss. It is a system that brings up a whole host of information on a senior's telephone every time someone calls. The system would show a photo of the person and their name. It would tell them the last time they spoke on the phone—and even a brief description of what they talked about. Another new invention would help seniors remember to take their medications on schedule.

There is a day-a-week pill caddy with sensors built it to tell whether or not a patient had come close to it or opened the particular day's drawer. A screen on the caddy displays reminders or hints about how to take the medication. This kind of technology improves patients' adherence to taking their medications as prescribed, which increases their effectiveness and improves their overall health. Imagine the differences these kinds of technology would make in the life of a senior who is suffering frightening and debilitating memory loss.

In the case of neurological illnesses like Parkinson's disease, telehealth has been shown to be a better way to manage medications and personalize treatment. Parkinson's patients can perform neurological tests on a laptop at home and have their success at these tasks reported to the doctor in real time. No longer will an annual visit to the doctor be the only opportunity to demonstrate how their illness is progressing and be the basis for the prescription the doctor writes. This kind of innovation could improve the quality of life for such patients and reduce the physical and economic toll that unnecessary medications cause.

But telehealth technologies do more than just help patients. There are some that also help the people who care for them. Many caregivers for people with Alzheimer's find themselves, caring for their patients in the middle of the night. Telehealth technologies have been developed to let someone else from their caregiver support group know that they're up and available to talk, even at 3:30 in the morning. A ''presence lamp'' system uses simple home security sensors and the internet to turn on a lamp in one person's home when their friend also happens to be awake in the middle of the night, and vice versa. It becomes a lifeline between family caregivers who could reach out for emotional and social support, even in those darkest and bleakest of hours.

All these innovations point to the fact that a technological revolution is going on right now in home health care solutions, and it's time health care reform brought those solutions into the mix. If done right, reform should do more than give affordable, quality care to all Americans. As these technologies prove, health care reform should also stimulate the economy with new jobs and industries that will allow us to care for our rapidly aging population.

Home health care will help put America at the forefront of a new health care services industry that will generate more than a million new jobs that can never be outsourced. Those jobs will come from inventing new home-based care technologies and using those technologies to deliver virtual and remote care services here at home and abroad.

I have already introduced legislation that uses the concept of coordinated home health care to help people on Medicare live healthier by managing their chronic conditions and reducing duplicative and unnecessary services, hospitalization, and other health care costs. This bill has broad bipartisan support, from Senators BURR and CHAMBLISS to Senators STABENOW, MIKULSKI, and, previously, the late Senator Kennedy.

My bill, the Independence at Home Act, establishes a 3-year Medicare pilot

project that helps Medicare beneficiaries with multiple chronic conditions remain independent for as long as possible in a comfortable environment. It provides for coordinated-care programs that hold physicians, nurse practitioners, physician assistants, and other team members accountable for quality, patient satisfaction, and mandatory minimum savings. The act was accepted into the Senate Finance Committee health reform bill and I will pull out all the stops to see it included as part of the final health reform legislation that the Senate will vote on.

Before Congress finishes writing the bill for 21st century health care reform, it is important to define what Americans are paying for, how best to deliver much-needed personalized care to patients where they live, work, and play, and how to make the U.S. a world leader in home-based care industries. The home can become a fundamental location for health and wellness and also a priority for reform. In addition, all this can be done with a focus on stimulating our economy with new jobs, technologies, and services for a world that will share the challenge of caring for an aging population.

I encourage my colleagues to ensure that health care reform is about new approaches to patient care, quality of life, and growing old with independence and dignity, not just about who's paying the bill. This is a chance to redesign our health care system with a new vision that sees the patient as the center of a more efficient and effective system. It is a chance to change our health care system to one that helps prevent disease, treat patients, support family caregivers, and enable seniors to maintain their independence, by bringing health care reform home.

MORNING BUSINESS

Mr. DORGAN. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak up to 10 minutes each.

The PRESIDING OFFICER (Mr. BEGICH). Without objection, it is so ordered.

VOTE EXPLANATION

Mr. BAUCUS. Mr. President, due to an unfortunate illness in my family, I regrettably missed rollcall No. 352. If I had been present, I would have voted ''aye'' on the passage of S. 1963, the Caregivers and Veterans Omnibus Health Service Act of 2009. This legislation is very important to veterans living in Montana. Many of Montana's veterans live in rural areas, hours away from the closest VA facility, and this bill will improve access to health care in those rural areas. I am pleased to see this bill passed with bipartisan support. We must uphold our promise to honor our veterans and provide them with the benefits they have proudly fought for and deserve.

HONORING OUR ARMED FORCES

STAFF SERGEANT RYAN L. ZORN

Mr. BARRASSO. Mr. President, I rise today to express our Nation's deepest thanks and gratitude to a special young man and his family. I was saddened to receive word that on November 16, 2009, SSG Ryan Zorn of Wright, WY, was killed in the line of duty while serving our country in support of Operation Iraqi Freedom. Staff Sergeant Zorn died near the town of Talifar in northwestern Iraq from injuries sustained when his armored vehicle overturned.

Staff Sergeant Zorn was assigned to the 1st Battalion, 34th Armor Regiment, 1st Brigade, 1st Infantry Division, out of Fort Riley, KS. Staff Sergeant Zorn grew up in Upton, WY, and joined the Army following his graduation from Upton High School. He loved his country, and loved serving his country. His mother JoAnn says this is what he lived for. He was on his third tour of duty in Iraq. His family and his faith were very important to him. Friends and neighbors remember him as always open and friendly, with a broad smile and a wonderful sense of humor. He was dependable and generous, always willing to help others without hesitation.

It is because of Ryan Zorn that we are allowed to go about our daily lives as free people. America's men and women who answer the call to service and willingly bear the burdens of defending our Nation deserve the deepest respect and gratitude of all Americans. They put their very lives on the line every day, and because of them and their families, our Nation remains free and strong in the face of danger.

Jesus says in the Book of John that, ''Greater love has no man than this, that he lay his life down for his friend.'' SSG Ryan Zorn gave his life, that last full measure of devotion, for you, me, and every single American. He gave his life serving and defending his country and its people, and we honor him for this selfless sacrifice.

Staff Sergeant Zorn is survived by his mother JoAnn, his father Myron, and his brother Todd. He is also survived by his brothers and sisters in arms of the U.S. Army. We say goodbye to a son, a brother, a friend, and an American soldier. The United States of America pays its deepest respect to SSG Ryan L. Zorn for his courage, his love of country and his sacrifice, so that we may remain free. He was a hero in life and he remains a hero in death. All of Wyoming, and indeed the entire Nation, is proud of him. May God bless him and his family and welcome him with open arms.

NATIONAL AMERICAN INDIAN AND ALASKA NATIVE HERITAGE MONTH

Mr. JOHNSON. Mr. President, each November, we celebrate National American Indian and Alaska Native Heritage Month to honor the original inhabitants of our great nation and celebrate their formative impact on American history. This month is an opportunity to promote the tenets of tribal sovereignty and recommit to the Federal Government's treaty and trust responsibilities to American Indians. I would like to personally honor the nine treaty tribes of South Dakota: the Cheyenne River Sioux, the Crow Creek Sioux, the Flandreau Santee Sioux, the Lower Brule Sioux, the Oglala Sioux, the Rosebud Sioux, the Sisseton-Wahpeton Oyate, the Standing Rock Sioux, and the Yankton Sioux. Each tribe's rich heritage greatly influences the character of South Dakota.

It is fitting that hundreds of tribal leaders journeyed to our Nation's Capital in early November to participate in the White House Tribal Nations Conference. President Barack Obama has committed to placing American Indian issues at the center of his administration, and the multiday conference was an important testament to the President's pledge to involve American Indian people in constructive dialogue. The conference allowed leaders from the 564 federally recognized tribes to interact directly with the President and representatives from the highest levels of the administration. The tribal leaders in attendance displayed the very diverse face of Indian Country. Each individual tribe forms a distinctive chapter of the American Indian story, yet the narrative contains many common themes of triumph and tragedy.

President Bill Clinton hosted the first tribal nations conference at the White House in 1994. It is not without precedent that President Obama invited leaders from all federally recognized tribes; however, I believe that this year's event is unmatched in its potential for progress. President Obama has charged each Cabinet agency with delivering a detailed plan of how to improve tribal consultation and how to address the complex challenges facing Indian Country. This Congress, with the leadership of President Obama, has an exceptional opportunity to improve the quality of life for American Indian tribes by consulting with tribal leaders and focusing on tribal sovereignty and the empowerment of Indian communities. For far too long, American Indians have endured a drastically underfunded health care system, crumbling education facilities, dismal economic prospects, and a subpar standard of living. It is essential to address this erosive cycle of poverty and marginalization in a thoughtful manner.

The diversity of American Indian tribes reflects the vibrant origins of our Nation. As the First Americans, sound American Indian policy is a precursor to our Nation's capacity to evolve and progress in an ever changing, diversifying society. We need to celebrate the proud ancestry and incredible sacrifices of American Indians. National American Indian and Alaska Native Heritage Month reminds us to promote diversity rather than suppress it, as diverse values and cultures erect the foundation of the United States.

American Indians contributed to the formation of modern political institutions as tribal confederacies influenced the foundations of early American democracy. In every conflict since the Revolutionary War, tribal members have courageously sacrificed their lives to help defend and preserve these democratic ideals. As the Federal Government works to assert a modern environmental ethic that can address climate change and natural resource scarcity, we have much to learn from American Indian communities. The environmental consciousness inherent in tribal culture promotes conservation and sustainability. American Indian communities have demonstrated that society can thrive and prosper without destroying the natural environment.

I hope this month provides students with the opportunity to explore the Thanksgiving story from the American Indian point of view. Observance of National American Indian and Alaska Native Heritage Month reaffirms this Nation's respect for American Indian people. I encourage everyone to participate in our celebration of American Indians. I would like to pay tribute to the more than 65,000 American Indians in South Dakota whose heritage enriches our communities. While the month of November serves as an important testament to American Indian culture, it is critical to make a daily commitment to advancing the quality of life of American Indians, in order for our Nation to walk forward with strength and purpose.

NATIONAL SURVIVORS OF SUICIDE DAY

Mr JOHNSON. Mr. President, I rise today to recognize Saturday, November 21, as National Survivors of Suicide Day. National Survivors of Suicide Day is a day of healing for those who have lost someone to suicide. In 1999, a Senate resolution created this annual event behind the efforts of Senator HARRY REID, who lost his father to suicide. This year, on November 21, over 230 conferences will take place internationally to allow survivors of suicide to connect with others who have experienced the tragedy of suicide loss.

The statistics about suicide are deeply concerning. In our Nation, suicide is the eleventh leading cause of death for all ages. Among young adults ages 15–24, there are approximately 100–200 attempts for every completed suicide. Suicide takes the lives of approximately 30,000 Americans each year, and a person dies by suicide about every 16 minutes. Suicide is an epidemic that tears families and communities apart, and we must do all that we can to prevent it.

A suicide survivor is an individual who has lost someone to suicide. It is estimated that for each suicide, seven other lives are altered forever because of the death. Every year, approximately 200,000 people become survivors due to this tragic loss of life. Many suicide survivors are left devastated, confused and weakened by their loss. Friends and family often experience depression, guilt, shock and anger. Unfortunately, there remains a stigma surrounding suicide and mental illness, and victims often shoulder some of the blame.

South Dakota is among a group of Western States that consistently has a higher rate of suicide than the rest of the country. The suicide rate for American Indians ages 15–34 is more than two times higher than the national average and is the second leading cause of death for this age group. The loss of these young people is a real crisis. We must provide tribes with the resources they need to implement culturally sensitive suicide prevention programs. It is critical to strengthen the social fabric to help improve mental health. On American Indian reservations in South Dakota, I have seen the catastrophic ripple effect that one suicide can have. Given the alarming occurrence of ''suicide clusters'' and imitative deaths that have occurred in Indian Country this year, it is imperative to provide support for those left behind.

I hope that National Suicide Survivors Day is an opportunity to promote the broad based support that each survivor deserves. We are not doing enough to fight this tragic epidemic that is taking the lives of so many in our communities. We must concentrate our efforts on addressing the root causes of suicide in Indian Country and throughout the Nation. It is critical to expand access to mental health services, including a focus on education, prevention and intervention. Furthermore, we need to acknowledge the obstacles that suicide survivors face during their grieving and encourage the involvement of survivors in healing activities and prevention programs. This is one of the goals of the South Dakota Strategy for Suicide Prevention. Finally, I believe that with appropriate support and treatment, suicide survivors can lead effective advocacy efforts to eliminate stigma and reduce the incidence of suicide.

AMERICAN DIABETES MONTH

Mr. JOHNSON. Mr. President, I wish today to recognize November as American Diabetes Month. National studies estimate 23.6 million Americans live with diabetes, and nearly one-quarter of this population has not yet been diagnosed. The number of South Dakotans living with diabetes has doubled since 1998, with more than 39,000 adults diagnosed as diabetics in 2008 and an estimated 10,000 not yet diagnosed.

American Diabetes Month focuses on increasing awareness of the disease, strengthening prevention efforts, and identifying associated health risks. The disease carries with it an increased rate of heart disease and stroke, high blood pressure, kidney disease, blindness, and amputation of the lower extremities, among other associated health problems. For the past few decades, the prevalence of overweight and obesity has steadily increased nationwide, increasing the prevalence of type 2 diabetes. As the prevalence of diabetes increases, we are beginning to understand the costs to both our citizens' health and to our economy. The high costs to our government in direct medical and indirect costs of lost productivity, coupled with the personal costs of rising health care coverage and treatment, make type 2 diabetes control and prevention a national priority.

Throughout my career, I have strongly supported initiatives to advance diabetes research, prevention, and education efforts. I commend the work conducted at the National Institutes of Health, the National Institute of Diabetes and Digestive and Kidney Diseases, and the Centers for Disease Control and Prevention to explore cures and treatments for type 1 and type 2 diabetes and prevent the development of type 2 diabetes.

Americans diagnosed with diabetes, whether insured or not, often face significant barriers in receiving timely, affordable treatment in our current health care system. Congress is currently considering comprehensive reform of our Nation's health care system. This is a historic opportunity to improve access to quality, affordable health care for all Americans and better manage the treatment of chronic diseases. Given the cost of diabetes to our citizens' health and personal finances and to our national economy, we must also continue to push to increase funding for diabetes research and prevention programs. American Diabetes Month provides an opportunity to learn more about the causes and health risks of diabetes and recognize its impact on our Nation and our families.

ADDITIONAL STATEMENTS

REMEMBERING SERGEANT WINFIELD THOMPSON SR.

• Mr. JOHNSON. Mr. President, I wish today to recognize the life of SGT Winfield Thompson Sr., an honored member of the Sisseton-Wahpeton Oyate. When this war hero and South Dakota native passed away November 6, 2009, our State lost a respected tribal member and a wonderful citizen who served as an inspiration to us all.

After entering the U.S. Army in April 1941, SGT Winfield Thompson Sr. was captured by Japanese forces in the Philippines on April 9, 1942. He was forced to march 90 miles over rough terrain with little food and water along with thousands of captured soldiers in what is today known as the Bataan Death March. After his capture, Sergeant Thompson was held at various prison camps and suffered horrible conditions until he was finally liberated in September 1945. Upon his rescue, he stood at attention, saluted, and said, ''Sergeant Thompson reporting to duty, Sir.'' During Sergeant Thompson's extraordinary military career, he was awarded the Prisoner of War Medal, American Defense Service ribbon with Bronze Star, Victory Medal, Asiatic Pacific Theater Ribbon with three bronze battle stars, Philippine Defense Ribbon, eight Overseas Service Bars, one Service Stripe and the Good Conduct Medal.

After his honorable discharge from the U.S. Army in May 1946, Sergeant Thompson returned home and married Virginia Redday. Winfield and Virginia were blessed with 7 children, 16 grandchildren, and 29 great-grandchildren. Winfield was preceded in death by his wife.

SGT Winfield Thompson Sr. embodied South Dakota values with his unwavering devotion to family and country, and I extend my deepest sympathies to his family on the loss of this great man.•

TRIBUTE TO WILLIAM J. ROGERS

• Ms. SNOWE. Mr. President, I wish today to extol the enormous legacy of selfless service, contribution, and, above all, patriotism of an extraordinary Mainer and American, William J. Rogers, and to recognize with the highest esteem the American Legion Post in Auburn, ME, founded by Bill and his fellow veterans, which will be appropriately named the ''William J. Rogers American Legion Post 153'' in his honor on November 29, 2009. This fitting accolade pays tribute to an individual who devoted his life to serving and defending our country, as well as tirelessly advocating for those who placed their lives in harm's way on our behalf—our courageous veterans.

Bill was one of the great sons of my hometown of Auburn, ME, where my roots run deep. In fact, on a personal note, I am proud to say we both graduated from the same high school, Edward Little. As fate would have it, years later, I enjoyed the pleasure of having Bill and his lovely wife, Connie, as wonderful neighbors of mine on Nottingham Road.

As a young man, Bill answered his country's call to serve during World War II and joined the U.S. Navy, training to be a pilot at the University of North Carolina at Chapel Hill along with Boston Red Sox legends, Ted Williams and Johnny Pesky Bill's roommate. As a naval aviator, Bill fought heroically and was awarded the Air Medal and Presidential Unit Citation for his wartime service, having deployed to fight in the Pacific, where he valiantly flew F6F Hellcats and Lockheed Venturas.

While Bill departed from active military service in 1946, his commitment to veterans and a lifetime of advocacy on their behalf was just beginning. Bill was a founding member of American Legion Post 153 in Auburn, where he held several offices at both the local and State levels including adjutant, vice commander, and department commander. On the national level, Bill became Maine's national executive committeeman, a member of the liaison committee to the National Public Relations Commission, and from 1965 to 1966 national vice commander. In 1976, Bill received the tremendous distinction of being elected national commander of the American Legion, the first national commander from the State of Maine—and we could not have been more proud.

Traveling more than 300,000 miles throughout the world in all 50 States and 17 countries, Bill was the voice of Legionnaires and veterans, meeting with leaders such as President Ford and President Carter. Maine and our Nation could not have had a better champion for the American Legion and our brave and noble veterans than Bill Rogers.

Throughout his life, in word and deed, Bill placed service above self and country above self-interest. He held sacred our country's obligation to stand by those who have stood by us, and I cannot imagine a more perfect testament to this outstanding Mainer and American who placed such a high premium on contributing to our Nation than to name Auburn's American Legion Post after him.•

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 10:40 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, without amendment:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1860. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

The message also announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1834. An act to amend the Small Business Act to expand and improve the assistance provided to Indian tribe members, Alaska Natives, and Native Hawaiians, and for other purposes.

H.R. 2781. An act to amend the Wild and Scenic Rivers Act to designate segments of the Molalla River in Oregon, as components of the National Wild and Scenic Rivers System, and for other purposes.

H.R. 3961. An act to amend title XVIII of the Social Security Act to reform the Medicare SGR payment system for physicians and to reinstitute and update the Pay-As-You-Go requirement of budget neutrality on new tax and mandatory spending legislation, enforced by the threat of annual, automatic sequestration.

The message further announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 212. Concurrent resolution expressing the sense of Congress on the occasion of the 20th anniversary of historic events in Central and Eastern Europe, particularly the Velvet Revolution in Czechoslovakia, and reaffirming the bonds of friendship and cooperation between the United States and the Slovak Republic and the Czech Republic.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1834. An act to amend the Small Business Act to expand and improve the assistance provided to Indian tribe members, Alaska Natives, and Native Hawaiians, and for other purposes; to the Committee on Small Business and Entrepreneurship.

H.R. 2781. An act to amend the Wild and Scenic Rivers Act to designate segments of the Molalla River in Oregon, as components of the National Wild and Scenic Rivers System, and for other purposes; to the Committee on Energy and Natural Resources.

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 212. Concurrent resolution expressing the sense of Congress on the occasion of the 20th anniversary of historic events in Central and Eastern Europe, particularly the Velvet Revolution in Czechoslovakia, and reaffirming the bonds of friendship and cooperation between the United States and the Slovak Republic and the Czech Republic; to the Committee on Foreign Relations.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3756. A communication from the Deputy Archivist, National Archives and Records Administration, transmitting, pursuant to law, the report of a rule entitled ''36 CFR Chapter XII, Subchapter B, Federal Records Management; Revision'' (RIN3095–AB16) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3757. A communication from the Chairman, Federal Energy Regulatory Commission, transmitting, pursuant to law, the Commission's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3758. A communication from the Chairman, U.S. Nuclear Regulatory Commission, transmitting, pursuant to law, the Commission's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3759. A communication from the Acting Director, Office of Personnel Management, transmitting, pursuant to law, a report entitled ''Agency Financial Report, Fiscal Year 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3760. A communication from the Chairman, U.S. International Trade Commission, transmitting, pursuant to law, the Commission's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3761. A communication from the Broadcasting Board of Governors, transmitting, pursuant to law, the Board's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3762. A communication from the Federal Co-Chair, Appalachian Regional Commission, transmitting, pursuant to law, the Semiannual Report, as amended, of the Inspector General for the period from April 1, 2009, through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3763. A communication from the Secretary, Department of Housing and Urban Development, transmitting, pursuant to law, the Department's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3764. A communication from the Secretary of Transportation, transmitting, pursuant to law, the Department's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3765. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; American Champion Aircraft Corp. Models 7ECA, 7GCAA, 7GCBC, 7KCAB, 8KCAB, and 8GCBC Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0745)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3766. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Boeing Model 747 Airplanes; and Boeing Model 757–200, –200PF, and –300 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2008–1326)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3767. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Rolls-Royce Deutschland Ltd. & Co. KG Model BR700–715A1–30, BR700–715B1–30, and BR700–715C1–30 Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0045)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3768. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Eurocopter France (ECF) Model EC 155B and EC155B1 Helicopters'' ((RIN2120–AA64)(Docket No. FAA–2009–0952)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3769. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Hartzell Propeller Inc. ( )HC–( )2Y(K,R)–( ) Series Propellers'' ((RIN2120–AA64)(Docket No. FAA–2006–25244)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3770. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Rolls-Royce Deutschland Ltd. & Co. KG. (RRD) Tay 650–15 Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2007–0037)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3771. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A300–600 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2008–0979)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3772. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; General Electric Company CF6–80C2 Series Turbofan Engines'' ((RIN2120–AA64)(Docket No. FAA–2009–0018)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3773. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A300 B4–601, B4–603, B4–605R, B4–620, B4–622, B4–622R, F4–605R, F4–622R, and C4–605R Variant F Series Airplanes Equipped with Simmonds Precision Products, Inc., Fuel Quantity Indicating System Sensors and In-Tank Harnesses Installed in Accordance with Supplemental Type Certificate (STC) ST00092BO'' ((RIN2120–AA64)(Docket No. FAA–2009–0324)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3774. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A300 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0997)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3775. A communication from the Acting Director of Sustainable Fisheries, National Marine Fisheries Services, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Cod in the Central Regulatory Area of the Gulf of Alaska'' (RIN0648–XS79) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3776. A communication from the Acting Director of Sustainable Fisheries, National Marine Fisheries Services, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries Off West Coast States; Modifications of the West Coast Commercial and Recreational Salmon Fisheries; Inseason Actions No. 4, No. 5, No. 6, and No. 7'' (RIN0648–XR27) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3777. A communication from the Acting Director of Sustainable Fisheries, National Marine Fisheries Services, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Cod by Catcher Vessels 60 ft (18.3 m) LOA and Longer Using Hook-and-Line Gear in the Bering Sea and Aleutian Islands Management Area'' (RIN0648–XS72) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3778. A communication from the Acting Assistant Administrator for Fisheries, National Oceanic and Atmospheric Administration, Department of Commerce, transmitting, pursuant to law, a biennial report relative to the use of federal assistance provided to Department of Commerce partners; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. KERRY, from the Committee on Foreign Relations, without amendment:

S. 2727. A bill to provide for continued application of arrangements under the Protocol on Inspections and Continuous Monitoring Activities Relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol's termination on December 5, 2009 (Rept. No. 111–100).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. CORNYN (for himself, Mrs. HUTCHISON, Mr. INHOFE, Mr. LIEBERMAN, Mr. COCHRAN, and Mr. BURR):

S. 2807. A bill to ensure that the victims and victims' families of the November 5, 2009, attack at Fort Hood, Texas, receive the same treatment, benefits, and honors as those Americans who have been killed or wounded in a combat zone overseas and their families; to the Committee on Armed Services.

By Mrs. SHAHEEN:

S. 2808. A bill to improve the Express Loan Program of the Small Business Act; to the Committee on Small Business and Entrepreneurship.

By Mrs. GILLIBRAND:

S. 2809. A bill to amend the Public Health Service Act to authorize grants for treatment and support services for Alzheimer's patients and their families; to the Committee on Health, Education, Labor, and Pensions .

By Mr. COCHRAN (for himself, Mr. WICKER, and Mrs. LINCOLN):

S. 2810. A bill to require the Secretary of Agriculture to provide emergency disaster assistance to certain agricultural producers that suffered losses during the 2009 calendar year; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. MERKLEY:

S. 2811. A bill to amend the Migratory Bird Treaty Act to provide for penalties and enforcement for intentionally taking protected avian species, and for other purposes; to the Committee on Environment and Public Works .

By Mr. BINGAMAN (for himself, Ms. MURKOWSKI, and Mr. UDALL of Colorado):

S. 2812. A bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. MENENDEZ:

S. 2813. A bill to increase corporate responsibility, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Ms. COLLINS (for herself and Mr. CONRAD):

S. 2814. A bill to amend title XVIII of the Social Security Act to ensure more timely access to home health services for Medicare beneficiaries under the Medicare program; to the Committee on Finance.

By Mr. GRASSLEY:

S. 2815. A bill to extend certain housing—related deadlines in the Heartland Disaster Tax Relief Act of 2008; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Ms. COLLINS (for herself and Ms. SNOWE):

S. Res. 358. A resolution designating December 12, 2009, as ''Wreaths Across America Day''; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 146

At the request of Mr. KOHL, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 146, a bill to amend the Federal antitrust laws to provide expanded coverage and to eliminate exemptions from such laws that are contrary to the public interest with respect to railroads.

S. 588

At the request of Mr. KERRY, the names of the Senator from West Virginia (Mr. ROCKEFELLER), the Senator from Florida (Mr. NELSON), the Senator from Maine (Ms. SNOWE) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of S. 588, a bill to amend title 46, United States Code, to establish requirements to ensure the security and safety of passengers and crew on cruise vessels, and for other purposes.

S. 619

At the request of Ms. SNOWE, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 654

At the request of Ms. MIKULSKI, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 654, a bill to amend title XIX of the Social Security Act to cover physician services delivered by podiatric physicians to ensure access by Medicaid beneficiaries to appropriate quality foot and ankle care.

S. 812

At the request of Mr. BAUCUS, the names of the Senator from Vermont (Mr. LEAHY) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 812, a bill to amend the Internal Revenue Code of 1986 to make permanent the special rule for contributions of qualified conservation contributions.

S. 1067

At the request of Mr. FEINGOLD, the names of the Senator from North Dakota (Mr. DORGAN) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1297

At the request of Mr. CONRAD, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1297, a bill to amend the Internal Revenue Code of 1986 to encourage guaranteed lifetime income payments from annuities and similar payments of life insurance proceeds at dates later than death by excluding from income a portion of such payments.

S. 1317

At the request of Mr. LAUTENBERG, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. 1317, a bill to increase public safety by permitting the Attorney General to deny the transfer of firearms or the issuance of firearms and explosives licenses to known or suspected dangerous terrorists.

S. 1583

At the request of Mr. ROCKEFELLER, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1583, a bill to amend the Internal Revenue Code of 1986 to extend the new markets tax credit through 2014, and for other purposes.

S. 1672

At the request of Mr. REED, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of S. 1672, a bill to reauthorize the National Oilheat Research Alliance Act of 2000.

S. 1780

At the request of Mrs. LINCOLN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 1780, a bill to amend title 38, United States Code, to deem certain service in the reserve components as active service for purposes of laws administered by the Secretary of Veterans Affairs.

S. 1790

At the request of Mr. DORGAN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 1790, a bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

S. 1803

At the request of Mr. MERKLEY, the name of the Senator from Tennessee (Mr. ALEXANDER) was added as a cosponsor of S. 1803, a bill to amend title 31, United States Code, to authorize reviews by the Comptroller General of the United States of emergency credit facilities established by the Board of Governors of the Federal Reserve System or any Federal Reserve bank, and for other purposes.

S. 1939

At the request of Mrs. GILLIBRAND, the names of the Senator from Pennsylvania (Mr. CASEY) and the Senator from Alaska (Mr. BEGICH) were added as cosponsors of S. 1939, a bill to amend title 38, United States Code, to clarify presumptions relating to the exposure of certain veterans who served in the vicinity of the Republic of Vietnam, and for other purposes.

S. 2097

At the request of Mr. WEBB, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2129

At the request of Ms. COLLINS, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 2129, a bill to authorize the Administrator of General Services to convey a parcel of real property in the District of Columbia to provide for the establishment of a National Women's History Museum.

S. 2747

At the request of Mr. BINGAMAN, the name of the Senator from Montana (Mr. TESTER) was added as a cosponsor of S. 2747, a bill to amend the Land and Water Conservation Fund Act of 1965 to provide consistent and reliable authority for, and for the funding of, the land and water conservation fund to maximize the effectiveness of the fund for future generations, and for other purposes.

S. 2757

At the request of Mr. MENENDEZ, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 2757, a bill to authorize the adjustment of status for immediate family members of persons who served honorably in the Armed Forces of the United States during the Afghanistan and Iraq conflicts and for other purposes.

S. 2785

At the request of Mrs. LINCOLN, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 2785, a bill to provide grants to improve after-school interdisciplinary education programs, and for other purposes.

S. 2793

At the request of Mr. LEAHY, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 2793, a bill to amend the Homeland Security Act of 2002 to provide for clarification on the use of funds relating to certain homeland security grants, and for other purposes.

S. RES. 341

At the request of Mr. CARDIN, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. Res. 341, a resolution supporting peace, security, and innocent civilians affected by conflict in Yemen.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. MERKLEY:

S. 2811. A bill to amend the Migratory Bird Treaty Act to provide for penalties and enforcement for intentionally taking protected avian species, and for other purposes; to the Committee on Environment and Public Works.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2811

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Migratory Bird Treaty Act Penalty and Enforcement Act of 2009''.

SEC. 2. AMENDMENT OF MIGRATORY BIRD TREATY ACT.

Section 6 of the Migratory Bird Treaty Act (16 U.S.C. 707) is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following:

''(c)(1) Except in the case of hunting and other activity allowed under section 3, whoever, in violation of this Act, intentionally and maliciously takes by any manner any migratory bird shall be guilty of a felony and, upon conviction, shall be fined not more than $50,000 or imprisoned for not more than two years, or both, for each violation.

''(2) Any person who intentionally and maliciously commits any other act or omission in violation of this Act or any regulations issued under this Act shall be guilty of a felony and, upon conviction, shall be fined not more than $50,000 or imprisoned for not more than two years, or both, for each violation.

''(3) The Secretary or the Secretary of the Treasury shall pay, from sums received as fines under this subsection and subject to the availability of appropriations, a reward to any person who furnishes information that leads to an arrest or a criminal conviction for any violation of this Act. The amount of the reward, if any, shall be designated by the Secretary or the Secretary of the Treasury, as appropriate. Any officer or employee of the United States or any State or local government who furnishes information or renders service in the performance of his or her official duties is ineligible for payment under this paragraph.''.

By Mr. BINGAMAN (for himself, Ms. MURKOWSKI, and Mr. UDALL of Colorado):

S. 2812. A bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. BINGAMAN. Mr. President, I rise today to introduce the Nuclear Power 2021 Act, which is cosponsored by Senator MURKOWSKI and Senator UDALL from Colorado.

This bill, along with Senator UDALL's bill S. 2052 are designed to give the Department of Energy a set of specific programmatic authorities to help address ways to lower the up-front capital cost of nuclear reactors. The National Academies of Science in their recent America's Energy Future study determined that by 2030 we will need essentially to double the existing base load power provided by nuclear energy or about another 100 gigawatts.

But before we can make such a large and dramatic increase in nuclear energy, I believe we must demonstrate the ability to construct ''first-mover'' reactors in the U.S. that are on cost and schedule. The National Academies likewise confirmed this as one of two principal demonstrations that must be carried out during the next decade to more fully understand the range of available options for controlling carbon emissions from energy production. The other challenge of commensurate importance that they identified is the demonstration of carbon capture and sequestration on a large scale for fossil-fuel based energy production.

In that regard, the bill I am introducing today addresses the topic of small modular reactors, which are typically rated with a capacity of less than 300 electrical megawatts; and that can be constructed and operated in combination with similar reactors at a single site. These reactors can be less capital intensive than the larger 1,000 megawatt reactors currently being licensed at the Nuclear Regulatory Commission; they have the potential to be built in a modular fashion much like our current fleet of nuclear submarines.

This bill is similar to the Department of Energy's Nuclear Power 2010 program; it concentrates not so much on the research and development of these reactors but demonstrating the ability to license them. Senator UDALL's bill authorizes the Department to conduct research on these reactors with the goal of reducing cost while operating them in a safe and secure fashion.

More specifically, this bill authorizes the Secretary of Energy to work in a public private partnership to develop a standard design for two modular reactors, one of which will not be more than 50 megawatts; obtain a design certification from the Nuclear Regulatory Commission for each design by 2018; and obtain a combined operating license from the Commission by 2021.

All of this effort would be cost shared by non-federal funds and selected under competitive merit review process while emphasizing efficiency, cost, safety and proliferation resistance.

The climate change issue we face today is too large to exclude any one

technology that can produce energy without emitting carbon dioxide. The National Academies report acknowledges the important role nuclear energy has and must play in a carbon constrained energy world; this bill I hope is another step to address some of the recommendations of this report. I hope my colleagues join me as cosponsors of this legislation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2812

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Nuclear Power 2021 Act''.

SEC. 2. NUCLEAR POWER 2021 INITIATIVE.

Section 952 of the Energy Policy Act of 2005 (42 U.S.C. 16272) is amended by adding at the end the following:

''(f) NUCLEAR POWER 2021 INITIATIVE.—

''(1) DEFINITIONS.—In this subsection:

''(A) COMBINED LICENSE.—The term 'combined license' has the meaning given the term in section 52.1 of title 10, Code of Federal Regulations (or a successor regulation).

''(B) DESIGN CERTIFICATION.—The term 'design certification' has the meaning given the term in section 52.1 of title 10, Code of Federal Regulations (or a successor regulation).

''(C) SMALL MODULAR REACTOR.—The term 'small modular reactor' means a nuclear reactor—

''(i) with a rated capacity of less than 300 electrical megawatts; and

''(ii) that can be constructed and operated in combination with similar reactors at a single site.

''(2) DUTY OF SECRETARY.—The Secretary shall carry out, through cooperative agreements with private sector partners—

''(A) a program—

''(i) to develop a standard design for each of 2 small modular reactors, at least 1 of which has a rated capacity of not more than 50 electrical megawatts; and

''(ii) to obtain a design certification from the Nuclear Regulatory Commission for each of the 2 standard designs by January 1, 2018; and

''(B) a program to demonstrate the licensing of small modular reactors by—

''(i) developing applications for a combined license for each of the designs certified pursuant to subparagraph (A); and

''(ii) obtaining a combined license from the Nuclear Regulatory Commission for each of the designs by January 1, 2021.

''(3) MERIT REVIEW OF PROPOSALS.—The Secretary shall select proposals for cooperative agreements under this subsection—

''(A) on the basis of an impartial review of the scientific and technical merit of the proposals; and

''(B) through the use of competitive procedures.

''(4) TECHNICAL CONSIDERATIONS.—In evaluating proposals, the Secretary shall take into account the efficiency, cost, safety, and proliferation resistance of competing reactor designs.

''(5) COST-SHARE REQUIREMENTS.—

''(A) DESIGN DEVELOPMENT.—Notwithstanding section 988, the Secretary shall require that not less than 50 percent of the cost of the development of each small modular reactor design under paragraph (2)(A) be provided by a non-Federal source.

''(B) LICENSING DEMONSTRATION.—Notwithstanding section 988, the Secretary shall require that not less than 75 percent of the cost of the licensing demonstration of each small modular reactor design under paragraph (2)(B) be provided by a non-Federal source.

''(C) CALCULATION OF AMOUNT.—Non-Federal contributions under this subsection shall be calculated in accordance with section 988(d).''.

By Ms. COLLINS (for herself and Mr. CONRAD):

S. 2814. A bill tb amend title XVIII of the Social Security Act to ensure more timely access to home health services for Medicare beneficiaries under the Medicare program; to the Committee on Finance.

Ms. COLLINS. Mr. President, I rise today on behalf of myself and Senator CONRAD to introduce legislation to ensure that our seniors and disabled citizens have timely access to home health services under the Medicare program.

Nurse practitioners, physician assistants, certified nurse midwives and clinical nurse specialists are all playing increasingly important roles in the delivery of health care services, particularly in rural and medically underserved areas of our country where physicians may be in scarce supply. In recognition of their growing role, Congress, in 1997, authorized Medicare to begin paying for physician services provided by these health professionals as long as those services are within their scope of practice under state law.

Despite their expanded role, these advanced practice registered nurses and physician assistants are currently unable to order home health services for their Medicare patients. Under current law, only physicians are allowed to certify or initiate home health care for Medicare patients, even though they may not be as familiar with the patient's case as the non-physician provider. In fact, in many cases, the certifying physician may not even have a relationship with the patient and must rely upon the input of the nurse practitioner, physician assistant, clinical nurse specialist or certified nurse midwife to order the medically necessary home health care. At best, this requirement adds more paperwork and a number of unnecessary steps to the process before home health care can be provided. At worst, it can lead to needless delays in getting Medicare patients the home health care they need simply because a physician is not readily available to sign the form.

The inability of advanced practice registered nurses and physician assistants to order home health care is particularly burdensome for Medicare beneficiaries in medically underserved areas, where these providers may be the only health care professionals available. For example, needed home health care was delayed by more than a week for a Medicare patient in Nevada because the physician assistant was the only health care professional serving the patient's small town, and the supervising physician was located 60 miles away.

A nurse practitioner told me about another case in which her collaborating physician had just lost her father and was not available. As a consequence, the patient experienced a two-day delay in getting needed care while they waited to get the paperwork signed by another physician. Another nurse practitioner pointed out that it is ridiculous that she can order physical and occupational therapy in a subacute facility but cannot order home health care. One of her patients had to wait 11 days after being discharged before his physical and occupational therapy could continue simply because the home health agency had difficulty finding a physician to certify the continuation of the same therapy that the nurse practitioner had been able to authorize when the patient was in the facility.

The Home Health Care Planning Improvement Act will help to ensure that our Medicare beneficiaries get the home health care that they need when they need it by allowing physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives to order home health services. Our legislation is supported by the National Association for Home Care and Hospice, the American Nurses Association, the American Academy of Physician Assistants, the American College of Nurse Practitioners, the American College of Nurse Midwives, the American Academy of Nurse Practitioners, and the Visiting Nurse Associations of America. I urge all of my colleagues to join us as cosponsors of this important legislation.

By Mr. GRASSLEY:

S. 2815. A bill to extend certain housing-related deadlines in the Heartland Disaster Tax Relief Act of 2008; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, today I have introduced a bill to extend deadlines by one year for three provisions in the Heartland Disaster Tax Relief Act of 2008.

The Heartland Disaster Tax Relief Act has been critical in rebuilding the lives and communities of those affected by the terrible floods and tornadoes from last year.

Because of delays in Federal funding and tighter credit conditions, many homeowners affected by the 2008 floods and storms will be unable to meet the deadline for the tax relief intended to help with recovery.

It is only fair to extend the deadline and give these homeowners the chance to recover and rebuild. A lot of people

are still trying to fix their ruined homes or move on to new housing. A house is ruined in a few minutes, but banks and governments take what seems like an eternity.

The first provision is a one-year extension of the provision allowing disaster victims with damage to their primary residence to use their own assets to buy a new home or repair an existing home by withdrawing money from their retirement plans without tax penalties.

The second provision is a one-year extension of a provision allowing disaster victims that have borrowed from their retirement account for disaster recovery to repay their own account without penalty.

The final provision is a 1-year extension of a provision allowing disaster victims whose banks cancel mortgage debt to not have the cancelled debt counted as taxable income. I urge my colleagues to help me in getting this important legislation enacted into law as soon as possible.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2815

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

SECTION 1. EXTENSION OF SPECIAL RULES FOR USE OF RETIREMENT FUNDS.

Section 702(d)(10) of the Heartland Disaster Tax Relief Act of 2008 (Public Law 110–343; 122 Stat. 3916) is amended—

(1) by striking ''January 1, 2010'' both places it appears and inserting ''January 1, 2011'', and

(2) by striking ''December 31, 2009'' both places it appears and inserting ''December 31, 2010''.

SEC. 2. EXTENSION OF EXCLUSION OF CERTAIN CANCELLATION OF INDEBTEDNESS INCOME.

Section 702(e)(4)(C) of the Heartland Disaster Tax Relief Act of 2008 (Public Law 110–343; 122 Stat. 3918) is amended by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 358—DESIGNATING DECEMBER 12, 2009, AS ''WREATHS ACROSS AMERICA DAY''

Ms. COLLINS (for herself and Ms. SNOWE) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 358

Whereas 18 years ago, the Wreaths Across America project began an annual tradition, during the month of December, of donating, transporting, and placing Maine balsam fir holiday wreaths on the graves of the fallen heroes buried at Arlington National Cemetery;

Whereas since that tradition began, through the hard work and generosity of the individuals involved in the Wreaths Across America project, hundreds of thousands of wreaths have been sent to national cemeteries and veterans memorials in every state and to locations overseas;

Whereas in 2008, wreaths were sent to 372 locations across the United States, as well as 24 sites overseas;

Whereas in December 2009, the Patriot Guard Riders, a motorcycle and motor vehicle group that is dedicated to patriotic events and includes more than 177,000 members nationwide, will continue their tradition of escorting a tractor-trailer filled with donated wreaths from Harrington, Maine to Arlington National Cemetery;

Whereas thousands of individuals volunteer each December to escort and lay the wreaths;

Whereas December 13, 2008, was previously designated by the Senate as ''Wreaths Across America Day''; and

Whereas the Wreaths Across America project will continue its proud legacy on December 12, 2009, bringing 15,000 wreaths to Arlington National Cemetery on that day: Now, therefore, be it

Resolved, That the Senate—

(1) designates December 12, 2009, as ''Wreaths Across America Day'';

(2) honors the Wreaths Across America project, the Patriot Guard Riders, and all of the volunteers and donors involved in this worthy tradition; and

(3) recognizes the sacrifices our veterans, servicemembers, and their families have made, and continue to make, for our great Nation.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2787. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2786 submitted by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) and intended to be proposed to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2787. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2786 submitted by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) and intended to be proposed to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1738, between lines 3 and 4, insert the following:

(3) HEALTH CARE FRAUD PENALTIES.—Section 1347 of title 18, United States Code, is amended—

(A) by striking ''Whoever'' and inserting the following:

''(a) IN GENERAL.—It shall be unlawful for any person, in connection with the delivery of or payment for health care benefits, items, or services, to'';

(B) by striking ''executes, or attempts'' and inserting ''execute, or attempt'';

(C) in subsection (a)(2), as so designated, by striking ''program,'' and inserting ''program.''; and

(D) in the matter following subsection (a)(2), as so designated, by striking ''in connection with the delivery'' and all that follows and inserting the following:

''(b) PENALTIES.—

''(1) IN GENERAL.—Subject to paragraph (2), whoever violates subsection (a)—

''(A) shall be fined under this title, imprisoned for not more than 10 years, or both;

''(B) if the violation results in serious bodily injury (as defined in section 1365 of this title), shall be fined under this title, imprisoned for not more than 20 years, or both; and

''(C) if the violation results in death, shall be fined under this title, imprisoned for any term of years or for life, or both.

''(2) MANDATORY MINIMUM SENTENCING.—In imposing a sentence under paragraph (1), if the violation of subsection (a) involves a loss of not less than $100,000, the defendant shall be imprisoned for not less than 6 months.''.

NOTICES OF HEARINGS

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on National Parks.

The hearing will be held on Thursday, December 3, 2009, at 2:30 p.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the following bills:

S. 760, to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the ''National World War I Memorial'';

S. 1838, to establish a commission to commemorate the sesquicentennial of the American Civil War;

S. 2097, to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I;

S. 2722, to authorize the Secretary of the Interior to conduct a special resource study to determine the suitability and feasibility of adding the Heart Mountain Relocation Center, in the State of Wyoming, as a unit of the National Park System;

S. 2726, to modify the boundary of the Minuteman Missile National Historic Site in the State of South Dakota, and for other purposes;

S. 2738, to authorize National Mall Liberty Fund D.C. to establish a memorial on Federal land in the District of Columbia to honor free persons and slaves who fought for independence, liberty, and justice for all during the American Revolution;

H.R. 1849, to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the National World War I Memorial, to

establish the World War I centennial commission to ensure a suitable observance of the centennial of World War I, and for other purposes; and

H.R. 3689, to provide for an extension of the legislative authority of the Vietnam Veterans Memorial Fund, Inc. to establish a Vietnam Veterans Memorial visitor center, and for other purposes.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send it to the Committee on Energy and Natural Resources, United States Senate, Washington, DC 20510–6150, or by email to allison_seyferth@energy.senate.gov.

For further information, please contact David Brooks at (202) 224–9863 or Allison Seyferth at (202) 224–4905.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Senate Committee on Energy and Natural Resources. The hearing will be held on Tuesday, December 15, 2009, at 10:00 a.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on S. 2052, a bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out a research and development and demonstration program to reduce manufacturing and construction costs relating to nuclear reactors, and for other purposes and S. 2812 the Nuclear Power 2021 Act.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150, or by e-mail to Rosemarie Calabro@ener.senate.gov

For further information, please contact Jonathan Epstein at (202) 224–3357 or Rosemarie Calabro at (202) 224–5039.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on November 20, 2009, at 2 p.m.

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

COMMITTEE ON FINANCE

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on November 20, 2009, at 10 a.m., in 215 Dirksen Senate Office Building.

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

PRIVILEGES OF THE FLOOR

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the privileges of the floor be granted to Nassim Zecavati, who is a fellow in my office.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. HARKIN. Mr. President, I ask unanimous consent that the following HELP Committee fellows be granted the privilege of the floor for the duration of consideration of H.R. 3590, the legislative vehicle for the Patient Protection and Affordable Care Act of 2009: Sara Selgrade, Bill McConagha, Stephanie Hammonds, Joe Hutter, and Caroline Fichtenberg.

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

Mr. ROBERTS. Mr. President, I ask unanimous consent that my staff member, Mr. Brett King, be granted the privileges of the floor.

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

Mr. DORGAN. Mr. President, on behalf of Chairman BAUCUS, I ask unanimous consent that the list of staff from the Senate Finance Committee which is at the desk be granted the privileges of the floor during debate on the motion to proceed to H.R. 3509 and the cloture vote on the motion to proceed.

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

The list follows:

Laura Hoffmeister, Scott Berkowitz, Mary Baker, Bridget Mallon, Blaise Cote, Maryum Janjua, Audrey Schultz, Kaitlin Guarascio, Margaret (Angela) Franklin.

CONDITIONAL ADJOURNMENT OF THE HOUSE AND CONDITIONAL RECESS OR ADJOURNMENT OF THE SENATE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H. Con. Res. 214, the adjournment resolution received from the House and at the desk.

The PRESIDING OFFICER. The clerk will report the concurrent resolution by title.

The legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 214) providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. DORGAN. I ask unanimous consent that the concurrent resolution be agreed to and the motion to reconsider be laid upon the table.

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

The concurrent resolution (H. Con. Res. 214) was agreed to, as follows:

H. CON. RES. 214

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on the legislative day of Thursday, November 19, 2009, or Friday, November 20, 2009, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Tuesday, December 1, 2009, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on any day from Friday, November 20, 2009, through Wednesday, November 25, 2009, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Monday, November 30, 2009, or such other time on that day as may be specified in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate if, in their opinion, the public interest shall warrant it.

ORDER FOR STAR PRINT—S. 1194

Mr. DORGAN. I ask unanimous consent that S. 1194, as reported by the Committee on Commerce, Science, and Transportation, be star printed with the changes at the desk.

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

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the majority leader, pursuant to Public Law 111–25, announces the appointment of the following individuals to serve as members of the Ronald Reagan Centennial Commission: the Honorable DIANNE FEINSTEIN of California vice Frank Fahrenkopf of Nevada and the Honorable JIM WEBB of Virginia vice Sig Rogich of Nevada.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. DORGAN. Mr. President, I ask unanimous consent that the Senate proceed to executive session to consider en bloc Executive Calendars Nos. 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 551, and all nominations on the Secretary's Desk in the Foreign Service; that the nominations be confirmed en bloc; the motions to reconsider be laid upon the table en bloc; that no further motions be in order; that any statements relating to the nomination be printed in the

RECORD; that the President be immediately notified of the Senate's action, and the Senate resume legislative session.

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

The nominations considered and confirmed are as follows:

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

Paul K. Martin, of Maryland, to be Inspector General, National Aeronautics and Space Administration.

EUROPEAN BANK FOR RECONSTRUCTION AND DEVELOPMENT

James LaGarde Hudson, of the District of Columbia, to be United States Director of the European Bank for Reconstruction and Development.

DEPARTMENT OF STATE

Jose W. Fernandez, of New York, to be an Assistant Secretary of State (Economic, Energy, and Business Affairs).

Frederick D. Barton, of Maine, to be Representative of the United States of America on the Economic and Social Council of the United Nations, with the rank of Ambassador.

MILLENNIUM CHALLENGE CORPORATION

Daniel W. Yohannes, of Colorado, to be Chief Executive Officer, Millennium Challenge Corporation.

INTER-AMERICAN DEVELOPMENT BANK

Gustavo Arnavat, of New York, to be United States Executive Director of the Inter-American Development Bank for a term of three years.

DEPARTMENT OF STATE

Frederick D. Barton, of Maine, to be an Alternate Representative of the United States of America to the Sessions of the General Assembly of the United Nations, during his tenure of service as Representative of the United States of America on the Economic and Social Council of the United Nations.

Robert R. King, of Virginia, to be Special Envoy on North Korean Human Rights Issues, with the rank of Ambassador.

William E. Kennard, of the District of Columbia, to be Representative of the United States of America to the European Union, with the rank and status of Ambassador Extraordinary and Plenipotentiary.

Carmen Lomellin, of Virginia, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador, vice Hector E. Morales, resigned.

Cynthia Stroum, of Washington, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Luxembourg.

Michael C. Polt, of Tennessee, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Estonia.

John F. Tefft, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Ukraine.

David Huebner, of California, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to New Zealand, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to Samoa.

Peter Alan Prahar, of Virginia, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Federated States of Micronesia.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Pamela S. Hyde, of New Mexico, to be Administrator of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

NOMINATIONS PLACED ON THE SECRETARY'S DESK

FOREIGN SERVICE

PN282–2 FOREIGN SERVICE nomination of Terence Jones, which was received by the Senate and appeared in the Congressional Record of April 20, 2009.

PN929 FOREIGN SERVICE nominations (126) beginning Andrea M. Cameron, and ending Aleksandra Paulina Zittle, which nominations were received by the Senate and appeared in the Congressional Record of September 10, 2009.

PN964 FOREIGN SERVICE nominations (168) beginning Laurie M. Major, and ending Maria A. Zuniga, which nominations were received by the Senate and appeared in the Congressional Record of September 17, 2009.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

ORDERS FOR SATURDAY, NOVEMBER 21, 2009

Mr. DORGAN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:45 a.m., tomorrow, Saturday, November 21; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the motion to proceed to H.R. 3590, with debate as provided for under the previous order. Finally, I ask that the Republicans control the time from 8 p.m. until 9:30 p.m. tonight.

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

PROGRAM

Mr. DORGAN. Mr. President, at 8 p.m. tomorrow, the Senate will proceed to a rollcall vote on the motion to invoke cloture on the motion to proceed to H.R. 3590, the legislative vehicle for the Patient Protection and Affordable Care Act of 2009.

ORDER FOR ADJOURNMENT

Mr. DORGAN. I ask unanimous consent that following the remarks of Senator ENZI, the Senate adjourn under the previous order.

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

The Senator from Kansas.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED—Continued

Mr. ROBERTS. Mr. President, I ask unanimous consent that I be permitted to engage in a colloquy with my Republican colleagues.

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

Mr. ROBERTS. Mr. President, this is the health care bill. There are a lot of things in this bill that I object to. The $2.5 trillion cost, the 24 million people still left uninsured, the unconscionable $½ trillion cuts to Medicare and our senior citizens, with another $½ trillion in job-killing tax increases, in my view, the stunning assaults on liberty, and the Orwellian policies making health insurance even more expensive—any one of these things would make me vote no on this bill. But one issue has me troubled the most; that is, the issue of rationing. We have several of my colleagues here who will speak to this subject, and we will engage in a colloquy. I don't think this issue has sunk in with the American people and, for that matter, the media.

I want everyone to understand something. This bill aims to control the government's spending by rationing your access to health care. Let me repeat that. This bill aims to control the government's spending by rationing your access to health care. There are at least four government entities—we decided to call them ''the rationers''—that will stand between you and your doctor, and these four entities are represented by the four walls on this chart behind me blocking the doctor-patient relationship. You can see a pair of senior citizens and with frowns on their faces and then we have the rationers. We have an institute, a board, a center, and a task force, some of which are in place now and some are not. But every Senator should know about them and every health care recipient or especially senior citizen should know about them. Senator REID's bill establishes the Patient-Centered Outcomes Research Institute—that is the first wall—to conduct something called comparative effectiveness research, or CER, which is research that compares two or more of the same treatment options for the same condition to see which one works best. That sounds like a good idea. But, unfortunately, when CER is conducted by a government under pressure to meet a budget, it can be manipulated in some very sinister and counterproductive ways, as has been demonstrated by the United Kingdom's CER Institute. They call theirs the National Institute for Health and Clinical Excellence. The acronym is NICE, but NICE is not very nice in Great Britain.

NICE is notorious for delaying or outright denying access to health care treatments based on CER that takes into account the cost of the treatment

and the government's appraisal of the worth of the patient's life or comfort. Some of the more shocking CER decisions handed down by NICE over the years include: restricting access to drugs to save seniors' vision from macular degeneration until the patient is blind in one eye, inconceivable; denying access to breakthrough treatments for aggressive brain tumors; and refusing to allow Alzheimer's therapy until the patient deteriorates.

The Patient-Centered Outcomes Research Institute will be the American version of NICE using CER to save the government money by rationing your health care.

Over the past few months, I have offered several amendments, along with Senators KYL, COBURN, and ENZI, to protect American patients from NICE-style rationing, to prohibit this bill from valuing cost containment over the care of patients. Unfortunately, they have all been voted down on party-line votes in the HELP Committee, the Finance Committee, and previously on the floor.

Let's move to the independent Medicare advisory board. That is the second wall between patients and their doctor. The Obama-Reid bill establishes a new independent Medicare advisory board, an unelected body of 15 experts who will decide Medicare payment policy behind closed doors with minimal congressional input—something that is happening all too often around here. Although the bill says this anonymous board shall not include any recommendation to ration health care, what else would you call denying coverage for Medicare patients based on cost? That is what this board will do—deny payment for knee replacements or heart surgery or breakthrough drugs, all to achieve an arbitrary government spending target. I don't know what you call that, but I call it rationing. Also notice that this board will necessarily ration access to health care based on age and disability. Its payment policies will only affect the elderly and disabled who receive Medicare.

What will be a patient's recourse if Medicare refuses to pay for an innovative new therapy that could save or prolong their life? These are the reasons why the Wall Street Journal has dubbed this board the rationing commission.

Let us move now to the CMS innovation center. We come to the third wall between the doctor and patients. The Centers for Medicare and Medicaid Services, or CMS—and every provider knows what that is—administers the Medicare Program upon which 43 million Americans rely. That is almost 15 percent of the population. CMS already rations care. This has already been referred to by Senator THUNE and others in their comments on the floor. It is not authorized to but it does so indirectly through payment policies that curtail the use of virtual colonoscopies, certain wound-healing devices, and asthma drugs. In fact, courts recently had to intervene to prevent CMS from rationing a relatively expensive asthma drug in Medicare because rationing is currently against the law.

However, the Reid bill establishes a new CMS innovation center which will, for the first time, grant CMS broad authority to decide which treatments to ration.

Let's go now to the U.S. Preventive Services Task Force. That is the last one right here. The U.S. Preventive Services Task Force is yet another panel of appointed experts—a lot of those in this bill—who make recommendations on what preventive services patients should receive.

Currently, the task force recommendations are optional, but the Reid bill bequeaths this unelected and unaccountable body with new powers to determine insurance benefit requirements in Medicare, Medicaid, and even in the private market.

The task force has already revealed the types of recommendations it will be making. Just last week it decided to reverse its longstanding recommendation that women get regular, routine mammograms to detect breast cancer starting at age 40. One has to wonder if the task force's abrupt about face has anything to do with the fact that the Federal Government's financial responsibility for these screenings and for the health care needs they could potentially reveal will be greatly expanded if this health care reform bill passes.

In the words of one prominent Harvard professor:

> Tens of thousands of lives are being saved by this screening, and these idiots want to do away with it. It's crazy. It's unethical, really.

The outcry from oncologists, the American Cancer Society, the American College of Radiology and breast cancer survivors and families across the country has forced our Health and Human Services Secretary, Kathleen Sebelius, to backpedal away from the task force recommendation, saying they do not affect government policy. As a matter of fact, Secretary Sebelius said: Let you and your doctor make the decision. But this bill relies on the task force's recommendation, some 14 times throughout the legislation, to set benefits and determine copayments and make grant awards. So contrary to the Secretary's assertion, if this bill passes, the recommendation of the task force will become government policy. Not only that, it will be forced onto private insurers as well.

Some may ask, after my comments: Why so cynical? Why not trust these tools that they will only be used for good, to advance medical science and patient care. I hope that is the case. To those folks I answer by showing this chart over here by Dr. Ezekial Emmanuel and his ''complete lives system.'' As many of you know, Dr. Emmanuel is the brother of White House Chief of Staff Rahm Emmanuel. He is a bioethicist, one of those special advisers to the President. Perhaps he could actually be the rationing czar.

Dr. Emmanuel has published very disturbing ideas on how to ration care, which could be summed up by this ''Brave New World'' humpback whale graph we have here, along with aging groups of the population.

Dr. Emmanuel's Complete Lives System—something that sounds a little bit like a cure-all elixir sold out of Del Rio, TX—basically works off the premise that the older you are, the more you have lived and, therefore, the less you deserve in terms of health care.

I would like to point out that the average age of a Senator is 62—just something for all of you to think about, as you look at this chart depicting the Complete Lives System.

As shown on this chart, if you are 10 years old, you are doing pretty good right here. Twenty years old, that is when you think you are bulletproof and you do not want insurance, but you have a lock under this plan. Thirty years old, you are in pretty good shape. Forty, here comes the roller coaster. Fifty, you are in trouble. Sixty, you might as well forget it. Seventy, well, you are off the chart.

President Obama has clearly listened to Dr. Emmanuel's counsel. Remember his observation in an interview this summer that, as patients get closer to the end of their life: ''Maybe you're better off not having the surgery, but taking the shots and the painkiller'' instead.

Well, as someone who falls toward the end of Dr. Emmanuel's bell curve here—as shown over here on this chart—this type of thinking is unbelievable: Telling someone they cannot have a knee replacement because they are too old? How old is too old, according to Dr. Emmanuel?

The Wall Street Journal reported on the age rationing that occurs in Canada. In that country, apparently 57 is too old for hip surgery. Perhaps they can drive south and find care right here in the United States. But I am not sure where they will go if this bill passes.

The White House may complain that I am taking Dr. Emmanuel's musings out of context. My response to that is this: This is the context right here. This is how the government will contain costs. All these policies must be viewed through the prism of these ideas: This institute, this board, this center, this task force follows that blueprint. This is the goal: to save the government money by rationing care, by basing that rationing on some pseudoscientific graph such as this. At least in the United Kingdom they are honest about it.

These are the tools of rationing. These tools will restrict your ability, and your family's ability, to get a knee replacement or a breakthrough cancer drug or treatment for Alzheimer's or a mammogram.

They will destroy the American health care system—the best health care system in the world. And they are the main reason why I will vote no on this bill.

I yield to Senator SNOWE.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. Mr. President, as I rise this evening after months of effort and countless hours of meetings, discussions, and markup in the Senate Finance Committee to craft a health care reform bill, I have come to the floor to talk strictly about the substance and policy of one of the most complex and intricate undertakings the Congress has ever confronted.

Instead, we are confronted with procedural gyrations that are as baffling to those living outside the beltway as they are, unfortunately, for those who would prefer to achieve broader agreement on some of the most critical elements of health care reform.

As one who has worked constructively to forge solutions to this endemic problem plaguing our health care system, I think it is absolutely an imperative to ensure affordable health insurance coverage to the people of this country. But it must be done in an effective, commonsense, and bipartisan way. It matters what is in those 2,000 pages.

That is why I find it deeply disconcerting that the Senate, in its artificially generated haste to begin debate, has resorted to this convoluted process before us in which we first vote to proceed to an empty shell bill, which is then replaced with actual health reform legislation that is the result of behind-the-scenes integration of the two bills that were passed by the Senate Finance Committee as well as the Health, Education, Labor, and Pensions Committee.

The reality is, beginning our deliberations in the Senate with tactics rather than transparency does nothing to enhance credibility with the American public at a time when so many are already understandably wary of the speed and direction of Congress on this transformational issue.

As I have mentioned on numerous occasions, it took a year and a half to pass Medicare to cover 20 million seniors. So we simply cannot address health care on the legislative fast track. I am truly disappointed we are commencing this historic debate on one of the most significant and pressing domestic issues of our time with a process that has drawn a political line in the sand and forestalled our ability to arrive at broad consensus on some of the most crucial elements of health care reform.

Again, I arrive at this moment as one who has been fully immersed in this issue with the Senate Finance Committee process and the so-called Group of Six within the committee, where we engaged in deliberations for almost 4 months, intensively, on a weekly basis—recognizing the perilous state of health care coverage in America and also recognizing the looming trajectory of unsustainable costs in our health care system is a critical problem that, indeed, must be solved.

Ten million more Americans have lost their insurance since the last attempt at health care reform in 1993. Today, 75 million Americans are burdened by inadequate or nonexistent coverage. Over the last decade, insurance premiums alone have risen by 131 percent—if you look at this chart, 131 percent, contrasting that with the growth in wages of 38 percent and inflation at 28 percent. That is what has happened over this last decade alone when it comes to health insurance costs.

In my home State of Maine, from 2001 to 2009, we have been hammered with a stunning 271-percent increase in average health insurance premiums in our small group insurance market. It has been estimated by the Business Roundtable that we can expect premiums to grow 166 percent by 2019, absent any reform.

So given this current trend, health care costs will continue to grow, and more than double the rate of inflation, further driving up premiums, sending the entirety of our health insurance system into a death spiral.

Health care spending could total over $33 trillion in the next decade, and average costs of an employer-based family health plan will reach $30,800 just a decade from now, should we fail to act.

So even as everyone has differing opinions on how to address this issue, virtually everyone I have encountered agrees the system is broken. In a recent poll that asked: ''How much, if at all, should the health care system in the U.S. be changed,'' an astounding 84 percent said either ''a great deal'' or ''a moderate amount''—84 percent.

The National Small Business Association reports that 62 percent of all small business owners want Congress to enact some kind of reforms—and no wonder, as our small businesses have experienced annual premium increases of at least 20 percent, year after year after year.

The reality that this is not simply a solution in search of a problem is what brought us together in the Senate Finance Committee in the so-called Gang of 6 that I—and I commend Chairman BAUCUS and Senator GRASSLEY as well. Chairman BAUCUS wanted to convene on a bipartisan basis earlier this year, which was the only bipartisan effort in any committee of the House or Senate. We met more than 31 times to debate policy, not politics, in attempting to reach a bipartisan consensus on reform legislation. This reflected the kind of extensive, meticulous process that an issue of this magnitude requires. Because the American people understand intuitively that when you are debating the future of one-sixth of our economy, and a matter of such personal and financial significance to every American, we should not be railroading solutions along partisan lines.

To that point, on a cautionary note for all of us, a recent Gallup poll concluded that neither party can boast that a majority of Americans are currently behind them on this issue. Without question, people are already apprehensive about Congress's ability to reform this system—with Gallup also finding that 66 percent of Americans also believe their Member of Congress does not have a ''good understanding'' of the issues involved in the current debate.

Well, if there is one thing I have learned from my more than 30 years of legislative experience, it is that the only way to allay people's fears is by systematically working through the concerns, the issues, and the alternatives. In fact, it was an adherence to those very tenants that led up to the Finance Committee markup that was reported out of the committee and which I supported because, while far from perfect, it produced watershed, bipartisan market reforms and navigated the ideologies on both ends of the political spectrum—by bolstering what works in our current system, building upon the employer-based system, and fostering choices, competition in coverage, and changing the accelerating cost curve of our health care spending.

At the same time, that was one, albeit significant, step in the process. As said in my remarks at the conclusion of the markup, it would be imperative moving forward that our course of action give deference to the scope and complexity of the issue—and there should be an inclination by the majority to earn broader support. The bottom line is, policies that will affect more than 300 million people simply should not be decided by partisan, one-vote-margin strategies.

Thinking back over the last century, just consider for a moment if Social Security, civil rights, or Medicare could have been as strongly woven into the fabric of our Nation had they passed by only one vote and on purely partisan lines. Instead, as you can see from this chart, these votes all occurred during a time when Democrats controlled both the Congress and the White House.

Social Security passed the Senate with 64 percent of Republican support, 79 percent of Republican support in the House; civil rights, 82 percent of the Senate Republicans, and in the House, 80 percent of Republicans; Medicare,

when it passed, in 1965, had the support of 41 percent of Senate Republicans, and in the House, 50 percent of the Republicans.

So there was significant bipartisan support because it engendered a process that yielded bipartisanship and a consensus-based approach. Those are not only impressive numbers illustrating the strong bipartisan support that landmark legislation has garnered in the past, but they would be nothing short of mythological in today's political environment. Because at a time when we are supposed to be in a world of postpartisan politics, here we are facing a vote along partisan lines. When it comes to the subject at hand, the most consequential health care legislation in the history of our country and reordering $33 trillion in health care spending over the coming decade, surely, we can and must do better.

In a recent column, David Broder captured perfectly the path we should be following. He wrote:

> Scholars will also make the point that when . . . complex legislation is being shaped, the substance is likely to be improved when both sides of the aisle contribute ideas.

I could not agree more. So when it comes to procedural gymnastics designed to move us to a purely partisan bill as quickly as possible, on an issue as monumental as health care, that only serves to enhance public cynicism at a time when congressional approval ratings already hover consistently in the 20th percentile range and after a vote on the House reform bill that occurred after a grand total of two amendments and 12 hours 32 minutes of debate on almost 2,000 pages of a document.

Consider that it has been more than a month since the Finance Committee completed its work on legislation—even as it concluded that, work remained to be done—a month in which progress might have been made toward building greater consensus on some of the most critical and contentious matters in this debate.

But that opportunity was regrettably forsaken. I cannot support moving to a health care reform bill on a procedural motion designed to prevail not on policy grounds but on partisanship. Because the result is, this procedural vote tomorrow presents a serious obstacle if you have substantial concerns about the legislation—as the process going forward will likely require a threshold of 60 votes to add, change, or remove any major provision, including a public option plan, that was not included in the final Finance Committee legislation.

I think we all appreciate the impetus for the public option; that is, a fundamental mistrust of the insurance industry. That is a sentiment I strongly share, as many have been victimized by their egregious practices in denying coverage based on preexisting conditions, rescinding coverage because someone actually has the temerity to get sick, or discriminating based solely on one's gender.

In my home State of Maine, that mistrust couldn't be more profound—where two companies controlling 88 percent of the market has resulted not only in the inconceivable increases in premiums I described earlier but has forced thousands in my State to purchase plans with a remarkable $15,000 deductible for an individual and $30,000 for a family.

As I was told by one of our insurance companies—one of the two in Maine that dominate the market—it has become one of the most popular plans by virtue of its affordability, by virtue of the fact that it is all people can afford in the State of Maine and certainly among small business owners. Well, that is unconscionable. That is unacceptable. When we think of their basic coverage having a $15,000 deductible for an individual, $30,000 for a family, that is not what you would describe as reasonable coverage.

In response to that, I have worked to implement principles on which many of us have been adamant: ending flagrantly unfair practices so no American can be denied coverage, no policy can be rescinded when illness strikes, and no plan can be priced based on health status or gender.

To address the dearth of competition in the market, we created health insurance exchanges to become a powerful marketplace for creating competition and lowering premiums by bringing in potentially 30 million new customers, which CBO believes could reduce costs up to 10 percent. That is not even talking about the tax credits and the subsidies. So clearly the exchanges will have a significant effect on lowering prices through administrative changes in competition.

I would argue that we have taken these groundbreaking steps to alter the competitive landscape. I strongly believe that inserting a government-sponsored plan in today's dysfunctional marketplace—before reforms can work to improve the market—could actually inhibit the entry of new competitors and could undermine achieving the highly competitive environment we must have to make industry deliver lower cost coverage.

Just when we want to provide Americans a wide variety of competitive plans, can inserting a public option into smaller States such as my own actually encourage new plans to enter those markets or will we see just a pair of plans—the existing dominant insurer and the government, and is that limited option really the choice Americans want? When we also consider the difficulties we have experienced in improving care and assuring prompt, fair, and accurate payments in Medicare and Medicaid, we certainly must ask whether a public plan would spur the innovation that is so vital in health care coverage.

But we also cannot leave the performance of insurance companies and the success of reform to chance. I have proposed there is a role for a Federal safety net plan if affordable choices that are specifically defined aren't offered in a given State. Moreover, under my provision, companies would submit their pricing a year prior to the open enrollment period, and if it is determined that affordable plans aren't available in a State, the insurer would have 30 days to resubmit their bid. At that point, if affordable plans still aren't offered, a Federal fallback is provided without delay. This will provide the certainty that affordable options exist so that no one falls through the cracks, while CBO also reports that the threat of a fallback in a State would also pressure industry to lower premiums.

In stark contrast, the bill we will consider on the floor not only incorporates a public option but also a State opt-out provision that will allow any State at any time to drop that public plan for any reason whatsoever, irrespective of whether their residents in that State actually have access to affordable plans. So if affordability is our goal—and it certainly is—then will someone explain to me exactly how an indiscriminate opt-out achieves that end when a State could decide on a political whim it would not allow a public plan and leave its residents without affordable choices?

It simply makes no sense. Rather, we ought to take the safety net approach at the forefront as we did in Medicare Part D, which spurred competition and, as a result, it never was triggered, and to ensure affordability not just in some States but in all 50 States. I happen to believe a person's Zip Code should never dictate their ability to access affordable health care coverage.

So the public option provision is of paramount concern. At the same time, in examining the proposed legislation, it is not my only concern. There are practicalities to what we are doing, and I am concerned, quite frankly, that this legislation misses the mark as far as addressing the needs of Main Street America. Just yesterday, the NFIB released a statement opposing the bill—the National Federation of Independent Businesses—saying that enactment of it would make health care for small businesses more expensive than what they can afford today—a ''disaster for small business'' is how NFIB describes it. That is coming from a group that supported the Senate Finance legislation and has been a constructive voice throughout the debate, so that ought to grab our attention.

Furthermore, in the Finance Committee I insisted that CBO provide an

affordability analysis of what a ''silver'' plan would look like, for example, and I used that analysis to do my own modeling on all of the plans. It helped me to assess premium affordability and render an informed evaluation about the approach overall. For the measure before us now, the CBO has yet to assess the question of affordability on this revised, integrated bill. So exactly how do we go forward on this legislation and consider it when we don't even understand some of the most fundamental aspects of this legislation? None of us can tell with adequate specificity at this point what an average plan will look like, which is what Americans are going to be asking us. What are the premiums? What are the deductibles? What are the copays? What are the coinsurance requirements?

These are questions Americans rightfully will ask and are asking. What will reform mean to them? What will it look like? What will they pay for? Those are the answers to the questions we do not have because we haven't had a chance to evaluate this legislation, and we are going to have a vote tomorrow night to move along party lines—to ram it, to jam it—and that is what I am hearing from my constituents. They say: Do you really know what is in those 2,000 pages? They are asking the right questions with great validity. They believe their lives are out of control because they see Washington and they think Washington is out of control because we don't have a profound understanding of what we are doing.

That is why it took so long in the Finance Committee for 4 months. It wasn't enough to be immersed in intensive discussions and deliberations. There were artificial deadlines that were set time and time again from March to April to May to June, July, August, September, October. It has gone on. Christmas now is the deadline. The State of the Union is the deadline. Why not just try to get it right?

I have heard time and again people say we just have to do something. Well, what I am hearing from my constituents and from many Americans is that it is not just doing something, it is doing the right thing. Every line and every word in this 2,000-page document matters because it is going to have profound ramifications and implications. There are unintended consequences. It is not just about cobbling something together in the dark of night. It is about making sure those mechanics work and what it is going to cost the average consumer, what it is going to do to small businesses, what it is going to do in this time of perilous economic climate. We simply must ensure that an affordable coverage option is available to every individual and small business.

I get back to the affordability question because that is the heart and soul of this matter. We have to be assured that we are going to provide affordable health insurance plans. That is why I recommended—and I am going to push that through the amendment process—that we open the ''young invincible'' or the catastrophic plan as described in the majority leader's bill. We should open up to everybody. It is now available to those under the age of 30, but we should open these plans to all to ensure that no one has to buy up into a more expensive plan if they don't choose to.

I have also advocated throughout this process for the very first time national plans which I included in the Finance bill, as small businesses should be able to purchase plans with uniform benefit packages sold across State lines which is vital to enhancing competition and increasing choices for consumers, and portability, and driving down premiums. In fact, we drive down premiums by more than 12 percent.

I will be introducing an amendment—because, regrettably, it is not going to be in the bill we will be considering—that States cannot opt out of these national plans because these plans should be able to be available to every State in the country.

Finally, with our mounting deficits and our struggling economy, if anything, we should be scaling back the scope of health care reform wherever possible. We should take our cues from the American people who rightly reject more taxes and expanded government bureaucracy that will constrain our future economic prosperity. So I am disturbed that the legislation we will be considering will increase Medicare payroll taxes by $54 billion over the next 10 years. That is diametrically opposed to the tack we should be taking. We should be finding ways for cutting back and scaling back. ''Practicality'' should be the word of the day.

Then we have the insertion of another new and costly program, the so-called CLASS Act. I understand its laudatory goals. If it is going to be providing long-term care, it is obviously very important. Proponents point to the fact that it will raise $72 billion over the first 10 years, but that is a bad timing shell game as it collects premiums in 2011 but doesn't begin paying benefits until 2016, near the end of our current budget window. CBO has concluded in the decade following 2029 the CLASS Act will begin to increase the deficit. How much sense does it make to create this new bureaucracy, this new program, that will begin providing similar benefits just 4 years before the Social Security disability insurance trust fund is expected to be exhausted as opposed to first fixing that program?

I intend to offer amendments as legislation is considered on the Senate floor, and the impending amendment process will be a true test of whether there is a will to improve this legislation in a nonideological, bipartisan manner. On that note, I hope the past is not a predictor of the direction we are headed because in the final analysis, no one has a monopoly on good ideas. It is not a conservative idea, moderate idea, or a liberal idea. It is a good idea to improve this legislation because that is what is going to be our most pressing, most focused, singular goal—to improve the legislation that will be before us, irrespective of who is offering the amendment or who has the votes or whether it is the 60 votes. That is my concern, if it is going to take 60 votes to undo and change those provisions that are absolutely essential to be modified.

The American people have expressed a sharp and legitimate note of caution as we pursue health care reform, especially during these challenging economic times. It is a message we would do well to reflect. So let the tone we set for this unprecedented debate rise to the level of the problems we have a responsibility to resolve. This is already an undertaking of historic proportions. Let's ensure this isn't the only historic legislation passed in the last half century on purely partisan lines.

Thank you, Mr. President. I yield to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. INHOFE. First of all, I thank the Senator from Maine. She used the very descriptive terms of ''ram it'' and ''jam it.'' That is essentially what is happening right now. I think everyone is aware—all the media have taken pictures of the closed doors. They know that just a handful of Democrats were in there. Ironically, there are a lot of Democrats who didn't know what was going on, either. But they came out with a product. It is not a good product, and I will talk more about the product in a moment.

But I think probably more significant and more concerning to a lot of the people I talk to is the manner in which this bill is being brought to the floor. It is beyond just being deceptive that the Democratic leadership plans to vote on Saturday night at 8 o'clock to proceed to H.R. 3590, a bill that has nothing to do with health care. This bill is one that passed the House in October of this year, 416 to 0. It would pass the Senate by a unanimous vote, I am sure. The bill is an eight-page bill to ensure that our military service members are not excluded from the first-time home buyer tax credits, and no one had any quarrel with that. The House side wouldn't have any quarrel, nor would we. But we all remember and America remembers that the House passed their health care bill, H.R. 3962, on November 7, late at night, on a Saturday night, the same type of thing we are looking at here.

Let me say one thing. I was surprised to hear the unanimous consent request

that was made just a few minutes ago because it was an admission—and I appreciate their honesty—that what we are going to be voting on tomorrow night has nothing to do with H.R. 3590. Yet that is what we are going to be moving to.

They stated that at 8 p.m. tomorrow night the Senate will proceed to a rollcall vote on the motion to invoke cloture on the motion to proceed to H.R. 3590, the legislative vehicle for the Patient Protection and Affordable Care Act. My thinking was—and I still think there are a lot of Democrats who would end up voting for this tomorrow night and would send out a letter to constituents: Oh, this is a vote that is going to help our military with some of the problems they have.

This reminds me so much, the way this is taking place, of what happened in the Environment and Public Works Committee when they were trying to get through the massive cap-and-trade bill which they did and they voted it out without any Republicans there. It is on the Senate floor right now. It is not going to be brought up because it is dead on arrival. The people of America realize they don't want to have the largest tax increase in the history of America on something that would do no good.

But the point is, the deceptive method to bring up that bill is the same thing we are dealing with now. I think by virtue of the fact they rammed it and jammed it, to borrow the terms from the Senator from Maine, out of the Environment and Public Works Committee caused it to go down. I think the same thing is going to happen here.

The second thing is a motion to proceed at 8 p.m. on Saturday night. Well, Saturday night. What are people doing on Saturday night? They are not watching TV. They are not listening to the radio. They have ball games and other things the American people do in the American way of life on a Saturday night.

Do you think it is just coincidental? That is the same time of night they ended up voting on the House health care bill, on a Saturday night. Of course, it got out with barely a majority.

Now, not only is the way in which the bill is being brought up questionable, the substance of the bill is definitely questionable. It has been repeated—I am trying to make a couple of comments about this that have not really come to our attention as much as other issues, the government-run health care bill—that Republicans are working to ensure that Washington bureaucracy does not get between the patients and their doctors. That is the big issue.

Now, you are going to hear shortly from my junior Senator from Oklahoma, Mr. COBURN, who is an OB–GYN. He will talk about that.

I don't think you have to have a doctor explain to you that if you, as in my case, have a very large family, with a lot of grandkids—we don't want the government telling us what we can and cannot do. A government-run universal health care system or a socialized system is not the answer.

All you have to do is listen to some of the testimony from individuals who have come here, such as members of the Parliament in Great Britain, who came and addressed us in this building and said: We cannot believe that something that has been such a failure, that we are trying to get away from, is something you are now trying to move toward.

The other day, in the Wall Street Journal they talked about a Canadian citizen who waited in pain for more than a year to see a specialist for his arthritic hip. The specialist recommended a state-of-the-art procedure, but the government bureaucrats determined that the patient, who was only 57, was too old for that procedure. Rationing is alive and well. If you don't believe it, go up in the northern part of the United States, to the Mayo Clinic or some of those others, and you will see the large number of Canadians who come down to ''barbaric'' America, with our system, because they couldn't get the treatment they needed through rationing in Canada.

The Democrats' bill represents an unprecedented expansion of government's control over health care. Oklahoma physicians shared with me in a July 23rd letter that they are concerned a public option plan will unfairly compete with the private market and ultimately crowd it out. It is a no-brainer. You cannot compete with the Federal Government. All they have to do is change and the competition is gone.

Under this bill, the government will tell people what type of coverage they can and cannot have, mandate that every American have health care or pay a tax, mandate employers to provide a certain level of benefits or pay a fine, introduce a government-run plan designed to destroy the private market, include new policies designed to control what drugs and procedures Americans can receive, and require a historic expansion of Medicaid. According to the Oklahoma Health Care Authority, the ones who administer the Medicaid Program called Soonercare, they estimate that this type of expansion could cost Oklahoma an additional $128 million each year, resulting in harmful cost to existing State priorities. By the way, the Oklahoma Governor and the State legislature are talking about going into a special session because of the problems we have—the budget problems. Of course, we would then inherit this.

This bill violates the President's promise not to raise taxes. I think we have covered that. The fact that they have taxes such as the 40-percent excise tax on the so-called Cadillac plans—that means if you, through your own decision, decide that for your family you want to have more extensive coverage, you will get penalized. You could have a tax imposed upon you of 40 percent because you wanted to have better treatment for your family. The CBO and the Joint Committee on Taxation have testified that these taxes and fees would be almost entirely passed on to consumers. The fact is that they estimate, by 2019, 89 percent of the taxes would be paid by those making less than $200,000 a year. It reminds me of the regressive nature of the cap-and-trade tax, which would affect the poor people more than the wealthier people.

Anyway, with the penalties and everything else in there, we are going to be looking at something that the American people don't want and should not have. That doesn't mean Republicans don't want to have reforms. We need reforms. We need medical malpractice reforms. I have two friends in Tulsa, two man-and-wife teams. There is Rick and Lisa Lowry. He is a cardiologist and she is a dermatologist. They moved to Texas. They will tell you the only reason they did it is because of the tort laws in Oklahoma. Then there is Boris and his wife Kathy, another pair of doctors. Boris is an electrophysiologist, and she is a pain management doctor. They moved to Fayettville, AR. This is what is happening right now.

We know what reform is. We know that HSAs have worked, giving people choice. We want to have some reform. We should keep in mind for tomorrow that, at 8 o'clock, if just one Democrat would say, no, I don't want a government-run system—just one—they wouldn't have 60 votes. It is going to be interesting to see if there isn't one. They will never get by with saying it was just a motion to proceed to a bill having to do with housing for the military. It will not happen. People are smarter than that. I hope at least one Democrat will oppose a government-run system. We will find out tomorrow night.

With that, I yield to the Senator from Alaska, Senator MURKOWSKI.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. I thank my colleagues and I thank particularly the senior Senator from Maine for her long, arduous work as part of a small group of Senators who did try, honestly and with great integrity, to advance this process so we would have a bipartisan product to deal with. I appreciate her efforts. I heard a little bit of her frustration as she spoke on the floor this evening. I thank her for her leadership.

I concur with my fellow Senator from Oklahoma that we all agree reforms

are needed in the health care world. We all agree that the status quo is not acceptable. But where we differ is certainly what leads us to the discussion this evening, and tomorrow, and up to the vote tomorrow evening at 8 o'clock.

Typically, this time of year, going into Thanksgiving and then the holidays that follow in December, we consider this the season of giving, where we give thanks and do a lot of giving back. Unfortunately, what we are looking at this particular November, with this particular bill, kind of makes it a season of taking—taking away your ability to choose the health insurance you want, taking away nearly $½ trillion by cutting from Medicare—a program that is already strapped, a program that provides so much for our seniors and the disabled. But we recognize that program is seriously underfunded and looking to literally go off a cliff by 2017—by taking more of your salary and increasing the Medicare payroll tax for government intrusion into your health care decisions.

This health care bill is a massive overreach by the Federal Government that will result in our government having more involvement in your family's health care decisions and greater government intervention, cutting into 16 percent of our economy.

Before we get into the policy debate on the health care bill, I asked one of the interns in my office to go down to the Dirksen post office. We had gotten an inquiry from a constituent from Alaska wanting to know if we could send a copy of the bill. The bill, as you can see on some of the Members' desks, is large. When it was weighed at the post office in the Dirksen building, it weighed in at 20 pounds 5.5 ounces. That is probably close to the size of the turkey my family and I will purchase for Thanksgiving. It is going to take about $45 to mail that by priority mail to Alaska. So we suggested that perhaps the Internet is a better option.

In this 2,000-plus page bill, you will find the government requiring that you comply with an individual mandate where the Federal Government is going to tell you you have to buy health insurance, regardless of whether the premiums are affordable. This goes back to the concerns of the Senator from Maine. So much of this is about the affordability. If we require individuals to purchase health care insurance but we have not done anything, or enough, to make it more affordable for them, all we are doing is setting them up for additional penalties. Failure to comply will result in a $750 penalty per person to a family.

We also know in this bill our government is going to be telling employers they have to comply with employer mandates, which place onerous penalties on a large number of our small businesses. These are businesses that have 50 or more employees. I think it is important to recognize that the SBA, Small Business Administration, defines a small business as one with 500 or fewer employees. But for the purposes of the employer mandate, we are going to say that if you have over 50 employees, you will be required to provide for that insurance.

Let's use an example here. Say you have a small business, you employ 51 employees, and one of those employees receives a Federal subsidy for health insurance. Under this Democratic health care reform bill, the employer will be fined $750 for each of its 51 employees—not just the one employee who receives a subsidy but for all of them. So if you are a small business owner in Alaska, in Anchorage, or Fairbanks, or Juneau, who runs a restaurant or a small hotel, that employer needs to know he could be subject to a total of over $38,000 in penalties if only one of his employees seeks a government subsidy. This penalty provision alone in the bill is estimated to raise $28 billion to pay for the Democratic health program.

The bill before us today also subjects Americans to health insurance that the Federal Government is going to define that this is what you have to have. What the drafters of this 2,000-plus page bill declare is it is an insurance plan with a 60-percent actuarial value. In other words, all of the discussion about ''if you like the health care plan that you have, you can keep it''—yes, in fact, you can, but only if it meets the definitions we are setting forth within this, and the requirement is that it is 60 percent of actuarial value.

In Alaska, we have over 88 percent of the health benefits that are provided to individuals and small businesses by the largest insurance company operating there, Premera Alaska Blue Cross/Blue Shield. We are told that 88 percent will not meet this 60-percent threshold requirement. So what does that mean? You have had your insurance plan through Premera and your employer provided it. But if it doesn't meet this threshold requirement, what then happens is that those small business employees will not be in compliance with the provisions of the bill, so you are going to see penalties assessed. Many of my constituents will see those penalties assessed. They may lose the insurance they have, which they like, but the penalty will be a massive increase in health care insurance premiums.

When we talk about the promises of health care reform and what we are going to make available to you, I think most people believe that with health care reform would come a reduction in premiums, or at least not incredible increases in premiums.

In this bill, we raid the strapped Medicare Program to pay for expanding the role of government in health care reform. We raid future payments to the Medicare patients through increased payroll taxes. I think it is important to recognize that this is an unprecedented and dangerous step that plays a shell game with Americans. We are going to increase your taxes through the Medicare payroll tax, but then we are going to divert that money to pay not for keeping Medicare solvent—I mentioned earlier the insolvency cliff out there—and we are going to divert that money not to keep Medicare solvent, not to increase funds to Medicare, not to increase patient access to doctors and nurses, which so many of my constituents are suffering from but, instead, we institute a new Medicare payroll tax that is used to pay for expanding the size of the Federal Government and creating yet another federally run health plan. We recognize that the insolvency of Medicare is real. The Medicare trustees report from 2009 said that Medicare is going to be insolvent by the year 2017. But the drafters of the bill don't write a reform bill to fix Medicare insolvency. Rather, they are using this as an opportunity to tax Medicare funds to pay for the creation of another Medicare-like system. This is truly the height of hypocrisy. It is working against what is right and what should be done for Medicare.

The inclusion of a 5-percent Medicare payroll tax is bad enough, but when one realizes that the tax is not indexed to inflation, one can only cringe at the financial pain that is ahead for America's middle class.

There may be many people out there saying, oh, you are increasing taxes on the rich and individuals earning $200,000 or more, and couples earning $250,000 or more, but you need to put this in context and recognize how far from the truth this can be.

Back in 1969, Congress enacted the alternative minimum tax, the AMT, to ensure that fewer than 200 individuals paid their fair share of taxes. Unfortunately, the AMT was not indexed to inflation, and today we have nearly 30 million taxpayers who face the long hand of the AMT tax, with many of them falling squarely in the middle of the middle class.

Congress has consistently taken action to protect the middle class from the AMT. We do this, as we know around here, on a year-by-year basis, and each year it is costing more than the previous year with the number of people who face the tax growing each year. The recent 1-year patch cost $70 billion. A 10-year fix is expected to cost $447 billion. Sadly, history has a habit of repeating itself, and Congress has demonstrated a consistent inability to learn from its mistakes.

My prediction is if the Medicare payroll tax increase becomes law, Congress will, once again, need to spend large sums of money to protect the middle class from this onerous new tax.

Let's delve into the Medicare and Medicaid restrictions on doctors and

nurses under these government health programs. In my State of Alaska, in our most populated city, Anchorage, we have very few general care doctors who are willing to accept Medicare patients. We had a study done not too long ago, and the number given in that study is there are 13 providers, 13 doctors who are taking on new Medicare-eligible individuals. In Alaska, if you are about to hit the magic age of 65, going on Medicare, you have Medicare as your primary insurance whether you like it or not.

What you learn when you are on Medicare is you have very few doctors willing to see you. Eighty-three percent of the primary care doctors in Alaska's largest city will not see Medicare patients. These individuals, who before they were 65 enjoyed unfettered access to care when on private health insurance, whether they had it through the municipality, Anchorage, or they worked for a private employer, they are now realizing the harsh realities of Medicare and that they are going to face some severe restrictions in access to a primary care doctor.

We are seeing it on a very accentuated basis in Alaska, but we are seeing it in many parts of rural America. It is almost unthinkable to me. A number of constituents have come up to me and have said: Look, just get us out of the Medicare system. Let us go out to the private market and purchase health insurance like we were able to do before we were on Medicare because, regardless of the contributions I make, regardless of how much I have paid into the Medicare system, it doesn't mean anything to me if I don't have access to care.

They are saying: I know I have worked all these years to pay in, but I want my old insurance back. It is because what we have done is restricted their access to services, and it is something they have never dealt with before.

This problem is not just in my State. According to GAO, we have States such as Colorado, Oregon, and New Mexico that are facing these major restrictions in access to primary care doctors. Senator Daschle, when he was doing his health care tour last year, when he was in Dublin, IN, and talking to doctors about how best to reform our health care system, the doctors in Dublin told the Senator that the Medicare reimbursement rates are not keeping pace with the costs of a medical practice. So if we know that private insurance pays significantly more than government insurance, then access under a government plan will undoubtedly be reduced. We have seen this both in the Medicare and the Medicaid Programs.

Under the Medicaid expansion program in this health care bill, we know that Medicaid is now going to include individuals up to 133 percent of poverty. Under the Democrats' health bill, the Federal Government pays all the costs covering newly eligible enrollees through 2016. This is good for the States. It will allow Alaska, for example, to expand the roll of the Medicaid Program and include more Alaskans on the State's Medicaid Program. CBO said after 2016, the share of the Federal spending is going to vary somewhat from year to year but ultimately would average about 90 percent.

If you are responsible for your State's budget and your State can no longer afford the Medicaid Program in the year 2017, when the Federal Government drops that coverage to somewhere around 90 percent, if your State is a balanced budget State such as Alaska and your State revenues are going down because of what is happening with tourism or a bad fishing season or the price of oil, what then do the States do to continue the Medicaid Program?

It seems to me there are a couple options. They can either drop the expanded Medicaid population or they could reduce reimbursements rates and place the Medicaid enrollees who once had decent care in Alaska in the same predicament as my Medicare constituents are currently in.

There is a reason why Democratic and Republican Governors have said this Medicaid expansion is the mother of all unfunded mandates.

While all these provisions I mentioned are certainly enough for me to decide not to support this health care bill, the most troubling aspect we are seeing played out in the news right now is the impact of government rationing, which will allow the government to deny access to health care services.

This is something Republicans have been speaking about all summer with regard to various health care bills. We have all seen throughout the news a great deal of concern over the announcement from the U.S. Preventive Services Task Force that it no longer recommends routine mammogram screening for women between the ages of 40 and 49. This task force's recommendation is just a look behind the curtain of what we can expect if the government runs your health care.

Under this bill, we are going to provide one person, the appointed position of the U.S. Secretary of Health and Human Services. We are going to give her the ability to make a wide variety of determinations, both on the health exchanges as well as in the government-run plan.

I am very concerned about what we are finding from this task force and what it means for both men and women who suffer from this deadly disease. I can tell you, without a doubt, what this has caused is great confusion. The task force came out with their recommendations and then, shortly thereafter, Secretary Sebelius came out saying women in their forties should continue to get mammograms. The task force is saying women should not even conduct self-breast exams. We have constituents who don't know what they should or what they should not be doing. This is why we need a hearing to better understand how this task force came to their conclusions.

But the bigger picture is, what we need to appreciate is this ordeal we have been dealing with this week is a glimpse into the chaos of what we could see with a federally run health plan and a massive expansion of the Federal Government's role in your health care.

I wish to mention, because there have been multiple accounts in the media about, no, we are not intending that this task force recommendation is going to change in any way what coverage might be available to women. I know that some of my colleagues on the other side of the aisle have recognized, in fact, that these recommendations do hold great weight with the policymakers and the insurance companies.

One of my colleagues from Maryland has said she plans to offer an amendment that would address or limit the cost of breast cancer tests for women 40 and older. She said otherwise insurance companies may use this new recommendation as yet another reason to deny women coverage for mammograms.

In fact, in the bill, there are at least 14 references to the U.S. Preventive Services Task Force. In section 4105 is a provision that would authorize the Secretary to modify benefits under Medicare if consistent with task force recommendations and deny payment for prevention services the task force recommends against.

This could be a situation we should be very concerned about how, with recommendations such as we are seeing come out of the task force, they inadvertently or perhaps advertently will impact a woman's access to care.

I know I have probably gone over my time, and the Senator from Oklahoma is waiting. I will close my comments by saying we do need health care reform. I echo the remarks of the Senator from Maine. We need to do it the right way. Setting an arbitrary timeline, saying we have to get it done by this holiday or that holiday or moving down the calendar—we have to take the time to do it right.

We have to bring down the premium costs so everyone can have access to affordable health care. Imposing mandates on individuals or on employers, if we haven't done anything to provide for greater affordability, we haven't helped the situation.

Unfortunately, this bill does not help us with the affordability piece. I am focused, as many of my colleagues are, on an alternative, a step-by-step approach to reduce our health care costs

to allow businesses to buy across State lines, allow co-ops to be formed so that fishermen in my State or other coastal States or employees of a small business can pool together to purchase affordable comprehensive coverage.

Just as important is certainly the need to preserve the rights of patients to see the doctors of their choice. We must make sure we are protecting Medicare coverage for seniors. We have to eliminate the discrimination based on preexisting conditions, ensure that expansion of government health programs will not result in restrictions in access to care because of reduced reimbursements to doctors and hospitals.

While this bill does attempt to address several of these issues—for instance, the one about eliminating discrimination based on preexisting conditions—it delays the implementations of some of the more worthwhile provisions until the year 2014.

We have bipartisan support on many of these pieces individually. So why would we not try to work on those areas where we do have agreement, where we do have consensus rather than waiting until 2014?

I held a townhall meeting in Chugiak, AK, last week. It was a pretty tough night. We had winds that were howling off the mountains, snow all over the place, and real slick and icy roads. Over 200 people decided to brave the weather to come and speak out on the issue of health care reform and what is happening in Washington, DC.

I will tell you, the one thing those constituents stood and repeated over and over was: Don't pass health care reform that is going to raise our taxes, that is going to increase our premiums, and that will cut Medicare.

We need to listen to these folks. We need to listen to the American people. We have an opportunity to do it right. There is a lot of good work that goes on by a lot of good people in this body and outside this Chamber. But we are at a point now where because of deadlines—artificial deadlines—we are forced to a process tomorrow evening where we are going to have a vote on a cloture motion on the motion to proceed. As my colleague from Oklahoma pointed out, it is a bit of a shell. We think we are going to this health care bill that is 2,000-some-odd pages, but, in fact, the vehicle we will be using on the motion to proceed is not what this is. I am not going to suggest it is bait and switch, but it could be bait and switch.

I do believe our opportunity to share our concerns about what is contained in this legislation is now. We need to take the time to explain to our constituents the concerns we have, the problems we have, the unintended consequences we believe are part and parcel of this legislation.

I thank the Presiding Officer for the time this evening and thank all my colleagues for their coordinated efforts to help provide a little bit of insight to the American people on what we are dealing with in the proposed legislation from the Democratic leader.

I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Oklahoma.

Mr. COBURN. Mr. President, first, I would like to say thank you for presiding. You drew the unlucky number tonight and I appreciate it.

We are embarking on a process that is going to start tomorrow night and people are going to cast a vote on a bill they have not read, and saying we ought to go on with it.

For just a little history, 97.8 percent of the time in the Senate that a cloture motion passed to proceed to the bill, the bill becomes law. That is an interesting statistic, especially when we are going to hear those who say they just want to have the debate. The fact is, that is not what is going to happen.

As one of the two practicing physicians in the Senate, I thought I would spend a little bit of time tonight talking about what I see is wrong with our health care system as well as talk about what I see as good about our health care system and then talk about the approach this bill takes. My staff has been through the vast majority of this bill. I personally have not, but I will. I will talk about how it affects us.

What is the real problem in health care today? What is it that keeps people from getting care? The No. 1 problem that keeps people from getting care is cost. It costs too much. Fully either one-fourth or one-third of every dollar we spend on health care does not help anybody get well and does not prevent anybody from getting sick.

There is an interesting study out by the Thomson Reuters report that says that $600 billion to $850 billion is wasted annually in all American health care.

When you break it down, it is broken down like this: 40 percent is health care waste, unwarranted treatment, overuse of antibiotics, use of diagnostic lab tests to protect against malpractice exposure. That accounts for $250 to $350 billion in annual health care spending. It is attributed to extra tests and procedures generated mainly from defensive medicine or Medicare's fee-for-service system.

The second biggest factor out of this $800 billion we are wasting is health care fraud. It is 19 percent of health care waste—at least $125 billion to $175 billion a year, and most of that is in government-run health care programs. Not the private—the private sector has less than 1 percent of fraud. They also have a denial rate that is one-half to a one-third of Medicare's rate in terms of denial of payment claims.

The third most important thing in terms of waste is administrative inefficiency. The large redundant volume of paperwork in the U.S. health care system accounts for $100 billion to $150 billion in spending annually.

The fourth most important area, 12 percent of health care waste is health provider errors, errors we make caused by me as the doctor, or a hospital, that causes us to spend money we should not have to spend.

Six percent of the health care waste is preventable conditions, such as somebody with diabetes getting their blood sugar out of control and ending up in the hospital; whereas if they had good care, coordinated care, it wouldn't have happened.

Of course, No. 6 is 6 percent of health care waste, and that is lack of coordinated care, where we do not coordinate the care, where doctors don't talk to one another, doctors don't talk to the hospital, doctors don't get all the information, so consequently we waste money.

So the first problem that plagues us is that cost is too high. We fully know that $1 out of every $3 we spend on health care is not helping health care. That is our pot of gold. That is where we lower the cost. Just think what health care would cost if it costs one-third less today or if it costs the same for the next 5 years. That means we could cover everybody who is not covered for free and have about $400 billion left over if we just went after where the pot of gold is.

The second problem with our health care system is we have disconnected the purchase of health care from the payment of health care, so that when I go to make a purchase I no longer use the discrimination that I use in everything else that I purchase, such as seeing if it is of value to me. I don't ask what it costs, I don't ask if it is the best way to get this, if it is the most economical way to get there. I don't question to make sure—are you sure I have to have this done? I don't necessarily get a second opinion. I don't ask, if it has to be done, where is the best place as far as efficiency and dollars to get it done.

The reason we don't ask those questions is because most of the time the money isn't coming out of our pocket because we have this perceived false belief that our insurance company or the government is paying for it. If our insurance company is paying for it, we are paying for it because for every 3.5 percent cost our company is paying for insurance, 2 percent of that would have been our wages. And for every $1 that we spend on Medicare, our grandchildren and our children are paying into that fund to pay for our Medicare. In fact, it does cost us, but we have disconnected that cost.

The third thing we have done is we have a Tax Code that says if you are fortunate enough to have your employer pay for your health care benefits, you get $2,700 more in tax benefit

than everybody who doesn't have their employer paying for their insurance. You get about $100 in tax benefit if you don't get your insurance through your employer. So we have a 27-fold discrimination that advantages those whose employer pays for their health care versus those who have to buy it on their own or their employer doesn't offer it.

That is wrong. It is not fair. It is unequal treatment, and it creates this maldistribution. But, even having said that, the cost for an individual plan versus the plan bought through your employer, if you buy it in a nationwide marketplace, if you could, it would be 20 percent less than what you could buy it for through your employer. Those are the real statistics.

Then the fourth thing I see that is wrong, as both a patient—I ought to stop here in a minute and tell everybody, at 61, almost 62 years of age, I am a two-time cancer survivor. I have had malignant melanoma and metastatic colon cancer. I also have atrial fibrillation. I have been a patient. I have been on the other side of my stethoscope as a patient.

What I see is, we have limited the options for people in this country. If your employer buys your health insurance, you have very limited options. You get take it or leave it most of the time. Here is what we are providing: You get to take it. If you don't take it, then you have to go outside and you loose that $2,700 advantage, so it comes out of your pocket.

We don't have the freedom to choose within our employer. We also have the States. We heard the Senator from Maine talking about the greatly increased costs in Maine. There is a reason Maine has the massive inflation in their health care insurance. They created the State plan that caused it, that truly limited the competition. So they have seen the results of limited competition because of what they installed. But every State has an insurance commission that both decides who is eligible to sell in the State but also follows the mandates; here is what the minimum is that you have to buy in your State.

Then, of course, if you have Medicaid, you have limited options because 40 percent of the physicians in this country will not see you. If you have Medicare, you have limited options because now about 15 percent of physicians, fast rising to 30 or 40 percent of the physicians in this country, aren't going to see you.

Then if you have VA, you get VA and that is it. You don't get to choose your doctor or you don't even get to choose your location. Here is where you will be, no matter how many miles it is, and here is the doctor you will see. The same thing with TRICARE essentially because TRICARE has limited coverage in terms of availability of all the physicians.

The fifth thing I see that is wrong is there is an absolute lack of transparency as to what something costs and what you can expect as far as quality outcome. That makes it hard to know how to buy, where to buy, or who to buy from. Who do you trust? So if there is no transparency in either quality or price, you are going to have a tough time making a decision. All of the things I am describing describe a lack of liberty, a lack of freedom.

We have government mandates. Have you ever gone to a hospital—this is a great question. One of my constituents wrote in and told me this, and I never had thought about it. Go to a hospital in the middle of the day and try to get a parking spot. Then go to a hospital at 10 o'clock at night, and the parking lot is almost empty. What you are seeing in the difference in the parking lot is the administrative bureaucratic overhead that is required in a hospital to manage the mandates that the government has put or the insurance company has put on the hospital.

If you look at it, fully one-third of the people in every hospital in this country don't do anything to help anybody get well. They are filling out forms, they are pushing the paper, much like this study I mentioned from Thomson Reuters.

Then we have the insurance mandate. What is wrong? If, in fact, you have a preexisting illness, you don't get insured. That is wrong. We need to fix that. Or if you get sick, insurance companies have figured out a way to drop you. That can't be right. That is why you bought insurance in the first place, and that is not just in the health insurance industry. Try filing a claim for a new roof on your house and see what your insurance costs do next year or if they will insure you. We get hail all the time in Oklahoma and we get roof damage and a lot of times if you have that 2 out of 10 years, they will not even reinsure you. So you have to go find somebody else.

It is a practice of risk management that they are using that doesn't think about the potential market of who their customer is. So I agree we ought to fix those things.

Then we have the costs. Already the Senator from North Dakota tonight talked about drug prices. The one thing he didn't tell everybody is that the reason drugs are cheaper in Canada is because they threaten not to honor intellectual property of this country.

There is a real good way to make sure drug prices go down. Both the Bush administration failed on this and the Clinton administration failed on this—and this administration. If Canada wants to tell our drug companies what price they will pay, then we will tell them what we will pay for their lumber, and we will tell them what we will pay for anything else they want to import to our country. But we put all the focus on the drug companies instead.

So I am going to get to my point. The other thing that is wrong is, on average it costs $1 billion per new drug just to go through the FDA process in this country because we have such a litigious society, that it costs two to three times more to approve a drug in this country than it does anywhere else in the world.

We have drugs that are fantastic drugs that are made by companies in this country that are not allowed to be sold in this country that have passed all the safety and efficacy standards of the European common market, but they can't get them through our Food and Drug Administration because the Food and Drug Administration is worried about somebody criticizing them if they ever make a mistake. They met the standards, did it right, recalled it, now they are afraid to approve anything because they are afraid somebody will be critical of them.

Another thing that is wrong is we have the lack of any real market forces. Insurance companies really don't have to compete.

They really don't have to compete. The government sets the price for everything, essentially, because Medicare says what they will pay and everything else is priced off that.

Here is another thing that is wrong with our health care system. We are starting to experience it. There is a maldistribution of physicians both in terms of geographic location and physician specialty. One in 50 graduates of med schools last year went into primary care. Everybody else went into specialty and subspecialty residencies. Why did that happen? The reason it happened is because the earning power of somebody who has 7 years of medical training is one-third of somebody who has 8 or 8½ or 9. How did that happen? Because Medicare set the payment rates. Medicare set the payment rates, so they created a maldistribution in terms of the payment for physicians.

Another thing I noticed as a practicing physician and as a patient is that our whole system right now has its emphasis on sick care, not on preventing disease, not on prevention, not on the maintenance of chronic disease. We wait until people get sick and treat them. That is expensive. The reason it is that way is because Medicare won't pay for prevention. They refuse to pay for prevention. If you sit down with a patient in your office, a Medicare patient, and spend the time to go through the risk factors and the lifestyle changes and their medicines, the things they need to do, you will not be compensated enough to pay the electricity bill for that office visit. So what has happened is we have incentivized people not to spend time with the patient. We have incentivized them to see more patients for shorter

periods of time and not listen to the patient and not spend the time on prevention because our dollars have been incentivized against it.

Then, finally, government systems are designed to be defrauded. If you think about it, it is easy to make $500,000 a month off Medicare; it is hard to get caught. All you have to do is know a whole lot about medicine, have a little bit of guts, and set up a vacant office somewhere and put one computer in it and run everything over the line, and you can rip off Medicare like crazy. We know the drug dealers in Florida are starting to shift away from drugs and into Medicare fraud because it is easier to do. They can make more money. It is harder to get caught, and when you do, the penalties are much less. It is designed to be defrauded, but we haven't changed that.

I have talked about the problems. Let me talk about what is great about American health care.

I want to make the point in a minute that the worst thing we can do in trying to fix what is wrong is destroy what is right. We have the greatest acute care anyplace in the world. If you get sick, there is no better place in the world to get sick than in the United States. I don't care where you are. The statistics bear that out. There is no question. If you get cancer in this country, you have a 50-percent greater likelihood of being alive 5 years from now than anywhere else in the world. It really doesn't matter what type cancer. There are some differences on some, but overall you are 50 percent more likely to be alive.

The third thing that is great about our country is, innovation in health care is two-thirds of the world. Actually, last year it was 74 percent of all innovation in health care came out of this economy. We have invested in the research. We have the scientists. We have the researchers who have pulled together technology, thought, experience, and research, and come up with great innovations that make big differences in life expectancy and quality.

The other thing is we have a very skilled workforce. We have some shortages. Our nursing shortage has been created by the government because we created a health care system that has both hospice care and home health care, but we made the only way that can effectively work is through registered nurses. So we sucked all the registered nurses out of the hospitals because of time constraints and lack of holiday work and lack of shift work. The best nurses want to go where they don't have any of those things. We created a shortage when we could have created a different class of somebody doing home health care rather than an RN. But that is what we have done. We have created this sucking sound, as Ross Perot used to say, and sucked the nurses out of the hospitals. Now we have this critical shortage of nurses in our country because of what the government did.

The other thing besides the skilled workforce, the nurse practitioners, the PAs, nurses, physical therapists, pharmacists, radiologists, doctors, surgical nurses—they are great in this country.

Then we have great medicines. If you think about it, the combination of medicines that saved my life with metastatic colon cancer were all developed here. Six months of chemotherapy, of being sick every day, has been worth every morning I see the Sun. It is this research, the investment in NIH, the quality of research, the committed doctors who will do the research, committed doctors who will take care of you when you are sick and you don't feel like communicating with anybody, but yet they are patient with you—they love you, they nurture you. We have a great system here.

If you have a cardiovascular event, this is the best place in the world to have one. If you have a heart attack, a stroke, if you get cancer, if you have an acute fracture of a limb or joint degeneration, this is the best place in the world to have it.

So I have outlined the problems, which are big, and the things that are good. What do we do with that? Our goal ought to be to not destroy all these good things while we fix the things that are not good.

How did we get in trouble? How did we get to where we have the highest percentage of our GDP, this thing that really limits people in care, cost—how did we get where we are? Why is it? Part of it has been innovation. About 30 percent of the cost increase we see in our country is because of innovation. It takes money to get innovation. When innovation comes out, we have to pay for the research that was not paid for upfront. About 30 percent of the health care inflation we see is from new products, new innovation, new ideas, new treatments, new strategies or procedures. But the rest of it goes back to this Thomson Reuters, where we have this inefficient delivery system of health care.

A question I asked my staff—and we did the research—what was health care inflation before 1970? Do you realize that most of the time it was less than the regular increase in inflation? What was the difference? What happened? What happened is the government got involved in health care. We created demand that was price-controlled demand, and all of a sudden the bubble started squeezing up.

The other point I wish to make is that most people don't realize that 61 percent of the health care in this country today is run through the government. If we have a problem with health care, we have to look at not where the 39 percent of it is but where the 61 percent is. Let me explain what that is. That is Medicare, TRICARE, VA, Medicaid, Indian Health Service, SCHIP, DOD, and FEHPB. That accounts for 61 percent of the people in this country who have health care. They are getting it through the government now. Our answer is more government? Our answer to the solution is more government?

What should our goals be? Our goals should include access for everybody; affordable prices; liberty to choose what is best for you and yours, not limited by your State, not limited by the Federal Government, it should be your choice; freedom to choose your caregiver. You don't get that in Medicaid. You don't get that at the VA. You don't get that at Indian Health Service. You limitedly get it through Medicaid. Another goal is security in your health care, knowing that no matter what happens, you will have health care. Those are things I think the Presiding Officer would agree with.

I am joined on the floor by the other physician in the Senate, Senator BARRASSO from Wyoming. I welcome him.

I wanted to spend 1 additional second outlining a few things.

Here is the bill we have on the floor, the Reid substitute. I will not talk about the parliamentary shenanigans that have gone along with what we are doing. The fact is, we are going to have a debate on health care. It couldn't have been said any better than by Senator SNOWE. Every major piece of legislation that has affected most people in this country has occurred on a bipartisan basis. If this gets passed, you will see a revolt in this country because it is not what the vast majority across party lines want to see. We need to meet in the middle.

Just so I can tell you what is in here or what is not in here, there is no provision in here guaranteeing that taxpayers will not finance abortion. There is no provision prohibiting the rationing of health care. You will see rationing of health care with this bill. We are seeing it now in Medicare more every day. CMS is not supposed to be doing it, but they have a reason not to do it. There is a law that says they are not supposed to do it, but it doesn't prohibit them. Now they are rationing about 17 things. They have made a decision on practicing medicine. You will see that.

There is zero number of Senators who are going to be required to enroll in the health care bill we will put everybody else on. There are nine new taxes created in this bill, nine new separate taxes. There are 13 pages in the bill's table of contents, single-spaced. This bill weighs 20.8 pounds. There are 36 pages in the CBO explanation of what they think it might or might not do. It has 70 new government programs. Think about what that means in terms of bureaucracy and then think about your choices, about who you want taking care of you and whether you and

that caretaker, that physician are going to get to decide what is best for you or some of these 70 new government agencies. And 1,697 times in this legislation we allow the Secretary of Health and Human Services to create, determine, and define critical things in this bill and write the regulations—1,697 times. There are going to be 1,697 new sets of regulations in health care in this bill alone. There are 2,074 pages. There are 2.5 million people who will lose their health insurance with this bill who have it today. They are going to get moved into some government program. There are still going to be 24 million people left without health insurance, if this is fully implemented, according to CBO. This bill costs $6.8 million a word. It is $1.2 billion per page. Ten billion will be needed every year for the IRS just to follow the regulations for the tax collection in this bill. That isn't even considered in the CBO score. There is going to be $8 billion in taxes levied on uninsured individuals. There is going to be at a minimum $25 billion a year in increased mandates on States for Medicaid; there is $28 billion in new taxes on employers not providing government-approved plans; there is $100 billion of fraud annually in Medicare; there is $118 billion in cuts to Medicare Advantage; there is $465 billion in total cuts to Medicare; there is $494 billion in revenue from new taxes and fees levied on individuals, on American families, and businesses. Mr. President, $2.5 trillion is the non-Enron accounting cost for this bill.

Finally, there is $12 trillion worth of national debt today, and this bill by itself will take it to $15 trillion in 10 years. It will increase the national debt in less than 10 years by $3 trillion.

So with 61 percent of the health care in this country already supplied by the government—and either bankrupt or going bankrupt or not giving the care that is promised; look at Native American care—we are going to do more government health care.

Senator MCCAIN had a great analogy the other day on this bill. This bill starts collecting taxes right away. The American people need to know the reason there is the delay in the onset of the benefits in this bill. It is because that is the only way they can make it score and look like it is not spending the amount of money it is spending.

But he used this analogy and I thought it was really great: This bill is like you buying a new home; you go get your mortgage, and you start paying on your mortgage, and you get ready to move in the house, and they say: Uh-oh, the deal was you can move in in 5 years, because that is when the benefits start, 5 years from now. But we want you to pay on it for 5 years before you get to move into it.

None of us would do that. Yet that is exactly what this bill does. It is not a bait and switch. It is just deceptive, and it is dishonest in its accounting. And, of course, Washington has been dishonest. We use Enron accounting. Anything that makes it look less expensive or us look better, that is how we account for it.

Finally, I would say this, and then I will yield to my colleague and fellow physician, Senator BARRASSO.

Of the things that are wrong with health care in America and the things that are right—the things that are right are because we have a patient-centered system; the things that are wrong are associated with a government-centered system.

This is a government-centered health care fix, and it is not even a fix. It does not address malpractice costs. It is somewhere between $100 billion and $175 billion a year in tests we are ordering that people do not need because we refuse to address the tort system in this bill.

What we need is a patient-centered result. What we need is meeting in the middle to solve this problem for the American people.

Abraham Lincoln said: America will never be lost by being destroyed from the outside. If we falter and lose our freedoms, it will be because we have destroyed ourselves.

This bill is the path to destruction for health care in America. Eighty percent of the people in this country will get along just fine with this bill. Twenty percent are going to suffer drastically under this bill because it totally ignores the clinical practice of the art of medicine. Everything is based on a government-run, government-mandated, government-controlled fiat that takes away your liberty, takes away your choice, takes away your freedom; and now we will move physicians from having to be 100-percent advocates for the patient to an advocate for the government first and the patient second. That is the first health care outcome we could have.

Senator BARRASSO.

Mr. BARRASSO. Mr. President, continuing along this line—because both of us have practiced medicine—I took care of families in Wyoming as an orthopedic surgeon for the last 25 years; Dr. COBURN in Oklahoma for longer than that. We know there are things that need to be corrected. There are improvements that need to be made. We need to fix what is wrong with the system, and that is what I hear every weekend when I go home. It is what I have talked about in the surgeons' lounge in the hospital. That is what I have talked about in the office with my patients. So we need to fix what is wrong with the health care system. But whatever we do, we have to make sure we do not make matters worse. So I say to my friend from Oklahoma, absolutely, my concerns are that this absolutely is going to make matters worse. It is going to increase premiums for families who have insurance. It is going to take almost $500 billion away from our seniors who depend upon Medicare for their health care. It is going to raise taxes on everyone in America—not just on people above a certain income level, on everyone.

They all are going to be impacted when you look at all the taxes that are going to be thrown on this. It is going to be passed along. People in America understand that. People know exactly what is happening here. That is why when I had a telephone townhall meeting earlier this week and asked: "Is this the right way or the wrong way? Do you think you are going to pay more?" Everybody thinks they are going to pay more. When asked: Do you think your system is going to get better or worse? They think it is going to get worse. Americans do not want to pay more and get less. That is not the value we as Americans want. It is not what we expect.

People say: Don't cut my Medicare. Especially, if you are going to try to do anything with Medicare, do it to save Medicare, which is already going to go broke in the year 2017. Don't do it to start some whole new, big government program. They say: Don't raise my taxes. People want to know what is going to happen to them, what is going to happen to their family.

What happens if they get sick? Well, they look at this and they say: We want practical, commonsense health solutions, not higher insurance premiums, not higher taxes, not Medicare cuts, not more government control over health care decisions. We want to have lower costs, improved access to providers, more choices. That is the whole crux of why we are doing health care reform, at least that is what I was told 9 or 10 months ago. When they said: We need health care reform. I said: Yes, we do.

I served 5 years in the Wyoming State Senate. We did major pieces of legislation, always in a bipartisan manner, as the senior Senator from Maine has said. Now we are trying to find a way where somebody is trying to get just the minimum number of votes to pass this—not because they want to say, let's see what we have that will work for people.

As doctors, we try to find solutions that work for people. We do not say: What is the very minimum we can do? That is what we are seeing here. We are saying: What can we do to get it right? What this bill is saying is: What can we do to get 60 votes, the minimum we can do to get this, to drag it over the next step along the line—not to solve the health care issue that faces our country.

We know we need to deal with access to care, quality of care, and the cost of care. As my colleague from Oklahoma said earlier, it is the cost of care that

needs the attention right now. Eighty-five percent of people like the care they have but they do not like the cost of that care. So what can we do to help get that cost down?

Everything I read and everything I know and everything I study and everything I believe from my years of practicing medicine and taking care of patients tells me this is going to drive the cost up for everyone in the country. And that is not just me.

The dean of Harvard Medical School said it just the other day. He gave the whole thing a failing grade. He said those ''people who favor the legislation are engaged in collective denial.'' And he went on to say that when you talk about the problems of cost and access and quality—with the cost, he said, this ''will markedly accelerate national health-care spending rather than restrain it'' and will ''do little or nothing to improve quality.''

Well, if you are going to spend much more money, you ought to get increased quality. But the problem is not that we are not spending enough money. We are spending enough money in the system. Half of all the money we spend in this country for health care goes for just 5 percent of the people—people who eat too much, exercise too little, and smoke. But there is nothing in this bill anywhere that gives an incentive to those individuals, to that one person to say: Hey, look, we want you to quit smoking. We want to help you lose weight. We want to help you get your cholesterol under control, through exercise get your diabetes under control, get your blood sugar down. There is nothing that gives an incentive to any one individual.

Now, there is a lot of money in here for roadways and streetlights and jungle gyms to encourage community health. But that does not work. What works better is an individual incentive to some person to say you are going to save this much money, get this much money, if you take responsibility for your own health. A lot of people try to do that on their own. But those are the 95 percent, not the 5 percent who are costing this country 50 percent of its health care dollars.

But I will ask my colleague from Oklahoma, do you see anything in here that focuses on that individual patient, a patient-centered approach, as opposed to a government-centered approach or an insurance company-centered approach? I see nothing here that is really focused on the individual patient, giving them incentives, giving them opportunities, giving that individual, American citizen more control, more freedom of choice, to help stay healthy and keep down the cost of their care.

Mr. COBURN. Mr. President, in answer to my colleague's question, there is not an incentive. This bill is full of mandates. And what it does not mandate it sets up panels to mandate. It sets up panels of bureaucrats to mandate. The real difference on this bill—and I believe we have big problems with the insurance industry, but I do not think you eliminate it. I think what you do is you clean it up and make it have to be competitive and fair and open and honest. What the bill does is it mandates.

Just this week, the Preventative Services Task Force came out with new recommendations for mammograms. If you are only thinking about cost, they are great recommendations. If you are looking at it only from cost—how do we most effectively spend the dollars—their recommendations are absolutely right. But if you are thinking about health, their recommendations are absolutely wrong.

You ask the thousands upon thousands of women last year under age 50 who had their breast cancer diagnosed early with a mammogram what they think about the Preventative Services Task Force's recommendation and listen to what they have to say. What they are going to say and what they are going to tell us is that would have made me odd woman out because I would not have had a mammogram. I am talking not high-risk patients. What they are talking about not screening—and that is what the majority of these mammograms find, with no symptoms, no increased risk—you are going to see that multiplied one-hundredfold in this system.

I know the Senator is old enough to have been trained in medicine the same way I was. There are three real tenets in medicine. The three tenets they drill into you are—the first thing is do not hurt anybody. Whatever you do, try not to hurt anybody. And in the practice of medicine and the art of medicine sometimes that happens, we do hurt people. Sometimes we hurt them on purpose to try to get them better. But the first is to do no harm.

The second is to listen to the patient. Well, the patient at this time in America is the American citizenry, where 85 percent of the people pretty well like what they have, and they want the good kept as we fix what is wrong.

Finally, the third tenet of medicine that almost every doctor is taught is, if it has already been done and it is not working, do not do it again, and do not keep doing it.

Well, let me tell you something. Medicaid is not working. Indian health care is not working. Medicare is broke. The States are broke under the weight of Medicaid. We should give great pause as we break the three tenets of medicine in hopes of saying we reformed health care.

When President Obama spoke to us under a joint session of Congress, this is what I believe he should have said. This is an important matter for America. It is important to us economically. It affects every individual in this country. And what he should have said is: I have not been leading very well on this because we are way over here on one side on this issue, and I am going to admit I have not been leading very well. But here is what I am going to do. I am going to bring us together in the middle where we can all agree on—it is kind of like Senator ENZI's 80-percent rule. It is a great rule. Senator ENZI has joined us. He is the ranking member of the Health, Education, Labor, and Pensions Committee. I want to bring us together and find something on which 80 percent of us can agree.

Had he done that, he would have been a hero in solving the problems in which we find ourselves. Instead, we are going to try to pass something that, before we are through with it, the vast majority of Americans are not going to want. And if you do pass it, and he does sign it, they are going to revolt.

So as our friend LAMAR ALEXANDER said: What we ought to do is start over. We ought to fix one step at a time the things we know are most important, as the author and promoter of association health plans suggests, where we increase the buying power; transparency in the insurance market; risk reevaluation so people can't cherry-pick; eliminate preexisting illnesses so they can't cancel insurance. All of those things we can do without creating all of these new programs, all these 1,697 times that the Secretary of HHS is going to write the rules and regulations.

I thank Senator BARRASSO, No. 1, for his insight and experience. I would leave our colleague, the senior Senator from Wyoming, with this thought: You have two doctors down here who happen to be Senators, who have well over 50 years of practice experience. I had a business career in the health industry prior to going into medicine. We diagnosis this bill as sick. We diagnosis it as something that should be pulled from the market, just as the FDA pulled Vioxx. It will not solve the problem; it will make the patient sicker.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I wish to thank the two doctors for their comments. I have been enthralled with what they have been saying. They have been doing a series of programs to help people understand what we could do with health care and how health care is being done. I am glad they point out that vast difference. Obviously, it was a very effective program. It was so effective that the other side decided to have a show too. They put up the two lawyers, and it shows one of the problems.

When the President did speak to us at the joint session, he talked about medical malpractice reform and how he was going to do it the next day. The only problem is what he was referring

to was a bill I did with Senator BAUCUS that was ignored in the HELP Committee and it was ignored in the Gang of 6 and it was ignored in the Finance Committee, something that would have gotten some medical malpractice reform going. I think that only saves about $54 billion. That is still a lot of money to me. It is a lot of money even in this bill, although this is a $1 trillion bill.

I appreciate the doctors. I particularly appreciate my colleague from Wyoming who has been here all day adding comments from his medical background and making a substantial contribution to having the people of America understand this bill. But the people of America understand the bill better than the people in this Chamber. That is the problem. In August there were town meetings and people were appalled at the number of people who wanted to go to those town meetings and the way they wanted to speak, and they explained to us why this method won't work. It wasn't because anybody organized them. If Republicans were that good at organization, we would still be in the majority. These were people who were concerned about health care and where it was going. They had read a lot about what had been said, and they are still reading about it, and they are still mad. This isn't where they want to go. The average person in America thought we were going to cut their health care costs or at least keep them from escalating. That isn't what this bill does. This bill builds a whole bunch of new programs and taxes people and steals from Medicare. That is not where the country wants to go. I know that is not where the seniors want to go. I have been surprised at the AARP endorsing the bill. Their members don't think so. Their members are appalled at what is in here and how it is going to affect Medicare.

But my real intent tonight is to discuss this bill and how the increase in health care costs raises taxes and particularly affects small businesses. It makes them less competitive. Small businesses across America are the engine of the economy. I don't know how many times I hear that around here—the engine of the economy. If small business is growing, the economy is growing. If small business is stagnant, people are still losing jobs in big businesses, and it is usually the ones who lose the jobs in big businesses that eventually get absorbed into the small businesses. It is a shift of a brain trust and it makes the small businesses grow and they stay the engine in the economy.

As many of my colleagues know, before I came to the Senate I was a small business owner. My wife and I owned three small shoe stores in Wyoming and Montana. When I talk about small business, I don't talk about it in the vacuum of the Senate floor; I speak from my life experience. I know what it is like to manage a small business, to keep the books, to pay the vendors, and always to serve your customers. In the Small Business Committee I like to remind them that even though the Federal definition of small business is 500 employees or less, the real engines of the economy are much smaller than that. Some of them are the ones that are just starting, where the owner of the business sweeps the sidewalk, cleans the toilets, waits on customers, and does the books, and definitely not in that order. That is the small business. That is a small business growing. Those are the kinds of businesses that becomes the big businesses. A lot of them fail. A lot of them know they are taking a risk, but thank goodness they are willing to take that kind of risk. They never expect the government to add to their risk, but they know it does.

I faced the challenges of making payroll and trying to negotiate good, affordable benefits for my employees. I have had that experience of sitting bolt upright in the middle of the night and saying, Tomorrow is payroll. How am I going to meet payroll? Sometimes you do it without paying yourself, but the business keeps going.

I have to say in a small business the employees are very close to the business. They understand how tenuous it is. They work and they participate and in the good businesses, they are all like family. So they don't have some of the same choices that the big, flexible companies do. I see where a company in Virginia is about to lay off—America On Line is about to lay off 2,500 people. The person who lays them off, do you think they know those 2,500 people? No, they won't know those 2,500 people. I suppose that makes it a lot easier. But in small business, they know their people. They want to do whatever they can to keep that brain trust, that skill, that ability around, and they sacrifice a lot to get to do that.

As a former small business owner, I also understand that if we pass this bill, it will harm the engine of economic growth, and it will be a disaster for millions of Americans. This bill will impose $493 billion in new taxes, and those fall disproportionately on the backs of small business men and women.

For instance, the new $54 billion increase in the Medicare payroll tax will hit approximately one-third of the small business owners across the country. These are the same businesses that employ over 30 million Americans. So why would this affect them? Do they make that much money? Well, that much money shows up on their books. Most of them are Subchapter S corporations, which means that every dollar of profit becomes their own income, even though they have to take most of it and put it back into the business in order to keep the business going and to grow the business. But some of them look like they make a lot of money.

There are some businessmen in Gillette, WY, and they started a restaurant. They now have six restaurants. I happened to be in one of their restaurants in Casper. Sanford's is the name of it. It is a brandnew restaurant, and when I was there, the owner happened to be there and he recognized me and he came over and visited. He knew we were working on this. He said, You know, they keep piling stuff on us. They think we are rich. Sometimes the things we have to file with the government because of our Subchapter S corporation make us look rich and cost us a lot in taxes. We are helping them to keep this government going, but we don't get to put it in our pocket. He said, When we started that first business, we each had $200 in our pocket and we were able to borrow enough money to start that restaurant. Each restaurant that we built has been a little fancier and a little nicer. The one you are sitting in right now cost $500 million to build. He said, You know, me and my partner still only have $200 bucks in our pocket. The rest of it we have had to plow back into the business. And when we plow it back into the business, it creates more jobs. There are more people working. I will tell you, those are good jobs, too.

I don't understand at a time when small business owners are struggling to pay their bills and to keep the lights on, the majority leader has decided we ought to increase their taxes. These businesses are fighting for their very survival. This bill makes it harder for them. Small business owners are also health care consumers like the rest of us. They take prescription drugs to treat diseases such as cholesterol and hypertension from the stress they are under, and they might also use a pacemaker or have a hip or a knee replaced. If this bill is passed, the prices they pay for all of those items will increase. They increase for the employees they have too who have those same things done.

This bill contains over $40 billion in new fees for prescription drugs and medical devices. The nonpartisan Joint Commission on Taxation has said these types of fees will ultimately be passed through—to whom? To the consumer, meaning that the small business owner is going to pay more for his health care and for the health care of his employees.

Many small businesses still manage to provide health insurance coverage for their employees, despite the ever-increasing cost of health insurance. I understand how hard it is to pay those ever-increasing costs. That is why I fought for years to help small businesses band together so they would be

able to get the same kind of discounts that insurers typically provide for the large employers. How would that work? Businesses would be able to band together through their associations across State lines, even nationwide, and build a big enough pool that they could effectively negotiate with the insurance companies or with the providers. I have to tell you, when I proposed that, the insurance companies didn't like it. We went ahead with it anyway. I got it through committee. I brought it here to the floor of the Senate, and I understand how hard it is to get health care reform done. I had a bill that was filibustered on the motion to proceed. I got 55 votes. I had three people who would have voted for it who weren't here. I got 55 votes. That wasn't enough. You have to have 60 in order to move on.

Here is the real irony. OLYMPIA SNOWE was ready to do the amendment that probably would have taken care of 80 percent of the concerns of the people, but because we couldn't do the motion to proceed, we couldn't offer that amendment. We couldn't finish the bill. As a result, there are no small business health plans that cross State lines. Yes, there are small business health plans. Ohio is the laboratory that I used to work the idea. Ohio already had this kind of thing within its State boundaries. There is a lot of population in Ohio. Wyoming doesn't have much population so we can't form these big pools, but Ohio could. I looked at what they had done and it was marvelous. It saved money. It gave more benefits than most of the insurance plans in the State. You know what they said to me? We could do better if we could cross that State line. If we could go nationwide or even across to one more State, we could do better for every one of our people, because we would have a little bigger pool and we could save more money. They said, in the initial phase of this, you know where most of the money is saved? I said, No, where? They said, In administrative costs. Each of those little businesses having to do their own buying, figuring, paying, costs a lot of money, about 38 percent of health care. That doesn't show up in premiums; that is a cost. Do you know what the Ohio small businesses were able to save? Twelve percent. Twelve percent. That is a huge savings, just in administrative costs. But, no, we weren't able to pass that on to these small businesses. Instead, we are coming up with a way to tax them more, regulate them more, which is not exactly my idea of how to fix health care.

Rather than lowering the costs, this Reid bill will actually increase the cost of insurance by creating a new $60 billion tax on insurers. Just like the new taxes on drugs and devices, the cost of the new insurance tax will be passed through to the consumers, meaning that small businesses will see their health insurance premiums go up even more.

The damage this bill will do to small business is, unfortunately, not limited to the new taxes it creates. The bill will also impose expensive new mandates and requirements on insurance that will have the effect of dramatically increasing costs for small employers. One of the worst provisions dealing with insurance market reform is the so-called shared responsibility for employers. What the authors of the bill are trying to hide behind and what sounds harmless is a $28 billion job-killing tax on employers.

Under the bill, if an employer doesn't provide health insurance benefits to any employee eligible for the new insurance subsidies, which includes families making up to $90,000 a year, then the employer has to pay a fine. The penalty is equal to $750 per employee for all the employees.

Let me say that again. If an employer doesn't provide benefits to an employee eligible for the new insurance subsidies, which includes families making up to $90,000 a year, that employer has to pay a fine. The penalty is equal to $750 per employee for all the employees, not just the one eligible for a subsidy.

The nonpartisan scorekeepers at the CBO plus nationally recognized economists have said the costs of this new tax bill will ultimately be paid by workers. Businesses that cannot afford to provide health insurance will pass the costs of these new penalties on to their workers in the form of stagnant or lower wages, reduced hours, and eliminated jobs.

According to one recent study by the Heritage Foundation, this new job-killing tax will place more than 5 million low-income workers at risk of losing their job, or having their hours reduced, and an additional 10 million workers could see lower wages and reduced benefits. That is what they have to do to stay in business.

The bill contains a narrow exemption for small businesses with 50 or fewer employees. Similar to many of the other poorly conceived provisions of the bill, even this exemption is likely to create unintended and harmful consequences.

What is the likelihood that a small employer with 50 employees right now will agree to expand their business if by adding that single extra employee they expose themselves to this new job-killing tax? Small businesses are the engine of economic growth. I cannot say that enough. They create the jobs in this country. But this provision will discourage the creation of new jobs.

Fifteen million Americans are currently unemployed and 19 percent of small businesses have reported that they reduced employment in their firms in the last 3 months. If this bill is passed, the Reid job-killing employer tax will mean that more Americans will lose their jobs. We ought to be concentrating on jobs. Instead, we are focusing on something that will kill jobs.

The Reid bill will also impose sweeping new regulations over the health insurance marketplace. Similar to most new regulatory schemes imposed on small businesses, this one will also mean increased costs for small businesses.

Small business owners know the current market for health insurance is not sustainable. According to a recent Kaiser Family Foundation report, costs for small businesses, those with less than 200 employees, rose by 5 percent from 2008 to 2009, and they are expected to rise again next year.

We all agree the status quo for health insurance is not acceptable. Equally unacceptable, however, should be any proposals that make the current situation worse. Unfortunately, that is exactly what the Reid bill will do.

The nonpartisan Congressional Budget Office, the administration's own actuaries, the National Association of State Insurance Commissioners, and at least six other private studies have all looked at provisions similar to what is in the Reid bill, and they all found that these provisions will drive up health insurance costs.

Actuaries at the consulting firm Oliver Wyman, which did one of the studies, estimated these provisions will increase premiums for small businesses by at least 20 percent. Last year, they had an increase of 5 percent. This is going to do 20 percent. I suspect most small businessmen will notice that, and they will also know where the blame lies. WellPoint, the largest Blue Cross/Blue Shield plan in the Nation, looked at their actual claims experiences in the 14 States in which they operate and concluded that the premiums for healthier small businesses will increase in all 14 States—in Nevada by as much as 108 percent.

The bill also eliminates consumer choices, requiring Americans to buy richer types of plans that cover more deductibles and out-of-pocket expenses. These plans typically have much higher premiums. That is right. Washington is going to tell you what kind of insurance you have to have, even if it is a lot better than what you have now and you like what you have now. That is not good enough. Washington knows better for you what you need in the way of health insurance. They are going to see that you get it. Boy, are you going to get it. These plans typically have much higher premiums. We have looked at the studies to see how many people have the quality of insurance we are talking about at the lowest acceptable level. If you don't do that, you get fined. OK.

Well, these new mandates will make it more difficult for small businesses to

adopt new, affordable, high-deductible health plans. These plans, when combined with health savings accounts, have been enormously successful in recent years in helping small businesses control health care costs. I know a secret here in the Senate. There are quite a few employees—particularly the younger ones—who did a little evaluation, because in the Senate everybody has the same choices and everybody gets to buy from the private market and everybody can pick how much they want to pay in premiums compared to deductibles. You can pay more premium, less deductible, or less premium and more deductible. The two balance out. People know that. Some of the astute kids in my office took a look at buying the insurance as opposed to doing the high deductible and putting it in a health savings account. They found out they could take the money it would cost for the regular plan and, instead, buy this high deductible and take the difference and put it in a savings account. The savings account grows tax free. It has to be used for health care, but it pays for health care things as they come up. In less than 3 years, the one putting in the least covered the entire deductible. So for the rest of the time, she would not have to put any more into that savings account. But she is smart. She said: I am putting that in there tax free, and someday I will need it. So she is continuing to grow that.

We have decided that is a bad deal. I will tell you, people around here are smarter than us. They are figuring out how to save money on health insurance already. I don't think they are going to like that.

Another thing you can do as an employee here is have a flexible savings account. That happens in a lot of businesses across the country. If you have company insurance, you can do a flexible savings account. This bill is going to do away with that too. That is the way to do it if you know you are going to have health expenses the next year that don't fall within your policy. You can put that money in the bank tax free and use it as those bills come due.

We are going to limit that, and that limit isn't going to have any fluctuation dealing with inflation, so in 2 or 3 years that program is gone. I don't know why these ones that encourage people to save and plan for the future are such bad ideas.

According to the Kaiser Family Foundation, 11 percent of small business employees are enrolled in HSAs. Average HSA premiums for small businesses are 20 percent lower than the traditional PPO plans, and the number of employers offering HSAs has nearly doubled over the last 3 years.

If you work for Starbucks, that is one of the small companies—not really. But Starbucks provides insurance to their people. They do it through HSAs. We are talking about getting rid of that, saying it is not good enough. There are going to be upset people.

The new mandates in the bill will prevent some high-deductible health plans from being sold because they do not provide a rich enough benefit.

Small businesses are not just purchasers of health care, they are also providers. Doctors, home health aides, and nursing home owners are all small business owners. They have a significant stake in how this bill turns out. You can tell from the two practitioners we have here who understand and had small businesses, they understand how this works. That is without even getting into the fact that the government, in Medicaid and Medicare, cuts what they pay so it is below their cost. You know how hard it is to run a business below cost? It is impossible. You have to shift the cost somewhere else so the people under private insurance pick up the costs.

I am reminded of some farmers who decided they could make a killing and drive the truck over to North Dakota and buy some eggs for just 24 cents a dozen. They could bring them back to their home State and they could sell them for a lot more. Of course, when they sold them and figured in the expense of picking them up, they found out they were only getting 20 cents a dozen for them. If that is the case, you cannot just buy a bigger truck and solve the problem. That is what doctors are finding. They are saying: I cannot afford to take Medicaid patients or Medicare patients. If you cannot see a doctor, you don't have any insurance at all. That is where we are driving this thing.

Unfortunately, a number of the provisions in the Reid bill will devastate these small health provider businesses. The bill cuts over $460 billion from Medicare over the next 10 years, slashing Medicare payments to hospitals, nursing homes, and home health agencies.

The Reid bill will cut over $15 billion in Medicare payments to the nursing homes. In a rural State such as mine, this level of cut will destroy many small business nursing homes and force the closure of the facilities that currently provide nursing home care to hundreds of Medicare patients.

Connie Jenkins, the executive director of the Star Valley Senior Center, south of Jackson, WY—a lot of people know where Jackson is, over on the western side of the State; it is the home of the Grand Teton National Park, below Yellowstone National Park. The director recently wrote to me about the important role nursing homes play in rural small towns in Wyoming. She noted that many small communities depend on nursing facilities to provide a large portion of the available jobs. She wrote that ''in a rural State, such as ours, closing of nursing homes would mean families traveling further to visit loved ones and, in some cases, loss of access altogether.'' It is important to be near the people who are in a nursing home. We have great distances and very small towns.

The Reid bill would also cut more than $40 billion in Medicare payments to home health agencies. According to the analysis done by one industry association, this level of cuts could put nearly 70 percent of all home health agencies at risk of having to close their doors.

Home health agencies provide valuable assistance to disabled individuals, allowing them to receive their care in their home. It is a lot cheaper than a nursing home. If these cuts are enacted and these agencies are forced to close, the patients will have to go back into institutional facilities to receive their care. In addition to devastating these small businesses, this proposal would clearly break the President's promise to protect Medicare beneficiaries and not reduce their benefits.

Many doctors, such as my colleague, JOHN BARRASSO, who has been on the Senate floor all day, have also been small business owners. Doctors are currently facing a 21-percent reduction in Medicare payments that is slated to go into effect in January. Despite cutting $460 billion from the Medicare Program, the Reid bill does nothing to fix the Medicare payment formula for physicians. Since 40 percent of doctors will not take Medicaid patients, that is now moved into Medicare, and I think 20 percent will not take Medicare patients. How would you like asking for an appointment and they say: Are you Medicare? And if you are, we are not taking you.

It can happen. That is not health insurance at all. Also, it is fascinating that Medicare doesn't have catastrophic coverage. We will talk about that. Unlike the Federal Government, small business owners cannot lose money on every Medicare patient and then hope to make it up on volume. A 21-percent payment cut is not sustainable, and it highlights why we need to fix the broken Medicare physician payment formula. Rather than stealing $460 billion from Medicare to create a new entitlement program for the uninsured, we should use those moneys to strengthen and improve Medicare.

Medicare is going broke. You saw the charts over there earlier. It is going broke. We are going to take $460 billion from it. Oh, but don't worry. The bill has a little provision in there where we are going to form a commission that, every year, will give us suggestions on how we ought to cut Medicare so that it stays solvent.

I don't know any other way you can put that: Cut Medicare to stay solvent. We had to form a commission to do that after we steal $460 billion from the

program. It cannot afford to have that taken out.

Another interesting thing on that commission is they already made a deal with the hospitals, and they cannot cut them, and the doctors were supposed to have a deal, although I think the deal has been broken because the low payments did not get fixed and the medical malpractice did not get included as they were promised. So I don't know if they are still in there. In exchange, they were supposed to not get any cuts.

The pharmaceutical companies were not supposed to get any cuts. I would love to have the time to explain the deal they have. Do you know whom that leaves? That leaves the nursing homes, the home health, and the Medicare patients themselves. They are going to pick up those costs that are each year prescribed to us to pass to save Medicare. Medicare money should go to Medicare.

The Reid bill also drives up health care costs for small businesses by its massive expansion of Medicaid. This bill includes the largest expansion of the Medicaid Program since it was created in 1965. In addition to trapping 15 million low-income Americans in the worst health care program in America, this Medicaid expansion will also increase costs for many small businesses.

Medicaid uses government price controls to set private rates far below what private insurers pay, often below the cost of what it costs to provide the care. According to one estimate, Medicaid pays only 60 percent of the rates paid by private insurers. This forces doctors to make up for their losses on Medicaid patients by increasing their costs to other purchasers. According to a recent estimate by the accounting firm Milliman, inadequate Medicaid payment rates resulted in physicians shifting $23.7 billion in costs onto private sector purchasers.

Enrolling 15 million more Americans into the broken Medicaid Program will only worsen this cost shift. That means if this bill is enacted, small business owners will see their health care costs increase as physicians and hospitals struggle to make up for inadequate payments for many more Medicaid patients.

In addition to doctors and hospitals, States also cannot afford to pay for this expansion of the Medicaid Program. The Reid bill imposes approximately $25 billion in new unfunded Medicaid costs on State budgets at a time when the States are facing a worse economic crisis in general than perhaps our economic crisis because they cannot just print the money.

When we were working with the Gang of 6, we had a table that showed how the $25 billion was distributed among the different States. The CBO estimate of the $25 billion never changed. But every day, we got a new sheet and the different States paid different amounts. Did you know that finally New York and Nevada got theirs down to what they thought was a workable level? I don't know if that is actually the way it will come out if people are just jimmying the numbers.

What this will mean for small businesses will be even higher taxes and fees, as States struggle to close the estimated $22 billion budget shortfall they will face in fiscal year 2011. According to the National Association of State Budget Officers, States have already enacted $23.8 billion in new taxes and fees in the current fiscal year. These numbers are only expected to increase as States see no end in sight to their current fiscal crisis.

Increased State and Federal taxes, higher health care costs, and Medicare payment cuts are the results small businesses are most likely to see if the Senate passes the Reid health care reform bill. While these would never be welcome changes, the Senate will be debating these policies at a time when small businesses face their most severe economic challenges since the Great Depression.

As I mentioned, unemployment is already at 10.2 percent. Even that number, which is the worst we have seen in 26 years, may actually understate the severity of the situation. The government estimates that up to 17.5 percent of the population may be entirely without a job or underemployed.

Other economic indicators paint a grim picture for a potentially jobless recovery. In October, new housing starts fell 10.6 percent, which is 30 percent lower than 1 year ago. Federal Reserve Chairman Ben Bernanke recently noted that the ongoing financial crisis has led to the reduction or elimination of bank credit lines for many small businesses. He also noted that the fraction of small businesses reporting difficulty in obtaining credit is near a record high, and these conditions are expected to tighten further.

Small businesses are the engine of economic growth that can lead this Nation out of its current economic crisis. Unfortunately, the Reid bill will have the effect of sand being poured into the gears of that engine.

The recent statement of the National Federation of Retail Businesses does the best job of summarizing the impact of the Reid bill on small businesses. They said:

> We oppose the Patient Protection and Affordable Care Act due to the amount of new taxes, the creation of new mandates, and the establishment of new entitlement programs. There is no doubt all these burdens will be paid for on the backs of small business. It's clear to us that at the end of the day, the costs to small business more than outweigh the benefits they may have realized.

I see I have run a few minutes over. I apologize to the Chair.

ADJOURNMENT UNTIL 9:45 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:45 tomorrow morning.

Thereupon, the Senate, at 9:36 p.m., adjourned until Saturday, November 21, 2009, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF DEFENSE

MARY SALLY MATIELLA, OF ARIZONA, TO BE AN ASSISTANT SECRETARY OF THE ARMY, VICE NELSON M. FORD.

PAUL LUIS OOSTBURG SANZ, OF MARYLAND, TO BE GENERAL COUNSEL OF THE DEPARTMENT OF THE NAVY, VICE FRANK R. JIMENEZ.

SOLOMON B. WATSON IV, OF NEW YORK, TO BE GENERAL COUNSEL OF THE DEPARTMENT OF THE ARMY, VICE BENEDICT S. COHEN, RESIGNED.

DEPARTMENT OF EDUCATION

KATHLEEN S. TIGHE, OF VIRGINIA, TO BE INSPECTOR GENERAL, DEPARTMENT OF EDUCATION, VICE JOHN PORTMAN HIGGINS, RESIGNED.

SECURITIES INVESTOR PROTECTION CORPORATION

SHARON Y. BOWEN, OF NEW YORK, TO BE A DIRECTOR OF THE SECURITIES INVESTOR PROTECTION CORPORATION FOR A TERM EXPIRING DECEMBER 31, 2012, VICE TODD S. FARHA.

ORLAN JOHNSON, OF MARYLAND, TO BE A DIRECTOR OF THE SECURITIES INVESTOR PROTECTION CORPORATION FOR A TERM EXPIRING DECEMBER 31, 2011, VICE ARMANDO J. BUCELO, JR., TERM EXPIRED.

DEPARTMENT OF STATE

DAVID ADELMAN, OF GEORGIA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF SINGAPORE.

OVERSEAS PRIVATE INVESTMENT CORPORATION

ELIZABETH L. LITTLEFIELD, OF THE DISTRICT OF COLUMBIA, TO BE PRESIDENT OF THE OVERSEAS PRIVATE INVESTMENT CORPORATION, VICE ROBERT A . MOSBACHER, RESIGNED.

DEPARTMENT OF STATE

HARRY K. THOMAS, JR., OF NEW YORK, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER—COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF THE PHILIPPINES.

CONFIRMATIONS

Executive nominations confirmed by the Senate, Friday, November 20, 2009:

EUROPEAN BANK FOR RECONSTRUCTION AND DEVELOPMENT

JAMES LAGARDE HUDSON, OF THE DISTRICT OF COLUMBIA, TO BE UNITED STATES DIRECTOR OF THE EUROPEAN BANK FOR RECONSTRUCTION AND DEVELOPMENT .

DEPARTMENT OF STATE

JOSE W. FERNANDEZ, OF NEW YORK, TO BE AN ASSISTANT SECRETARY OF STATE (ECONOMIC, ENERGY, AND BUSINESS AFFAIRS).

FREDERICK D. BARTON, OF MAINE, TO BE REPRESENTATIVE OF THE UNITED STATES OF AMERICA ON THE ECONOMIC AND SOCIAL COUNCIL OF THE UNITED NATIONS, WITH THE RANK OF AMBASSADOR.

MILLENNIUM CHALLENGE CORPORATION

DANIEL W. YOHANNES, OF COLORADO, TO BE CHIEF EXECUTIVE OFFICER, MILLENNIUM CHALLENGE CORPORTATION.

INTER-AMERICAN DEVELOPMENT BANK

GUSTAVO ARNAVAT, OF NEW YORK, TO BE UNITED STATES EXECUTIVE DIRECTOR OF THE INTER—AMERICAN DEVELOPMENT BANK FOR A TERM OF THREE YEARS.

DEPARTMENT OF STATE

FREDERICK D. BARTON, OF MAINE, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SESSIONS OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS, DURING HIS TENURE OF SERVICE AS REPRESENTATIVE OF THE UNITED STATES OF

AMERICA ON THE ECONOMIC AND SOCIAL COUNCIL OF THE UNITED NATIONS.

ROBERT R. KING, OF VIRGINIA, TO BE SPECIAL ENVOY ON NORTH KOREAN HUMAN RIGHTS ISSUES, WITH THE RANK OF AMBASSADOR.

WILLIAM E. KENNARD, OF THE DISTRICT OF COLUMBIA, TO BE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE EUROPEAN UNION, WITH THE RANK AND STATUS OF AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY.

CARMEN LOMELLIN, OF VIRGINIA, TO BE PERMANENT REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE ORGANIZATION OF AMERICAN STATES, WITH THE RANK OF AMBASSADOR.

CYNTHIA STROUM, OF WASHINGTON, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO LUXEMBOURG.

MICHAEL C. POLT, OF TENNESSEE, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF ESTONIA.

JOHN F. TEFFT, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO UKRAINE.

DAVID HUEBNER, OF CALIFORNIA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO NEW ZEALAND, AND TO SERVE CONCURRENTLY AND WITHOUT ADDITIONAL COMPENSATION AS AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO SAMOA.

PETER ALAN PRAHAR, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE FEDERATED STATES OF MICRONESIA.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PAMELA S. HYDE, OF NEW MEXICO, TO BE ADMINISTRATOR OF THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES.

THE ABOVE NOMINATIONS WERE APPROVED SUBJECT TO THE NOMINEES' COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

PAUL K. MARTIN, OF MARYLAND, TO BE INSPECTOR GENERAL, NATIONAL AERONAUTICS AND SPACE ADMINISTRATION.

FOREIGN SERVICE

FOREIGN SERVICE NOMINATION OF TERENCE JONES.

FOREIGN SERVICE NOMINATIONS BEGINNING WITH ANDREA M. CAMERON AND ENDING WITH ALEKSANDRA PAULINA ZITTLE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON SEPTEMBER 10, 2009.

FOREIGN SERVICE NOMINATIONS BEGINNING WITH LAURIE M. MAJOR AND ENDING WITH MARIA A. ZUNIGA, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON SEPTEMBER 17, 2009.

SENATE—*Saturday, November 21, 2009*

The Senate met at 9:45 a.m. and was called to order by the Honorable PATRICK J. LEAHY, a Senator from the State of Vermont.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

O Shepherd who neither slumbers nor sleeps, as we labor this weekend, we desire You to be near to guide us with Your wisdom and love. Use our lawmakers as instruments of Your providence, leading them beside still waters, restoring their energy and bringing them to Your desired destination. Give them the stature to see, above the walls of prideful opinions, the path to the greatest good. Lord, sustain them with Your strength, preserve them with Your grace, instruct them with Your wisdom, and protect them with Your power. As an intentional act of will, may they commit to You everything they think, say, and do today. We pray in Your sovereign Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable PATRICK J. LEAHY led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, November 21, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable PATRICK J. LEAHY, a Senator from the State of Vermont, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. LEAHY thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

THANKING SENATOR LEAHY

Mr. REID. Mr. President, on this Saturday, the Senate, in one of its unusual sessions, it is very good to see one of the more senior Members of the Senate presiding over the Senate. A lot of presiding is left to the more junior Members. It is indicative of the teamwork of the Senator from Vermont, one of the most senior Members of the Senate, chairman of the Judiciary Committee, and someone who is always there when there is a need for something to be done, as it is today to open the Senate.

I have such fond memories of my friend from Vermont. I can remember the first time we met. We were in Florida. I was running for the Senate. It was 1986 and the Senator from Vermont was running for reelection, even then a senior Member of the Senate.

Even though the two of us are almost twins as far as our age goes, the Senator from Vermont has a significant amount of seniority, although he never uses that in any way other than to work for the betterment of the people of Vermont—and I say that seriously. We had a conversation in the cloakroom today, and we were not talking about ball games last night, we were talking about problems of the people of Vermont, things the distinguished presider today indicated he thought could help a little for the State of Vermont. I am very grateful the Senator is here today.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the motion to proceed to H.R. 3590. Under a previous agreement, the debate will continue with alternating hours from 10 a.m. to 6 p.m., with the majority controlling the first hour. The time from 6 to 6:30 in the evening will be under the control of the majority; 6:30 until 7:15 p.m. will be under the control of the Republican side; from 7:15 to 7:30 the majority will control that time; the time from 7:30 to 8 will be for the two leaders, with Senator MCCONNELL controlling the first 15 minutes. At 8 p.m. tonight, the Senate will proceed to a rollcall vote on the motion to invoke cloture on the motion to proceed to the health care legislation.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The distinguished Republican leader is recognized.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, as we move toward tonight's all-important vote, we will have 10 more hours of discussion of this 2,074-page bill, which represents the top part of this stack. The other 2,000-page bill is the House-passed bill. Senators will have an opportunity to express themselves on the merits of this proposal.

What do we know for sure as we move toward this debate? We know Americans oppose this bill. They are not buying the claim that this legislation would do anything whatsoever to lower our staggering deficits.

In tomorrow's Washington Post, David Broder, their distinguished senior columnist, certainly not a political conservative, expresses his reservations as a citizen about the steps we could be about to take. Broder says, in part, in his column:

The day after the Congressional Budget Office (CBO) gave its qualified blessing to the version of health care reform produced by Senate Majority Leader Harry Reid, a Quinnipiac University poll of a national cross section of voters reported its latest results.

The reason Broder picks Quinnipiac, he said, is he is familiar with the pollsters and the process, knows they are thoroughly nonpartisan and credible. Of course, the Quinnipiac Poll is echoed by every other poll we have seen, no matter who has taken it. We know the American people are opposed to this 2,074-page proposal.

Broder points out that in the Quinnipiac survey, less than one-fifth of voters, 19 percent—a near 19 percent of the sample—support this bill.

Nine of 10 Republicans and eight of 10 independents said that whatever passes will add to the torrent [a literal torrent] of red ink. By a margin of four to three—

This is extremely significant—

By a margin of four to three, even Democrats agree this is likely [that this will produce a torrent of red ink].

That fear contributed directly to the fact that, by a 16-point margin, the majority in this poll said they oppose this legislation moving through Congress.

It is not just the American people who are saying that, the experts are saying it as well. Broder points out that every expert—this is Broder:

[E]very expert I have talked to says that the public has it right.

In other words, the experts agree with the public opinion polls that this 2,074-page bill is a budget buster. He quotes the executive director of the Concord Coalition, a bipartisan group. He says—this expert says:

. . . there's not much reform in this bill. As of now, it's basically a big entitlement expansion, plus tax increases.

He also decries the gimmickry involved in putting this bill together. Broder points out the majority leader's:

. . . decision to postpone the start of the subsidies to help the uninsured buy policies from mid-2013 to January 2014—long after taxes and fees levied by the bill would have begun.

That is the only way they can make the CBO declare it budget neutral, deficit neutral.

In fact, we know that over a 10-year period, once it is fully implemented, the cost of this will be $2.5 trillion. Americans do not think higher premiums, higher taxes, and massive cuts to Medicare is reform. They certainly do not think it is what we need at a time when 1 out of 10 working Americans is looking for a job and the Chinese are lecturing us about debt.

Do we want to pass this staggering spending program at a time when many would argue our international bankers, the Chinese, are lecturing us about debt? At this time of economic crisis, we need to make things easier for people struggling out there, not harder.

Make no mistake, the Democrats' plan we will vote on tonight would make life harder for the vast majority of Americans. It raises their taxes, it raises their health care premiums, it cuts their Medicare, and drives millions off the private insurance they currently have. When fully implemented, this plan would cost, as I indicated earlier, $2.5 trillion. That is the equivalent of three failed stimulus bills.

Perhaps most shocking of all to most people is the conclusion of the Congressional Budget Office that this bill would actually drive up health care costs, not down. This massive bill, at a time when Americans are asking us to control health care costs, according to the independent Congressional Budget Office, actually drives up costs.

The American people are scratching their heads. They thought the idea behind all this was to try to lower costs. Perversely, what we are doing is the opposite.

Americans will have an opportunity to hear their elected representatives in the Senate express their views on this legislation all day today. Senators who support this bill have a lot of explaining to do—a lot of explaining to do. Americans know a vote to proceed on this bill, to get on this bill, is a vote for higher premiums, higher taxes, and massive cuts to Medicare. That is a pretty hard thing to justify supporting. Every Senator who goes on record saying we need to proceed to this monstrosity of a bill will, in effect, be voting for higher taxes, higher premiums, and cuts in Medicare.

It is a pretty hard position to justify. It is a pretty hard position to explain to your constituents. Frankly, I don't think it can be explained, and I don't think the American people do either.

I yield the floor.

The PRESIDING OFFICER (Mrs. GILLIBRAND). The majority leader is recognized.

HEALTH CARE REFORM

Mr. REID. Madam President, my friend, the Republican leader, is living in a different world than most everyone else. For him to lecture the Senate on debt is beyond the pale. He, one of the Republican leaders during the last years, voted at every opportunity to spend more money in Iraq, without a penny of it being paid for—$1 trillion it is now said to be—on a war of choice and not a penny of it paid for. To lecture us now on debt, when not only the war but the other actions of the Bush administration drove this country into deep debt? If one read the papers today or listened to Newsday, you will find economists all over America said the stimulus is working. Only 25 percent of the money has now been spent, and they recognize that but for the stimulus, we would be in a worldwide depression. That is all over the news today.

To focus on an editorial by a man who has been retired for many years and writes a column once in a while is not where we should be. Where we should be is recognizing America deserves a debate on health care reform. Last year, 750,000 Americans filed bankruptcy. Over half of those bankruptcies were because of medical expenses. Over half of the people who filed for bankruptcy because of medical expenses had health insurance. Do we need to do something on health insurance reform? Of course, we do.

It speaks volumes to recognize that insurance rates over America during the last few months are skyrocketing. Why? Because the insurance industry has an insatiable appetite for more profit. How are they able to do this when other businesses can't do it? They can do it because they are exempt from the antitrust laws of this country. The only business, other than Major League Baseball, that has that is the insurance industry. We are going to take a look at that in this legislation. Shouldn't we at least talk about it?

My friend the distinguished Republican leader is saying he doesn't think we should even have a debate on this issue, even though last year 750,000 Americans filed bankruptcy, most of them because of health expenses.

In addition to that, the morning news indicates that longtime conservative Republican Tommy Thompson, longtime Governor of the State of Wisconsin, Cabinet officer in the Bush administration, the Secretary of Health and Human Services, endorsed the legislation we will vote on this afternoon. To show it is bipartisan, Richard Gephardt, former Democratic leader of the House of Representatives, endorsed this, and many others.

Anyone who says this legislation contains an entitlement expansion is obviously someone who has not read the bill. One of the things we have in this legislation is a provision called the CLASS Act. What does it do? It allows someone to voluntarily pay $120 a month into a fund. They do it for 5 consecutive years. If they become disabled, there is money there for them. Ever since I have been in the Congress, we have been looking for a way to take care of the aged, infirm, and disabled. It is not an entitlement; it is voluntary and fully paid for, as is the rest of the bill.

To talk about all this debt—I don't know what world, what sphere they are living in. The Congressional Budget Office, a nonpartisan organization—not always good—I wish they would have come up with some other numbers because we got no credit for all the wellness things we do in this bill that will save lots of money. We received no credit for that. But in spite of that, everything in the bill is fully paid for. It reduces short- and long-term debt. It expands coverage. This chart says ''94 percent,'' but it is actually 98 percent because CBO does not give us credit for people in Medicare. So 98 percent of Americans are covered. It contains insurance market reforms, and lots of them. It contains delivery system reforms.

The key elements of this health care reform bill, I repeat: It reduces short- and long-term deficits, expands coverage, promotes choice and competition, reforms the insurance market, and improves quality of care. All we are asking today is to have a debate on it. Why would anyone be afraid, in the greatest debating society, supposedly, in the world, to debate health care? What are they afraid of?

He said anyone who votes for this is going to have a lot of explaining to do. That is really Orwellian. Have a lot of explaining to do if they vote to allow the debate to continue? I think quite the opposite. I think any reasonable human being would feel the same way. Shouldn't we debate health care reform in America today, with 50 million people uninsured, and this legislation is going to take care of 98 percent of Americans?

This legislation looks out for small businesspeople. Right now, most small businesses don't have health insurance for their employees. Do they not have health insurance because they are mean or cheap? No. They can't afford it. The insurance industry has made it impossible to pay for because of their huge profits.

Someone not voting to allow the debate to continue is going to have a lot of explaining to do. Even though my friend is Orwellian and said that if you vote to allow debate to continue, you will have a lot of explaining to do, how could you be a Senator and be afraid to debate health care reform?

Simply, this legislation, on which we will vote on a motion to proceed to this evening at 8, saves lives, it saves money, and it saves Medicare—a pretty good deal.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of the motion to proceed to H.R. 3590, which the clerk will report.

The bill clerk read as follows:

Motion to Proceed to H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

The PRESIDING OFFICER. Under the previous order, there will be debate until 6 p.m., with the time controlled in alternating 1-hour blocks, with the majority controlling the first hour.

The Senator from Vermont.

Mr. LEAHY. Madam President, I am glad to see my colleague and neighbor from New York in the chair, an extraordinarily hard-working Member of the Senate. I am not surprised, on a Saturday morning, that she is here.

Before I begin, I wish to state my appreciation for the kind words from the majority leader for the Senator from Vermont. He and I have been friends for decades. I am glad to see the work he has done in bringing this bill to the floor. I intend to work closely with him.

Decision time is near on health insurance reform. I will vote today to end the filibuster so the Senate can begin this important, historic debate to improve and reform our Nation's health insurance system. Let's not duck the debate. Let the debate begin. Let's not hide from votes. Let's have the courage to vote. Stand up and vote on the amendments. Let the American people know where we stand and not say: Well, it never came up because of the filibuster. We can end the filibuster today. We can get going. We can let every American know where we stand.

The sentries of the status quo again have spared no effort to kick the can down the road, as they have done before. The country suffers when there is a failure to act on serious challenges that millions of ordinary Americans face in their daily lives. This is a defining moment for the Senate and for the country. I rank this along with other major decisions such as the creation of Social Security and Medicare and the Civil Rights Act. We have been talking about health insurance reform for more than 70 years, before I was born. The Senate should not now prevent a real debate on health reform by hiding behind the figleaf of a procedural filibuster.

A bill worthy of this debate has been produced, after months of arduous work. Opponents of reform, unfortunately, have wasted much of the public's time by provoking arguments over their distortions about what health reform means. Spurious rumors were spread about death panels. One mailing opposing this bill claimed that reform would mean denying care to people based on their voting records. How desperate can these entrenched powers get, those who want to stop health care reform? These are the tactics of obstruction in the service of the status quo.

Meanwhile, what the American people yearn for are constructive solutions. They want an honest debate, not a filibuster. That is what they deserve, and that is what we owe them.

A Vermonter came by my office to talk about health reform, as so many have over the last several months. I hear this every time when I am home in Vermont. If I am in the gas station putting gas in my car, if I am in the grocery store, if I am coming out of church on Sunday, I hear this. This Vermonter is a physician. He has a special perspective from inside the system. He recalled stories about his father, also a very respected doctor, who practiced in the days before Medicare. He remembered the devastation his father felt when he was forced to turn away elderly Vermonters because they did not have health insurance.

It may be difficult today to even imagine this, but before Medicare, older Americans were routinely driven into poverty during their retirement years by health expenses. Before Medicare was launched in 1964, nearly half of seniors over 65 had no health coverage and more than one in three lived in poverty. Today, because of Medicare, virtually everyone 65 and older has health insurance. The poverty rate among seniors has plummeted. More than 100,000 Vermonters have Medicare insurance.

The arguments that were made against creating Medicare may sound familiar. Opponents of Medicare, when it first came up, tried to demonize the plan. They claimed it would never work. How could government run a program like this? They ignored those older Americans living in poverty. But eventually Members from both sides of the aisle, Republicans and Democrats, worked together. They passed a bill that is one of the most successful and popular programs in America today. Vermont's entire congressional delegation, which at that time was Republican, supported passage of that landmark legislation.

Today, we have a health system with contradictions. Federal investments in research and private investments in development have produced modern medical marvels in the equipment, training, techniques, and drugs that are available to many Americans. Yet in the prices we pay, in the lack of access to basic medical care, in the loopholes and the redtape that plague ordinary Americans in our health insurance system and in overall results in so many categories, we get far less for our enormous health care spending than do the citizens of countries whose health care costs are only a fraction of what ours are. Tens of millions of Americans have no health insurance at all. Employers who want to offer health insurance to their workers are being priced out of even having that option anymore. Self-employed Americans must pay dearly to afford any insurance, and they can lose their coverage at the whim of an insurance company's bureaucracy. In no modern nation except ours are families actually driven into bankruptcy by illness. In fact, medical expenses are one of the top reasons for bankruptcy in America today.

In the absence of a fair and sensible health insurance system, families, businesses, and taxpayers have been dragged along by an inflationary curve that only worsens with time. Next year, small businesses, already suffering from skyrocketing medical costs, will see their premiums rise by an average of 15 percent. That is twice the rate of last year's increases. Drug companies have boosted prices of brand-name drugs by about 9 percent over the last year—the steepest increase in years. All you have to do is look at the huge salaries paid to their executives, and you know where that money is going. It is not going to help the health care of the average American.

Can't we fashion an American-made solution so our citizens can have high-quality, affordable care and access to basic health insurance? Of course we can. We are Americans. We can develop that.

The bill introduced this week by the majority leader and by Senators BAUCUS, DODD, and HARKIN will give millions more Americans access to quality, affordable health care. It would end discriminatory treatment of those who change jobs or have preexisting conditions.

I have pushed and will continue to push to accomplish the three c's of choice, competition, and cost control, as we reform our health insurance system.

I am encouraged that the Senate bill includes a public option that I have strongly supported. I might say, the majority of Americans strongly support it. I will stand with others as we make our case for keeping it in the reform plan as part of this process.

I was proud to join Senator BROWN and a core group of more than 20 other Senators who introduced a resolution affirming our support of a public option. A public option would give consumers more choices to select affordable and quality health insurance plans, while helping to drive down overall medical costs through real competition in the health insurance market.

To further enhance the advantages of a competitive market, I have introduced the Health Insurance Industry Antitrust Enforcement Act of 2009. This would repeal the antitrust exemption for health insurance and medical malpractice insurance providers. Closing this loophole in our antitrust laws is long overdue, and I will offer my legislation as an amendment to the bill to do that. Antitrust enforcement promotes competition. It helps to lower prices and expand consumer choice.

Another factor that contributes to the rising medical costs all Americans face is fraud within the health insurance system. The scale of health care fraud in our system today is staggering. Studies estimate that between 3 percent and 10 percent of all our health care spending, both public and private, is wasted through health care fraud. That is somewhere between $60 billion and $220 billion each year—money we should have for health care, not going in the pockets of crooks.

To help wring this waste out of our system, Senator KAUFMAN and I and others have proposed the Health Care Fraud Enforcement Act. Our bill would toughen sentences for those who commit health care fraud, strengthen support for prevention, investigation, and prosecution of health care fraud, and sharpen the legal tools we need to go after this fraud. It would prevent waste in spending. It would hold accountable those who do the stealing. Experience shows antifraud efforts give taxpayers a superb return on investment, with a payback of between $6 and $14 for every dollar we spend on enforcement.

I am pleased the majority leader included provisions in this bill to address the issue of health care fraud. I will work with Senator KAUFMAN and others to strengthen that bill.

Vermont has helped pave the way for some of the reforms included in this bill, and now, for the third year in a row, Vermont has been ranked as the healthiest State in the Nation. Vermont is one of the earliest leaders in expanding the State Medicaid Program, under reforms led by former Gov. Howard Dean and others. Yet under the current form of this bill, Vermont would not share the enhanced Federal match to be offered to other States. That would amount to a regressive policy with adverse practical ramifications for Vermont, a State that is a leader in expanding access to health care. I was heartened in my conversation this morning with the majority leader when he told me he will try to correct that problem. But we cannot correct any of these problems until we debate the bill. Let's not hide under our desks because we are afraid to stand up and vote and debate.

The people of Vermont have given me the honor of representing them in the Senate for 35 years. I have joined in many debates that were contentious yet ultimately productive. I have been on the winning side. I have been on the losing side. But as we leaf through the pages of history, we can read of many times when the Senate has shown its remarkable ability to rise up to reflect the conscience of the Nation. Those moments were forged in the crucible of national need, against the anvil of the tempered will of the Senate's membership.

This Senate can do that again. Our dear friend, Senator Ted Kennedy, said it so well in the letter about the health reform imperative that President Obama read to a joint meeting of Congress. This is what Senator Kennedy reminded us:

> What we face is above all a moral issue; that at stake are not just the details of policy, but fundamental principles of social justice and the character of our country.

This is such a time. It is my hope and belief the Senate I love will once again rise to the occasion.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. BENNET. Madam President, I would like to first thank the Senator from Vermont for his excellent remarks in support of what is, after all, just a vote to get us started on the debate on health care, a procedural vote to allow us to be able to amend and improve the bill in the coming weeks.

Madam President, virtually every single Member of this body in the Senate is a Member of the baby boom generation. In my view, it is a generation of Americans—I was born in the last year of that generation—given more opportunity than any generation of people in the history of this planet because our grandparents and our parents were willing to make hard choices, understanding that part of our national creed, part of our legacy is assuring that we are expanding opportunity for those who come after us.

We are having this health care debate at a moment in our country's history beset by incredible economic difficulties. This is the worst recession since the Great Depression. But we now know even during the period of economic growth before our economy fell into this terrible recession that working families were struggling.

During the last period of economic growth, median family income in the United States actually declined. As far as I know, it was the first period of recovery in the history of the United States when median family income actually went down. It was at the same time the cost of health insurance was soaring—in my State by 97 percent—with the cost of higher education in my State going up by 50 percent.

We were saying to working families: You are living in an economy with incredible weakness, where the growth is surging ahead of a mountain of debt, but you are not getting ahead.

Just this week, we learned that in the great State of California they are increasing the tuition for their universities by 30 percent. The University of California, the California system has been the envy of the world for decades, and now it is being put out of the reach of working families.

So we have much to do—much to do—to make sure we honor the legacy of our parents and our grandparents. We honor the legacy of the "greatest generation" and this generation, the baby boom generation, to ensure that we leave behind us not diminished opportunity but more opportunity for our kids and our grandkids.

There is much we need to do to make sure we have a health care system that works not just for a few people but for everyone, an education system that works not just for a few kids but for everyone, and that we have an economy in the United States that values the contribution that everybody can make.

My sense in this health care debate is that the people of my State—and I know people around the country—are deeply dissatisfied with business as usual. They hate the current system. They know it is not working for them and their families. They know they are not able to make the choices they need to make to have stability for their families so they can get ahead economically.

But, on the other hand, they are deeply worried about our capacity to make it worse. It is hard to blame people when you hear the special interests' rhetoric coming out of Washington, DC, or when you turn on your cable television set at night and watch what people have to say. You can understand why people are concerned that we have the capacity to make it worse.

But that is why I am so pleased about the piece of legislation the majority leader has brought before us. We have never been closer to reforming our health care system, so we can address runaway health care costs, enact insurance reform, construct stability and predictability in health care for families and small businesses.

The Senate legislation before us is that promising new way forward. Coloradans, as I said, have not been shy at all about letting me know about their views of the current system and what their concerns are about what we might do.

Like people across the country, they know the current system does not work

for them. But they are worried, as I said a minute ago, that we are going to make it even worse.

This bill represents a substantial improvement over business as usual. I congratulate the majority leader for listening to not just a small group of people but to people across the aisle, to people all across the country in crafting this piece of legislation.

First of all, the most important principle of the bill is that it is paid for. We already had about $5 trillion of debt when the last President became President. We are now at $12 trillion. There has been an unbelievable spike between 2000 and today. We have put an enormous burden—as the father of three young girls, I feel this very personally and very keenly—an enormous burden on our kids and our grandkids.

Our debt is now $12 trillion. Our entire gross domestic product—our entire economy—is $14 trillion. Our deficit is $1.4 trillion, 12 percent of our gross domestic product. That is utterly unsustainable. We know the biggest driver of our medium-term deficits is rising Medicare and Medicaid costs, and the biggest driver of those is rising health care costs.

This bill, unlike Medicare Part D—a very worthy program passed during the last administration—this bill is paid for. That drug program for seniors was not paid for. Instead of paying for it, instead of making hard choices, what we said to our kids and our grandkids was: You pay the bill. By the way, that is what we have said about tax cuts. That is what we have said about the wars in Afghanistan and Iraq. We have to put an end to this. This bill at least starts to head us in the right direction. It does not fix our fiscal crisis, but it is an important step forward.

As I mentioned a few minutes ago, for working families, the current system has been a complete disaster, as their income has remained flat or gone down, as their health care premiums have gone up by 97 percent. Even though there is a lot of conflict out there about what the way forward should be, about a specific policy choice here versus a specific policy choice there, I can tell you, one thing everyone in my State agrees with is that their health care has not improved by 97 percent over the last 10 years. They are paying more and getting less. Coverage is getting weaker, as it gets more expensive.

Small businesses are getting crippled by the system we have today. They pay 18 percent more than large businesses to cover their employees, just because they are small. Sometimes people say to me: Well, Michael, don't you know that is because the pool of employees is smaller? It is harder to spread the risk. I say: I understand that. But as a businessperson, from a business perspective, that is ridiculous—the idea that a small businessperson, trying to execute their business plan, trying to execute their vision to grow their business, is going to spend 18 percent more for something and not get 18 percent more productivity out of it, or not get 18 percent, in this case, better health care coverage out of it. In fact, the reverse is true. It is ridiculous.

By the way, one of the things that is interesting to me about this debate over a public option is that people do not seem to understand what is actually happening before our eyes. As the costs of insurance are going up every year, few and fewer people are able to get insurance through their employer, fewer and fewer employers are able to offer insurance to their employees, which is heartbreaking for many of our small business owners because these are family businesses that for years have provided health insurance to their employees. They view it as part of their pact with their employees to help them get ahead. But they cannot do it. So they are dropping them from the rolls.

Where are these folks ending up, those who are now uninsured? Well, two places: Medicaid, if they are poor enough, or in the emergency room, getting covered with uncompensated care that we, the taxpayers, are paying for.

We have a public option. It is the least intentional and most expensive public option you can imagine. When we are talking about the changes we are making here, we need to understand what is going on in the daily lives of people all across our country.

The figures we have from the Congressional Budget Office show that this bill will reduce the deficit, not add to it, will cut our deficits over the first 10 years by $130 billion, over the next 10 years by $650 billion. That is $780 billion.

One thing we know about those numbers is they are not going to turn out to be exactly accurate. But here is the goods news: The CBO is unable to score the benefit of prevention. They are unable to score the benefit of wellness. They are unable to score or focus on primary care instead of emergency room care. There is good reason for that because that comes down to execution—how well is the program implemented. Those of us who are proponents of reform carry a very heavy burden to make sure the execution is good and that we carry this through. But the good news is, if we do a good job, we will save money.

I want to say a word about Medicare because there has been a lot of discussion from people who are opposed to reform who are saying we are cutting Medicare. They are saying we are hurting seniors. But what they will not tell you is that the worst possible scenario is not taking action now on critical Medicare reform. As I said earlier, and said in many speeches, our Medicare Program, on its current path, is headed for fiscal crisis.

Policy experts on both sides of the aisle have said we need to reform our Medicare delivery system. We need to stop basing payments on every procedure and every test. Instead, we should look at successful models such as our own Denver Health, the Rocky Mountain Health System, and the Mayo Clinic in Minnesota. We know they have better quality and better outcomes, not just for seniors but for everyone.

This bill builds on what works locally. That means protecting the guaranteed Medicare benefits for every senior, and for years to come. It improves Medicare solvency. We make sure doctors will not see a 20-percent cut in their payments. It makes the entire Medicare system more affordable and will save taxpayer dollars.

Critics say no to reform. They are content with a system that pays by the test, test after test, instead of outcomes and patient-centered care. That approach will assure that Medicare is bankrupt by 2017. We need to do better than that for seniors. We need to protect Medicare.

Included in this health care reform bill is a version of a bill I introduced based on great work being done in Colorado. It is called the Medicare Care Transitions Act. We looked at the $17 billion Medicare was spending on hospital readmissions. Currently, one out of every five patients leaves the hospital and returns within the same month. We looked at places in Denver and Grand Junction where the readmission rates are 2 percent compared to the national rate at 20 percent. What we saw was that they coordinate care. As people go from place to place, these health care systems track where they go with a system of electronic medical records, what medications they use, what doctors they see. They focus on patients—on patients—when making decisions. So when we talk about these delivery systems being unnecessary, tell that to the 12 million Medicare seniors who got readmitted to the hospital within the very first month they were let out of the hospital. We owe so much more to these seniors, and we owe a lot more to the American people.

Health care reform must stop the rising costs that are bankrupting working families, small businesses, and our economy. If you like your coverage, you should be able to keep it. We need to put an end to denials based on pre-existing conditions. We need to give people more affordable options, including a public option. One thing is clear. Business as usual cannot be an option. The debate is bigger than politically charged issues. We have to keep our eye on the ball and not get distracted by the same old, tired, special interest politics that have kept us from reforming our health care system since Harry Truman was President.

Health care reform should not be about changing our laws on abortion. I

think the House went astray when it adopted new language with unintended consequences for women. The Senate bill already makes sure we do not use taxpayer dollars to fund abortion. That is why I opposed the House Stupak language.

I want to end this morning on what I am for. I am for insurance reform. I am for making our small businesses more competitive by reining in skyrocketing health care costs. I am for reducing premiums for working families. I am for more consumer choice, including the ability to voluntarily choose a public option. By the way, one thing I have noticed is that as people start to understand they are going to be required to have health insurance as part of this plan, what they are saying is, I want all the options. I want a private option, a public option, a nonprofit option. I want to be in a position to make the best decision for my family.

I am for reform that squeezes our wasteful spending so we can reduce our deficits in the long term. Throughout this entire debate, my focus has been on our working families and small businesses. There is plenty in this bill for you.

The time for talking is over. We should pass this bill. But tonight what we should do is make sure we allow the Senate to debate the bill, to improve the bill. There are things in this bill I want to change and things I want to make better in the coming weeks. But I believe that if we pass this reform, we will have taken a very important step forward to saying we are here to honor the legacy of our parents and our grandparents. We are here to say as one generation to the next that we are going to carry that legacy forward and make sure we are making the hard decisions to provide more opportunity for you, not less. This is only one step of that.

I mentioned education earlier. I mentioned our economy earlier. My hope is that in this debate, what we can do is begin to learn how to set the special interests aside for the benefit of the American people. If we can do that, there is not a doubt in my mind that we will honor our grandparents' legacy.

Thank you, Madam President. I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Madam President, even though America has the best doctors and the best nurses, our Nation spends too much on health care for what it gets. Because the problem in American health care will not cure itself, I rise in support of this motion to proceed to beginning the debate about how to fix American health care.

Before I lay out the many provisions in Majority Leader REID's bill that constitute real reform, I wish to talk for a couple of minutes about how the Senate can come together, Democrats and Republicans, to fix American health care. I have had a chance to visit with almost every Member of the Senate in their office on this issue, to listen to them, and it is very clear to me that both Democrats and Republicans have valid points. I believe my party is absolutely right in saying you cannot fix American health care unless all Americans get good quality, affordable coverage. If you don't cover everybody with that kind of coverage, what happens is those who are uninsured shift their bills to the insured folks who are already getting shellacked, and there is an underemphasis on prevention. So my party is right that to fix this, we have to offer all Americans secure, quality, affordable coverage.

I think colleagues on the other side of the aisle have valid points as well. They focus on the need for marketplace forces, for choice, for competition. I subscribe to each of these principles as well.

I think many believe it is an absurd fantasy that before the Senate completes its work on this legislation, the Senate could actually come together, Democrats and Republicans. I simply don't share that view. Let me be clear: It is my intent when this bill gets to the floor to work very closely with Majority Leader REID and with all of our colleagues to finally break through, to get beyond some of the polarization, the near brawling we have seen in townhall meetings where folks sit in opposite sections depending on their political points of view. That is not the American way to face big challenges. This certainly is such a challenge.

I believe fixing the economy and fixing American health care are two sides of the same coin. We can't spend more than 16 percent of our gross product on health care, spot our foreign competition hundreds of millions of dollars a year, and have enough money left over to focus on education, transportation, and domestic needs. The reason so many Americans don't see their take-home pay go up is because health care gobbles up all the costs in sight. So this is certainly a big enough challenge that it demands that the Senate get beyond the fighting—near brawling—about this subject across the land. On the basis of the conversations I have had with colleagues, I continue to believe the Senate can break through and produce a bipartisan bill, working with Senator REID, working with colleagues on both sides of the aisle.

In terms of the real reforms that are in Senator REID's bill, some of the most important have to do with the delivery system—the way American health care is essentially experienced across the land. The fact is that today's delivery system essentially rewards inefficiency. Payments are based on volume rather than quality. In my part of the country, we have plans like Kaiser and Group Health, and we have actually been in the forefront of trying to move away from a system that rewards inefficiency, rewards volume. What we have shown is that changing these incentives pays off. People can be healthier and America can do it for less money.

Senator REID's bill begins to move in the direction of what we have been doing in our part of the country for some time. His bill promotes what are called accountable care organizations. There are also changes in reimbursement. Probably folks on Main Street are not familiar with what is called ''bundling.'' In effect, instead of paying for each specific service, under bundling there is essentially one payment to reward trying to deliver care in an integrated fashion.

We have been able to have included in the legislation incentives to care for folks at home. The majority leader included a version of the bill I introduced called the Independence at Home Act that is backed by many colleagues on the other side of the aisle, and many Democrats as well. When we think about the challenges of American health care going forward, we certainly ought to agree it makes sense to deliver more good quality, affordable care at home, rather than forcing the sickest Americans to spend a big chunk of their day fighting through traffic simply to get to a doctor's office, and we have the technologies, we have the trained physicians and nurse practitioners to offer these kinds of services at home. I highlight the fact that this is real reform, it is in Senator REID's bill, and Republicans and Democrats alike are behind it.

The majority leader makes a number of long overdue changes in the private health insurance market. In many respects, today the private health insurance system is simply inhumane. What we have is a system that rewards cherry picking; where the private insurance companies take only the healthy people and send the sick people over to government programs more fragile than they are. What we need is a very different system where the private insurance companies compete on the basis of price, benefit, and quality, and not who is the best at selecting out the good risks.

Senator REID's bill does away with the unconscionable practice of pre-existing condition exclusions and the practice of rescission where the insurance companies abruptly drop coverage for the sick. The bill also does away with charging a person more simply because they are sick, because they are a woman, or because they work in a high-risk job.

These are very constructive insurance reforms. We are going to try to build on those as we go forward in the legislation. Colleagues should make no mistake about it: The insurance changes in Senator REID's bill are very real reform.

I wish to focus for a few minutes, though, on what I think is the great promise of this legislation for health care in the future. Since World War II, there has essentially been no market for American health care. Back in the days of wage and price controls, we didn't have a way to get good health care to Americans and we simply said we will put it on the backs of employers. They were patriotic citizens then, like there are patriotic citizens now, and they said, We will figure out how to do it. We are going to have to pass on the costs in the form of higher prices for goods and services. That probably made sense back then. We had people essentially work at a job for 20 or 25 years, and after their last day at work they got a gold watch and a dignified retirement. Today, there is a very different economy. The typical worker changes their job 11 times by the time she is 40. She needs a different set of health care choices. She needs the opportunity to be empowered to go into the marketplace to hold insurance companies accountable and to get more value for her health care dollar. The majority leader in his bill lays the foundation for this kind of system.

He establishes a system of what are called health insurance exchanges. They are kind of like farmers markets for health insurance. Senator REID has improved this so that these farmers markets, these exchanges, could only let in good-quality plans, and under Senator REID's bill, it will be possible to more easily compare the plans in these exchanges. This is something I have been interested in for years, really going back to the days when I was co-director of the Oregon Gray Panthers, because I think it is simply bizarre that it is possible in other parts of American life—in a Costco store or any other big store—to compare products, look at alternatives, have a measure of uniformity, and not have that in American health care.

What Senator REID's bill does is set the foundation for a marketplace so that health care in 2009 will be dramatically different than it was, say, 60 years ago, in 1949, when I was born. I don't see anybody outside the Capitol driving a car from 1949, but much of American health care still resembles the middle of the last century. Senator REID, through his legislation, lays the foundation for modernizing that.

I would like to see more people in these new marketplaces, the exchanges, more quickly. Under the estimates we have been given, only about 10 percent of our population would be able to enjoy the fruits of real choice and real competition. Real choice and real competition in that marketplace is the path to holding premiums down. My goal in the years ahead is to allow every consumer—every consumer, for example, in New York and Oregon—to be able to deliver an ultimatum to their insurance company. That ultimatum should be: Treat me right or I am taking my business elsewhere. It is that simple. That is the way we do it in every other part of American life.

By the way, that is the way it works for all of us here in the Senate. We belong to a real marketplace. We belong to a real exchange called the Federal Employees Health Benefits Program. If a Member of the Senate doesn't like his health care coverage in November of 2009, come January of 2010, that Member of the Senate can take his business elsewhere, to another insurer that does a better job. I think that kind of marketplace—the marketplace every Member of the Senate now enjoys—ought to be available to everybody else in the country. I think there ought to be public choices. I think there ought to be private choices. I think all Americans ought to be able to have access to all of those choices. We are not going to be able to have real insurance company accountability, real choice, and real competition unless we make the exchanges robust and get more people in.

To illustrate the fact that the majority leader and other leaders, such as Chairman BAUCUS, are open to new ideas, just yesterday the majority leader and Chairman BAUCUS and I agreed on an approach that will allow more people to enjoy the marketplace, the fruits of a competitive system, more quickly, when they indicated yesterday they would support my legislation to expand access to the exchanges for those who otherwise would have forgone having health insurance under health reform. Let me emphasize that—letting folks get to the exchanges who otherwise would have no health insurance at all. We have been able to do it. According to the CBO, we will be able to add an additional million people, middle-class folks walking on an economic tightrope, at 10 percent or less of what it would cost to have those people get their coverage through Medicaid or through subsidies. It is my intent to work with the majority leader and Chairman BAUCUS closely to allow others to have a chance to be part of this kind of competitive system. I commend the majority leader and Chairman BAUCUS for their commitment to work with me, as this bill goes to the floor, to expand access to the marketplace.

Let me close with one last point. I see my colleague from New Mexico in the Chamber, and he is a welcome addition to the Senate.

A lot of Americans listening may wonder why the Senate is turning its attention to health care when there is so much economic hurt in our land. The fact is, fixing the economy and fixing American health care are literally two sides of the same coin. We have to rein in these costs. We have to rein in these costs for Americans to have more take-home pay, to be in a position to pay for essentials, and to allow our workers to compete in ferociously challenging markets around the world.

It is time to move beyond the town-hall brawls of this past summer and for the Senate to work with Senator REID and all colleagues to break through and deal with this critical issue, the premier long-term challenge of our time for our economy, and do it in a bipartisan way. I urge my colleagues to vote for the motion to proceed.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico is recognized.

Mr. UDALL of New Mexico. Madam President, I appreciate very much listening to Senator WYDEN and his comments on health care reform. He has been one of the leaders when it comes to working in the Finance Committee and looking for significant reforms on health care. I look forward to working with him in that capacity.

The health care reform we are debating today will impact every person in this country. Whether you are searching for affordable insurance for yourself or watching helplessly as a loved one is denied coverage, every American stands to gain something through this historic legislation.

In my home State of New Mexico, the people I represent don't just have a lot to gain from this reform, they also have a lot to lose if this reform is not enacted. For New Mexicans, the status quo isn't an option. That is because without this health care reform our State is expected to experience the largest increase in insurance premiums of any State in the Union. In 2016, without this reform, a family of four in New Mexico can expect to pay an astounding $28,000 a year in health care premiums. That will consume more than 56 percent of that family's projected income for the year. Affordability is already one of the key barriers to obtaining coverage in my State. Since 2000, premiums for residents have risen 110 percent. As a result, almost one in four people doesn't have insurance, giving us the second highest uninsured rate in the Nation.

Enactment of this reform legislation would make as many as 249,000 middle-class New Mexico residents eligible for premium credits to ease the burden of these high costs. In addition, almost 238,000 New Mexicans would be eligible for new private coverage through the exchange or through their employer and another 124,000 would be eligible for the new expanded Medicaid coverage. For the families who already have insurance, they win too. They will likely see lower premiums, thanks to the increased competition in the market. The bottom line is that with this reform the vast majority of New Mexicans would have access to quality, affordable health care for themselves and their families.

Reform will also benefit New Mexico's small businesses. In 2006, less than

35 percent of small businesses in my State offered coverage for their employees. That figure means our State ranks dead last in employer-sponsored insurance in the Nation—a dubious distinction, to say the least. I have talked to a lot of these small business owners over the past month. They all tell me pretty much the same thing: I would love to offer coverage to my employees, but it is just too expensive. They say they are having a hard time affording insurance for their own families. To those small business owners, I say that help is on the way. The Patient Protection and Affordable Care Act will help you provide insurance to your employees by providing Federal tax credits of up to 50 percent of premiums should you choose to offer coverage.

In addition to lowering costs for individuals and families and helping small businesses, this reform would also give our rural communities additional tools to provide quality, affordable health care for all of their residents.

Of the 2 million people who call New Mexico home, about 700,000 live in rural areas. They are more likely to be uninsured and often must travel hundreds of miles for preventive or emergency care—if they are able to find any care at all.

In this bill, we have included pay incentives to recruit more physicians to serve in these underserved rural areas. We will improve dental services in rural areas, we will extend Medicare payments for ambulances in rural areas, and we will expand the Telehealth Program so that rural residents may receive specialized treatment not available in their local areas.

Finally, we make sure this legislation won't result in an unfunded mandate for our State government, which is already experiencing the pain of budget cuts, thanks to the economic downturn. This legislation would require the Federal Government to cover 100 percent of the cost of the Medicaid expansion from 2014 to 2016 and 95 percent of that cost after that.

When it comes to health care today, too many New Mexicans are living on a cliff, teetering on the edge of financial ruin. All it would take is an illness or job loss, and they could fall into the abyss of medical invoices, bill collectors, and bankruptcies. For these New Mexicans, the status quo isn't an option. This bill offers a life rope to these New Mexicans to pull them back from the precipice. Passing it would provide stability and security to those who have insurance, affordable coverage to those who don't, and lower costs for families, businesses, and government.

This is a historic moment. I urge my colleagues to join me in seizing it. Let's begin the debate on this long-overdue legislation to reform our broken health care system.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Madam President, I ask unanimous consent to be allowed to speak in a colloquy as it evolves on our side.

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

Mr. GREGG. We are joined by a number of the distinguished members of our caucus. They have thoughts they want to express. We want to discuss a couple of points.

Before I turn to the Senator from Missouri, I want to make a point, because I have been listening to a lot of the discussion on the floor, and I have participated and listened to a lot of it on television, from my colleagues on the other side of the aisle. They continue to use this number. They claim this bill will cost $800-some-odd billion and that is the number that has been reached as the expenditure on this bill. That is a totally dishonest number. That is the ultimate shell game. That is Washington cynical politics.

Do you know how they get to that number of $800 billion as a cost of the bill? It is a 10-year number, by the way. That is a lot of money, $800 billion. That would run the State of New Hampshire for probably 100 years. Missouri is a little bigger, but it would run that State for a while, and it would probably run Alabama for a little while. South Dakota could probably run for 200 years on that. That is not the real cost of this bill, though. That is not the cost of the bill.

The way that number was arrived at—and I think the American people need to understand this. If that number was so dishonestly arrived at for the number of the bill, what is wrong with the rest of the bill that they haven't been told about? That was a 10-year score for what the bill cost was, but they don't start spending money under this bill until the fourth and fifth year. In fact, the cynicism exceeds that. They couldn't get the score they wanted—they couldn't get the score they wanted from CBO, so they moved back another year in the 10-year cycle. They went from 4 years to 5 years as to the starting point of most of the spending in this bill.

What they claim to the American people is the 10-year bill is going to cost about $800-plus billion. But what they don't tell the American people is they are not spending anything in the first 4 or 5 years of the bill. No, they do raise your taxes throughout the 10-year period. They do cut Medicare throughout the 10-year period. But they don't spend the money. They don't start the programs until the year 2014, when this bill is fully phased in.

When all these new programs, this massive expansion of entitlements is created, brand-new entitlements, when all this new spending occurs, this bill will cost $2.5 trillion over that 10-year period—$2.5 trillion. That is the real cost of this bill. That is how this government is going to grow in a 10-year window as a result of this spending.

I say to my colleagues, I think most of us understand we already have a huge debt problem in this Nation. We are passing on to our kids a country with so much debt they are not going to be able to afford it. Every year for the next 10 years, without this health care bill, the President has proposed budgets which will run a $1 trillion deficit, every year, on average, for the next 10 years. Sometime this month, we are going to have to raise the debt ceiling of this country because we reached $12 trillion in debt. Then it is going to have to be raised again because we are running up these massive deficits.

The debt owed by this country will exceed 80 percent of our gross national product—80 percent of our gross national product at the end of that 10-year period—and will exceed 60 percent of our gross national product within 2 years. Those are unsustainable numbers. Yet a bill is being proposed that is going to expand the size of government by $2.5 trillion.

It is alleged it is paid for, and we are going to get into a discussion in some depth because I think that is an equally cynical number as a result of bait and switch.

I just wished to clear the air as to the real cost of this bill because I found it uniquely cynical that it would be represented that this bill costs $890 billion, whatever the number is. It does call into issue the credibility of the rest of the numbers that are being thrown out by the other side of the aisle when they use that number, which is a 5-year number that they claim covers the 10-year cost, when they don't do anything in the first 5 years.

I appreciate the indulgence of the Senator from Missouri. I understand he wishes to speak and then we will go to the Senator from Alabama and then the Senator from South Dakota and then have a discussion about some of the issues, such as costs, how it affects Medicare, how it affects small businesses, how it is going to affect your personal insurance.

Mr. BOND. Madam President, I thank the Senator from New Hampshire. I wish to clarify some things he said because they are truly important. I wish to make sure everybody understands it because Senator GREGG, in his position on the Budget Committee, as well as his other positions in writing this bill, is intimately acquainted with the costs of this bill.

The cost for 2010 to 2019, how much was the cost for that 10-year period?

Mr. GREGG. That is $1.2 trillion because between the period 2010 and 2014, there are no expenditures because they don't start the programs until 2014.

Mr. BOND. Is this the total expenditure or are these just the expenditures that are not covered after 2014, that are not covered by the so-called tax or revenue raisers? In other words, does this all go onto the debt?

Mr. GREGG. No, those are total expenditures which are represented to be offset by cuts in Medicare, increased fees, and increased taxes.

Mr. BOND. Cuts in Medicare. How much are the cuts in Medicare?

Mr. GREGG. When fully phased in, in the 10-year period, 2014 to 2023, the Medicare cuts are $1.1 trillion.

Mr. BOND. Madam President, $1.1 trillion cuts in Medicare. How much are the taxes and the other ''revenue raisers'' in that period?

Mr. GREGG. The taxes and fees during that period—this period, when it is fully phased in—are approximately $1.5 trillion.

Mr. BOND. So how much will go onto the debt? How much is uncovered?

Mr. GREGG. Actually, if you accept these assumptions that we are going to cut Medicare by $1 trillion and take that to create a new entitlement instead of using it to help Medicare be more solvent and then we are going to raise taxes and fees by $1 trillion—remember, most of this is not going to come out of the wealthy. It is going to come out of small businesses and higher premium costs to people on insurance or it is going to come out of HI taxes. If you accept that logic, which I find to be a bit of a reach, then it will not have any impact on the deficit in that timeframe because they have cut Medicare to pay for it, and they have raised all these taxes to pay for it.

Mr. BOND. My friend has been very active in the Budget Committee. How many times have we cut Medicare, have we allowed Medicare cuts to go into effect? I think that is a rather rare occurrence, isn't it?

Mr. GREGG. That is a fascinating question because I was chairman of the Budget Committee the last time we tried to do something in the area of the rate of Medicare costs because we received a directive from the Medicare trustees that Medicare had to be made more cost-effective or else it was going to go broke. So we suggested, when I was chairman of the Budget Committee—and everybody in this room voted for it, by the way—that we should reduce the rate of growth of Medicare by $10 billion on a $1 million timeframe. In other words, Medicare was going to spend $1 trillion over a period, 5 years. We were going to suggest a $10 billion reduction in that rate of growth which was going to be paid for by requiring people who were getting Part D premiums and had high income to pay for part of their premiums—people such as Warren Buffett would not be subsidized by people working down at the local restaurant.

We did not get one vote from the other side of the aisle. We passed it by having the Vice President sit in the chair and break the tie. That was $10 billion over 5 years.

So I think this idea that you are going to do $1 trillion over 10 years and pay for this—first off, if you are going to reduce spending or raise Medicare taxes, it should go to pay for Medicare solvency because Medicare is insolvent. It shouldn't go to create a new entitlement. Senior citizens, paying into Medicare all their lives, should not have their money taken to start a brand-new entitlement for other people, and that is what this bill does.

As a practical matter, we are not going to do that. We know that. We know this is all going on the debt. Ninety percent of this is going to end up on the debt.

Mr. BOND. I thank my colleague from New Hampshire because he has been a very solid, consistent, credible voice. What he is pointing out today is that the legislation we are debating has major implications for every American family, every American taxpayer, every American small business.

In the 1992 election, President Clinton's famous slogan was: ''It's the economy, stupid.'' Seventeen years later, it is again the economy that is a major issue facing the people. But this time the majority party does not seem to be paying attention. Instead, the majority has used its supermajority position to spend trillions of dollars that we don't have, including a misnamed stimulus that stimulated the growth of the deficit and the Federal Government but not jobs. We had takeovers and bailouts of banks, insurance companies, and major auto manufacturers. They have adopted a budget that would double the debt—the debt our grandchildren owe—in 5 years and triple it in 10.

It is little wonder that the unemployment rate has skyrocketed, because employers are afraid to hire. Families are seeing their budgets strapped such as never before. But the bill before us is a crowning achievement of the drive to destroy our economy and hope for the future.

Just 1 year after a narrowly averted financial collapse, with unemployment at its highest level since 1983, instead of how to create jobs, we are debating a bill that will take over one-sixth of our economy and likely kill jobs.

Don't get me wrong, our health care system is in need of reform. It costs too much, too many people are uninsured, there are too many junk lawsuits and too much defensive medicine and not enough focus on prevention and wellness.

While we all agree reform is necessary, the American people expect us to answer the questions: How much will reform cost and can we afford it? Will it lower health care costs? Can you keep your current plan? What role will the government play?

The answer to two and three on this bill is: No, it will not lower our health care costs; no, you will not be able to keep your current plan.

Then the question is: Who will make health care decisions? We are seeing evidence that they have government committees that say when you can get a mammogram, when you should get Pap screening.

Will Americans and Members of Congress have time to evaluate what is in the legislation? We hope today, as yesterday, that we will bring out for the American people the cost of this bill because what we are seeing in this massive pot, 2,047 pages, is there is a lack of commonsense reform. It is filled with costly budget gimmicks and asks the people of America to spend over $2 trillion on proposals that will heap a mountain of debt on our children and grandchildren.

Two trillion dollars is an almost unfathomable amount of money. But in Washington, trillion is the new billion, and that is not the kind of health care reform Americans want. It is not reform at all. It spends too much, it taxes too much and it cuts Medicare too much and does not provide reforms we need. Nearly $½ trillion in taxes will be added on the backs of the American people, $28 billion in taxes on businesses, which will kill jobs at a time when we have over 10 percent unemployment and even higher if you include the number of people who are no longer working or underemployed. These higher costs will ultimately be passed on to American workers and consumers.

Anybody who thinks you are going to tax health care insurers, device providers and expect that those costs will not be passed on to the consumers—that is you and me, Madam President. The head of the Congressional Budget Office and the Joint Committee on Taxation have said these higher taxes are passed along, and they will land on families, small businesses, and individuals.

It will also force Americans into a government-run health care plan. It will ration care and limit access to lifesaving treatments and put a bureaucrat between you and your doctor. In life, two things you can count on are said to be death and taxes. I didn't expect to see them both in a health care reform proposal.

We call this a pig in a poke. The only way to sell a pig in a poke is to hide from Americans what their tax dollars are buying. If I were to outline all the problems in this 2,000-page bill, we would be here until Thanksgiving. It is sort of like a mosquito in a nudist colony—there are so many targets to attack in this bill we don't know which one to hit.

Let me give you just a few. As the Senator from New Hampshire pointed out, the real cost of this bill to the

American people is a whole lot more than they admit. The majority is claiming that the bill only costs $850 billion, but the way the majority gets to say that is because they are pulling a great smoke-and-mirrors trick.

Even more incredible is the Democrats' claim their bill will cut the deficit. It is a great scheme, but no one outside Washington actually believes this health care bill will do anything but increase costs and pile more debt on our kids and grandkids, and they are right.

Right now, as the ranking member of the Budget Committee has pointed out, the national debt already exceeds $12 trillion. This bill will put more on that. The true cost of the bill is not just a ''he said, she said.'' Even the nonpartisan Congressional Budget Office acknowledges that the majority's bill includes gimmicks that hide the true cost of the bill.

Part of the majority's scheme to hide from Americans the true cost is the great stunt, as the Senator from New Hampshire described, to push back implementation of parts of the reform to 2014 but start collecting money in taxes now. That means tax now and pay later. That sure makes your numbers look good, doesn't it?

For example, Medicaid expansion does not begin until 2014. That is in section 2001. Section 1311 says health insurance exchanges are not fully operational until January 2014. Section 1323 says a public health insurance option is not available until 2014. Most of the major insurance reforms, however, in section 1253 take effect in 2014.

The tax on health insurance starts in 2010. That is section 9010. Section 9009 says the tax on medical devices starts in 2010. Section 9008 says the tax on pharmaceutical manufacturing starts in 2010. That is even worse than the Senate Finance Committee bill which initially had it starting in 2013, but it is a great gimmick to allow them to hide the cost of the bill. Claiming savings of $122 billion by recording taxes over 10 years and only scoring costs over 6 years would get an officer in a publicly traded corporation sent to jail. Move over, Bernie Madoff. Tip your hat to a trillion-dollar scam. This is magnificent, and that is in this bill. I am glad all Americans can read it. They can check out the sections I cited.

Even the Congressional Budget Office has called ''bull'' on this stunt, saying it would be difficult to maintain the savings the majority has been touting. No wonder. And the true cost, as the Senator from New Hampshire has pointed out, is $2.5 trillion. But it will also be increasing taxes. In fact, everyone will be taxed one way or another. Forget what the President promised about no taxes. Sections 9004 and 9010 will tax Americans who have insurance. Section 1501 will tax Americans who do not have insurance—almost $8 billion. Taxes will be placed on medical device manufacturers, section 9009; and as the CBO has said, those taxes will be passed on in the form of higher prices and thus in the form of higher insurance premiums.

Because of the tax on health insurers, section 9010, the CBO and the Joint Committee have said these taxes will be passed on in the form of higher health care premiums. PricewaterhouseCoopers says that is $487 a year per family. That is how much these taxes on the health insurers and health payment plans will cost the average family.

Employers will be taxed. About $2 billion in new taxes will be placed on employers who do not meet government approved health care plans. That is section 1513. That is where American workers are going to pay for it because that is where they lose their jobs. Headlines in the Wall Street Journal and letters I have seen from leaders of businesses say we are not expanding; we cannot afford to expand; we cannot afford to take on more employees.

Why are we having a jobless recovery? Because the threats of Washington's overspending, overcontrolling, overtaxing, and overregulating are telling prospective employers that they are about to hit the ditch with all the things the Government is putting on them.

For all of the taxes and mandates, according to CBO, about 5 million Americans would lose their employer coverage. That is because the costs would go up, the regulations would go up. Currently, 83 percent of Americans have health insurance, and they are concerned that it costs too much. Americans want affordable health care, but this bill raises the cost of health care. New taxes and mandates will be passed on to American families, the American taxpayers, and American small businesses.

The bill still leaves 24 million Americans without insurance. According to the CBO, the government-run plan will have higher premiums, and the CBO said it will drive up the cost of health care. This was supposed to lower the cost of health care. It will not do anything of the kind.

To sum up, $2 trillion in more spending gets the American taxpayer, in the 2,074 pages, a Federal bureaucracy that increases the cost of health care, raises premiums, slashes Medicare for seniors, and puts unfunded burdens on States.

Let me just make two last points: The States, according to CBO, will get coverage for these new Medicaid eligibles for the 2 years that they will get covered and then they will dump it on the States—$25 billion. There is a $25 billion cost.

The Senator from New Hampshire and I were both Governors of our States. I can tell you, States do not need that kind of burden, particularly in their difficult circumstances.

Slashing Medicare for seniors? In Missouri, Medicare already only pays 80 percent of the costs. More and more hospitals and doctors have to limit the number of Medicare patients they can accept. If we continue, and if they push through this Medicare cut, then fewer and fewer Medicare patients are going to be able to get health care.

I hope my colleagues will listen to what the American people are telling us and vote against the bill. That is certainly the message I am getting from Missouri.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Madam President, I thank Senator BOND. He has certainly delineated some of the fiscal impossibilities in this bill, as has our former Budget chairman, now ranking member of the Budget Committee, JUDD GREGG. He studied this very hard. The information he provided to this Congress and to the American people is accurate.

I have tried to think what I should say about this bill this morning and be realistic and honest and boil it down to its essence. The 2,000 pages that sit on that desk, how should we talk about it?

Let me just say the claim from our colleagues is that they have a great plan to reform health care and it will fix the problems in health care. We do have problems in health care that need to be fixed. They are going to provide methods and additional funding and provide millions of people with insurance who didn't have it before—although 24 million will remain uninsured. At the same time, they will save $130 billion over 10 years, and we are supposed to be grateful and say how pleased we are that you have been able to pull off this event.

But the first reaction most American people have had, and it is a sound one, is, wait a minute, that is pretty dubious. How can you do that? Do you remember that song from the ''Sound of Music''? ''Nothing comes from nothing, nothing ever could,'' sang Julie Andrews.

The result is the phrase I came up with: ''Shell game.'' Senator GREGG used that phrase. I think that is exactly what we are talking about. When it became obvious to everybody who could add that this great vision, the wild chimera they had that they could do all these things, would not work as they dreamed it, the mountebanks began their chicanery.

In my remarks I will not attempt to point out all the manipulations in this bill, just some of the more obvious that are inescapable.

First, you ask: Why do they do this? The answer is the numbers don't add up. They cannot make the numbers do what they want them to do. So they either have to be honest and talk about

massive cuts openly or massive tax increases. The American people are not sure about that. To add a whole new monumental health care program at a time of colossal financial stress in our country, with debts the likes of which our Nation has never ever seen before, are we now going to start off on a monumental multitrillion-dollar bill that will not pay for itself?

We have this great promise, and it is not adding up. Do they slow down? Do they begin to think if they can't do everything they promised in the campaign, and they would love to do, and they wanted to do, what progress can they make step by step in a rational way that we can afford in this time of unemployment and unprecedented deficits? No, that is not what they decided to do.

What they decided to do is go forward anyway and call anyone who had the temerity to say their ''emperor has no clothes,'' that they are ''Dr. No,'' they are against everything. They don't believe in any reform.

That is kind of the idea we are hearing, and that is not correct.

The bill is just too much, it goes too far, too fast, and costs too much. We don't have the money. The American people know this. That is why they oppose this bill. They are not opposed to reform and progress. They are opposed to this legislation, this 2-foot tall, 3-foot tall, 2,000-page piece of legislation.

They don't dislike President Obama, but they don't like this policy he is trying to promote. You say: Let's have some facts about it. I can't explain everything, but I want to share a few things.

Madam President, I ask to be notified after 5 minutes.

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

Mr. SESSIONS. A critical, essential part of fixing a broken health care system is to end the growing problem of payments to our doctors. Republicans and Democrats have not been good on this issue in the past, but the problem grows worse each year. Essentially, in the balanced budget amendment of 1997 we limited the amount of payments to doctors. After a while it became clear the cuts were too severe, and each year we put money back in. But the law still mandates major cuts. In fact, today if we don't do what we call the doctor fix each year, they will have a 23-percent reduction in reimbursements, they get paid less. This is for Medicare. And they get paid less for Medicare than other insurance already, so doctors are going to quit doing it if we have a 23-percent reduction in what they get paid for doing their work.

How much does it cost to permanently fix that as the medical profession assumed we were going to do and as the President and his team have indicated they plan to do? It costs $250 billion. That is a lot of money. That is not a new program, this is an obligation that we have now. Does this plan fix that? It fixes it for 1 year. So it goes out 1 year and then the CBO score assumes the doctor payments will drop 23 percent and be 23 percent lower for 9 years.

If we add that up, that is $250 billion. It allows the folks in the know here to manipulate the numbers and hide a $250 billion debt we owe. We can't cut doctors that much, and we are not going to do it. We have not been doing it, and we will fix it every year, in fact, and that is—what I will say is, we will spend the $250 billion, and it should be in this bill. They didn't do it.

Just a few weeks ago, they met in this secret room down the hall, and they got to talking and said: What are we going to do about the doctors? How are we going to fix the doctors?

We could raise taxes.

Well, we raised taxes $500 billion. We can't raise them any more. Can we cut Medicare?

Gosh, we have cut it $500 billion. We can't do that.

What can we do? We promised the doctors fix to get them their pay.

So they offered—it would be hilarious if it weren't so serious—they offered legislation a few weeks ago to just pay the doctors all this money permanently, outside of the health care reform in a separate bill, every penny of it going to the debt, unpaid for.

Even 13 Democrats couldn't swallow that. They voted no, and it failed. But the House did it. They passed it, did they not, I ask Senator GREGG, unpaid for? Horrible. Another $250 billion added to our debt.

So that is a shell game. It is like you have a hole in your roof and you don't want to spend the money to fix it, so you move across the hall into another room and pretend the hole isn't there. Somehow you are not going to fix it when you know you have to fix it.

They say: Don't worry. See, our plan is budget neutral. It is deficit neutral.

If you take the $250 billion, one thing right there, it is not neutral. It is in deficit already. It is in deficit already. You have to watch that pea and see how it moves around in the shell. But what we need to have a sense of is that this is a program we have never had before. It not only adds to the debt by not fixing the doctor payments, it raids existing programs, Medicare and Medicaid, both of which are in serious trouble. It raids them in the first 10 years and, as Senator GREGG said, much more later, $549 billion. And it raises taxes $493.6 billion. So it is pretty easy to say I have a deficit-neutral program if I assume I am going to take $500 billion out of Medicare and raise taxes $493 billion. It is budget neutral. Everybody should thank me. That is what the paper said the other day: Budget neutral. We are so proud of ourselves.

The American public are not buying this. They are a little bit skeptical. Medicare is going broke. Everyone knows that. We have been working on that for a number of years. All of us are concerned about this iceberg in front of the Titanic which is Medicare's deficiency.

The PRESIDING OFFICER. The Senator has consumed 5 minutes.

Mr. SESSIONS. I thank the Chair.

We need to save this program before we create a new one. It is so simple. If we are going to raise taxes $500 billion, has anybody asked where that money should go? Should the $500 billion in new taxes go to create a new program or maybe should it be used to put Medicare on sound footing or maybe it should be used to pay for military expenditures that have the highest budget in years, or maybe to reduce the debt which, I point out to friends and colleagues, is the greatest debt this Nation has ever seen. There has been nothing like it ever. In 2008, our debt was $5.8 trillion. In 5 years, 2014, it will be $11.8 trillion. In 2019, it will be $17.3 trillion, tripling in 10 years. According to the Congressional Budget Office score, it does not include money to fund the health care program.

How big are those numbers? I won't spend a lot of time on it. I will point out that people can understand when you borrow money, this debt doesn't come from thin air. You borrow it. China, other places loan us money. We owe them money. That is how we get the money. And look at the interest rate. My goodness. Alabama's budget is about $8 billion a year; $800 billion in this year is 100 years of our budget. The interest the United States paid on our debt in 2009 was $170 billion. That is a lot of money. The Federal highway bill is $40 billion. All of the Federal highway spending is around that amount. But in 10 years, according to the CBO, we are going to be paying in that 1 year interest of $799 billion. It is like nothing we have ever seen before. That is why people say our spending is on an unsustainable course.

The first thing we need to do to bring spending under control is to fix the critical problems that must be met. You don't start new programs that are likely to spiral out of control and far exceed the prognostications we have seen today.

I thank the Chair for the opportunity to share my thoughts. I am glad our colleagues are here. I know others would like to talk.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. THUNE. Madam President, I appreciate the great job done by my colleagues from Missouri, Alabama, and New Hampshire in pointing out many of the concerns we have with regard to this bill and why we think this is a bad direction to go.

You have heard my colleagues talk about a massive expansion of government, tax increases, premium increases; obviously, the very serious

problem we have with our national debt and the deficits we are racking up every single year, to the tune of about $1 trillion or north of there, $1.4 trillion last year, on a pathway to hit that target this year.

I have heard my colleagues on the other side talk repeatedly about Republicans not having their own solution. I have to say, maybe the reason they haven't been seeing the Republican solution is because they have been hiding behind this voluminous 2,100-page bill at a cost of $1.2 billion per page. Republicans—hundreds of times, if not thousands—have come to the floor and outlined a step-by-step solution to dealing with the health care crisis and the concerns most Americans have which is the high cost of health care. Unfortunately, many of my colleagues on the other side perhaps have not been able to see that because they can't see around this $2.5 trillion expansion of the Federal Government they seem intent on pushing through the Senate. Republicans have talked about buying insurance across State lines, small business health plans, tort reform, incentives for wellness and chronic disease management. There is a whole range of things that could be done to address the concerns of the American people about the high cost of health care that do not involve a $2.5 trillion expansion of the government, a 2,100-page bill, at a cost of $1.2 billion per page.

The other thing I have heard my colleagues say is we have to do something. People in this country are dealing about the high cost of health care. They are. We all hear it. We hear it from small businesses, from families, and from individuals. Everybody is concerned about the high cost of health care. In fact, a number of my colleagues on the other side have said of all the bankruptcies that occur every year, most occur because of the high cost of health care. Get this, America: Under their proposal, you will go bankrupt sooner. Because they drive the cost of health care up. They don't do anything to bend the cost curve down.

I want to show a chart which points out what happens to the cost curve under the Democratic plan we are talking about. The blue represents the current cost curve. That is the increase in health care costs we would see if nothing is done, year-over-year increases into the future. What we would expect, if we were going to reform health care, is that line starting to bend down a little bit so that health care increases go down over time instead of up.

What happens? Under this proposal—and this is the CBO; this isn't what I am saying or any of my Republican colleagues, this is what the Congressional Budget Office says—the Democratic plan we are talking about increases the cost of health care. It bends the cost curve up; $160 billion more will be spent on health care if their plan gets enacted. All those people who are concerned about the high cost of health care today are not getting any relief under the Democratic plan. In fact, their lives will get much worse—in particular, those who already have health care.

There are some in this proposal who will get some subsidies to buy insurance in a health care exchange. That affects about 19 million Americans. But there are 182 million Americans who currently have health care who, if this bill passes, are going to be faced with higher taxes and higher premiums. That is the way it works. They are ineligible to get any subsidies to buy insurance. In fact, they don't have any more options available to them. What they are facing is higher taxes that they will be faced with under this bill, as well as higher premium costs.

If you are the average person who is worried about cost, which I think most Americans are, and you are watching what is happening here in Washington, you have to be asking yourself: What is the whole purpose of going through a health care reform debate if, in fact, it doesn't do anything to drive down the cost of health care?

My colleagues have pointed out that when you spend $2.5 trillion, when you expand the Federal Government by that amount, when you raise taxes on medical device manufacturers, on prescription drugs, on health plans themselves, and when you cut Medicare providers and, if you believe this, this is something that seems hard to fathom, that any of this would ever take effect, but this $2.5 trillion is paid for in the form of Medicare cuts and tax increases, tax increases when it is fully implemented over a 10-year period, as the Senator from New Hampshire pointed out, about $1.2 trillion, about $1.1 trillion in Medicare cuts—who in this Chamber believes that $1.1 trillion in Medicare cuts is going to occur? There was a discussion between the Senator from New Hampshire and the Senator from Missouri about what happened a few years ago when the Senator from New Hampshire was chairman of the Budget Committee and proposed cutting $10 billion out of Medicare over a 5-year period, which amounts to $2 billion a year. What we are talking about here is $1.1 trillion over 10 when fully implemented or $100 billion a year. When he proposed cutting $2 billion a year over 5 out of Medicare, there wasn't a single Democratic vote in support of that. In fact, the Vice President had to come back from a trip to Pakistan to vote on it to try and reduce Medicare by $10 billion. They are talking about, when it is fully implemented, $1 trillion in Medicare cuts. Do you know who that hits?

Mr. GREGG. Will the Senator yield?

Mr. THUNE. Yes, sir.

Mr. GREGG. It is important to know where that cut is proposed to primarily fall. Is Medicare Advantage used by a number of seniors in South Dakota?

Mr. THUNE. It is. I assume it is in New Hampshire.

Mr. GREGG. Under this plan, it will be eliminated for all intents and purposes.

Mr. THUNE. That is where a big share of the savings is going to hit, senior citizens, right squarely between the eyes, if they get benefits under Medicare Advantage. In addition, $135 billion comes from hospitals; $15 billion from nursing homes; $40 billion from home health agencies; $8 billion from hospices. Does anybody believe all that will happen? And if it doesn't happen, guess what, it all goes on the Federal debt.

I thought it was interesting that last week when the President was in Asia, the Chinese raised the issue with him about what happens if health care reform passes. They weren't worried about universal coverage or a public option. They were worried about what impact it is going to have on the deficit.

According to the New York Times and their reporting on his trip:

> The Chinese wanted to know in painstaking detail how the health care plan would affect the deficit, said one participant.

They are worried about their investment because they are the biggest buyer of American debt. What happens to all these Medicare cuts that are proposed? We couldn't get 51 votes to cut $2 billion a year out of Medicare a few short years ago, and they are talking about cutting, when it is fully implemented, $100 billion a year. Does anybody believe we will cut $15 billion out of nursing homes? I don't think so. Here we are. How do we pay for it?

If it isn't paid for in Medicare cuts or tax increases, it all goes on the Federal debt which is growing at over a trillion dollars a year.

This is a bad deal for the American taxpayer. It is a bad deal for the 182 million Americans who already have insurance. They don't get anything out of this. What do they get? Higher taxes and higher premiums.

Listen to what CBO says: $160 billion in additional health care costs over this time period. It bends the cost curve not down but up. That is what we get. That is why so many business organizations have come out opposed to this, because they know the impact it will have on small businesses. The best way to get health care coverage to more people in America, as long as we continue to have an employer-based health care system, is to get people a job. People who are struggling with the economy right now and losing jobs, the thing we ought to be doing is figuring out how can we provide incentives for small businesses to put people back to work, not how can we kill jobs by raising taxes on small businesses.

That is exactly what we are doing right here. That is why every business

organization—the National Federation of Independent Businesses, to the Chamber of Commerce, the National Association of Wholesaler-Distributors, right on down the list—is opposed to this bill. They know the impact it would have on small businesses and their ability to create jobs. The best way—best way—you can get health insurance today in America is to get a job. This bill kills jobs.

I yield to the Senator from Louisiana.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Madam President, I rise to share the same sorts of concerns as my colleague from South Dakota. I share the concerns, more importantly, of citizens all across Louisiana who have echoed those same thoughts to me over and over again as I have traveled the State. Like so many of my colleagues, I have spent a lot of time these last few months reaching out to my constituents, my fellow citizens in Louisiana, in every part of the State.

During the August recess, obviously, there were lots of townhall meetings around the Nation. I held 21 in Louisiana, in every corner of the State. Since then, I have held six more townhall meetings. I continue to do other types of outreach. For instance, yesterday—since we had a 1-day opportunity—I flew home specifically to do a few things, including having a roundtable of doctors, including two past presidents of the AMA, other health care providers, small business representatives, leaders in the pro-life community, and it was a roundtable discussion specifically to focus on the Reid bill.

In all that process, since the August recess and even before, I have heard certain themes over and over again, no matter where I was in Louisiana. One of those themes was great concern about what this Congress is thinking of doing on health care but not just because of the significance of health care, which is vitally important, which is personal to every American, but also because of how it fits into a trend so many Louisianians and so many Americans are seeing over the past year—a trend of dramatically increasing Federal Government power and intervention and dramatically increasing Federal Government spending and debt.

People have been passionate about health care. Again, part of that is because that is a very personal issue, and a bill such as this affects literally every single American. But, again, a big part of it has been that Louisianians are also connecting the dots. They see a bigger picture, which concerns them. Louisianians have been connecting the dots to a government takeover of banks and insurance companies and car companies, with the CEO of GM literally being fired and hired in the Oval Office, and now, potentially, one-sixth of the U.S. economy through health care.

So there is a broader concern and theme I have heard over and over, which is an explosion of Federal Government power and intervention and an explosion of Federal Government spending and debt. This bill, unfortunately, does nothing except to confirm my constituents' worst fears in that regard. It is more of the same. It is more of that theme. It is another big dot they will be connecting in that trend, and I share that concern.

One specific issue that goes to that concern is the so-called government option or public option because that strikes a lot of people, including me, as a big, open door to dramatically increasing the Federal Government's role and dominance in health care in our country—one-sixth of our economy. Why do I say that? I truly believe the government option—if this bill passed or anything similar to it passed—would be the dominant option overnight and, perhaps, the only option in a few years.

Let me explain why. I will just point to one provision, which is the so-called pay-or-play mandate on business. Under this Senator Reid bill, as under previous versions of this idea, such as the Senate HELP Committee bill, a business—virtually any business in the country—would, for the first time, have a legal mandate, and the mandate would be to provide health insurance up to a certain minimum defined by Federal bureaucrats or the business would have a choice. The choice would be, if you do not want to provide that health insurance, well, you can write a penalty or fee check to the government instead.

What is wrong with that? Well, the penalty or fee check in this bill is pretty much set at $750 per employee per year. How does that equate into a business's bottom line in the choice businesses would face? Well, businesses that do provide health insurance nationally pay an average of not $750 per employee per year but $6,100 per employee per year. So what sort of choice do you think that is going to present to business? What sort of result would you expect?

In this brave new world, if the bill passes, everyone is guaranteed coverage in some form or fashion, and business has a choice: $6,100 per employee per year or $750 per employee per year. I think, for a lot of small businesses under extreme competitive pressure, that is not going to be a hard choice. It is going to be an easy choice. The result for tens of millions of Americans who have coverage now they are reasonably satisfied with through their employer, the result is going to be getting dumped off that coverage, with businesses saying: Well, there are other options now. There is the government option. Good luck. We can't afford it. We have to be competitive. We have to go with our bottom-line decision—$6,100 per employee per year or $750 per employee per year. I think the clear result will be tens of millions of Americans getting dumped off coverage they have now that they are reasonably satisfied with.

Do not take my word for it. Other outside experts, the Lewin Group and others, say dumping will occur and could, in fact, be massive; tens of millions of Americans—under their analysis of a previous bill that had largely the same provisions—over 110 million Americans. So that is a problem with regard to ballooning Federal Government intervention, power, domination of the marketplace.

Again, as I said a few minutes ago, another part of that theme and concern I heard over and over was ballooning Federal Government spending and debt. Here again, this Reid bill does nothing to allay those fears. In fact, it does a lot to increase those fears.

There has been a lot of talk and a lot of reports of the CBO score of $848 billion over 10 years. First of all, $848 billion is a lot of money. That is a lot of Federal Government spending and growth. It is hard to get your hands around that figure. What does that mean? If someone had started spending $1 million a day when Jesus Christ was born and kept spending $1 million a day, we would not yet be up to that figure. So that is a lot of money.

But what is worse, that figure is artificially low. The true cost of the bill is much greater. There are a number of budget gimmicks the ranking member on Budget, Senator GREGG, and others have talked about that prove that $848 billion figure is truly low compared to the full cost of the bill.

What am I talking about? Well, the biggest budget gimmick is the fact that the spending side of the bill does not kick in for the first 4 years. The tax side, of course, as always, kicks in immediately. So the tax increases, the fee increases, et cetera, kick in immediately. But the benefit spending side of the bill does not kick in for the first 4 years. So that is what will occur in the first 10 years of the bill's life, should it be passed. Therefore, in that CBO score of the first 10 years, what the CBO is scoring is 10 years of tax increases and only 6 years of spending. So that is a huge budget gimmick which helps produce that artificially low $848 billion or so.

In fact, we should be looking at the first 10 years of full implementation; in other words, the first 10 years when not only all the tax provisions are kicked in but everything on the benefits spending side is kicked in. That is basically from 2014 to 2024. What are the numbers there when you look at the real first 10 years, the first 10 years of full implementation? The real numbers are not $848 billion—as big a figure as that is, spending $1 million a day since

Jesus Christ was born and you still would not be up to it—but there the analysis is $2.5 trillion over 10 years.

Again, Louisianians see this, Americans see this as another big dot to connect, part of a huge trend of exploding Federal Government power and exploding Federal Government spending and debt. What does that represent in terms of that explosion of spending and debt? It also represents enormous new taxes, and that goes to the cost issue my distinguished colleague from South Dakota was talking about.

When I talk to Louisianians specifically about health care—not just these broader trends and these broader concerns they are very focused on but specifically health care; OK, we have to fix certain issues in health care—what is the top issue? Virtually everyone in Louisiana says cost, ballooning cost. Whether they have coverage now or they are struggling to get coverage, the issue is cost. What can we do about cost?

Again, this bill does nothing to fix that. It makes it worse. As was illustrated with Senator THUNE's graph, it pushes the cost curve up and not down. Part of the reason it does that is, in that $2.5 trillion of activity there are enormous taxes, and those taxes become built into health insurance premiums. So premiums do not go down, they go up. They go up in a major way.

What are some of these we are talking about—again, enormous tax increases, enormous tax increases across the board, taxes on choice and well-being. Flexible spending which allows individuals to have a tax-free account for medical needs, that is limited. That is downgraded and capped at $2,500 a year. Taxes on over-the-counter medicines that many patients' families and seniors depend on, that is a tax increase of $5 billion; reduced deductions for health expenses, again, another tax increase; higher Medicare payroll taxes; the rate on wages in excess of $200,000, a very large tax increase; over and over again, major tax increases. The bill would impose $28 billion in new taxes on employers that do not provide government-approved health care plans. There is a tax increase of $53.8 billion, over 10 years, in terms of the Medicare population.

So, again, there are huge tax increases that are part of that, and that is the major reason that cost curve is not being pushed down. In fact, it is being pushed up.

As I approach this bill, after looking at it carefully over the last few days, my first bottom-line question is: How does it respond to those dominant concerns I have heard over and over again from Louisiana citizens all across the State over the last several months? What does it do about ballooning Federal spending and debt? What does it do about the growth of government power and intervention and the cost of health care?

Sadly, it fails on all those accounts. It moves us in the wrong direction on all those accounts. So I urge my colleagues to adopt a different approach, to vote no tonight, to not move to this approach, to adopt a far more focused, positive approach that responds directly to those concerns of the American people.

I yield back my time.

Mr. GREGG. Madam President, what is the regular order?

The PRESIDING OFFICER (Ms. CANTWELL). The Democrats control the next hour. The Republican time is expired.

Mr. GREGG. Thank you, Madam President.

Mrs. GILLIBRAND. Madam President, I ask unanimous consent that the next hour be under the control of the majority controlled as follows and in the order listed: Senator GILLIBRAND, 5 minutes; Senator WHITEHOUSE, 20 minutes; Senator LANDRIEU, 17 minutes; and Senator CANTWELL, 18 minutes.

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

Mrs. GILLIBRAND. Madam President, as I rise today to speak in support of the Patient Protection and Affordable Care Act, I wish to say that this is truly historic legislation which I am very proud to support which will ensure all Americans will have access to quality, affordable health care. It will at long last make the necessary changes to contain costs that have truly spiraled out of control, and it will make enormous progress to address the many disparities in our health care system that are discriminatory toward women.

The Congressional Budget Office has determined this bill will provide coverage for more than 94 percent of Americans—98 percent when accounting for the elderly population—while reducing the spiraling costs of health care and trimming the deficit over the next 10 years and beyond.

Sixty years after Harry Truman first talked about the need to guarantee affordable, quality health care for all Americans, we are on the brink of a historic vote to move one step closer to achieving this goal.

In 1994, the last time we seriously considered health care reform, opponents argued that if we reformed our health care system, health care spending would skyrocket and health care quality and access would decrease. The opponents succeeded in 1994, and health reform was defeated. But in the absence of reform, look at what has actually occurred. Since 1994, family premiums have risen by over 150 percent. In 1993, the average annual premium for employer-sponsored family coverage was $5,000. This year, the cost for coverage is over $13,000 per year. By 2016, family health insurance is expected to reach over $24,000. In my State of New York, that is simply unaffordable.

Today, we spend more than 16 percent of our gross domestic product on health care, nearly twice the average of other developed nations—an astounding $2.2 trillion every year. What do we get in return? More than 47 million Americans are uninsured. In 2007 and 2008, 86.7 million Americans—1 out of every 3 Americans under 65—went without health insurance for a period of time. Every day, 14,000 Americans lose their health insurance.

Many of the same opponents who defeated reform in 1994 are trying to do it again. I ask them to please consider what has actually occurred over the last 15 years. Think about the damage that has been caused to our economy, our families, our workers, and consider taking a stand that is on the right side of history this time.

The bill before us lays a foundation for truly reforming our health care system. I commend Majority Leader REID for his work in merging the two Senate committee bills.

This bill includes a robust public plan for which I have strongly advocated. I believe this will increase competition and lower costs across the system. Through a public plan and the establishment of health insurance exchanges, the bill makes quality health care truly affordable and accessible to everyone—all Americans. The health insurance exchanges will streamline the system and offer insurance at affordable premium rates, capped by income, for low- and middle-income Americans. No longer will health care be out of the reach of millions because of cost.

This bill also ends discrimination against women, which we have faced in our health care system for far too long. Women shoulder the worst of the health care crisis, including outrageous discriminatory practices in care and coverage. The National Women's Law Center reports that a 25-year-old woman pays up to 45 percent more for the same health insurance coverage than a man her age. Some of the most essential services required by women are simply not covered by insurance plans, such as childbearing, Pap smears, and mammograms. A standard in-hospital delivery costs between $5,000 and $10,000, and much more if there are complications. This bill ends the practice of denying health care to those with preexisting conditions. In the current system, pregnant women are often turned down for health care coverage because insurance companies would rather evade this cost. Pregnancy should never be the basis for losing coverage. In America, this sort of institutionalized discrimination is wrong. This reform bill ends the practice of charging women more than men and requires that these basic health care services are included.

The bill also lays the groundwork to reward health care providers for the

quality of care they provide, not necessarily the quantity. Hospitals and clinics across the country will model the success at places such as Bassett Healthcare in Cooperstown in upstate New York. It also uses new methods to reduce medical errors and prevent costly illnesses.

Some would prefer that we continue on the current path, leaving millions without insurance and paying for it through a hidden tax that all insured Americans pay to cover the cost of emergency care. But the majority of Americans think the time has now come to address this problem and fix our broken system.

The vote today is an important step on the road to reform. In the next few weeks, we will all have the opportunity to debate this bill and make important modifications. I am encouraged to see improvements from previous bills in the merged bill before us, including better protections for middle-class families' benefits and increased funding to States for Medicaid, both of which I look forward to continuing to improve.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. GILLIBRAND. May I have an additional 30 seconds?

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

Mrs. GILLIBRAND. I thank the Chair.

I welcome the opportunity to work with my colleagues on this historic legislation. For the next few weeks, I will work to strengthen the provisions for States such as New York that have strong Medicaid Programs, and I will also work to ensure that funding for our safety net hospitals remains intact.

Now is the time to act. The bill before us provides quality affordable health insurance for every American, reins in the high costs, makes our system more efficient, and addresses some of the grave disparities in the system that discriminate against women. I urge my colleagues to join me in voting yes on the motion to proceed on this bill.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. WHITEHOUSE. Madam President, I had the occasion to listen to some of the remarks of our colleagues on the other side of the aisle. It forces the conclusion that the irony department of the Republican Party is working overtime these days.

The criticisms of this bill are over deficit and cost. We are hearing these criticisms about deficit from the party that, when it had control in the Bush years, ran up over $8 trillion in our national debt—$8 trillion, the biggest spendthrifts in history, an orgy of fair-weather debt. They didn't have any hesitation about deficits then. On the wars in Iraq and Afghanistan, we have never heard any interest in having those paid for on a current basis. Borrowing for wars is completely satisfactory to them, it appears. When they had the chance to amend Medicare, they added Part D, and they ran up the cost immensely by providing a special protection for the pharmaceutical industry so that it can dictate prices to the Federal Government. The Federal Government can't negotiate with the pharmaceutical industry for Part D pharmaceuticals. That costs the Federal Government a fortune. Do they mind? No. They spend on deficits over and over. Now, when at last we take on the insurance industry, suddenly they discover a concern about deficits. Well, I would urge that based on that trajectory, these remarks have a lot less to do with the deficit than they do with protecting the insurance industry.

There is another clue of this as well, and that is the concern about cost. We all, indeed, are concerned about cost. But I think the best thing we could do about cost in health care is to pass a public option. Why do I say that? I say that because the Director of the Congressional Budget Office has said that changes in government policy which we adhere to in this bill have the potential to yield large reductions in both national health expenditures and Federal health care spending without harming health. It is not just a possibility. He goes on to say: Many experts agree on the general direction in which the government must go to get those cost savings. But they conclude they can't put a specific score on them yet for the following reason: The specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning.

Now, who is going to develop those changes that will save costs while improving the quality of our health care system over time through experimentation and learning? The public options. There will be public options, if the original health plan is followed, in all 50 States. Each would have to stay within its State on balance, solvent, could not go to the Federal Treasury to make up losses. So they have to look for reform in order to continue to succeed. They would be 50 engines of reform, of experimentation, and of learning.

Who is against the public options? The insurance industry, because they don't want the competition. They love an environment in which they are immune from the antitrust laws—almost uniquely in American business—and in which they have incredible market share. In many cases, there are only two dominant insurers in the entire market around this country. So they love having these huge market shares to be able to dictate price, to be immune from the antitrust laws, and they don't want the competition.

Guess who else is against the public options. Our Republican friends. It is very hard to find any daylight between the position of the insurance industry and the position of our Republican friends.

The problem with this is that it is not just about numbers and it is not just about statistics; it is about people. It is about people by the hundreds of thousands, but it makes their stories better when you actually come down to cases. So let me mention a few cases.

I talked a few weeks ago about one of my very dearest family members who fell victim to the system when his insurance company tried to deny him the indicated treatment prescribed by a world-class physician from the National Institutes of Health on the grounds that it was so-called ''not the indicated treatment.'' This was an individual who had received a devastating diagnosis. He had gone to the top expert for that diagnosis in the country at the National Institutes of Health. He had been told what he should do. He had been told, indeed, that was very standard. This was not anything exotic; this was essentially the automatic way you should treat a particular condition. When he filed it with his insurance company, some faceless bureaucrat said: No; we know better than the top expert at the National Institutes of Health. That is not the indicated treatment.

From that, and from thousands and thousands of Americans who have had their claims denied and have had insurers try to intrude between them and their doctor and interfere with the care their doctor thinks they need, we can tell one thing: the insurance companies do this for a bad motivation, which is to save costs. Of all of the stories I have heard, of all of the stories our colleagues have related here on the Senate floor, never once has there been a story of an insurance company that stepped in and said: Oh, wait a minute, that is not the indicated treatment; the indicated treatment is actually more expensive than what your doctor has indicated. Always, it is less expensive. Go figure.

I wish to share another story today about a person who is close to me, a member of my staff. His name is Richard Pezzillo, and he has hemophilia. He has gotten the treatment he has needed so far, but he has been lucky, and it illustrates how luck now enters into our equation in health care.

In 2003, after a very turbulent airplane flight, Rich unfastened his seatbelt from the airplane, collected his things, and suddenly realized things were going badly wrong. He started to feel tremendous pain. He started vomiting blood. Simply wearing his seatbelt in that turbulent aircraft had caused Rich to begin to bleed internally, inside of his stomach, eventually requiring that his gallbladder be removed.

Rich is a kind and thoughtful young man from North Providence, RI. He was hospitalized in very serious condition. He spent nearly 3 weeks in the hospital. Thankfully, he received excellent treatment, and today he works here in my Washington office. The doctors, the nurses, and the hospital staff in Rhode Island gave Rich the best treatment. He now leads an energetic, vigorous life and does well at a challenging job.

But the stunning part about Rich's story is his treatment and his treatment cost—$1.5 million. At least that is what they said. If you look at a copy of the billing sheet, you will see that the insurance company said that his billing, here, for instance, was $366,240.

The insurance company allowed only $106,000. That is what was actually paid, which gives you a sense of how much funny business is going on in the private health insurance industry and in the health care sector, when an insurance company can get away with paying about one-third of the bill's cost.

We have heard a lot of talk about how burdensome it is for Members of Congress to make it through a 2,000-page long health care bill. If you actually reduce its size to the substantive language—and I am elaborating on what the House bill would do, which is about the same as ours—the substantive language is less than a Harry Potter novel. My daughter could read Harry Potter novels when she was 13. I don't think it is asking too much of our colleagues to plow through a bill that represents one-sixth of our economy—when it is the size of a Harry Potter novel. It would be a good idea.

Rather than fighting about the 2,000-page bill, how about Rich's $1.5 million health care bill? The hard truth is, Rich was able to get lifesaving treatment because he was lucky, since he hadn't graduated from college yet and was still covered by his parents' insurance policy. Because he was covered, the hospital only charged his insurer less than half of that—$106,000. What if things had been different? What if he needed treatment a couple of years later when he wasn't on his parents' policy and couldn't afford his own? What if he had applied for his own coverage but was denied by an insurance company because his illness was deemed a preexisting condition? What if Rich's father lost his job and his health insurance along with it or what if Rich's parents' policy had a limit on benefits, and they had to pay the rest of the $1.5 million out of pocket?

Rich would have been a victim not just of his illness but of the health care status quo. If he or his family had been uninsured, they almost certainly would not have been able to afford the full care Rich needed. Their financial future would have been irrevocably altered—probably ruined.

Luck is no way to run a health care system. Unfortunately, Americans need all the luck they can get when dealing with health insurance companies that use every bit of their bureaucratic guile and financial might to delay and deny health insurance benefits they are obligated to provide.

For example, in March 2006, the Arizona Department of Insurance ordered health insurance giant United Healthcare to pay fines of more than $364,000—the largest in the department's history. Regulators found that the company illegally denied more than 63,000 claims by doctors without examining all of the information needed to accept or deny a claim. It looks as if they were just on automatic pilot to deny them.

In January 2008, California insurance regulators found that a subsidiary of United Healthcare had committed more than 130,000 violations of law in handling claims. For example, the company inappropriately denied more than $750,000 in claims on the grounds that insureds had a preexisting condition. The regulators found that the companies ''made large-scale and willful decisions to use broken systems to process claims and respond to providers, while continually and effectively collecting premiums.'' The total potential liability of the company for all violations is $1.3 billion.

Last year, United Healthcare's CEO, Stephen Helmsley, made $3.2 million and holds almost $120 million in stock options.

The health care reform bill we are talking about today would right this massive power imbalance between the health insurance industry and ordinary Americans who are getting rolled over by it. It would empower average Americans to take control of their health and financial future. Rather than taking their health insurance premium dollars to the health insurance ''casino,'' they could take them to the bank.

Unfortunately, many on the other side of the aisle wildly misrepresent both the status quo and how reform would empower consumers. The opponents of reform depict our bill as an Orwellian takeover of the system.

Madam President, let me close with a story that illustrates how ironic and completely wrong these cries of ''death panels'' or ''government interference'' really are.

In 2000, Christiane Hymel—insured by a subsidiary of Blue Cross Blue Shield of Louisiana—scheduled an appointment for a routine physical. During the examination, she reported to her doctor her history of back pain and weakness in her legs over the past year and a half. Her doctor ordered x rays of her spine and referred her to a neurologist.

The neurologist, after detecting troubling symptoms, ordered an MRI. In accordance with her insurance policy, the doctor sent Blue Cross a request to preauthorize the MRI. The day before the MRI was scheduled, Blue Cross denied that request on the basis that the service was for a preexisting condition—Mrs. Hymel's back pain.

Mrs. Hymel appealed the insurance company's decision in accordance with the terms of her policy, but Blue Cross never processed the appeal.

After Blue Cross denied coverage for the MRI, Mr. and Mrs. Hymel were told that the MRI would cost about $4,000. They started saving up for it. It took 3 months to save up the money necessary to pay cash for the procedure, but they eventually did. The MRI showed that Mrs. Hymel had massive tumors involving ''nearly the entire cervical and thoracic [spinal] cord.'' She was immediately scheduled for surgery. Helpfully, Blue Cross stepped in to deny coverage for that as well, stating it was for a preexisting condition.

Mrs. Hymel's neurosurgeon later testified at trial:

> Tumors inside the spinal cord are growing tumors, as they grow, they cause damage to vital structures in the spinal cord, which are important to walking, sensation, and breathing.

The longer the wait in removing a tumor, the more damage the tumor will cause to the spinal cord. The doctor testified:

> Two-thirds of Mrs. Hymel's current condition and disabilities were the direct result of the growth of the tumor during the 3 to 4-month delay between the time Blue Cross denied the MRI until the time Mrs. Hymel was able to pay for it by herself. Additionally . . . this delay also caused the tumor's quick recurrence, necessitating the second surgery.

In ruling for Mrs. Hymel in her lawsuit against Blue Cross, the court described the consequences for Mrs. Hymel of this 3-month delay the insurance company caused by denying her MRI:

> Mrs. Hymel testified that when she first woke up from surgery, she could not move her arms or head and she thought she was paralyzed. She felt painful burning sensations in her body. . . . While she was in the surgical ward, she contemplated committing suicide. During her hospital stay, she suffered from bowel obstruction, fecal impaction, and had to wear diapers. Mrs. Hymel didn't see her children in the hospital until two weeks after the surgery, and when her children finally saw her, they were scared of her and would not touch her. Mrs. Hymel spent approximately eight months in a wheelchair after her surgery.
>
> Mrs. Hymel is house-bound, she cannot take a shower, work in her garden, ride a bike, swim, or drive, as she had frequently enjoyed prior to the surgery. . . . Mrs. Hymel must also take large doses of medication to relieve the burning and shocking sensations from which she suffers. She cannot be touched on her back or leg, because the second something touches her lower back, it's like fireworks that go off.

Every day that insurance companies delay or deny payment is another day they earn interest on your premiums,

adding to their profits and adding to the funds that support their massive executive pay packages. When Blue Cross of Louisiana failed to pay for Mrs. Hymel's MRI, it wasn't just making a mistake, it was making a calculated decision—a heartless, profit-maximizing decision. Christiane Hymel's story isn't just a sad tale, it is a symptom of a disease that is spreading through the private health insurance system.

For many Americans like Christiane and Rich, our health care system is a casino, where a roll of the dice or spin of the roulette wheel determines one's fate. Such an irrational and random system doesn't comport with the society that Franklin Roosevelt described in his 1944 State of the Union:

> We have come to a clear realization of the fact that true individual freedom cannot exist without economic security and independence. Necessitous men are not free men.

These days I think it would be more proper to say necessitous men and women are not free men and women.

By passing health care reform, we will take health insurance off the casino floor for the average American family and make it a reliable part of every family's economic foundation. No longer will happenstance or chance determine whether treatment will be paid for. No longer will the casino wheel determine whether Rich Pezillo gets his treatment or that Christiane Hymel does not. Parents of kids like Rich Pezillo would not worry whether their son's illness could lead him to be turned down for that preexisting condition or whether a layoff or lack of insurance could deny their son the treatment he needs.

Necessitous men and women are not free men and women. Let's redeem FDR's promise by passing health care reform. Let's bear in mind, as we go forward, the nature of the arguments that are made against health care reform and the astonishing coincidence between the arguments made between health care reform by our Republican colleagues and by the barons of the health insurance industry. There seems to be literally no daylight between those arguments.

If we are going to turn around the extraordinary spiraling costs of health care, we are going to have to do it by reforming the delivery system. The best way to do that is the public option. Yet they oppose it.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. WHITEHOUSE). Without objection, it is so ordered.

Ms. CANTWELL. Mr. President, my colleague, Senator LANDRIEU, was going to be next, but I will switch times with her. She will join us on the floor shortly.

I want to join my colleagues this morning and talk about this important issue of controlling health care costs. That is why we are here. We know Americans are facing higher and higher health care costs and that we can do something to drive down the costs of our health care system. We know health care costs are not only strangling us, but they are impacting our constituents, our budget, and they are leaving 47 million Americans without insurance.

Our aim is to promote better quality care and get costs under control. Whether those costs be to consumers struggling to pay insurance premiums or to our government, we need to make sure we are doing all we can. Doing nothing in this debate is allowing health care costs to continue. I want to make sure my colleagues on the other side of the aisle who talk a lot about this legislation understand that if we do nothing, we are going to leave the American people and our budget in serious danger by not controlling health care costs.

As always, in this debate we must keep in mind Federal spending, and the numbers on Federal spending are stark.

In terms of doing nothing, if the U.S. Government does nothing, health care spending will double in the next decade. That is, we spend about $810 billion on health care. That is one-third of our total Federal budget. If we do nothing, Federal spending is going to go to $1.56 trillion. That is because we are not controlling health care costs, baby boomers are reaching retirement, and Medicaid and Medicare costs are ballooning. One-third of our Federal budget is a big enough bite. But if we do nothing, then our health care priorities are going to push out other priorities of our Federal Government.

The biggest area where we could control costs is in Medicare. Medicare is 57 percent of all Federal spending, and it is getting bigger. By 2020, Medicare spending alone will reach $1 trillion, doubling the $466 billion we spend today. That is to say that Medicare spending has been doubling in the last 10 years, and if we do nothing as our colleagues on the other side of the aisle are suggesting by not moving forward on this legislation, then it is going to double again. This is unsustainable because if we do not address this, Medicare is going to bankrupt us.

The prospects are just as daunting when it comes to our Medicaid budget because Medicaid spending over the next several years will also double, and it has doubled in the last 10 years. States are struggling, as many of us know, with what they can do to help sustain Medicaid since they pay for part of that for individuals.

So we see we are in a situation where doing nothing is an irresponsible way to go. In fact, for our constituents, they are seeing a 120-percent increase in insurance premiums. While we are worried about the impact on the Federal Government, they are worried about the impact on them, on their individual budgets. That means the average family today pays about $7,000 more per year for the same health care benefits than they did a few years ago. If you think about that, that means that is less money for them, less money for their families, less money to meet the other bills in the family.

Why has this happened? If we look at what has happened in our country, we see that wages have not gone up. In fact, during that same 10-year period of time, wages have only gone up 29 percent, health insurance premiums have gone up 120 percent. And where has the insurance industry been? The insurance industry has seen a 428-percent increase in profits over the last 10 years.

That is why we need to do something about controlling health care costs. We cannot let the American people continue to be subject to such huge increases in premiums and then have the insurance industry walk away with huge profits and American consumers make less and less.

What is going to happen if we do nothing, if we do not advance this bill to control health care costs? Those same premium increases we have seen in the last 10 years are also going to go up again. In fact, they are projected to go up another 7.9 percent in annual growth. That is, every year, they are going to go up another 8 percent. That is unsustainable. That means somebody is going to be paying $10,000 or more than what they are paying for their health insurance today for the same health care benefits. That is why doing nothing and not advancing this bill is just acquiescing to the fact that everybody is going to pay more for health care.

What makes this number so scary is that it is four times the rate of inflation over the same period. That means what we need to do is look at general inflation, which is usually about 2 percent. But health care inflation, as is shown on this chart, is more like 8 percent. If we do nothing to change this, Americans are going to continue to do with less because health care costs are demanding more and more of their budget.

What do we do about this? We certainly want to make sure that we change the system, and that is one of the reasons I support driving down costs by having a public option. We know that two factors are involved: We don't have enough competition and there are very concentrated markets in health insurance across the country. Many times there are only one or two insurance providers providing coverage

in a market. They might have 94 percent of the market. It is too concentrated. We know if we provide an alternative in the marketplace, we can help drive down costs.

One provision in this bill of which I am very supportive is the basic health plan because it lets States negotiate with private insurers for lower costs. In my State, this program has been in place for 20 years. It has been able to provide those who participate in the program—about 70,000 people today—a 30- to 40-percent savings if they had to buy that plan as an individual from a private insurer. That is incredible success in driving down the cost.

Why? I call it the Costco model because like when you go to Costco and you buy in volume, the State of Washington, buying in volume on behalf of those individuals, was able to drive down the cost of health care for those individual citizens. They were able to choose between four different plans, and they were able to get access to a very good proposal for health care for them.

The underlying bill includes language that says you could provide this basic health plan if States opted into it and cover 70 percent of the currently uninsured in America. I like this proposal because it gets us cheaper insurance for that population.

Why subsidize insurance companies by giving tax incentives to buy more expensive insurance when what Americans want is to drive down the cost of health care by having the same negotiating clout that big businesses or other entities have?

I hope we can continue to work and maybe even expand this provision to make it even more robust and to drive down costs.

What is clear is that the cost of the uninsured is adding to our health care costs. In fact, the fact there are people in America who are uninsured is adding about $1,000 to our health care premiums overall. That is about $43 billion a year to our health care system.

If we can change our health care system and get more people into something such as the basic health plan, we would be able to drive down costs, and that is why that plan is so valuable.

We should not forget that our current system, besides insurance reform, needs provider reform. The reason why provider reform is so important is because our current health care system is flawed. It is driving up the cost of Medicare and health care in general because of the payment system. Basically, the current payment system perpetuates more spending. In fact, there is something like $700 billion in waste in our current system. If you think about it, it is this fee-for-service loop that I call it where you order more and you end up having more waste in the system, you have more spending, you have more use, and it keeps going. That is primarily because we pay doctors on volume. We pay doctors for how many patients they see every day, and we pay them for how many tests they order. Consequently, the cost continues to spin out of control.

As I was saying, we spend about $700 billion on health care that we do not need to spend. That is in duplicated tests, unnecessary procedures, excessive insurance overhead, uncoordinated speciality care, and preventable hospitalization.

We heard from many people during the health care debate that we have to do something to change this system. In fact, one of the witnesses before the health care committee said:

> We have to go after how we reimburse physicians. The current system is the most broken part of Medicare.

What are we doing in this legislation to fix that? We are changing the way we reimburse for health care. In fact, we are going to look at how to get lower costs with better results. This is important because I don't think there is a person in America who doesn't know what it is like to go into a doctor's office and feel they are always in a hurry or feel as if the doctor didn't hear everything you had to say. This is about changing and rewarding physicians on the outcome of your health care so you can have shorter waiting times, better access to doctors, more coordinated care, and better outcomes.

We think if you change the health care system, which this bill does, to drive down costs and get better outcomes, we are going to have better health care in America.

We can continue on the path which I think my colleagues on the other side of the aisle want by not voting to move forward on this legislation, we can have less coordinated care, going from specialist to specialist without having that care coordinated and have unnecessary tests, but then everybody in America is going to be paying for those costs. Everybody is going to be paying higher health care premiums because of it.

What we need to do, which is what exactly this bill sets us on a course and path to do, is to pay for value not for volume, to pay physicians on the value they deliver and the outcome of their patients instead of volume.

If we did nothing else in health care reform but to change our payment structure to focus on this premise—paying for value and not for volume—then we would be delivering great long-term savings to our health care system.

We have other things we need to do, and that is in the area of long-term care and Medicaid because in our long-term care system, we are seeing a doubling in health care costs, primarily because of long-term care. When you think about our Medicaid budget, everybody thinks Medicaid is this program to help the low-income population. Medicaid is turning into a long-term care program for the elderly in America. That is, they cannot get long-term care access so they are spending down so they qualify under Medicaid to basically get on that system to cover their long-term care.

We can see that right now Medicaid is paying half of its funds, and that is an expense that is going to continue to grow.

We have made some reforms in the State of Washington to make that cheaper. We have said let's invest in home care instead. Instead of having everybody go to nursing homes, whether they need to be there or not, let's focus on the long-term care system reforms that keep people in their community and instead use the Medicaid budget to advance other things while keeping patients at home.

I think every senior in this country would rather have their health care delivered at home than in a nursing home, but our current Federal system continues to reward long-term care in nursing homes instead of in community-based care. This legislation starts us on a path to change that direction, to move closer to long-term care community services.

We did this in the State of Washington, again, over 20 years ago and have reaped huge benefits. If we took an individual in the system today, the cost is only about $22,000 per individual. If we had not reformed the system as we did 20 years ago, we would be paying $42,000 for that same individual. So we have been able to drastically cut the amount of money we are spending on long-term care.

This legislation includes the same kind of cost control reforms in long-term care as some States have already implemented. That is why we have to get at controlling health care costs. If we do not control health care costs in this area of long-term care, we are not going to control health care costs overall in America.

What does reform mean? Why are we here today to talk about the cost of health care and what we need to do? Why are we here talking about advancing this legislation so we can get this debate on the floor for the American people?

It is clear we need to have more competition through a public option, we need smarter reimbursement rates to incentivize value, and we need better use of Medicaid dollars.

The PRESIDING OFFICER. The Senator's time has expired.

Ms. CANTWELL. I thank the Presiding Officer. I hope my colleagues on the other side of the aisle will consider the important cost controls in this measure.

I yield the floor.

The PRESIDING OFFICER (Ms. CANTWELL). The distinguished Senator from Louisiana is recognized.

Ms. LANDRIEU. Madam President, I first want to commend my colleague, Senator CANTWELL, the Senator from Washington State, who has worked so hard and so long and in such a professional way. She has been extremely helpful to me through this process, and I want to acknowledge that and thank her.

Before I make a statement, I also want to comment about a few other colleagues who have been extremely helpful and supportive, not just to me but I think to the entire Senate, beginning with Senator HARRY REID, our leader, who, with patience and persistence and care, has led us to a bill that is before the Senate. The question today is whether we should proceed. I would like to say that, in my view, no other Member of the Senate could have accomplished what he has today. I think many Senators share that sentiment.

No. 2, I want to recognize the extraordinary work of the Senator from Oregon, Senator RON WYDEN, who, 2 years ago, before the Presidential election had really gotten underway, before it was really ever clear as to who might win, Senator WYDEN put down a bill called the Healthy Americans Act, which I was very proud to support, and I still am so proud of that effort today. That bill has the support of seven Republicans and seven Democrats. It is a truly bipartisan effort that would accomplish, in my view, what many Americans are asking for: a marketplace that is fixed and reformed, more affordable choices for individuals and small businesses and families, and a real effort to curb the rising and alarming cost to the Federal taxpayers, given that the percentage now of our GDP spent on health care is almost exceeding 16 percent, twice as high as any nation in the world. That is alarming. The Healthy Americans Act went a long way to help frame my thoughts on this debate. We are going to continue to work together through this process.

I also thank Senator BLANCHE LINCOLN who, because of her persistent leadership, has pushed and prodded Members of this body to ensure that we had the time necessary to review this bill. In so doing, she helped to assure our constituents, whether they are for or against the direction we are moving, knew that we had the time necessary to make an informed decision. I think I have used that time very well these last 2½ days. I have been in meetings with economists, on the phone with health care experts, talking with people from my State as well as around the Nation. I have used that time well and wisely. Senator LINCOLN led the charge to ensure that we had the time we needed, and I am glad to have supported her in that effort. I know she will be speaking on the floor later today, giving her final views on where we are. I commend her for her leadership.

Madam President, I come to the floor today to acknowledge to speak on the business before the Senate today, and that is the question of whether to proceed to debate on the Patient Protection and Affordability Act, a bill that is the best work of the Senate to date on a subject of significant importance to the people of my State and the country. I have decided to vote today to move forward on this important debate.

My vote should in no way be construed by the supporters of this current framework as an indication of how I might vote on the final bill. My vote is a vote to move forward, to continue the good and essential and important and imperative work that is underway.

After a thorough review of the bill, as I said, over the last 2½ days, which included many lengthy discussions, I have decided that there are enough significant reforms and safeguards in this bill to move forward, but much more work needs to be done before I can support this effort.

Over the past many years, and in particular the last 6 months, I have heard from people all across Louisiana that their insurance premium costs are simply too high and continue to rise without warning, threatening the financial stability of their families and their businesses. I have also heard the pleas and cries of many people who need health coverage but they cannot find it anywhere within reach of their budgets.

Through months of public meetings in VFW halls, school gyms, and in hospitals and health clinics from New Orleans to Shreveport, and in large and small communities throughout my State, it is clear to me that doing nothing is not an option, nor is postponing the debate.

Spirited debate and good-faith negotiations in this Senate have produced a bill that contains some amazing and cutting-edge reforms that will, I am hopeful, reduce costs for families and small businesses while reducing the debt burden of the Federal Government. But these reforms must be implemented properly and carefully, and they must be put in place in a timely fashion.

Small business owners across the country have told me time after time that in order to grow their businesses and create jobs, they need affordable health insurance and they need stable and predictable costs. Yes, they would like their costs to be lowered, and I am going to stay focused like a laser on doing just that. But what they also need is predictability—they need to be able to plan for the future, something they cannot do when the cost of healthcare spikes violently from year to year.

As we all know, today, under the status quo, small business owners are frequently confronted with impossible choices when an employee or employee's family member gets seriously ill. They can expect exorbitant cost increases of up to 20 percent in their premiums when just one of their employees gets sick. Then they are confronted with the excruciating choice of going to that employee and those family members and saying: I am sorry, to save my business and the other 10 employees, we need to let you go. Here is $1,000 or $2,000 or $5,000. You are on your own. Good luck.

That is a tragic story, painful, depressing, and it has to stop.

I appreciate the hard work of many business owners and organizations that have helped to craft portions of this framework because they have remained at the negotiating table. They didn't run and hide, they remained at the table. I am asking them today to stay at this table.

Before I discuss the work that needs to be done to improve this bill, I would like to discuss some of the points in this bill that encourage me to move forward.

Small business owners, under the current framework of this bill, would no longer be confronted with these kinds of volatile costs. This bill prevents insurance companies from escalating their rates or dropping their coverage after someone gets sick. That important change goes a long way in stabilizing the amount small businesses will have to pay for their health plans, and it allows business owners to do what they do best—plan smart investments, grow their businesses, and then help us grow our economy.

In recent years, economists have found that workers' wages have remained largely stagnant. Why? Because employers are paying more and more for health care that we are indirectly subsidizing through the current Tax Code and so have less and less money to pay real wages that workers in large and small businesses could actually take home, put in their pockets, and spend in much more productive ways. The bill we are debating would encourage employers to move away from high-cost benefit plans, and instead increase the amount that working families can take home. That is an important change from the status quo.

In addition, this bill would ensure that the majority of Louisiana families would pay no more than 10 percent of their income for health care. That is still high. But today families in Louisiana pay an average of 30 percent of their income on healthcare costs. And economists project that if we do nothing, that total will climb to 60 percent of an average family's income that will have to be spent trying to afford health care. This bill changes that trajectory. So while some people still think that 10 percent or 12 percent may be too high, it is a lot better than 60 percent, which

is the direction we are heading today if we do nothing. That is real progress.

These reforms I have just mentioned are necessary and are too important a goal for the Senate to abandon its work. But, as I have said, there is a great deal more work that needs to be done.

I would like to mention briefly just a few of the significant changes I would like to see be made to this bill.

No. 1, in order to increase choices for small businesses, we must enhance and expand tax credits that are in this bill for small businesses, particularly for business with 25 fewer employees. If we can expand tax credits for slightly larger small businesses with between 25 and 50 employees, that would be significant progress. Current projections are that 96 percent of all businesses that have more than 50 employees have coverage. That is a good statistic, and those larger businesses have some choices. But we need to give small businesses more choices. It is these small businesses that are leading the country on its way out of this recession. And we need to help them in that effort.

In addition, I will continue to fight for more tax equity for the 27 million Americans who are currently self-employed. Every chairman of the Small Business Committee—both Republican and Democrat, I understand, for the last 25 years—has asked for this to be addressed. It is time to make progress on that effort now.

No. 2, in order to really deliver our promise to hold down costs for families, we should think about focusing on ways to prevent premiums from being excessively raised between the time this bill is enacted, if it ever is, and the time it actually goes into effect. Many of the provisions in this bill, because of cost considerations, which I understand, do not go into effect until 2014. Well, today is 2009. That's a long time between now and then, and we need to make sure that companies do not jack up their premiums in anticipation of the market reforms this bill will make, as we have seen the credit card industry do in anticipation of the important reforms we made earlier in the year. Americans cannot afford to allow that kind of predatory behavior.

Finally, I remain concerned that the current version of the public option included in this bill could shift significant risks to taxpayers over time unnecessarily, and I will continue to work with my colleagues to find a better and bipartisan solution for this issue. I have suggested that a freestanding, premium-supported, competitive community option that would trigger on a date certain, if our private market reforms fail to work, might be a possible compromise. That would include language that Senator SNOWE and other of my colleagues have been working on for several months.

Because I am hopeful we can make progress on each of these concerns and others through an amendment and debate process that is open and transparent, I believe that it is incumbent upon me to allow the bill to move to debate on the Senate floor.

I stand ready to work together with my colleagues to fashion a principled and hopefully bipartisan compromise in the end to achieve what the people in my State need, and what many Americans need, and which we really have to do our best to try to give them.

Finally, I know my time is up, but I would like to ask a personal privilege for just 1 more minute to address an issue that has come up, unfortunately, in the last 24 hours, driven by some very partisan Republican bloggers. So I think I need to respond and will do so now.

One of the provisions in the framework of this bill has to do with fixing a very difficult situation that Louisiana is facing. For reasons that are simply beyond my comprehension, some partisans have decided to attack me for leading an effort to address a serious budget shortfall facing my state.

The reason for this situation goes back to the disastrous hurricanes of 2005. I am not going to review the horrors of Katrina and Rita. The levees broke, and by the way, the courts have just ruled that the Corps of Engineers was, as I have said from the beginning, responsible. But I will comment more on that at another date.

But, nonetheless, in 2005 Louisiana experienced two of the worst natural disasters in recent memory. In an effort to aid the recovery, Congress stepped in with a massive aid package for Louisianans—thank you—that infused grant dollars and direct assistance.

Some of necessary one-time recovery dollars, in addition to the increased economic activity, were calculated into our State's per capita income. The result has been that Louisiana's per capita income——

The PRESIDING OFFICER. The time of the Senator has expired.

Ms. LANDRIEU. I ask for 1 additional minute?

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

Ms. LANDRIEU. The result is Louisiana's per capita income was abnormally inflated. You can understand that. There were billions of dollars that came in from insurance and road, home, and community development block grants.

In addition, labor and wage costs went up because there was a constriction in the market, which any economist can tell us always happens after a natural disaster. As a result, when we did the calculation under the law, it made us seem as if we were a state with a high per capita income like Connecticut and not a state with a low per capita income like Louisiana, almost as if we had become rich overnight. That was not the case. Our State is still as poor as it was, if not poorer as a consequence of those devastating storms. I am not going to be defensive about asking for help in this situation. It is not a $100 million fix, it is a nearly $300 million fix. It is the No. 1 request of my Governor who is a Republican. He explicitly asked that I pursue these funds. It is unanimously supported by every Member of our delegation, Democratic and Republican. I am proud to have asked for it. I am proud to have fought for it. I will continue to. But that is not the reason I am moving to debate.

The reason I am moving to the debate, as I expressed in this statement, is that the cost of healthcare is bankrupting families and it is bankrupting our government. We cannot afford the status quo.

I thank my colleagues for their graciousness. I know I have gone over my time, but I wanted to get that on the record. I support moving forward with the debate and look forward to working with them to improve it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Madam President, I wish to express my deep concerns about Senator REID's bill on two very critical issues. These are not the only things of which I am critical but I wish to focus on two issues: coverage of abortion and conscience clause protections for medical providers opposed to abortion.

As we can see, the Stupak compromise amendment, which was supported by 64 House Democrats and a majority of Republicans, reads:

> No funds authorized or appropriated by this Act may be used to pay for abortion or to cover any part of the costs of any health plan that includes coverage of abortion.

That is all it says. It should be abundantly clear to each Member of this body. The House of Representatives overwhelmingly passed pro-life language exactly 2 weeks ago that is markedly different from that contained in the Reid proposal. The House provisions, in contrast to the terribly flawed provisions in the Reid bill, contain language that would not only safeguard the rights of the unborn but would also prevent medical providers from being coerced into performing procedures that violate their conscience. The Stupak-Pitts amendment was adopted by a significant margin, 240 to 194. That represents 55 percent of the House of Representatives, including 25 percent of the Democratic caucus.

Even more telling happens to be two polls released this week by the Washington Post and ABC News and CNN. They confirmed that 61 percent of the American population do not support Federal funding for abortion. This vote

should serve as a strong signal to each Member that these protections cannot be ignored and must be contained in any measure we adopt. Unfortunately, the language in the Reid bill explicitly allows what the Stupak-Pitts language would prevent. The Reid language authorizes abortion in the government-operated health plan or the public option and Federal subsidies for insurance coverage that include abortion. It is not the Stupak-Pitts language.

The sanctity of life is not an issue that can be traded away for political expediency. During committee consideration of the health reform legislation, I offered two important pro-life amendments. The first amendment, which I offered in both the HELP Committee and the Finance Committee, strictly prohibited Federal dollars being used to finance elective abortions. The second amendment provided conscience clause protections to medical providers opposed to abortion. In other words, we should never force people who have a conscience against abortion to have to perform abortions or participate in abortions. This language was based on the Hyde-Weldon provision contained in every Labor-HHS appropriations bill since 2004. It also was included in the House-passed bill. Both my amendments were defeated.

I notice my colleagues, Senators BROWNBACK and JOHANNS, are in the Chamber. I ask both of them: What is wrong with including the Stupak-Pitts language in the Reid bill?

Mr. BROWNBACK. Madam President, I, first, thank my colleague for offering these amendments in committee.

In both the HELP and Finance Committees, you said: Let's put in the Hyde language, and both times the amendments were defeated in committee. I appreciate my colleague raising it. Proponents of the Reid bill will tell us the abortion funding language is essentially the Hyde language included in the annual Labor-HHS appropriations bill. That is plain wrong. The Hyde amendment specifically removes abortion from government programs. The Reid bill specifically allows abortion to be offered in two huge new government programs. The Reid bill tries to explain this contradiction by calling for segregation of Federal dollars when Federal subsidies are used to purchase health plans. This segregation of funds, though, actually violates the Hyde amendment, which prevents funding of abortion not only by Federal funds but also by State matching funds within the same plan. Simply put, today Federal and State Medicaid dollars are not segregated, and the Reid bill specifically authorizes something the Hyde amendment specifically rejects.

Mr. JOHANNS. If I might join in, it is enormously important we lay a good record as to what this is all about and why the Hyde amendment has been the law of our Nation for so long. It is important. Therefore, I direct a question to Senator HATCH.

Please, if you would, describe how the Hyde amendment works today.

Mr. HATCH. Today's Hyde language, which has been in every annual Labor-HHS appropriations bill since 1976, specifically prohibits Federal dollars being used to pay for abortions except if the pregnancy was the result of rape, incest, or the life of the mother is in danger. The Hyde language applies to all five of the federally funded health care programs: Medicare, Medicaid, Indian Health Services, TRICARE, and the Federal Employees Health Benefits Program or the FEHBP. However, it is important to note that today there is no segregation of Federal funds in any Federal health care program—none. For example, the Medicaid Program receives both Federal and State dollars. There is no segregation of either Federal Medicaid dollars or State Medicaid dollars. States that do provide elective abortions for Medicaid beneficiaries must do so from a completely different account; that is, State-only dollars. No Federal or State dollars from the State Medicaid Program may even be placed in that ''State only'' pot of money.

Mr. JOHANNS. That was an excellent explanation of what Hyde is about. It underscores why we are so upset about the unbelievable expansion that is going to occur if this Reid bill is passed. You mentioned the Federal Employees Health Benefits Program. Let me take a minute to talk about how that works because, again, I think it underscores the point we are making today. Let me give an example. The current Federal Employees Health Benefits Program does this. It has 250 participating health plans that do not cover abortion. Federal employees pay a share of the cost.

The Federal Government, through tax dollars collected, pays the balance. So it is a mixture of Federal employees' contributions through their paychecks and the Federal Government getting the money through tax dollars. Federal employees cannot opt for elective abortion coverage because taxpayer dollars are subsidizing the cost of their employee plan. You can see how we have tried to remain true to the distinction you talked about. As many have said during the debate, if it is good enough for Federal employees, then why isn't it good for the rest of the citizens?

I ask Senator BROWNBACK, what is in the Reid bill that does not reflect the current Hyde language? And if I could maybe direct that to both of you or to Senator HATCH.

Mr. BROWNBACK. Well, if I could follow up quickly on the last point, I think it is clear that if we are not going to put this in the Federal employees benefit insurance system, then we should not put it in this system. Yet this is a billing expansion that is taking place. The Democratic health bill would explicitly authorize abortion to be covered in the government option. It also mandates that there must be abortion coverage in every insurance market in the country. This is an enormous expansion, a radical departure from the 30-year policy that represents the Hyde amendment. The abortion language that was included in the bill is a huge departure from 30 years of bipartisan Federal policy prohibiting Federal tax dollars paying for elective abortions. The language in the Senate bill explicitly authorizes the Secretary of Health and Human Services to include abortion in the public option and permits government subsidies for plans that pay for abortion.

The Capps language, commonly referred to in the Senate bill, contains a clever accounting gimmick that proponents say separates private and public funds for abortion coverage. However, it has been proven over and over by outside reviewers that the Capps measure would include both abortion coverage and funding in the government-run public option as well as for those plans in the insurance exchange. Representative BART STUPAK, a Democrat from Michigan, explained the issue very clearly in an op-ed he wrote yesterday. He wrote:

> The Capps amendment, which is the basis of the Senate language, departed from Hyde in several important and troubling ways: By mandating that at least one plan in the health insurance exchange provide abortion coverage; by requiring a minimum $1 monthly charge for all covered individuals that would go towards paying for abortions; and by allowing individuals receiving Federal affordability credits to purchase health insurance plans that cover abortion. Hyde currently prohibits direct Federal funding of abortion. The Stupak amendment is a continuation of that policy—nothing more, nothing less.

I would like to ask Senator HATCH about this provision, about what we need to talk about on the exchanges and the types of plans that will be included in the exchanges and about how this is an expansion of the abortion language.

Mr. HATCH. Isn't it true that one health plan must be offered in the exchange that covers elective abortions? Isn't that a departure from Federal policy?

Mr. BROWNBACK. The Reid health care reform bill would require at least one health care plan to offer elective abortions in each State health insurance exchange. However, nothing in the Reid bill ensures that the one plan that must cover elective abortions be the plan that is most affordable or least affordable. In other words, if I do not wish to have a plan that covers elective abortions but all I can afford is that plan, where does that leave me? Should my constituents have to compromise their own moral code in order

to receive health care; in other words, that they would have to buy a plan that covers abortion?

Mr. HATCH. That is right.

Mr. BROWNBACK. Today, no Federal health program requires the coverage of elective abortions. This is a clear departure from current law, and I cannot imagine us forcing people to pay for insurance that covers abortions when it is so unconscionable to so many of the American people.

I also would like to make one other point perfectly clear. The Stupak-Pitts compromise amendment would not prohibit the ability of women to obtain elective abortions as long as they use their own money to purchase these policies. I think it is important we get that piece of it clear as well.

Mr. HATCH. I am glad the Senator did clarify that.

I say to Senator JOHANNS, isn't it true that the Stupak amendment, passed in the House by a considerable margin, allows women to purchase, with their own money, separate supplemental health coverage that may include the coverage of elective abortions—if they do it with their own money?

Mr. JOHANNS. I say to Senator HATCH, I am glad you raised that issue. Yes, that is correct. Your understanding is correct. Women would be allowed to purchase separate elective abortion coverage with their own money.

I ask Senator BROWNBACK, do you have a comment on that, or a question?

Mr. BROWNBACK. Well, I think this is a key thing for us to keep in mind, that it is true that women can purchase separately, with their own money, use their own funds to be able to provide for their own abortion coverage. But what we are saying here today is that we should not have this as part of the Federal Government. We should not have it as part of the Federal funding program. We should not be using taxpayer dollars to fund abortions, as we have not done for 30 years. That has been the longstanding bipartisan program. But it is not prohibited that an individual could go ahead and buy this service on their own.

Mr. HATCH. Well, I would add, too, it is absolutely correct that the Stupak language allows women to purchase both a supplemental policy for the coverage of elective abortions and a comprehensive health care plan that includes coverage of elective abortions as long as they pay for their plan with their own money. It allows that.

Mr. JOHANNS. Let me just interject something here because I think this is a very important point to make, following up on what Senator HATCH just said. Some say that a person would never want to purchase a separate rider to cover abortion. It just would not happen, they say. But they misunderstand what the Stupak language actually allows.

Let me be clear about this. If a woman wants her health insurance plan to provide elective abortion services, she does have the choice to purchase a health insurance plan that provides that on the exchange. She just has to pay for it with her own money. Am I correct in that interpretation or have I misunderstood that?

Mr. HATCH. That is correct. A woman may purchase with her own funds either a supplemental policy that covers elective abortions or an entire health plan that includes the coverage of elective abortions. Look, a woman has always been able to do that, and frankly, we do not deny her the right to do that. What we say is, taxpayers should not be paying the cost of it. They should not be called upon to pay for elective abortions.

Mr. BROWNBACK. I say to Senator HATCH, as someone who has been in this body for some years and as someone who has followed this issue courageously for many years, what we are asking for, again, is just what has been established since 1977 in this body and in the House.

Mr. HATCH. Yes. That is current law, that Federal funds may not pay for abortion or plans that cover abortion. Now that is the fundamental component of the Hyde language. And to be clear, the Stupak language does not prevent people from purchasing their own private plans that include elective abortion coverage.

Let me just change for a second here. I would like to now talk about the conscience clause. To me, this is extremely important: the conscience clause protections for medical providers. The conscience clause protections in the final House bill for pro-life providers are not included in the Reid bill. They are in the House bill but not in the Reid bill. The House adopted language that codified the essence of the Weldon-Hyde conscience protections, including in the annual HHS appropriations bills since 2004.

This summer, the House Energy and Commerce Committee accepted these protections unanimously during consideration of their bill. Let me emphasize that point: unanimously, there was not one objection to it. That means all members of the committee—with ideologies ranging from the chairman, HENRY WAXMAN, who represents Hollywood, CA, to the ranking Republican, JOE BARTON, who represents a conservative congressional district in Texas—they all recognized the importance of adopting this language.

In contrast, the Reid bill has stronger protections for abortion providers than for providers who have conscience objections to abortion. On one hand, abortion providers may not be ''discriminated'' against for performing any abortion anywhere. On the other hand, pro-life providers must cite a particular ''moral or religious belief'' to prevent discrimination. This is narrower than current law under Hyde-Weldon.

Moreover, it does not extend the protections to pro-life health plans. In other words, a Catholic health system that requires a local hospital to stop providing abortions in order to become part of its health system could be accused of discrimination.

What is wrong with this picture?

Let me ask Senator JOHANNS, don't you think it makes sense to protect health care providers who have objections of conscience to abortion so they are not forced to provide abortions?

Mr. JOHANNS. Absolutely. As the Senator offers this explanation about a Catholic health care provider, it hits right to the heart of this issue. I most certainly agree with the Senator and I want him to know that many Nebraskans agree with him and agree with me on this issue.

I got a letter recently from a gentleman out in western Nebraska, from a little community called Ainsworth—a great area of our State. He wrote to me and said this:

> I urge you to support freedom of conscience which protects professionals from being forced to participate in abortion and other anti-life practices, which include end-of-life issues.

I had another constituent from Gretna, NE, more on the eastern side of our State, and this constituent wrote to me and said this:

> I am also very disturbed to learn that health care workers may be forced to act and speak contrary to their own consciences. I find it shocking to believe that this is being considered within a serious conversation/debate.

We are going to put up a chart. President Obama has weighed in on some of these issues. President Obama gave a speech to a joint session of Congress. We all remember that was on September 9 of this year. He said this:

> And one more misunderstanding I want to clear up—under our plan, no federal dollars will be used to fund abortions, and federal conscience laws will remain in place.

The President has gone on to state on multiple occasions that he would not support abortion in a health care bill. The President has stated that over and over. The President has also stated on multiple occasions—both as a candidate and as President—that it is his goal to lower the incidence of abortion. That is what he says, not what the Democrat-led Senate has done, though, relative to this bill, which he has embraced. And it is not what the leadership has done in this bill.

You see, my colleagues, I see this as a radical abortion approach, a radical piece of language. And you can go right to the bill itself, to pages 116 to 124 of this 2,074-page bill, and you can read it yourself.

I have to tell you, there is so much about this bill that is bad policy, but

this is especially damaging. The President promised us he would not let it happen. Do the President and the Members of his party, who control the Senate, who wrote the bill behind closed doors, do they really believe abortion is health care? Why didn't they just strip this language out? Why didn't they adopt the Stupak language, which was voted upon in the House, the Stupak compromise? Why didn't they adopt that, knowing that 64 Democrats had signed on to that language?

What do you think about the President's commitment and his promise to us not to use Federal dollars to fund abortions? I say to Senator BROWNBACK, I would like to hear his thoughts on that.

Mr. BROWNBACK. I was there that evening, along with the Senator and Senator HATCH and almost all of the Senators, when the President was addressing us on health care. I remember vividly sitting there and listening to these words, the ones you just mentioned. He was very clear, very concise; there was no fudging around on it:

> And one more misunderstanding I want to clear up—under our plan, no federal dollars will be used to fund abortions, and federal conscience laws will remain in place.

Yes, that is specifically violated in the bill, and they had a very simple route to change it. They could have just put the Stupak language in that has already passed the House. That is the Hyde language that has been agreed to by this body and others for 30 years here. Instead, they put in this abortion-expansion language.

I will show another chart here a little bit later on. The last time we funded abortions here was between 1974 and 1977, right after Roe v. Wade and before the Hyde language in 1977. Do you know how many abortions were funded annually by the Federal Government at that period of time? If we are going back to that policy, if we are looking to go back to that era where the Federal Government was funding it, Medicaid funded as many as 300,000—300,000 annually. Now, I would ask everybody, pro-choice or pro-life, do you want your taxpayer dollars to pay for 300,000 abortions a year? I do not think anybody wants to see us do that.

President Clinton we all remember very clearly saying often that he wanted to make abortion safe, legal, and rare. Adding 300,000 does not do that.

So the President took the time, in a carefully tailored and vetted speech that all of us were there to hear—the Presiding Officer, as well; it was nationally televised in prime time—to tell Congress the words we have quoted here today and to make that specific promise. And that promise is broken in the Reid legislation before us today. We sat there in the House Chamber and heard him say those words. Our constituents watching the speech at home heard those words. I have to believe these are the kinds of broken promises that are making our constituents lose their trust in government.

But the fact is, as so many people have pointed out, abortion is very much in this health care bill. Many Democrats and Republicans acknowledge this. Mr. STUPAK, whom I have quoted several times, is just one of them.

If we want to do more than just pay lipservice to lowering the incidence of abortion, we need to oppose the motion to proceed, and we should have had the Stupak compromise language included in the bill in the first place since the President clearly stated he did not want Federal dollars to be used for the funding of abortion.

Consider the fact that when Federal funding is not available for abortion, fewer abortions occur. When Federal funding is available, as we have seen in the past, thousands more will occur.

As shown on this chart, here is why the Hyde amendment is so important. The administrators running the Medicaid Program funded, as I noted, over 300,000 per year. That is almost 1 million abortions paid for by the country's taxpayers out of their pockets when the Hyde language was not the law of the land. That was until the Hyde amendment was enacted in 1976 because the American people disagreed with being forced to pay for abortions. Whether they are pro-choice or pro-life, they did not want taxpayer dollars to go for this.

One other example of government ushering abortion policy through health care legislation is when the Commonwealth of Massachusetts recently passed its State-mandated insurance, Commonwealth Care. They failed to include an explicit exclusion of abortion, like Senator HATCH tried to get in committee or like they had in the House language, the Stupak language, so abortions there were funded immediately in Massachusetts. In fact, according to the Commonwealth Care Web site, abortion is considered covered under ''outpatient medical care.''

The Federal Government should not go down this road. The President made a commitment to the American people, and the Democrat-led Senate has failed to include that commitment in this bill. They included radical language that will increase the incidence of abortion.

I say to Senator JOHANNS, don't you think it makes sense to protect health care providers, when we look at that issue here, who have objections of conscience to abortions so they are not forced to provide abortions?

Mr. JOHANNS. Absolutely. It absolutely makes sense. I say to Senator HATCH and Senator BROWNBACK, one of the things that has been very remarkable to me—this bill just came out, as you know. It was behind closed doors for weeks and weeks and came out in the middle of the night, actually.

Mr. JOHANNS. Madam President, pro-life groups weighed in on this bill immediately. For all of the complexity, for all of the definitions, for all of the buried language, they saw immediately what this bill was all about. Pro-life groups across the board have opposed the provisions of this legislation. No pro-life group has taken the bait. They represent millions of Americans across this great country.

Let me, if I might, take a moment and quote from what they have said. The National Right to Life Committee—and again I am quoting—says this:

> Senate Majority Leader Harry Reid has rejected the bipartisan Stupak-Pitts amendment and has substituted completely unacceptable language that would result in coverage of abortion on demand in two big, new Federal Government programs.

The United States Conference of Catholic Bishops has weighed in. They said this one is the worst bill so far—the worst one so far on this issue. Again, I am quoting:

> The conference believes the bill violates the long-standing Federal policy against the use of Federal funds for elective abortions in health plans that include such abortions, a policy upheld in all health programs covered by the Hyde amendment: the Children's Health Insurance Program, the Federal Employee Health Benefits Program, and now in the House-passed Affordable Health Care for America Act. We believe legislation that violates this moral principle is not true health care reform and must be amended to reflect it. If that fails, the current legislation should be opposed.

The Family Research Council says this, describing the legislation as a:

> . . . direct attack on the principles set forth in the Hyde amendment over 30 years ago. This bill is one only an abortionist could love.

Concerned Women for America said the following:

> In a dramatic departure from current policy, the Patient Protection and Affordable Care Act will provide government funding for elective abortions. Over all, this bill raises serious pro-life concerns.

Senator HATCH referred to polls. The polls indicate the majority of Americans do not want their tax dollars paying for elective abortions. According to that CNN/Opinion Research Corporation survey, 6 in 10 Americans favor a ban on the use of Federal funds for abortion. It also indicates that the public may also favor—literally favor—legislation that would prevent many women from getting their health insurance plan to cover the cost of abortion even if no Federal funds were involved. This poll indicates that 61 percent of the public oppose the use of public money for abortions for women who cannot afford the procedure.

I have to ask the question of Senator HATCH: When will we listen to the American people on this important issue?

Mr. HATCH. I ask Senator JOHANNS, have you seen similar polls indicating

that a majority of Americans do not want their taxpayer funds used for paying for elective abortions? Have the Senator seen those national polls?

Mr. JOHANNS. I have. We have seen the polls. We have gotten letters from our constituents. Consistently, in poll after poll, we can see what the American people are saying. They do not want their tax dollars to fund abortions.

Mr. HATCH. Madam President, let me ask a question to both Senator BROWNBACK and Senator JOHANNS. I know my constituents are very upset about the possibility of their tax dollars being used to pay for elective abortions. I even brought a few of their letters down to the floor so I could read them. If you don't mind, I wish to read them. Can I take a few minutes to do that?

Mr. BROWNBACK. Please do.

Mr. HATCH. These are just a few. We have all kinds of letters. I thought I would mention a few of these since they are on point here, as far as I am concerned.

Here is one from a woman, a Ph.D., the President of AUL Action, Charmaine Yoest:

DEAR SENATOR: On behalf of Americans United for Life, AUL Action, I write to express our strong opposition to the Senate proceeding to Majority Leader Reid's health care reform bill, the Patient Protection and Affordable Care Act. Majority Leader Reid's bill does not include the Stupak-Pitts language added to H.R. 3962, which is necessary to prevent Federal funding of abortion. AUL Action will score against all votes to proceed to this bill because it does not contain the Stupak-Pitts language. Majority Leader Reid's bill explicitly allows the Secretary of the Department of Health to include abortion coverage in the ''community health insurance option'' and allows Federal subsidies to go to private insurance plans that include abortion coverage. In addition, the bill also requires that at least one private plan in each exchange provide coverage for all abortions. The passage of a health care reform bill without language explicitly excluding abortion coverage and funding is unacceptable to pro-life Americans. We strongly encourage you to vote against all procedural motions to move to the majority leader's bill, including cloture on the motion to proceed.

Sincerely,

CHARMAINE YOEST, PH.D.,
President and CEO of AUL Action.

Here is another one. It is from one of my personal constituents.

DEAR SENATOR: As an American with a growing disdain for the heavy handedness and disregard for the wishes of the American people, I adamantly oppose any plan brought to the table that would require me to pay for abortions with my tax dollars. Any government-run health care system with this provision is bad for America and violates the deep convictions of many Americans. Furthermore, I am infuriated by Senate Majority Leader Harry Reid's deceptive course of action in secretively creating his own version of a health care reform plan. Reid's underhanded tactic diminishes the opportunity for public debate and scrutiny which flies in the face of our legislative process. I strongly oppose Harry Reid's health care overhaul plan to nationalize our system. I urge you to oppose any nationalized health care bill and any plan containing an abortion mandate.

Here is another one. This is an e-mail to me. It says this:

Hello, Mr. Hatch. I am writing for 4 registered voters in my family which include my husband, my parents, and myself. We are very concerned about the Federal health care legislation. We believe that it must support several of our beliefs. We believe that life must be respected and cared for from conception to natural death. As such, we do not want any of our tax dollars going to abortions or euthanasia. We have a desire for the continued support of the Hyde amendment of 1976. Our family supports charities which provide counseling and material goods needed by families who have an unplanned pregnancy. We want to support them in having the baby and caring for themselves and the child. We do this by donating things that are needed by the mom-to-be during her pregnancy. We also have donated furniture and other things needed by the baby. These have been given to Birthright—a program supported by donations. We want access to health care for all. This includes fair treatment of our immigrants. We do not want any of their health care that they may be receiving right now to be taken from them. In the Bible, God tells the Jews to be kind to the aliens, as they themselves were aliens at one time in their promised land. Our family also wants a freedom of conscience clause that allows for health care workers to refuse to take part in procedures involved in an activity that goes against their choice. Please consider our beliefs.

Whether you agree with every word of these, they are interesting.

Here is another one:

During the floor debate on the health care reform bill, please support an amendment to incorporate long-standing policies against abortion funding and in favor of conscience rights. If these serious concerns are not addressed, the final bill should be opposed. Life should be respected from conception to natural death. I am a retired teacher and am hoping to be able to receive the care I choose to have until my natural death. My care should not be based on my productivity in society years from now. Thank you for your stand on abortion in the past.

Then she has a PS:

My parents don't have and do not know how to use a computer to contact you. They feel the same as my husband and I feel about the above issues.

Then she lists the names of her parents.

Here is another one:

DEAR SENATOR HATCH: I am a registered Democrat strongly in favor of health care reform. I am also committed to protecting the unborn and to safeguarding the conscience of each health care provider who is uncomfortable with providing abortion services. During floor debate on the health care reform bill, please support an amendment to incorporate long-standing policies against abortion funding and in favor of conscience rights. If these serious concerns are not addressed, the final bill should be opposed. Genuine health care reform should protect the life and dignity of all people from the moment of conception until natural death.

Another one.

SENATOR HATCH: During floor debate on the health care reform bill, please support an amendment to incorporate long-standing policies against abortion funding and in favor of conscience rights. If these serious concerns are not addressed, the final bill should be opposed. Genuine health care reform should protect the life and dignity of all people from the moment of conception until natural death.

I also have a petition to Senator ORRIN G. HATCH opposing using taxpayer dollars to fund abortion. This petition says:

One out of every three babies conceived is a victim of abortion, a tragedy that has claimed more millions of innocent lives since the Roe v. Wade Supreme Court decision legalizing abortion on demand. Every abortion is a gruesome act that ends an innocent human life and cannot be tolerated in a civil society. The pro-abortion lobby is seeking to hide abortion funding into virtually every piece of ''must-pass'' legislation, including continuing resolutions, budget and authorization bills, so-called ''economic'' bills, and even the Defense authorization bill. I urge you to actively oppose and, if necessary, filibuster all attempts to use the budget to force Federal funding of abortion and abortionists and to pack the courts with activist, pro-abortion judges.

I thought I would read a few of those interesting letters to set a tone here. I have received all kinds of letters, but I chose a few, at random, to read on the Senate floor this afternoon.

Mr. BROWNBACK. I was recently at a Veterans Day parade in Leavenworth, KS, and I had a number of people coming up to me opposed to the health care bill. I had one come up to me and say they were in favor of it and all the rest were opposed. It starts on the basis that it is fiscally insane what we are considering doing with $12 billion in debt, and then we are going to add a multitrillion-dollar entitlement program on top of this. The Federal Government is hemorrhaging money. Why on Earth would we do that? Then they are scared about what else is in the bill, and then this feature comes up as well.

Finally, Senator JOHANNS was putting in statements from various groups, and I ask unanimous consent that this statement from the United States Conference of Catholic Bishops be included at the end of our colloquy.

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

(See exhibit 1.)

Mr. BROWNBACK. The Catholic Bishops issued this yesterday and said this:

The legislative proposal recently unveiled in the Senate does not meet these moral criteria. Specifically, it violates the long-standing Federal policy against the use of Federal funds for elective abortions and health plans that include such abortions—a policy upheld in all health programs covered by the Hyde Amendment, the Children's Health Insurance Program—

SCHIP, which Senator HATCH helped to get started—

the Federal Employees Health Benefits Program—

that Senator JOHANNS spoke about—

and now in the House-passed ''Affordable Health Care for America Act.'' We believe legislation that violates this moral principle is not true health care reform and must be amended to reflect it. If that fails, the current legislation should be opposed.

This is the Catholic Bishops, generally in favor of health care reform, and they are saying this fails on this account and must not be in this legislation and can't be considered as part of health care reform.

Mr. HATCH. I ask Senator JOHANNS, where do we go from here? We are going to have a cloture vote at 8 o'clock tonight on the motion to proceed. What would be the advice on that?

Mr. JOHANNS. I thank the Senator. Let me, if I might, before I address that, tell my colleagues how proud I am to stand here with these two champions of this issue, Senator BROWNBACK and Senator HATCH. They have a remarkable history of every time they had an opportunity standing strong on an issue that I must admit is not the most popular issue in Washington, DC, to promote, and I admire their courage.

To address the relevant question of the day, the Stupak protections, that compromise that was reached in the House, it is not in this bill.

Of course, since it is not in this underlying bill, this Reid bill, it is very unlikely to be in the final bill. I wish somebody could disprove this. But, very simply, there aren't enough pro-life Senators to break this provision and get the Stupak amendment passed on the Senate floor if we propose it as an amendment—and I am sure it will be—there just aren't enough.

That is why I have been making the case over the last 48 hours that the motion to proceed is the key vote on abortion in the health care debate. The most important pro-life vote that a pro-life Senator will cast, I believe, in the entire time they are here is on this motion to proceed. I have seen all the arguments from many, saying this is a procedural vote; that there is nothing to worry about; that it just begins debate, and we might potentially vote this bill down, and we can do some amendments and some tweaking.

But the facts suggest otherwise. The Congressional Research Service has looked into this. Between the 106th and 110th Congresses, there were 41 cases, according to the Congressional Research Service, in which the Senate approved a motion to proceed and then proceeded to a vote on the final bill. Do you know what the end result of those 41 cases were, when the motion to proceed was approved? It was 40 times out of 41—about 97 percent—went on to receive final approval. In other words, all but one passed into law.

This suggests to me this vote tonight at 8 o'clock on the life issue is very well determinative. Some of my colleagues also argue if we don't like the bill, we should not block the opportunity to amend it, and they say let us proceed.

I don't believe, if you are truly pro-life as a Senator, you can make that argument. Here is why: Everybody in the Senate knows what it will take to amend the Reid bill on something like this. It will take 60 votes. It is the way the Senate operates. It will take 60 votes. Again, I say to Senator HATCH and Senator BROWNBACK, I wish I could count 60 pro-life Senators. I wish I could do that. But by anybody's count, I believe—mine included—there aren't 60 here.

I believe if you are pro-life, every opportunity you get to stand for the life issue, you must stand for that issue. These truly are our most vulnerable citizens. I feel very strongly that at 8 o'clock, when we are gaveled to a vote, we need to stand up on this issue—this life issue—or there is a 97-percent chance it is lost.

I will conclude my thoughts on this by saying this: There were many strong and courageous pro-life Democrats in the House. I watched that. That was remarkable. Can you imagine the pressure they were put under? This evening, we just need one—not many, just one Democrat—who will come here and say I am pro-life. If we don't stand together tonight, this bill will radically expand abortion, and I cannot live with that.

Mr. HATCH. I thank the Senator for his remarks. I thank both Senators BROWNBACK and JOHANNS.

Before coming here, the Senator was the Secretary of Agriculture. He is from Nebraska. By any measure, he is a very sincere, dedicated, and principled person. We all know that, and I think the world of the Senator.

I appreciate standing on the Senate floor with the Senator to chat about this matter. Senator BROWNBACK, without question is a leader in this body in protecting the rights of the unborn. It is one of the things I most love about him. There are many things that cause all of us to hold the Senator from Kansas in very high regard and esteem. He is principled and dignified about it. He is friendly to everybody. But the Senator doesn't mince words when it comes to standing up on these very important issues.

Look, all we are saying is, let's protect the Hyde language. You do that with the Stupak-Pitts language. What is wrong with including that language? All we want to do is not have federal funds pay for abortion. The vast majority of people in this country feel that way too.

Second, why should people of conscience, who really and sincerely believe that abortions are wrong, be forced to participate in abortions in any way, shape, or form? Unfortunately, this bill could lead to that forced participation. I just do not understand what is so difficult about including the same language included in the bill passed by the House of Representatives. What is so problematic about our body doing the same?

If you are a nurse, doctor, health care practitioner, Catholic hospital, or an LDS hospital out of Utah, if we have the Stupak-Pitts conscience protection language passed by the House, you cannot be forced to participate in abortions. These are highly religious people with highly religious motivations who have made this the greatest country in the world. If we do not change this language in the Reid bill, there will be Federal funding of abortion, and there will be people who could be pushed toward participation in abortion.

Mr. BROWNBACK. It has been my pleasure to join Senators HATCH and JOHANNS on this effort. I have worked with both of them in many different capacities and jobs.

This is as serious a pro-life vote as I have seen. If this gets passed, the Federal Government will be funding somewhere north of 300,000 abortions a year. If it was 300,000 back in the 1974-to-1976 timeframe, with the growth in U.S. population, you are probably looking at north of that number of Federal taxpayer dollars funding abortions. I cannot imagine many people in this country being satisfied about that kind of number taking place. I can't imagine that. But that is our past experience when the government funds abortion.

Those are the numbers we are talking about. I note, too, the country has a longstanding ethic and moral code. We are a moral people, and we have been from the outset. Some people say this or that, but a big part of that has been that basic moral code, that basic thought within the Judeo-Christian ethic that we respect life. This goes back to when Moses talks to the people about going into the Promised Land. He is giving his last lecture to the Jewish people before going into the Promised Land. In that last lecture—Moses doesn't get to go in himself, but he gets the people together. They march for 40 years in the wilderness. He knows he is not going in, but they are, and he gives a lecture.

Deuteronomy 30:19 says something that is applicable here:

This day I call heaven and earth as witnesses against you that I have set before you life and death, blessings and curses. Now choose life, so that you and your children may live.

This is in the fundamental ethic and background of our country. That is what we have to choose today. Do we choose life or death? Choose life, so that you and your children might live.

As Senator JOHANNS notes, we just need one vote on the other side to change this, and this language gets pulled out and Stupak gets put in. Just one vote. If we cannot get to 60—and you have to get there—and that one person says: I am not going to do it,

unless you put Stupak in this, it changes. We need just one to choose life, and it will change. It has been a pleasure to join with both Senators today.

EXHIBIT 1

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS,
Washington, DC, November 20, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: On behalf of the United States Conference of Catholic Bishops (USCCB), we strongly urge the Senate to incorporate essential changes to the Senate's health care reform bill to ensure that needed health care reform legislation truly protects the life, dignity, consciences and health of all. We especially urge the Senate to act as the House has in the following respects:

Keep in place current federal law on abortion funding and conscience protections on abortion;

Protect the access to health care that immigrants currently have and remove current barriers to access; and

Include strong provisions for adequate affordability and coverage standards.

The Catholic Bishops of the United States have long supported adequate and affordable health care for all. As pastors and teachers, we believe genuine health care reform must protect human life and dignity, not threaten them, especially for the most voiceless and vulnerable. We believe health care legislation must respect the consciences of providers, taxpayers, and others, not violate them. We believe universal coverage should be truly universal, not deny health care to those in need because of their condition, age, where they come from or when they arrive here. Providing affordable and accessible health care that clearly reflects these fundamental principles is a public good, moral imperative and urgent national priority.

Sadly, the legislative proposal recently unveiled in the Senate does not meet these moral criteria. Specifically, it violates the longstanding federal policy against the use of federal funds for elective abortions and health plans that include such abortions—a policy upheld in all health programs covered by the Hyde Amendment, the Children's Health Insurance Program, the Federal Employee Health Benefits Program—and now in the House-passed ''Affordable Health Care for America Act.'' We believe legislation that violates this moral principle is not true health care reform and must be amended to reflect it. If that fails, the current legislation should be opposed.

PROTECTING HUMAN LIFE AND CONSCIENCE

Specifically, we urge you to include the House-passed provision that keeps in place the longstanding and widely supported federal policy against government funding of elective abortions or plans that include elective abortions.

In the aftermath of the overwhelming and bipartisan House vote for the Stupak-Smith-Ellsworth-Kaptur-Dahlkemper-Pitts Amendment, there has been much misunderstanding of what it does and does not do. This amendment does not change the current situation in our country: Abortion is legal and available, but no federal dollars can be used to pay for elective abortions or plans that include elective abortions. This provision simply keeps in place existing policy and allows Congress to honor the President's commitment that ''no federal dollars will be used to fund abortions.'' The amendment does not restrict abortion, or prevent people from buying insurance covering abortion with their own funds. It simply ensures that where federal funds are involved, people are not required to pay for other people's abortions.

Thus far, the pending Senate bill does not live up to President Obama's commitment of barring the use of federal dollars for abortion and maintaining current conscience laws. The bill provides federal funding for plans that cover abortion, and creates an unprecedented mandatory ''abortion surcharge'' in such plans that will require pro-life purchasers to pay directly and explicitly for other people's abortions. Its version of a public health plan (the ''community health insurance plan'') allows the Secretary of HHS to mandate coverage of unlimited abortions nationwide, and also allows each state to mandate such abortion coverage for all state residents taking part in this federal program even if the Secretary does not do so. The bill seriously weakens the current nondiscrimination policy protecting providers who decline involvement in abortion, providing stronger protection for facilities that perform and promote abortion than for those which do not. The legislation requires each region of the insurance exchange to include at least one health plan with unlimited abortion, contrary to the policy of all other federal health programs. Finally, critically important conscience protections on issues beyond abortion have yet to be included in the bill. To take just one example, the bill fails to ensure that even religious institutions would retain the freedom to offer their own employees health insurance coverage that conforms to the institution's teaching. On these various issues the new Senate bill is an enormous disappointment, creating new and completely unacceptable federal policy that endangers human life and rights of conscience.

IMMIGRANTS AND HEALTH CARE COVERAGE

We support the inclusion of all immigrants, regardless of status, in the insurance exchange. The Senate legislation forbids undocumented immigrants from purchasing health-care coverage in the exchange. Undocumented immigrants should not be barred from purchasing a health insurance plan with their own money. Without such access, many immigrant families would be unable to receive primary care and be compelled to rely on emergency room care. This would harm not only immigrants and their families, but also the general public health. Moreover, the financial burden on the American public would be higher, as Americans would pay for uncompensated medical care through the federal budget or higher insurance rates.

We also support the removal of the five-year ban on legal immigrants accessing federal health benefit programs, such as Medicaid, the Children's Health Insurance Program, and Medicare. Legal immigrants, who work and pay taxes, should have access to such programs if needed. Removing the ban would help ensure that legal immigrants, who were widely praised in past immigration debates for their many contributions and for playing by the rules, will still have access to health care.

ACCESSIBLE AND AFFORDABLE HEALTH CARE

The Catholic bishops have advocated for decades for affordable and accessible health care for all, especially the poor and marginalized. The Senate bill makes great progress in covering people in our nation. However, the Senate bill would still leave over 24 million people in our nation without health insurance. This is not acceptable.

The bishops support the expansion of Medicaid eligibility for people living at 133 percent or lower of the federal poverty level. The bill does not burden states with excessive Medicaid matching rates. The affordability credits will help lower-income families purchase insurance coverage through the Health Insurance Exchange. However, the Senate bill would still leave low-income families earning between 133 and 250 percent of the federal poverty level financially vulnerable to health care costs. Overall, the average subsidy provided for in the Senate bill is $1,300 less than the average subsidy in the House bill. Improvements to the bill should be made so that low-income families have reasonable out of pocket expense for health care.

Immediate reforms are included in the bill that should be helpful in providing relief to the uninsured and underinsured. Additionally, reforms that will strengthen families and protect low-income and vulnerable people such as eliminating denial of coverage based on pre-existing conditions including pregnancy; eliminating life time caps; offering long-term disability services; and extending dependent coverage to uninsured young adults—are significant steps toward genuine health care reform. We urge the Senate to maintain these provisions.

These moral criteria and policy objectives are not marginal issues or special interest concerns. They are the questions at the heart of the health care debate: Whose lives and health are to be protected and whose are not? Will the federal government, for the first time in decades, require people to pay for other peoples' abortions? Will immigrants be worse off as a result of health care reform? At their core, these health care choices are not just political, technical, or economic, but also moral decisions. This legislation is about life and death, who can take their children to the doctor and who cannot, who can afford decent health care coverage and who are left to fend for themselves.

Our appeal for health care legislation that truly protects the life, dignity, health and consciences of all reflects the unique perspectives and experience of the Catholic community. Our hospitals, clinics, and long-term care facilities provide quality health care to millions. Our dioceses, institutions, and ministries purchase health care for many thousands of employees and their families. Our emergency rooms, shelters, clinics, and charities pick up the pieces of a failing health care system. Our Catholic moral tradition teaches that health care is a basic human right, essential to protecting human life and dignity.

For many months, our Bishops' conference has been working with members of Congress, the Administration and others to fashion health care reform legislation that truly protects the life, dignity, health and consciences of all. Our message has been clear and consistent throughout. We hope and pray that the Congress and the country will come together around genuine reform.

Sincerely,

BISHOP WILLIAM F. MURPHY,
Diocese of Rockville Centre, Chairman, Committee on Domestic Justice and Human Development.

CARDINAL DANIEL DINARDO,
Archdiocese of Galveston-Houston

Chairman, Committee on Pro-life Activities.
BISHOP JOHN WESTER,
Diocese of Salt Lake City, Chairman, Committee on Migration.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. FRANKEN. Madam President, I ask unanimous consent that the next hour be equally divided between the following three Senators: FRANKEN, LINCOLN, and LEVIN.

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

Mr. FRANKEN. Madam President, I rise today to express my strong support for the Patient Protection and Affordable Care Act.

I commend Leader REID, Chairman HARKIN, Chairman BAUCUS, and Senator DODD for their leadership that has brought us to this critical point. We are on the verge of passing legislation that will do more than any bill in recent history to make our country healthier, our economy more stable, and our working families more secure.

Make no mistake, this bill will change. There will be amendments to it that will make it an even better bill. There may be amendments that make it less to my liking and, therefore, a less good bill, to my point of view. But the final bill will make health care available to more tens of millions of Americans. It will make health insurance more secure for all Americans who have it and will put an end to the unsustainable trajectory that we are now on with the cost of health care, and will avert an otherwise inevitable catastrophe to our health care system and our economy.

The reality right now is that we are denying millions of Americans their shot at the American dream because of our irrational health insurance system.

Right now, if you have been sick, insurance companies can refuse to cover you or charge you ridiculous premiums. If you get sick, your insurance benefits can run out when you need them the most.

Right now, people without insurance do not get preventive care. Instead, they go to the emergency room when they cannot hold out any longer. This is the least-efficient and most expensive way to deliver care, and those of us who do have insurance pay for it. It costs every insured family more than $1,100 a year in additional premiums to pay for those who don't have health insurance.

Right now, if you are a woman who has had a C-section or if you have been a survivor of domestic violence, health insurance companies can arbitrarily decide not to cover you. That is because having had a C-section or being a survivor of domestic violence is considered by many insurance companies to be a preexisting condition. That is wrong.

What is even more egregious is that while millions of Americans struggle to pay for health care, insurance executives continue to make obscene salaries. From 2000 to 2007, a period of 8 years, Americans saw their premiums almost double. During that same time, we saw more than 6 million more Americans become uninsured. During that same time, insurance company profits rose 428 percent—428 percent. That is all you need to know to understand why we have to pass this bill—428 percent in 8 years. No wonder the insurance companies are fighting this bill. Of course they don't want to be subject to antitrust laws. They are making outrageous profits by gouging American families. Make no mistake, that is what this is about.

This bill will change all that. It will fundamentally transform how health insurance works in this country. This bill guarantees secure coverage that will be there for Americans and stay there when they need it the most. This is not going to help just individual Americans; it is going to help small businesses too.

There are urgently needed changes that will go into effect the day the President signs this bill into law. Effective immediately, preventive services, such as colonoscopies and cholesterol tests, will be covered by all insurance plans at no cost. This will make prevention a priority, not an afterthought. We will detect cancers earlier and stop chronic diseases, such as diabetes, in their tracks. Not only will this save innumerable lives, it will lower the long-term cost of health care for all of us. This is one of the key ways health care reform transforms our system of sick care into a true health care system.

Effective immediately, any new health insurance plan will let your children remain on the family policy until they are 26. That is big. Say you are a parent whose kid has been ill in the past, maybe she had asthma and she just graduated, say, from the University of Minnesota. Your daughter is just out of school, and she wants to find a job. We all know this is a big enough challenge in this economy. While she plans for her future, the last thing she should have to worry about is how she is going to get health insurance.

The good news is, after health care reform, she will have secure coverage until she gets on her feet. She can either stay on your plan until she is 26 or once the exchange is up and running, she can purchase an affordable plan through the exchange.

Also, effective immediately, we will hold health insurance companies accountable by making them give rebates if they spend more than 20 percent of premiums toward profits, marketing, or administration. I am proud to have championed this safeguard with my colleagues, Senator ROCKEFELLER and Senator WHITEHOUSE.

The current reality is, most of us do not know where our health insurance premiums go. It is challenging enough to understand a billing statement from your health insurer, much less track where your money is being spent. We are going to change that.

Thanks to Senator JACK REED, the Senate bill also requires transparent reporting of how health insurance companies are spending your money. This transparency is especially important as we cover an additional 31 million Americans under this bill. We know from their profit margins that right now insurance companies are price gouging. But clear reporting will help us hold them accountable for every dollar we invest in health insurance.

Based on our experience in Minnesota, I know we can do even more to rein in marketing, wasteful administrative costs, and profits in health insurance. In the coming weeks, we will debate this bill, amend it, and make it even better. I will be pushing to require an even higher percentage of your premiums go toward actual health care.

The reason I believe we can provide higher quality care without excessive profits is because Minnesota already does it. We are distinguished by the fact that 90 percent of Minnesotans are served by a nonprofit health plan. These plans outperform their national peers and are able to put an average of 91 cents of every premium dollar toward actual health care services—91 cents out of every dollar.

In other plans throughout the Nation, you may find less than 60 percent of your premium is put toward health care. The rest is for overhead, marketing, and profits. By taking the profits out of the health insurance industry—not taking them out but lowering them to a reasonable level—Minnesota health plans do a better job of helping our residents live healthier, longer lives. As we begin debating this bill on the Senate floor, it is essential that health insurance companies get the message loudly and clearly that their top priority must be serving patients, not creating more and more profits, not a 428-percent increase in profits in 8 years.

Under the Senate bill, we will stop insurance companies from denying you coverage or charging you more because of preexisting conditions. This will end the egregious industry practice of discriminating against survivors of domestic violence. Insurance companies

also will no longer be able to charge women more for their health coverage just because they happen to be a woman.

We will ban lifetime caps and end unreasonable annual limits on your benefits. These insurance market reforms will help Americans, but they will be particularly life changing for families such as the Battersons who live in Bloomington, MN. Linda Batterson has three daughters. She owns her own business, and her husband Bud is a realtor.

The Battersons have some relatively minor health problems—asthma, allergies, and back problems. But because health insurance companies can charge them more based on their health history, their only health care option in Minnesota is a high-risk pool. This year they are paying nearly $21,000 for health care—$21,000 for their insurance. This is not a Cadillac plan. Neither the Battersons' businesses nor their family can sustain these costs.

But the good news is, the Battersons will get relief under our bill. They will be able to go to the exchange and find an affordable plan. Health insurance companies will not be able to charge the family more because of their health history. If companies are going to raise rates, they will have to publicly disclose and justify any increase.

I think we can all agree that one group of Americans who suffer under our current system is small businesses. Across Minnesota—from Bemidji to Spring Valley—I have talked to small business owners who want to do the right thing. They want their workers to be healthy, but they cannot afford the current unpredictable and skyrocketing rates.

In Minnesota, we have 92 percent of our State covered, and we have invested resources to create the MinnesotaCare Program to make sure low-income residents are covered. But even with all this success, the uncontrolled cost of health insurance is forcing us to tighten our belts and make sacrifices that no American should have to make, such as small businesses having to choose between laying off workers or dropping health insurance for everyone.

I am pleased to tell you this bill will bring real relief to small businesses across our country. We will even the playing field so small businesses can do the right thing for workers without sacrificing their bottom line. This will make them competitive with large employers and with companies from overseas so they can attract the best and brightest workers.

Right now, small businesses are often priced out of the markets. They may be lucky to find just one or two carriers willing to cover their workers. So the first important change that health care reform can bring is choice of plans for small businesses. They will be able to participate in the exchange which will offer them a choice of reliable plans. This coverage will be less expensive and provide better coverage than what is available today.

Right now, if you are a business with, say, 15 employees and 1 of them gets sick or has a baby, your premiums are going to go up dramatically. That is because your risk pool is 15. But when you choose from policies on the exchange, your risk can be pooled with hundreds or even thousands of other businesses. That is the whole point of insurance, to spread the risk over the greatest number of people.

The second key benefit for small businesses is tax credits to help business owners purchase coverage. Effective immediately, these credits will ease the burden on small business owners who offer coverage but are being squeezed in the current market. For business owners who have not been able to offer insurance, the tax credits will provide a new incentive to begin covering their workers, keeping the workforce healthy and productive.

Today I have touched on just a few elements of the health care reform bill. I will be back. I have touched on insurance market reforms and provisions tailored to the needs of small businesses. But this just scratches the surface. The public option will bring much needed competition, and the incentives for high-quality care will make us all healthier. Taken together, these elements will bring our country into a new era in which high-quality and affordable health care is a reality in this country.

Passing national health care reform this year is my top priority because I have listened to Minnesotans across my State. They have told me loudly and clearly that the current health insurance system is not working for them, and they have told me they want access to care. I have heard them.

They want to know they can start a small business without worrying about the cost of health insurance because one of their kids has a preexisting condition. They want to know they will have health care when they need it the most. They want insurance companies to prioritize health services over profits. They are looking for us to fulfill our promise to pass comprehensive health care reform this year.

I look forward to working with all of you to make this a reality.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mrs. LINCOLN. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

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

Mrs. LINCOLN. Madam President, I have asked for this time today not only to address my colleagues in this body but to speak directly to my constituents at home in Arkansas. After many months of debate on health care, we are nearing yet another important step in a very deliberative process. Today we are voting on whether to continue to discuss how to improve health care in America or to stop the debate.

I personally have carried the mantle to improve health care for Arkansas throughout my public service, like many of my colleagues and so many others as well who have worked hard on this issue. Over the last several decades the advance of medical technology and our Nation's changing demographics have placed new demands on our health care system that it is not designed to meet.

Our vote later this evening is not the first step toward making the necessary adjustments in health care, nor will it be the last, without a doubt. The Finance Committee on which I serve and which is led so ably by my good friend from Montana, Chairman BAUCUS, has produced what I still describe as the most responsible approach to health insurance reform. We deliberated for more than 22 months, incorporating recommendations from experts all across our great Nation and proved, through our bill, that America can achieve unprecedented health insurance reforms that expand coverage, reduce cost, and provide stability for those with existing coverage.

We accomplished these goals without posing long-term risk for taxpayers. It was not a perfect bill. We never see perfect bills around here, quite frankly, but I can honestly say I will fight hard so our final product will more closely resemble the commonsense, deficit-reducing plan we produced in the Senate Finance Committee.

At times like this I think it is very important for each of us to remember the very reasons we began this debate. Small businesses and working families are reaching the breaking point financially because of the relentless rise in health care costs. Nationally, our economic recovery will only be slowed by the inflationary cost of health care. Taxpayers and the insured are already bearing the cost of medical treatment for the uninsured at the most expensive point of delivery, in our emergency rooms. Health care in America today is a model that waits until people get sick rather than focusing on the wellness, prevention, and good management of illness that keeps people out of the hospital and from having the most costly care needs.

Our current health care system wastes money and is so inefficient that the United States spends more than twice as much per person while insuring a smaller portion of our population than the average spending in 29 other industrialized nations. There simply are not enough health insurance options available to most Americans

today when in at least 17 States, including my home State of Arkansas, only one insurance company controls more than half the insurance market, and in at least 22 States still only two carriers control half or more of the market.

Patients and doctors are routinely making treatment decisions with little or no objective information about which treatments are more effective. American capitalism is based on choice and competition because when these elements are present, consumers can most always find the best value for their money. That is not true in health care. So by creating health insurance exchanges through which small businesses and individuals can choose from a menu of private plans, we can enhance cost transparency, create head-to-head competition, and allow market forces to reduce prices.

These are facts. These are facts, and whether we are Republicans or Democrats or independent, I believe we can agree on most all of them. I know the great majority of Arkansans believe these facts and want to see us accomplish these reasonable goals.

For months now, groups from outside my State have assigned various motives to my deliberations on health care and tried to define the meaning of my vote. According to the last tally, there has been more than $3.3 million worth of media ads that have been purchased in my home State of Arkansas by groups from outside of our State—certainly none by me—and most with my name in the ad. Still, I have continued to approach this issue as I always do. These outside groups seem to think this is all about my reelection. I simply don't think they know me very well.

I am focused on my opportunity to influence the final version of health care legislation in a way that most helps my State. That is why the people of Arkansas sent me here. They sent me here because they know I am going to work hard to do the best job possible and to do the right thing; to stand my ground on my principles.

I have avoided the extremist claims from the left and from the right and tried to pull the commonsense solutions from among all the policy options so that we get health care reform that benefits Arkansans and all Americans. That is our job in this body, to represent our States in this unbelievably historic body, the Senate.

The truth is, this issue is very complex. There is no easy fix, and it is imperative that we build on what is already working for health care in America and not turn away from the problems we face. We keep building until we can truly say one day that all American citizens will have access to quality and affordable health care. In order to improve upon and build upon what we already have, I do not support the creation of a so-called robust, government-administered public plan.

I believe we should work to make sure we do not expose American taxpayers and the Treasury to long-term risks that could occur over future government bailouts of a public plan. Rather than create an entirely new government-run health plan to compete with private insurers, I support health insurance reform that focuses on changing the rules of our existing employer-based private health insurance system. I believe we should change the current rules that permit insurance companies to bully their customers and cherry-pick healthy patients, so we can force them to compete with each other.

My first loyalties are with the people of Arkansas—not insurance companies, the health care industry, or my political party. In fact, I authored an amendment during consideration of legislation in the Senate Finance Committee which limits taxpayers' subsidies for health insurance companies that pay their top executives millions in salaries. Responsible health insurance reform should ensure that insurance executives are not receiving a personal windfall, and that companies they work for are not receiving excessive tax breaks while at the same time profiting from government requirements on consumers to buy insurance.

The reason we are having this vote is because our Republican colleagues object to beginning debate and consideration of amendments on health care legislation. Although I do not agree with everything in this bill, I have concluded that I believe it is more important that we begin this debate to improve our Nation's health care system for all Americans rather than simply dropping the issue and walk away. That is not what people sent us here to do.

Attempts by the National Republican Party and other conservative groups to portray this as a vote for or against this particular health care reform bill are untrue and deliberately misleading. The vote tonight will mark the beginning of consideration of this bill by the full Senate, not the end. Republicans have sought to revive their political party by opposing any real solution to our Nation's health care crisis. In fact, this vote for or against a procedure that allows us to begin debate on health care reform is nothing more and nothing less. Put simply, those who vote yes on this vote believe our Nation's health care system needs reforming, and they are ready to have an honest and open debate in the Senate about how to best achieve that reform. I am not afraid of that debate, nor am I afraid of coming before this body to say what I believe is the most important thing we can do to reform health care. I hope none of us are. Our country needs us too desperately now to be making good decisions and moving forward.

I will not allow my decision on this vote to be dictated by pressure from my political opponents, nor the liberal interest groups from outside Arkansas that threaten me with their money and their political opposition; the multitudes of e-mails and ads we have received, unbelievable types of threats about what they are going to do and how they are going to behave. The fact is, I am serious about changing our health care system, as most Arkansans and most Americans are. I am not with those who seek to avoid the debate, nor with those who use political attacks to achieve their narrow goals. I will vote in support of cloture on the motion to proceed to this bill.

But let me be perfectly clear. I am opposed to a new government-administered health care plan as a part of comprehensive health insurance reform, and I will not vote in favor of the proposal that has been introduced by Leader REID as written. I, along with others, expect to have legitimate opportunities to influence the health care reform legislation that is voted on by the Senate later this year or early next year. I am also aware there will be additional procedural votes to move this process forward that will require 60 votes prior to conclusion of the floor debate. I have already alerted the leader and my colleagues that I am prepared to vote against moving to the next stage of consideration as long as a government-run public option is included. The public option, as a part of health insurance reform, has attracted far more attention than it deserves. While cost projections show that it may reduce costs somewhat, those projections don't take into account who pays if it fails to live up to expectations. If, in fact, premiums don't cover the cost of the public plan, it is taxpayers in this country who are faced with the burden of bailing it out.

Our colleagues cannot ignore the growth in the Federal Government since the year 2000. I can assure you that the American people have not ignored it. According to the American Institute for Economic Research, government spending grew by 55 percent under President Bush. As he was leaving office, government launched a massive bailout of Wall Street. Then it was the domestic auto manufacturing industry that needed taxpayer funds to survive. And finally, in order to revive a dying economy, it took a government economic recovery package to save or create hundreds of thousands of jobs. We can argue about the necessity of these unprecedented steps, but we need not argue about the impression they have made on the American people. We should be stopping the growth of government, not expanding it more. Without the public option, we could still force private insurance plans that participate in the exchanges to provide

standard benefit packages that are easy to compare and more fairly priced. We will be bringing millions of new customers to the exchanges so insurers should be motivated to lower prices and be competitive.

I have pledged to dialog with Leader REID regarding my concerns that remain about this bill. I look forward to continuing that dialog on improvements that I believe are necessary in order to meet the challenge. I will be asking my colleagues to consider these additional important changes I believe will improve our chances for real health insurance reform and that can also enjoy the support of most Arkansans and most Americans.

Some of these include that the legislation remain deficit neutral, now and in the future, and curbs future cost, that it protects Medicare beneficiaries for seniors and extends solvency of the Medicare Program, that it improves accessibility and affordability of health insurance for employees and owners of small businesses and the self-employed through access to health insurance exchanges and tax credits, that it enhance choice and competition of health insurance plans for small businesses and individuals without the inclusion of a government-run public option, and that it build our Nation's health care workforce and ensure continued access to quality health care providers, especially in rural America.

Today I know I will ultimately be held accountable by my constituents in Arkansas for all of my votes on health care, not the National Republican Senatorial Committee, not by other groups from outside my State that continue to engage in a conversation they have begun. I know my decision to support the upcoming cloture vote on the motion to proceed is not my last nor only chance to have an impact on health care reform.

I am optimistic and encouraged about the step we are preparing to take in the Senate, to amend and craft a bill that will improve access to quality, affordable coverage options for the residents and businesses of my State who desperately need relief, a bill that improves the quality and efficiency with which we deliver health care, all without adding to our Nation's deficit and while lowering the cost of health care over the long term. I am committed to using every power of my office to achieve success on this issue by enacting meaningful reforms that will benefit the people of Arkansas and our Nation.

I have spent the last several months in a passionate dialog with my constituents about health care reform. It was not only in townhall meetings where I heard from Arkansans. I had hundreds of conversations with many of them in groups and one-on-one conversations. They may not be in agreement about solutions, but I can assure my colleagues that each Arkansan I speak to expects us to roll up our sleeves and get this right. We can. Following the vote tonight, the bill that will be laid before us will not be the only possible solution. I know my decision to support cloture on the motion to proceed is not my last or only chance to have an impact on overall health care reform. My strongest hope is that each of us can lay political fortunes aside and make the tough, commonsense choices our constituents expect of us, whether you are a Democrat or Republican, and look at what we face and the challenges of our Nation. Make sure that as we are working toward an end result, that each of us is working as hard as we can to come up with a pragmatic solution that our constituents expect of us. We may not get this opportunity again in our lifetime.

Today I am thinking about the Arkansas working family who can't pay their mortgage because of their sick child's medical bills. I am thinking of the Arkansas small business owner who told me that more than 20 percent of the cost of running his business now goes to health insurance for him and his workers. I am thinking about the 450,000 Arkansans who have no health insurance. I am not thinking about my reelection, the legacy of a President, or whether Democrats or Republicans are going to claim victory in winning the debate. I hope all of my colleagues join me in looking forward to working with the leader and all of our colleagues in the days and weeks ahead as we strive to solve a problem whose solution is long overdue.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. LEVIN. Madam President, in a few hours we will take an important step on the road to health care reform. Our vote will come after months of analysis and debate and years of growing concern on the part of our constituents that the American health care system is in need of fundamental reform. Two Senate committees have approved reform legislation. We will vote later today on whether to open debate on a third one which merges the two produced by the Senate Finance and HELP Committees. Much time and attention has been focused on the provisions in this legislation which will expand the number of Americans who are covered by health insurance, a goal I wholeheartedly share. But a compelling reason for reform and a major reason to vote in favor of allowing the Senate to debate health care reform is the serious and worsening signs that for those Americans who have health insurance, our health care system is no longer working as it should.

Increasingly, Americans with health insurance are at catastrophic financial risk, if they get sick. Increasingly, working families with insurance are unable to afford the escalating premiums they face to maintain their often inadequate coverage. Increasingly, businesses large and small that offer health insurance to their employees are buckling under the crushing weight of spiraling costs for their employees. Increasingly, families find that caps on their coverage leave them exposed to devastating medical bills. And increasingly, arbitrary insurance company practices that boost their own profits are shortchanging Americans, denying coverage because of preexisting conditions, and searching for ways to deny patients the treatments they need and have paid for through their premiums.

Democrats are not alone in pointing out these problems. The Republican leader himself has said:

> Every Republican in Congress supports reform.

That is the Republican leader who said that every Republican in Congress supports reform. He did not say many Republicans. He did not say most Republicans. Every single Republican in both Chambers of Congress, the Republican leader tells us, wants to reform the health care system.

How will any reform happen, reform proposed by Democrats or by Republicans or by anybody? Only when this body can bring a bill to the floor of the Senate for debate and amendment, only when we work with our colleagues in the other Chamber to resolve differences between legislation approved by the Senate and that approved by the House, only when Congress sends the President a bill he is prepared to sign into law. Speeches will not reform health care. Polls and cable television shout fests, none of that will reform health care. We, the Members of the U.S. Congress, and we alone, can reform health care.

We must listen to constituents, advocacy groups, physicians, insurers, health care experts, economists and anyone else with constructive ideas. Ultimately, it is we who must act. To do that, we must begin to debate here on the floor of the Senate the many complex issues that must be resolved. That is all today's vote will do, give the Members of the Senate the chance to come together in a sincere effort to work together, resolve our differences, and address an issue on which there is, we are told, even by the Republican leader, general agreement on the need for reform.

Two Senate committees have already spent months seeking the proper ways to reform the health care system. The Senate Finance Committee has held over 50 meetings on health care reform legislation in the last year. The Health, Education, Labor and Pensions Committee spent 13 days marking up its legislation. So we have made progress. We are at least in position to

do what this body was designed to do and is supposed to do: deliberate and decide.

The minority opposes the legislation we are trying to bring to the floor for debate and amendment. They say they do not like the bill. But why deny the Senate the opportunity to debate the subject of health care reform? Why prevent us from considering it? Why not offer amendments to the bill if you do not like it or offer a substitute measure for it?

There are parts of the bill in which I would like to see changes. I would like to make health insurance even more affordable for working families, and I am willing to require that those earning more than $250,000 a year, for instance, pay a higher and, in my view, more fair and more appropriate tax rate to make that greater affordability for working families possible.

Income data shows that in recent years only the wealthiest 10 percent of Americans have seen any real increases in income and that those increases are concentrated in the wealthiest 1 percent of the country, while the vast majority of Americans have lost ground. At the same time, most Americans are coping with falling income, they have been hit with massive increases in health insurance premiums. So I am willing to support an increase in upper income tax brackets to end that unfairness.

Other sources of revenue, such as ending the abuse of offshore tax havens, can and should go toward doing other things we should be doing in this bill. For instance, I am concerned that the annual fee on insurance providers contained in the merged bill would treat nonprofit and for-profit insurers the same way. Millions of Michigan residents receive their insurance from Blue Cross Blue Shield of Michigan, a nonprofit company, which is the insurer of last resort in our State, providing coverage to residents who cannot find it elsewhere. We need to find ways to reform the insurance market without negatively impacting the not-for-profit insurance companies that are the insurers of last resort and that provide high levels of coverage in return for the premiums they collect.

On these and other issues, I will continue to study the details of the legislation, discuss them with colleagues and constituents, and I will support improvements where needed. What I will not do is vote to block efforts to reform a system that simply is not working well for those who have health insurance, as well as for those who do not.

The need for reform is generally acknowledged. How can we then not open debate? How can we not discuss, offer amendments, consider alternatives, make changes, and vote on reform legislation? That is the only path to health care reform. There is no other way. And for those who proclaim their belief in the need for reform to stand in the way of that debate is, at best, starkly inconsistent.

A vote against even opening debate is a vote in favor of the status quo, which my constituents and the vast majority of Americans can no longer afford. They can no longer afford it because it is bankrupting them, in many cases literally bankrupting them. A study this year, published in the American Journal of Medicine, found that in 2002, 62 percent of all individual bankruptcies in the United States involved medical costs.

That is a tragedy. You should not be forced into bankruptcy because you get sick. But it gets worse. Three-quarters of those bankruptcies involved people who had health insurance when they got sick. Let me repeat that. In the United States, almost two-thirds of all bankruptcies are linked to medical costs, and three-quarters of those bankruptcies occurred even though the debtor had health insurance. That is adding absurdity to tragedy and demonstrates the inadequacy of health insurance for those who are covered.

We must act to reform a health care system so broken that it crushes Americans under a mountain of debt. One of my constituents, a Kalamazoo man, had what he thought was adequate health care coverage when 3 years ago he needed surgery to replace two sections of his aorta. But his coverage left him an out-of-pocket cost of nearly $40,000. That is the sum that stood between this man and lifesaving surgery. Financially devastated by the costs, he declared personal bankruptcy. He wrote to me:

> No one should die because they cannot afford health care, and no one should go broke because they get sick.

He is right.

We must act to reform a health care system so broken that it leaves the mother of a young Michigan State University student worried that her daughter will not get the care she needs. This 24-year-old student has insurance. Yet when she began to have unexplained seizures, her coverage would not pay for all the tests needed to determine their cause. Even after declining some prescribed tests because she could not afford them, the young woman's doctors eventually discovered the cause of her seizures: a brain tumor. This mother worries that her daughter will lose her insurance, will be forced to declare bankruptcy, and that the family will have to find some other way to cover the massive expense of her lifesaving care—all while coping with the other financial strains hitting her family and so many others. The mother writes:

> We will lose too many bright young people if something is not done.

She is right.

We must reform a health care system so broken that it sent a minister from Jackson, MI, on a weeks-long odyssey to keep her insurance because she became pregnant—a joyous event for most families but apparently just another preexisting condition to insurance companies. When this expectant mother moved from a church in Massachusetts to one in southern Michigan, her new church immediately sought, for their new minister, to find her health insurance. But company after company declined to cover her because of her pregnancy. She and her church spent weeks researching the issue, changing insurance agents, providing document after document, pleading with insurance companies. She wrote me:

> I had two volunteers, myself, and two insurance agents working on the situation constantly for over a month.

And she said:

> If you have the time and energy, and some good help, and are willing to spend a month hassling with the system pretty much continuously . . . then you can sometimes, with a great deal of luck, work the system.

Reflecting on her experience, this minister writes:

> It is clear to me that we are desperately in need of health care reform.

She is right.

The legislation the majority leader has brought forward will do much to ease the hardship on millions of Americans. It has benefits for those who already have insurance through their employer, with steps to rein in skyrocketing premiums and to reduce the risk of financial ruin for those who have health insurance.

In addition to helping those with private insurance, this legislation provides important benefits for seniors covered by Medicare. Medicare beneficiaries will receive free preventive care benefits, and the bill will reduce the enormous costs many seniors face when they fall into that doughnut hole, so-called, in the Medicare Part D prescription drug program. Because of these important improvements in care for seniors, AARP has recommended that Senators vote in favor of beginning debate on this bill tonight.

The legislation also contains important provisions to improve information technology in the health care sector, pushing for uniform billing practices and developing standards that will lead to the computer systems of health care providers being able to talk to the computer systems of insurance companies, reducing mountains of paperwork and other inefficiencies that drive up health insurance premiums.

Americans who move from one employer to another will no longer face the risk of being denied coverage at their new job because of a preexisting condition.

We must allow debate to begin. If we act, millions of those who already have insurance at work will benefit. If we act, millions without insurance will

get it, along with help to pay for it, so we can end the current wasteful situation in which emergency room care—vastly more expensive than primary care through a family doctor—is used for nonemergency purposes by those without health insurance.

We can only accomplish these things if we vote today to begin debate on this legislation. We can only accomplish these things if we are willing to honestly and vigorously debate the best ways to achieve it. So I urge our colleagues not to close the doors of this Chamber to debate on one of the most urgent problems Americans face. I ask our colleagues to allow the Senate to begin deliberations on health care reform and not to turn away from the opportunity and the responsibility before us.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. CORKER. Madam President, I know the time is slightly before the hour. I do not know if there are any Democrats who want to speak beyond the Senator from Michigan during this hour. With that, I think we are anxious to get going.

Madam President, I ask unanimous consent that the Republican speakers be permitted to enter into a colloquy during the time controlled by the minority, which I understand ends at 4 o'clock today. Is that correct?

The PRESIDING OFFICER. That is correct.

Without objection, it is so ordered.

Mr. CORKER. Madam President, just to make sure people who may be watching the Senate floor understand what is happening, Republican Senators took all day yesterday and today to read the bill and to actually go through sections of the bill to discuss it and make sure all of us are very familiar with the various pieces of it.

I think all of us are united in concern about the way this bill is paid for. It is hard for me to believe that anybody could suggest that taking $464 billion out of Medicare, which is insolvent, would be a way to fund a new entitlement; or that pushing down an unfunded mandate to States, which we are going to talk about in just one moment, makes any sense at all—$25 billion worth; or increasing the Medicare tax, which would not be a tax to make Medicare more solvent, but instead go to a new entitlement program—we all know Medicare is going to be insolvent by the year 2017; and to have a bill that pays for itself over 10 years by having 6 years' worth of costs against 10 years worth of revenue; and then to have something such as the CLASS Act, which I know the chairman of the Budget Committee has called a Ponzi scheme, where, in essence, you create a program that takes in premiums over a 10-year period on a new entitlement for long-term care—another new entitlement, I might add, in addition to the one we are talking about today—it takes in those premiums but bars any money from going out for 5 years. So what you have is, in essence, a collection system that creates $72 billion. So I think all of us are very concerned about how this is funded.

But today we want to talk about our tremendous concerns with the Medicaid expansion that is taking place. I am joined by a number of Senators who have had vast experience in State government and vast experience in health care.

I think the American people have now realized this bill insures, per the CBO, 31 million additional people. But the expansion that causes that to occur is that 15 million people now will be on Medicaid who are not on Medicaid. It is the largest expansion of Medicaid in U.S. history.

What we are doing to make sure this works budgetarily is we are forcing States to pick up the tab. I got an e-mail last night from my State—and I know other States are going to be talking about that, or people from other States. But last night, the State sent me an e-mail and said this was going to cost our State almost $800 million.

Our State has been well governed for years. The senior Senator from Tennessee was Governor in the middle-eighties. We have had both Republicans and Democrats who have governed our State very well. In our State, we do not expect our revenues to be back to 2008 levels until 2013. So you can imagine that our Governor, who is on the other side of the aisle, is very concerned about us here in Washington saying he has to expand his Medicaid Program. We are going to expand it around the country by 15 million people, and he has to pay for it. He is more than upset about that particular issue.

I know people here in Washington—the Washington establishment—generally speaking, are upset about the fact that States actually balance their budgets. We don't do that here, but in order to show almost disrespect for the way our States, in most cases, have to balance their budgets, what we are saying is we are going to make it more difficult on them by making sure that in order to reach a goal, we force our States, through an unfunded mandate, to cover an additional 15 million people under their Medicaid programs.

Let me just mention that I thought we were actually going to do health care reform. I know there is probably a lot of laughter taking place in the halls of this building today because I thought when we talked about health care reform, that is what we were going to do.

We know Medicaid is one of the worst programs that ever existed as it relates to health care. Let me just mention a couple stats. The Cancer Journal published that Medicaid recipients were two to three times more likely to die from the disease than people who were not on Medicaid. The American College of Cardiology in 2005 said Medicaid patients were almost 50 percent more likely to die after coronary artery bypass surgery than patients on Medicare or private pay. Forty percent of physicians in our country don't even take Medicaid. In urban areas, 50 percent of specialists have blocked patients from entering their program.

So I wish to say just this and then I will stop because I want to hear from other colleagues who have been around here for awhile. But when I was back home during August, citizen after citizen said to me: I know we are going to have health care reform. What I would like is just to have what you, Senator, have. That is what I would like to have. I know Senator BURR worked on a bill that would do that. It would create the ability for people to participate, as we do, in choice. I know Senator ALEXANDER worked with Senator WYDEN and others, and I worked with Senator BURR in the first Congress to create legislation that did that. As a matter of fact, Senator WYDEN, from the other side of the aisle, created a bill that did away with Medicaid. It gave Medicaid recipients the same kind of choice that we in the Senate have. But it seems to me, Senator REID's bill goes in exactly the opposite direction.

What it does, in order to add 31 million people to the rolls, 15 million people are being forced into Medicaid. So I would think, then, that in order to make sure we are treated just like our citizens, one of the first votes we might take is that we agree, as Senators, to be treated the way the majority of people in this program are being treated, and I assume that going on Medicaid with those same results for our families would be something we would embrace. I think all of us heard from citizens across this country that they want the same choices we have. But in the name of reform, we are going in the opposite way and, again, locking them into nonchoices, nonphysicians, bad outcomes, and going in exactly the wrong way we should be going and, to boot, making States pay for it.

There is one class of people, though, who are not treated that way in this bill. I have tremendous respect for those immigrants who have come into our country in a legal way. Let me make sure people understand that. Sometimes my southern drawl confuses people. I have tremendous respect for people who have come into this country in a legal way. The Reid bill does this. He respects them too. What the Reid bill says is, if you are born in America and you are from 100 to 133 percent of poverty, then you are barred from receiving a subsidy and are forced to be on Medicaid, but if you come into this country as a legal immigrant, you actually can receive a subsidy to purchase a private insurance policy. I find

that most interesting. I don't know if some of my other colleagues—I know Senator BURR has spent a lot of time on this.

I find this reform very troubling. I know the Senator has worked hard to give Medicaid recipients the same choice as we have. I don't know how you feel about the reform that is before us.

Mr. BURR. I thank my colleague from Tennessee. I think it is important, throughout this education of the American people of what is in 2,074 pages, to remind them that for every word in here, it costs the American taxpayer $6.8 million; for every page, $1.2 billion.

I think one has to look a little further at this reform aspect. Does this bill truly reform health care? I think as you read through the bill what you find are the words ''require,'' ''must,'' or ''shall'' 4,677 times. You find the words ''tax,'' ''fee,'' or ''revenue'' 899 times. You find the word ''agency,'' ''department,'' ''bureau,'' ''commission,'' or ''panel'' 470 times. But we are told this bill does reform health care. We are told it increases competition, it provides more choice, it stimulates innovation. Yet we find the word ''choice'' 40 times. We find the word ''innovation'' 25 times. We find the word ''competition'' 13 times.

I suspect their intent is to fix what they haven't reformed by allowing the Secretary of Health and Human Services, in 1,677 spots, to define or determine what congressional intent was. Think about that. This bill basically turns over a lot of the decisionmaking to the current or future Secretaries of Health and Human Services to decide what we meant in the Congress.

Well, my good friend from Tennessee raised a lot of things on Medicaid, and I wish to talk about Medicaid, but I also wish to mention that, once again, we are paying for this by cutting $464 billion from our Nation's seniors. That is a trust fund. They have paid in premiums. Similar to the CLASS Act—it shouldn't be a surprise to us that they are going to steal money out of the CLASS Act that hasn't even been created yet because in the bill it is taking $464 billion from seniors who have paid into it for a lifetime, and within that group of seniors, 11 million seniors are going to have their benefits cut because they chose Medicare Advantage as their preferred insurance product. It is not a question of whether they can keep what they have; they can't keep it because their benefits are going to be cut, and that affects America's low-income seniors the most.

As a matter of fact, in this bill, we fix doctor payments for 1 year. So, in 2011, doctors' reimbursements are going to be cut 23 percent. I see Dr. BARRASSO on the floor. So we know more doctors are going to stop covering Medicare beneficiaries. The pool is going to get smaller. We are going to affect every senior's health.

Mr. CORKER. In essence, Medicare will become more similar to Medicaid because of this bill. Less physicians will be covering Medicare recipients because this bill, instead of using the $464 billion to make sure physicians are paid, will leverage a new entitlement. So my assumption is, this program, unless something else happens, will become more similar to Medicaid. Medicare will become similar to Medicaid.

Mr. BURR. The Senator from Tennessee is 100 percent correct. Today, 40 percent of our Nation's physicians under Medicaid will not see patients because the reimbursements are so low.

Reform in health care means you have to eliminate cost shifting. As Dr. BARRASSO knows, cost shifting means when somebody goes in for a service, gets health care delivered, and doesn't pay or somebody goes in who is underinsured, gets delivered a service, and their reimbursement doesn't sufficiently meet the needs of the cost of that service delivered. But it doesn't stop there. Medicaid reimburses at 72 cents of every dollar of service provided. Today, for every Medicaid beneficiary in America, every time they receive a service from a doctor, a hospital, or wherever, 28 cents is shifted over to the private side to those who pay out of pocket, to those who have private insurance.

If you are reforming health care, you can't reform health care without eliminating cost shifting. Yet in this plan, we increase the rolls of Medicaid by 15 million individuals. In essence, what that means is we are going to have cost shifting on steroids now. We are going to have more cost shifting than we had before, which means a higher inflation rate on private health care, that which we pay out of pocket or that which employers, in fact, provide for their employees.

As a matter of fact, incorporated in this bill is a disincentive for small business success. I am not sure everybody has read to that point in the bill yet, but for a company that today can't afford, because of their competition to offer health care—the day they hire their 51st employee, the Federal Government will send them a tax bill of $38,250. At a time when we have 10.2 percent unemployment, 11 percent in North Carolina, small business is going to be the engine of job creation in this country, and we are saying as soon as you are successful enough that you hire the 51st person, if you don't offer the health care we tell you you have to offer, we are going to send you a tax bill of $38,250.

Unfortunately, it doesn't stop there. For the Medicaid beneficiaries, for the Medicare beneficiaries, for everybody in America where we have said drugs are too high, devices are expensive, innovation costs money, what are we going to do? We are going to tax drug companies. We are going to tax medical device companies. We are going to actually raise the cost of our ability to detect something earlier, where our options are greater and, hopefully, through having those options earlier, in fact, we are going to be able to treat a disease or cure it much cheaper.

I might add it is somewhat ironic that we are going to tax vaccines at a time when the industry is trying to meet the needs for vaccines for H1N1 across this country. This bill puts a new tax on the vaccine industry we have tried to revitalize in America.

Let me suggest to my colleagues, this is not a health care bill. This is a layaway plan. In fact, what we have been presented is a plan where they are asking Americans to pay for it for a number of years—4, to be exact—before they get their product. We are going to pay in, in taxes; we are going to pay in, in Medicare shift; we are going to begin to increase the rolls in Medicaid, to wait 4 years down the road before we get the product, before we get any benefit out of it. What we are going to find 4 years down the road is that costs change. You see, it sold as a $849 billion plan today, an $849 billion health care reform package. Well, that is not what it is. If you look at it truly over 10 years, it is a $1.2 trillion plan. If you wait to start until the benefits are paid and look at it for a real 10 years of revenue and benefits, it is a $2.5 trillion plan.

We can't even be honest enough with the American people that we tell them exactly what it is going to cost. But you would expect that out of a layaway plan, and, in fact, that is what we have in front of us.

Let me suggest to my colleagues that if you reform health care, you can have coverage expansion without additional taxpayer investment. You can't take the things that are broken in our system and actually increase their use, such as Medicaid, and expect at the end of the day you are going to be able to save money, provide a better level of care; more importantly, that you are going to have a population that gets the benefits everybody else does: a medical home, preventive care, chronic disease management. It doesn't happen in Medicaid today. It will not happen when you increase the rolls of Medicaid. It will only happen when you reform health care, and this bill does not do it.

I thank my colleague from Tennessee.

Mr. CORKER. Our colleague from North Carolina has worked extensively on this issue. I think we have a couple Senators who have some business off the floor that is very important. I think Senator BARRASSO may be one of those, and I think Senator JOHANNS is in the same boat. I know as a physician, the Senator actually knows something about health care.

Mr. BARRASSO. Twenty-five years taking care of families and the people of Wyoming. I have taken care of people on Medicaid and Medicare. We heard from Senator BURR about North Carolina and Medicaid as well as Medicare and I have concerns about both. I take care of all patients, regardless of their ability to pay. So what we know right now is that the Mayo Clinic—and the Mayo Clinic in Rochester, MN, has been held up in the Senate by our colleagues. It has been held up by the President of the United States as the model for what we should try to get to do in America for health care. The Mayo Clinic has now told Medicare and Medicaid patients they are not welcome. It has put out the sign: No vacancies for you. It is astonishing. It is hard to believe the Mayo Clinic would say: No thank you, we don't want you, but they have done that.

Mr. CORKER. So I guess if you had Medicaid, it is kind of like, in many cases, you have something that is not usable; is that correct? I know Senator ALEXANDER has spoken to an analogy in the past in that regard, but it makes it pretty difficult if you are a Medicaid recipient.

Mr. BARRASSO. As the senior Senator from Tennessee said, it is like having a bus ticket when no bus is coming. Others commented in the paper that it is like putting more people into a sinking ship.

Why would the renowned Mayo Clinic not want to see these patients? They are sending out letters saying if you are from these surrounding States—Wyoming and others in the Midwest and the Rocky Mountain West send many patients there—you cannot do it. The Mayo Clinic is able to provide the kind of care they do because they take very few Medicaid patients, they take very few Medicare patients, and they take people who have insurance. That is why we know premiums go up when more people are on Medicaid. There are actually two hospitals in Rochester, MN—Mayo Clinic, where 5 percent of their patients are on Medicaid. At the neighbor hospital in the same community, it is 29 percent of their patients.

The hospitals in Tennessee cannot take everybody out of town. We have to take care of those people. When reimbursement is so low by the Federal Government, which is the biggest deadbeat payer in the world when it comes to health care—the deadbeat Federal Government pays so little, the Mayo Clinic wants nothing to do with them. That is why they came out against these proposals.

Harvard Medical School gave these proposals a failing grade and said people who support these are collectively in denial, because they know we are looking at a health care bill that will raise the cost of care, to be paid for by raising taxes and cutting Medicare for seniors. Our seniors on Medicare cannot even get into the Mayo Clinic. It is fascinating. Mayo set up a branch in Arizona. They say they will no longer accept Medicare for patients seeking primary care at its facility in Arizona: We don't want them. No vacancies for you. If you want to come in, you have to pay additional fees—a $250 annual fee plus anywhere from $174 to $400 a visit if you are on Medicare.

Mr. CORKER. I assume that by the Reid plan taking $464 billion out of Medicare savings and not using that money to deal with this huge doc fix issue—the fact that physicians are going to have a 23-percent cut in a year, they are not dealing with that. I know it costs about $247 billion to keep them whole. I assume that would keep many physicians, such as the Senator's former colleagues from—it would cause them to drop Medicare recipients, is that correct?

(Mr. LEVIN assumed the Chair.)

Mr. BARRASSO. It will absolutely prevent new Medicare and Medicaid patients from getting in. The Medicare cuts will prevent doctors from taking new patients and may cause them to drop others. The concerns are so large, and the concerns aren't just for the doctors. I am concerned for the people in Wyoming, who depend upon Medicare for health care. I know the Senator is concerned for them in Tennessee. How will they get the care they need? More people are coming of Medicare age every day.

This big bill, this monstrosity, will cut close to $500 billion from people who depend on Medicare for their care. The American people—those watching—need this care. But this takes it away to start a whole new government program. It is not fixing the program that is going broke already.

So the hard reality is—and I think the spokesperson for the Mayo Clinic said it well. She said that ''it simply is the reality of the health care business and how we are going to be able to continue our mission when these payments are so far below what it costs to provide the care.''

You are not even talking about staying open, keeping the doors open, breaking even. The reimbursements are so far below what it even costs the Mayo Clinic—the model being held up by Senators on the other side of the aisle—so far below what it costs them to provide care. So as we look at this and say how can we take care of and help the people of America get health care, quality care, what we need to do is be aimed at driving down the cost of care. This means an increase of the cost of care and premiums. They are going to do it by raising taxes, and everybody will be affected. The Senator from North Carolina, a State with an incredible background in technology and advances in medical devices—anything that taxes them will be passed on to everybody, regardless of income level. Every patient in America will suffer. The Mayo Clinic—the world-renowned Mayo Clinic, where anybody in America would like to go for their care—I heard the Senator from Tennessee say, in addition to what the Senator from North Carolina said, that people in his State want to have the same level of care you would have. We would all want that. The Mayo Clinic says if you are on Medicare or Medicaid, like many of the other States, don't come here, because we cannot afford to have you, because Washington—the biggest deadbeat payer of all time—isn't paying enough to keep our doors open.

Mr. CORKER. I know to the people in Tennessee this doesn't pass the commonsense test—a whole new entitlement when we cannot take care of the ones we have. I know the people in Wyoming are also that way. The people in Tennessee know this bill will cause the private insurance they now have to go up, which is exactly the opposite effect Americans want. We have a former Governor here, who has important business off the floor in a minute. He has run their Medicaid Program. He wants to speak to this issue. I thank the doctor, Senator BARRASSO, somebody who actually knows about health care, for being here to talk about this issue.

Mr. JOHANNS. I thank Senator CORKER on behalf of not only myself but the folks back home in Nebraska for giving me a few minutes today, and I also thank Dr. BARRASSO. When he talks, I want to listen. I am so tempted to yield my time to him because he is so knowledgeable in this area. I do have a few things I want to say.

It occurs to me that after the vote tonight, what we should do is declare a recess for 2 weeks. We should take this bill out across our States and listen to the people. We should listen to the doctors, like Dr. BARRASSO, who are on the front lines every day. We should listen to the nurses and hospital administrators and say: What do you think? I think we would get an earful.

I did four townhall meetings during the short recess around Veterans Day on health care issues. I have been all over the State of Nebraska. Let me tell you a story—and every single Senator can tell this same story. I visited a small hospital in our State, the critical access hospital—and Dr. BARRASSO is familiar with these. Under Federal law, these hospitals are 25 beds or under. They are in our small communities, not only in Nebraska but all across America. They have no margin for error, because all they do is hospital services. They don't have an exercise program or whatever. It is hospital care they provide. I asked the same questions to those doctors and administrators. I would say: Let me ask you, first, could you run this hospital and

keep it open on Medicaid reimbursements? It was 100 percent unanimous: We would go broke.

I asked a second question: Could you keep this hospital open on Medicaid and Medicare reimbursements? It was 100 percent unanimous. They say: No, we would go broke.

What does this bill do? It expands Medicaid. Fifteen million people will be added to Medicaid—the largest single expansion in Medicaid in the program's history. Nearly half of the reduction of the uninsured in this bill is due to moving people onto Medicaid, a program that if you had to live on those reimbursements, and you were a critical access hospital, you would close your doors. That is shocking to me. Who were they listening to when they wrote this bill? Why can't we take these staff people, who have been holed up in the majority leader's office for 6 weeks, to Nebraska or Wyoming or Oklahoma or Tennessee or Texas? It makes no sense to me.

I came here saying I was going to work to solve real problems for real people. We say that a lot out there. Let me give you a real people perspective about my State. Again, every Senator can tell this story. I was in a beautiful little community hospital—a critical access hospital, with 25 beds or less—in Valentine, NE, in a beautiful part of our State along the northern tier. It is a beautiful area, the Niobrara River Valley. There are great people there. It is off the interstate. It is a beautiful part of our country. Pick up a Nebraska map, because when I say this—if you look at the map, it will bring home what I am talking about. Between Chadron, NE, in the northwest part of the State, and O'Neill, NE, closer to the north central part of the State, lies Valentine. That little hospital in Valentine is the only hospital in that northern area that is providing deliveries for babies.

When you pass this bill and you expand Medicaid that they can't live on, and the reimbursement rates are disastrous for them—if you mess around with that hospital's ability to deliver babies, you have a crisis in the northern part of my State. You can tell that story over and over.

I wanted to talk about this last thing, and I will do it quickly, because other colleagues want to speak. As a former Governor, I dealt with Medicaid to try to balance the budget. I was the Governor in Nebraska post-9/11, when our economy and the Nation's economy tanked. We had to cut budgets over and over. My State of Nebraska just finished a special session. They cut about $300 million from the State budget. Four hundred people, the Associated Press reported, will lose their jobs because of these very difficult budget decisions.

Here is the point I want to make: When this is fully in effect, we will drop into the States—my State included—billions of dollars worth of unfunded mandates for Medicaid—billions of dollars in a program where already 35 to 40 percent of our doctors cannot afford to take Medicaid patients, and they are saying: We would go broke if we had to. We are adding insult to injury by telling our Governors they have to figure out that in addition to the historic problems they are having with their budgets, they have to deal with an unfunded mandate. In a moment of candor, one of my colleagues who worked on this for years said something when I asked: Why Medicaid? It is so problematic. Why all these millions on Medicaid? In a moment of candor he said to me: Because it makes the score look better.

Mr. CORKER. Yes, it is the cheapest route for us and the most expensive way for the States. This has been mostly about moving money around. I have not seen a lot in here that has a lot to do with reform. I appreciate the comments about Medicaid and what it will do to your State. After having been a Governor, I know that Dr. COBURN, the Senator from Oklahoma, is here, and we have the Senator from Texas, who has been highly involved in every health care meeting we have had. Senator HATCH helped create SCHIP years ago. I think he knows that in this bill not only is there an unfunded mandate for Medicaid, not only are there taxes and Ponzi schemes, such as the CLASS Act, that have been put together, it doesn't fund an existing program such as SCHIP. That is another huge burden of $40 billion or $50 billion. I don't know if Senator ALEXANDER wants to speak to that. I thank Senator JOHANNS for being here. I know he has a meeting off the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. I express my gratitude to the Senator from Tennessee for leading this important discussion on Medicaid. If I can pull back for a moment, I think it is important because this is such a complex subject, as we can see from this 2,074-page bill. We need to define our terms. Medicaid, obviously, is a program for low-income people, shared by our State and Federal Governments. Medicare is for seniors, paid for entirely by the Federal trust fund, $38 trillion in unfunded federal liabilities to two entitlement programs, both of which are in terrible financial shape. Rather than make this better, this bill makes it worse. I will describe very quickly how in my State of Texas. I have watched on C–SPAN and on the floor Senators come here and say tonight we are having merely a procedural vote on whether to proceed to the debate.

I thought we had been having a debate about health care reform for the last year or so. I point out that under the Senate rules, we will not be able to change one period, one comma, one sentence, one part of this bill unless we can get 60 votes to do so. So the increase in premiums, the taxes on small businesses and the middle class, the cuts in Medicare, this expansion of Medicaid—all of these are a fait accompli unless 60 Senators vote to change it. That is under the rules of the Senate.

It is not true, in my humble opinion, that people can come in here and say: We are going to vote yes to proceed tonight at 8 o'clock, but it doesn't make any difference, the debate is just beginning. Not so.

I again thank the Senator from Tennessee for raising this concern. Both of our Tennessee colleagues have been in the forefront of discussing this issue.

I think this is shameful. The expansion of Medicaid in this bill to cover 60 million Americans is shameful. It consigns people to a health care gulag which they cannot get out of, where they get bad outcomes in terms of their health care, where they cannot find doctors who will treat them at the low rates paid for by Medicaid, and it bankrupts our States.

The Medicaid officials in Texas have told me, after their preliminary review of this 2,074-page bill, it will cost Texas taxpayers, in addition to their Federal liability, $20 billion over the next 10 years.

Our friends who have been Governors have told us, as Governors and as State legislators, they have to make terribly hard choices. But when the Federal Government imposes an unfunded mandate on the States to pick up $20 billion over the next 10 years, what does that do to our ability to do other things, such as law enforcement, higher education, and the like? It shoves those to the side because the Federal Government is going to jam this down the States' throats—another unfunded mandate—and it disrupts those States, as the Senator says, that are operating on balanced budgets. They do not have the luxury of printing money like the Federal Government.

Mr. CORKER. Mr. President, did the Senator from Texas see this weekend where college students in California were having public protests about the huge increase in tuition out there? Yet here we are getting ready to pass something that is going to drive that up even more because the State of California will have to cover more Medicaid recipients without the money being provided. So this is going to exacerbate that situation. I don't know if the Senator saw it this weekend.

Mr. CORNYN. The Senator is correct. It is a 32-percent increase in fees and tuition, and that is in California alone, which is bankrupt already. This is the direct result of the irresponsibility coming out of Washington, DC, forcing more costs on them.

I know there are other colleagues who want to talk about this topic, and

I want to have this continued conversation. I think this is a good format for parsing what is in this bill.

Let me mention one anecdote in Dallas, TX. If you are a Medicaid recipient, or a low-income child or beneficiary in Dallas, TX, only 38.6 percent of the doctors will see a new Medicaid patient—38.6 percent. In other words, 61 percent will have restricted access to Medicaid because, as the Senator from Tennessee and the Senator from Wyoming pointed out, it only pays about 72 percent of what a private insurance policy would cover.

Mr. President, 85 percent of Americans have private insurance, and they pretty much like what they have. They think it costs too much, and we agree. We want to help them bring down that cost. But we have these safety net programs which, frankly, do a lousy job. They promise coverage, but they deny access because of low reimbursement rates.

Let me give an anecdote of what this means to 6-year-old Ruth Guerra in Dallas, TX. I took this article from the Dallas Morning News, dated June 3. It says:

When Ruth Guerra, 6, tries to write, holding the pencil puts just enough pressure on her left pinky to make it bleed. With her condition, if she falls down while playing or a classmate accidentally brushes against her, she bleeds.

Last week [her mother] Sandra Ramirez . . . took time off from her hourly job at the Dollar General after another one of Ruth's bleeding episodes.

Unfortunately, because she qualifies for Medicaid—and while people in Washington say: Isn't it great; we are going to give 60 million people Medicaid—what it means for Ruth Guerra is that she has to wait 6 months to get an appointment with a doctor who will actually see her. That is what I mean when I say this bill consigns 60 million people to a health care gulag they cannot get out of.

I agree with the Senator from Tennessee. We need to provide the American people with choices that Members of Congress have, among an array of choices. What this does with the mandates, with the force-feeding Medicaid on people such as Ruth Guerra and on the States, along with the huge budget deficits that are going to come from it is shameful.

Mr. CORKER. I thank the Senator for his contributions, being down here on a Saturday on a very important issue. I know Senator COBURN is here. Senator ALEXANDER is here. I don't know what order they may want to speak. It looks like it is Dr. COBURN.

Again, each Monday, typically in his State, he is actually seeing patients. He knows something about Medicaid. He knows something about health care. Many of the reforms he put forth would give people a choice, low-income citizens a choice like we have. But, instead, this bill confines them to Medicaid. I know he is going to talk about that.

I thank the doctor very much for being here.

Mr. COBURN. Mr. President, I thank Senator CORKER.

I have had the distinct pleasure of delivering over 2,500 babies for Medicaid insurance and taking care of their children. These are wonderful folks. I didn't do any differential between Medicaid and private insurance in my practice, but most of my colleagues did.

The heartbreaking part about Medicaid is that when you have a sick child who needs a specialist, you cannot get one. You just cannot get one. You say: Why can't you? Do they not care? Yes, they care. But you know what. Because of the Medicaid reimbursement for pediatric subspecialities—pediatric cardiologists, pediatric oncologists, pediatric hematologists—there are not any.

We only have two pediatric cardiologists in the city of Tulsa serving 1.9 million people. Try to get an appointment for a Medicaid patient there. I can hardly get a regular one. How did that happen? The reason we have a shortage of pediatric subspecialities is directly related to the Medicaid system in this country because the reimbursement is so low that you cannot afford to have a high percentage of Medicaid patients in your practice and still pay your bills.

So what consequently has happened is doctors do not go into pediatrics, and then they do not go into the subspecialities of pediatrics. So I end up having 8-month-old children seen by adult cardiologists or adult hematologists because there is no available doctor to see them because we have created a system through the substandard reimbursement of Medicaid that has directed people coming out of medical school away from that speciality.

As a matter of fact, last year, if you take all the medical students who graduated from medical college, whether it is osteopaths or allopaths, M.D.s or D.O.s, 1 in 50 went into primary care. That is general internal medicine, family practice, or pediatrics, only 1 in 50.

We have 50 million baby boomers going to hit Medicare in the next 7½ years, and we are not going to have the primary care doctors there to take care of them. The reason is because through government programs, we have incentivized doctors not to do primary care. Consequently, we don't get there.

The other point I will tell you is that if you look at perinatal mortality rates in our population across the country, it is, No. 1, directly related more to poverty than it is to anything else. But the second most important factor is that if you are in Medicaid, you are twice as likely to have a perinatal mortality event—in other words, your child dies after childbirth—than if you are in private insurance. It doesn't matter what your culture is. If you are poor, but you have private insurance, the likelihood your baby is going to do better is greater.

Think about that: a promise we are going to give you care, but the result of the care is going to be less good. We are going to give you care, but it is not as good care, and it is not available care. We are going to make you wait in line, but we are going to call it care.

Care delayed is care denied. Let me say that again. Care delayed is care denied. If, in fact, you have a problem that needs attention, and you cannot get what you need, it does not matter what Medicaid does if you cannot get treatment.

If you look at the subspecialities in Medicaid, 65 percent of them do not see Medicaid patients. We have about 40 percent in primary care who will not see a Medicaid patient. We have about 65 percent of the specialities, because there is such a shortage in the specialities, that what we are saying is we are going to have 60 million people in a system that says: You get care, but guess what. It is not available; you are on Medicaid.

Senator WYDEN did offer a plan, I say to Senator CORKER, that would put every Medicaid patient in this country, except dual eligibles, into private insurance. So did we with the Patients' Choice Act, the first bill introduced on our side of the aisle. We take the stigma off saying you have a low-paying plan, and we give them the same kind of insurance we have right here in this body. By doing it, we save the States $1 trillion over the next 10 years. Think about that.

But that isn't nearly as important as we have a major increase in the positive outcomes for Medicaid patients. You cannot talk about Medicaid without talking about Indian health care because as you add up Medicaid to Medicare to TRICARE to VA to Indian health care, when you add all that up, the government is running 61 percent of our health care right now. No wonder we are in trouble.

I do not deny there are big problems with the insurance industry. I do not deny we need a Patients' Bill of Rights that protects people's rights and their interests. I do not deny we need transparency in the insurance industry both on price and quality. I do not deny anything.

The question we ought to ask is, if we are going to truly reform health care, are we going to allow everybody, when they say they have health care, no matter where they get it, to have an equal shot at getting equal care?

You see, this bill does not do that. This bill puts Medicaid patients in jail and says: If you happen to be lucky enough, the lucky 60 percent to get into the line, you will be OK. And if you need a subspecialty, if you happen

to be part of the lucky 35 percent, you will be OK. But everybody else is in jail. You are in monopoly jail. We are promising—the government—to do that.

A final point—and then I will yield so others can talk—is the idea that my State—Texas is a big State. It is our southern neighbor. They sometimes have a better football team than we do. They certainly did this year. We are about one-eighth the size of Texas in terms of population. We cannot afford $2.8 billion over the next 10 years, I say to Senator CORNYN. We are going to say we are going to cover 15 million people and some of those will be in Oklahoma. We cannot afford it.

What we can afford is to insure them if we make true changes in care, if we truly change and incentivize preventive care, management of chronic disease—if we truly reform health care. These bills do not reform health care. What they do is grow government.

They are not going to change outcomes, other than except they are going to limit what you can and cannot do through cost-effective comparativeness.

As we look at this bill, what we need to do is think about those we are going to promise something we are not going to deliver. We are going to call it a system, but they are not going to have it available.

I thank Senator CORKER for leading this discussion, and I yield.

Mr. CORKER. I thank Dr. COBURN. As I listen to him, I realize we have a health care reform bill before us where half the money, $460 billion, is taken from a program that is insolvent. Instead of making it more solvent—a program that would take $38.6 trillion in the bank today, earning Treasury rates to make it solvent—it is a pretty big number—we are taking $½ trillion out of that program to leverage a new entitlement. The reform we are getting out of that is we are moving half the folks into a program that not a person in this body would want to be a part of; is that correct?

Mr. COBURN. That is correct.

Mr. CORKER. That is not the kind of health care reform I thought we were going to be doing. I am shocked. As a matter of fact, as I said many times, I don't think there is a person on the other side of the aisle who would vote for this bill if you and I offered it; do you think that?

Mr. COBURN. Probably not. But the Senator sparks one question. Think about this, and I have experienced this as a physician.

I care for patients and they lose their job, they have a financial catastrophe, and all of a sudden they become dependent on Medicaid. We continue to see those patients. But do you know what normally happens? You lose your insurance, you loss your job, you come on hard times and go on Medicaid. You can't go back to the doctor you had before because they are not taking new Medicaid patients. So somebody you have been with for 15 years, all of a sudden you can't get back in because they are not going to pay enough for them to care for you. It is a discriminatory system that says we will send you down the line.

That doesn't mean there are not truly caring physicians in this country, but it has to be said, outside of pediatrics, if you want to look at quality parameters, the Medicaid population ends up going to the less-qualified, the less-experienced, the less-good-outcome physicians in this country.

Mr. CORKER. I thank the doctor. It is so good to hear from somebody who has dealt, year after year, with Medicaid recipients with his compassion.

Senator HATCH from Utah, I don't think there is a person in this body on this side of the aisle who has spent more time trying to make sure the poor children of our country have health care. No one has done that. I know he is here to speak today about this huge Medicaid expansion. I thank the Senator for the leadership he has shown in this body for years, ensuring that young children in this country have appropriate health care.

Mr. HATCH. I thank my colleague for leading out here, talking about this very important issue. You and your senior colleague from Tennessee are great Senators and mean a lot to all of us.

It is funny to me that the people in this body don't listen to the only two doctors in the body, and both of them are excellent physicians. Both of them are concerned about people. Both of them make such cogent arguments in the field of health care. I think we have had a very good argument by Senator COBURN, from Oklahoma—one of our two doctors in the Senate.

Senator BARRASSO is an orthopedist, a specialist. He has come here to fight for the causes he believes to be right. He knows what is trying to be put off on America today is not right.

Our States are facing a historic deficit of more than $200 billion right now. Yes; that is what our States are facing right now without this bill. One of the biggest drivers behind this is the Medicaid Program, which takes up an increasing share of our States' budgets across the country.

The Senate bill, which is nothing more than a 2,074-page takeover by Washington of our health care system, calls for the biggest Medicaid expansion ever—133 percent of the Federal poverty level. That is 150 percent in the House bill, if we pass that monstrosity.

My home State of Utah only allows Medicaid coverage of up to 133 percent of the Federal poverty level for infants, children under the age of 5, and pregnant women. Other categories of citizens are, however, covered at different levels. For example, nonworking parents are only covered up to 48 percent of the Federal poverty level.

This bill will now massively expand the level of Medicaid coverage to 133 percent for everyone. Who is going to pay for that? Our colleagues say the Federal Government will. What are they going to pay for it with? We are running the Federal Government right into bankruptcy. It is ultimately going to be the responsibility of the States and the States can't do it. Think of New York, New Jersey, California, just to mention three. Let's not forget that the House has already passed a Medicaid expansion of 150 percent of the Federal poverty level. The Congressional Budget Office estimates this massive entitlement expansion will cost States an additional $25 billion over the next 10 years.

You heard me right, $25 billion more. That is over the next 10 years.

However, if history has taught us anything about the way things work in Washington, I believe this number is actually a huge underestimation and the real impact on our States will be much higher. I would like to read the following excerpt from a letter sent to me by Governor Herbert, our Governor in the great State of Utah, and what this Medicaid expansion would mean for my State. It is a quote. This is what my Governor has to say:

> As I am sure you know, Utah, like most other states, is suffering from the negative impacts of nationwide recession. As we prepare the state's fiscal year 2011 budget, we face continued cuts to agency budgets and reduced government services on top of painful reductions made last year. The unfunded mandate of a forced Medicaid expansion will only exacerbate an already dire situation. If required to increase our Medicaid program as envisioned in Washington, Utah, and most every other state, will be forced to find the money to do so through other means. This will require states to either raise taxes or continue to cut budgets in areas currently suffering from a lack of funding, such as public and higher education.

We are seeing a real life example of this in California right now. Faced with a mounting State budget crises, we recently saw that the State-run University of California system had to hike its tuition rates by 32 percent—32 percent!

I don't know about anyone else, but I will not allow this to happen in my home State of Utah just because Washington thinks it is a good idea to keep expanding government programs on the back of our States.

Here is the reality that our States are facing:

Unemployment rates rose in 29 States in October. A significant number of States are facing unemployment rates much, much higher than our national rate of 10.2 percent—the highest in 26 years: Michigan, 15.2 percent; Nevada, 13 percent; Rhode Island, 12.9 percent; California, 12.5 percent. In fact, California, Florida, Delaware and

Washington, DC, posted their highest unemployment rates since 1976.

The last thing we need right now is for Washington to impose more liability on the states.

This alone should be a reason enough for every Senator to stop and rethink their decision about letting this ''tax and spend'' bill move forward.

But I have to tell you, I know what is behind all this. Ever since I have been here, there has been a push to have more and more people moved into Medicaid. Why is that? Because if they can push more and more people into Medicaid, then ultimately we will have a single-payer system—in other words, socialized medicine in this country, where the government will control everything. That is what is behind a lot of this bill.

I have to tell you, what bothered me an awful lot about this bill is that even the CBO Director, whom I find to be an honorable, honest man, Dr. Elmendorf, he said that if we go to a government plan—which is a hallmark of what our friends on the other side want to do—then you could have almost 10 million people going into that plan. However, if you look at the Lewin Group study, they say if you go to a government plan, we could have 119.1 million people going into the new plan.

What is it going to be, the 10 million or the 119.1 million? I guarantee it is going to be a lot closer to the 119.1 million than it will be to the 10 million.

Our friends on the other side started criticizing the Lewin Group after this report. They have quoted them for years before this report. Now that they don't agree with our colleagues on the other side, they think it will only be 10 million. Don't kid yourselves. If you had to choose between the 10 and the 119 million, you know doggone well it will be closer to the 119.

If we move millions of more people over from private insurance into government health care, I can't tell you the pressure that will be on America, the pressure that will be on the health care professionals.

We heard from one of the great doctors in this body, whom we ought to listen to, that we can't get the primary care people to take care of people now on Medicaid, let alone adding millions more under this expansion.

I thank my colleague from Tennessee for his leadership on this. I am happy to be here to say a few things about it because I have spent a lifetime working on health care issues. Before I ever got here, I actually tried medical liability and defense cases, defending doctors, nurses, hospitals, health care providers. I know what these costs are. They are just beginning to explode.

If this bill passes, it is going to be an explosion of health care costs such as we never dreamed possible.

I am very concerned about this. It is all driven by a desire to get, right here in Washington, control over all of our health care. If we do that, we deserve the problems we are going to have.

I thank my colleagues for the great work they are doing.

Mr. CORKER. I thank the Senator very much for coming. No one in this body knows more about what is happening in public programs than he. We heard for the last 55 minutes from the Senators from Texas, Oklahoma, Wyoming, Utah, North Carolina, Nebraska. I can't think of a better person to close us out this afternoon than the distinguished Senator from Tennessee. I am fortunate to serve with this Senator. He was a Governor, an education Secretary. He knows what he is talking about. I am proud the senior Senator from Tennessee is going to close us out on what I think has been an outstanding hour on the floor.

Mr. ALEXANDER. Mr. President, for those who are watching, Republican Senators are reading through the bill, reading the bill in its entirety. It is kind of like reading the entire New Testament in Greek. It is better to have somebody help interpret it. We have been talking about page 396, title II, subtitle A, section 2001, which expands Medicaid. We have heard eloquent statements about how moving 15 million low-income Americans into a program called Medicaid, which is a medical ghetto, is not health care reform. We have also heard Senator after Senator say what right do we have to expand Medicaid and tell the States that you are going to pay for it. What kind of arrogance do we have to say that to States that are in their worst fiscal condition since the Depression?

The Reid bill requires states to expand Medicaid eligibility to cover all persons under 133 percent of poverty, which means those earning about $14,000 per year for an individual and about $29,000 per year for a family. Individuals who are not otherwise covered by an employer-sponsored insurance would not be eligible for tax credits. In effect, every American below 133 percent of poverty would be locked into Medicaid which is like confining them to a medical ghetto. With this bill we are on path to expand the largest ''public option'' we already have, Medicaid, and it could bankrupt the States, because they will be paying for it. As the former Governor of Tennessee, I do not see how Tennessee can pay for their part of the Medicaid expansion included in Senator REID's health care bill without a new income tax, or seriously damaging higher education by raising tuition like California just did, or both.

I am opposed to this expansion of Medicaid, which, according to the CBO, would cost States an additional $25 billion, and add 15 million people to the Medicaid Program. This would be the largest single expansion of Medicaid in the program's history. Why? Because nearly half of the reduction of the uninsured in the Reid health care bill is due to people moving into the government-run program that is Medicaid.

Expanding Medicaid to cover uninsured individuals is a terrible vehicle for health care reform, because dumping this many more people into that program will increase problems for beneficiaries getting access to care and for maintaining quality. Plus the program is already riddled with fraud and abuse; this would just invite more of that. Most Governors are struggling with Medicaid in its current form, and they agree that expansion is a bad idea. This includes Democratic Governors.

Tennessee's Medicaid Program is called TennCare. The Tennessean from Thursday printed an article that reports how ''People covered by TennCare may face new limits on their coverage and reductions in their benefits next year, under a plan unveiled Wednesday to help slice state spending.'' The article continues, ''The limits are meant to help TennCare, the State's Medicaid program for the poor, pregnant women and children, meet Govenor Phil Bredesen's goal of reducing spending by most State agencies by as much as 9 percent as the State deals with a shortfall in tax receipts that could reach as much as $1.5 billion over the next two fiscal years.''

If the Reid health care bill is passed, TennCare might introduce a $10,000 annual cap on hospital coverage for the 1.2 million enrollees. Additionally, they might also eliminate coverage for occupational, speech and physical therapy, and limit enrollees to no more than 15 outpatient procedures and 15 lab procedures in a year. This past Sunday, the Tennessean ran another story titled, ''Bredesen faces painful choices as TN begins budget triage'' which states ''there is no quarrel with the general position that Tennessee State Government faces a grim situation'' and the Governor anticipates that roughly $750 million in cuts will be needed for the next fiscal year. To make matters worse ''state tax collections are already $101.3 million less than assumed when this year's budget was enacted.''

Another article from the Tennessean reported that the State ''might release as many as 4,000 non-violent felons, possibly even including people convicted of drug dealing or robbery, under a plan outlined Monday by the Department of Corrections to deal with the state's budget crisis,'' and Tennessee is not alone in its budget crisis. Even though many States are going through budget crises much like Tennessee, Senator REID has proposed to as even more costs onto these States. Earlier this month, the National Governors Association released a fiscal survey of the States and an accompanying release, ''The State Fiscal Situation: The Lost Decade.''

That report said:

The recent economic downturn started in December 2007 and likely ended in August or September 2009, making it one of the deepest and longest since the Great Depression.

It went on to say:

Medicaid spending, which is about 22 percent of state budgets, averaged 7.9 percent growth in FY 2009, its highest rate since the end of the last downturn six years ago. Medicaid enrollment is also spiking, with projected growth of 6.6 percent in FY 2010 compared with 5.4 percent in 2009.

We don't yet have an estimate from Tennessee of how much Senator REID's bill will cost the state, but we expect it to be in the ballpark of what the Senate Finance bill would have cost, which according to Governor Bredesen would have cost an additional $735 million over 5 years. Tennessee can't afford to get a $735 million bill from Washington. Not only is it wrong to ask states to pay for expanding this program, but I think it is wrong to dump low-income Americans into a government-run program that is failing.

Medicaid is a program that, if given the choice, none of us would join. A 2002 Medicare Payment Advisory Committee survey found that ''approximately 40 percent of physicians restricted access for Medicaid patients,'' meaning they won't take new Medicaid patients, because reimbursement rates are so low. Only about half of U.S. physicians accept new Medicaid patients, and yet this is how the majority leader proposes we cover the uninsured.

Why is there such an access problem for people on Medicaid? It is because Medicaid reimbursement rates to doctors and hospitals are so low. Medicare pays 80 percent of what the private insurers pay and Medicaid pays about 72 percent of what Medicare pays. Which means if you are a doctor or a clinic, or a hospital, you get paid about 60 percent for serving a Medicaid patient versus one of us who has his or her private health care. You can see why this spells trouble, and the Senate bill does nothing to fix this problem. In fact, by dumping 15 million more people into the program it will only make things worse. Who would want to be one of those 15 million people?

In addition to access problems, the quality of care for Medicaid patients is significantly lower than those with private insurance, and even those with no insurance. According to a survey by the National Hospital Ambulatory Medical Care, Medicaid patients visit the emergency room at nearly twice the rate of uninsured patients, and a 2007 study published in the Journal of the American Medical Association found that patients enrolled in Medicaid were less likely to achieve good blood pressure control, receive breast cancer screening, or have timely prenatal care than similar patients enrolled in private plans. Another study of cancer patient outcomes found that even after adjusting for patients who became eligible as a result of their cancer diagnosis, Medicaid patients have significantly lower survival rates than non-Medicaid patients.

The final example I will give today of why dumping 15 million more people into Medicaid is such a bad idea comes from the Government Accountability Office, GAO. The GAO has determined that the program is plagued by fraud and abuse. In 2009, the GAO labeled Medicaid as a ''high-risk'' program, finding $32.7 billion in improper payments in 2007 alone. That is 10 percent of the program's total spending.

As a former Governor, I am particularly concerned about the impact and expansion of Medicaid would have on the State budgets and the resulting squeeze on higher education spending. When a governor looks at his budget and sees the things he has to pay for like elementary and secondary education, prisons, roads, and Medicaid. Then a Governor looks at the things they want to spend money on like higher education and a Governor, knowing they have to balance their budgets every year, can't spend money he or she doesn't have, so something has to give, and it's usually higher education. As I noted earlier, the New York Times reported Friday that the University of California Board of Regents will raise undergraduate fees 32 percent by next fall to make up for steep cuts in state funding. The article goes on to report that ''The University of California now receives only half as much support from the state, per student, as it did in 1990. Even with the higher student fees, the system needs a $913 million increase in state financing next year to avoid further [budget] cuts.''

From 2000 to 2006, spending by State governments on Medicaid has risen 62.6 percent, because of that higher Medicaid spending; higher education has only seen an increase of 17.1 percent over the same time period. As a result, tuition at a public 4 year university has risen an average of 63.4 percent. So Congress passes a generous Medicaid benefit, and the governors have to pay the bills. Then the governor has to say to our college students: your turn, pay up. Expanding Medicaid is exactly the opposite of real health care reform.

Senator CORKER, you were the chief financial officer of the State of Tennessee. You were the mayor of Chattanooga. How would you like it if someone in Washington passes a program and sends you the bill?

Mr. CORKER. I would be losing a lot of sleep right now. I know people all across the country who have to act responsibly, unlike us, are losing sleep over what we are getting ready to do to States across the country.

Is the Senator finished? Is that the point?

Mr. ALEXANDER. I think we are out of time.

The PRESIDING OFFICER. The Senator has 25 seconds remaining.

Mr. ALEXANDER. The Governor of Tennessee, who is a Democratic Governor, has estimated that the cost to our State of this bill, of moving 15 million Americans into this medical ghetto, is about $800 million over 5 years. In my view, finding that much money would seriously damage higher education, raise tuition in Tennessee like California's, which just went up, or require us to enact a new State income tax, or all of those things at once.

I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. I ask unanimous consent the next hour of Democratic time be controlled as follows: 10 minutes under the control of SCHUMER, with the remaining 50 minutes of time available for various Democratic Members to engage in colloquies.

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

Mr. SCHUMER. Mr. President, today we stand at a crossroad. We can continue to turn a blind eye to the very real, very dangerous threat burgeoning health care costs pose to our economic future or we can choose the path to restoring economic opportunity in this country by tackling what my dear friend, Ted Kennedy, called the ''great unfinished business of our society.''

As so often is the case at any major crossroads in our history, embarking on what we all know is the right path is difficult. Indeed, this is the single most difficult undertaking I have ever seen in my 30-year career as a legislator. But my colleagues and I know what has to be done. Tonight is only one step down the road. There will be more procedural hurdles, more disagreements, more pressure from our opponents, more television ads, and many amendments. But I have no doubt we will pass this bill.

There have been many attempts over many decades in many Congresses to reform health care. This time, moral and economic necessity will guide us over the finish line. It is unacceptable that in this country—the wealthiest, greatest country in the world—there are Americans who are forced to choose between their health care and rent, between their health care and food, between their health care and an education. But there are. And there are too many of them, and that must change.

Consider these facts: Health care costs are out of control. Premiums for New York families have doubled in the last decade. Premiums have risen far in excess of inflation while median income has remained stagnant. Costs have risen so much that more than 20 million Americans have skipped a doctor's visit for no reason other than cost and 23 million Americans have premiums so high they consume $1 out of

every $8 earned. Health care costs now account for a staggering 16 percent of our GDP, far more than any other industrialized country in the world. For every dollar a small business in the United States spends on health care, its foreign competitors spend a mere 63 cents. Yet the health care of the U.S. workforce lags behind all other industrialized countries. Plain and simple, our small businesses will no longer be able to compete unless we act to reform health care.

Even among those Americans fortunate enough to have coverage, nearly 88 million don't have health care they can rely on. That is half of all Americans age 18 to 64 and their families. And 46 million of these Americans have a serious preexisting condition that has made it harder or more expensive for them to get coverage. In addition, 37 million of these Americans had a gap in their coverage during the last year.

Our health care system is holding our economy hostage. The entrepreneur in Binghamton who does not take a chance, who does not leave a job to start his own firm because he is afraid of losing his family's health care; the college graduate in Oswego, days away from losing her parents' coverage, takes a job because it provides health care, even though that health care eats up a quarter of her paycheck—each of these individuals who limit their potential because they are concerned about their health care should inspire action among all of us.

Passing this bill is an economic imperative. The broken system we have is not only a burden on the present, it is a tax on the future. Every day we do not act to fix the health care system is a day that handcuffs our economy. It drains it of productive workers who do not treat illness. It drains businesses of money they could otherwise use to innovate and outperform their foreign competitors, and it drains it of savings and wealth that every American should have in retirement as a reward for a lifetime of hard work.

Inaction is not an option. The consequences of failure are simply too high. Premiums will climb higher, benefits will erode further, businesses will buckle under the cost of insurance, and Medicare will go bankrupt. Yet our Republican colleagues would rather see us fail. At every turn, they have obstructed our path with procedural delays, with calculated misinformation, and sometimes with outright falsehood. I am amazed they are against a government health care plan, but they want to protect Medicare. Medicare is a government health care plan. You can't have it both ways.

Yet when Democrats move to protect consumers from insurance company abuses, Republicans fight to allow these companies to drop, deny, or limit coverage for the people who need it most. When Democrats tackle waste, fraud, and abuse in our health care system, Republicans cry foul to preserve the status quo. When Democrats fight to protect and strengthen Medicare for future generations, Republicans try to weaken it.

Tonight, there is no question what path our Republicans will take. They will follow the map handed to them by the big insurance companies—protecting industry profits, defending unfair practices, and ignoring the threat rising health care costs pose to America's economic future. They will continue to speak with two tongues against government health care and for Medicare. You can't have it both ways.

Our Republican colleagues will not stand in our way. The road ahead is not a smooth one, but the wind is now at our backs. The American people want reform, and we will have the votes to finally deliver it to them. Sure, changes will be made to improve the bill as we move forward, but we will pass this bill. We will finish this great, unfinished business.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. I ask unanimous consent to engage in a colloquy with the Senators from Maryland, Delaware, Massachusetts, and others who will be joining us later in the hour.

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

Ms. KLOBUCHAR. Mr. President, as the Senator from New York has so eloquently stated, the time for health care reform is now. We cannot afford to wait any longer. We can't afford to wait, for the middle class.

There are a lot of numbers that get thrown out in the debate, but I think we can say it pretty simply by just using three numbers. Those numbers are 6, 12, and 24. What do those numbers mean? Ten years ago, the average family in this country paid $6,000 for their health insurance. Now they are paying $12,000. That is an average. I know of one small business in northern Minnesota, a backpack company, paying $24,000 for a family of four. One guy started a company with five employees. He now has 15—a growing business. He is paying $24,000. The average right now is $12,000 for a family of four. Where is it headed if we don't bend the cost curve for middle-class families—$24,000 average, little towns all over America, $24,000, 10 years from now. That is not the kind of stability the middle class needs.

The middle class needs to know, people I know all over my State need to know that if their kid gets sick, they still can have health care coverage; that if their kid goes to college and they want to keep them on their policy, they can still do that. That is what we are talking about when we talk about stability.

The other piece of this reform effort that is so important, coming from Minnesota, a State with high-quality, highly efficient care, is the cost issue, that we begin the long journey of reforming our Medicare cost so that we actually promote the kind of high-quality care we see in my State at places such as the Mayo Clinic and we promote the kind of efficient care we need to see.

My favorite example is in Pennsylvania, the Geisinger Clinic. They had diabetic patients. They decided it was not going that well. The patients didn't feel that good about their treatment, and the quality they wanted was costing too much. They tried something else. For routine cases, they said they will see nurses and see them more often. The more difficult cases went to endocrinologists, and they reviewed the routine patients' records. Higher quality care, happier patients, better care, lower costs—$200 per patient per month—that is what happened. They got less money for that higher quality care, less money. That is what we are talking about. We want to use those kinds of models so we get higher quality care for America at a more efficient rate.

Some of my colleagues across the aisle have been using the name of the Mayo Clinic in vain. This matters to me because I come from Minnesota. It is the home of the Mayo Clinic. The minority has suggested that the Mayo Clinic doesn't want any part of this bill. They have said the Mayo Clinic wants nothing to do with this bill. They have said the Mayo Clinic—and this is an exact quote from the Senator from Wyoming—''is no longer taking Medicare or Medicaid patients.''

Let me set the record straight. Like anyone in this country, the Mayo Clinic is looking at this bill. They like some provisions, and they don't like others. They have specifically said they support the creation of accountable care organizations, bundling of payments, the creation of an independent commission to evaluate Medicare solvency, which is in the Senate bill, the MedPAC idea. They are supportive of these issues because right now it is becoming harder and harder for them to cope with the current Medicare payment system.

This allegation that they are no longer taking these patients is completely incorrect. They made a decision not to take about 80 patients a year from the State of Nebraska because they weren't getting paid. They are still taking all Medicare-Medicaid patients from Minnesota and the contiguous States. This is not a small amount. Forty percent of Mayo patients are on Medicare. Six percent—I wrote this on the back of an envelope driving in with one of their chief doctors, so you know it is accurate, unlike the ''facts'' we are hearing over there. Forty percent of their patients are on Medicare, 6 percent on Medicaid, 46

percent are on Medicare or Medicaid. Sixty percent of their business is from Medicare or Medicaid.

It is just false. But what is true is that they want to see reform. They want to see reform of the Medicare and Medicaid system. They want to have it based on quality, not on quantity. That is why they support the quality index I sponsored, along with Senator CANTWELL of Washington.

Just putting your head in the sand and hiding behind the stacking of that bill—by the way, we had a three-page bill with the Bush TARP plan, that didn't work out that well when there were no accountability measures in that. That is not going to bring us the kind of health care reform the Mayo Clinic wants to see for the rest of this country.

I heard a lot in Minnesota from small businesses. Small businesses are paying 20 percent more than big businesses for their health care right now. Why should employees of little businesses, which are really the entrepreneurial engine of our States and the Nation, why should they have to pay 20 percent more than people who work for big businesses? This reform effort allows them to pool their numbers, allows them to join together so they can buy private insurance off an exchange with the same kind of numbers you have at a major corporation.

I know the Senator from Maryland has been very devoted to the idea of helping small businesses.

I ask Senator CARDIN about this specific issue. How does the Senator see this as helping small businesses in Maryland and helping the middle class in his State?

Mr. CARDIN. Let me thank Senator KLOBUCHAR for setting the record straight as it relates to the Mayo Clinic. It is interesting, I have had conversations with people at Johns Hopkins University, the University of Maryland Medical Center. I hear the same thing. They desperately want to see health care reform. The cost issues are beyond their ability to maintain the excellence of our health care system. We have to get health care costs under control.

If I might point out, I was listening to my colleagues on the other side give every reason why we should not move forward with the debate, saying: Don't worry, things will be OK. Those were the same arguments they made 15 years ago, which was the last opportunity we had to debate comprehensive health care reform. They blocked it from being on the floor of the Senate 15 years ago.

What has happened in the last 15 years, after they said: Don't worry about it. Everything will be OK. Just keep on with our current system of protecting the private insurance companies. They will do a great job.

In the last 15 years, we have seen health care costs go up, $912 billion, almost a three-time increase. We have seen the per capita cost of health care go from $3,400 to $8,100. We have seen that share of our economy in the last 15 years go from 13 percent of our economy to over 17 percent of our economy. We need to act.

One more number I want to give because it affects Mayo Clinic and affects Johns Hopkins because in many cases they are the provider of last resort, where no one else will give care. Also, the number of the uninsured has increased since 1993 from 39 million to 46 million.

The legislation that is being brought forward by our vote later today will reduce the number of uninsured by 31 million. Mr. President, 98 percent of Americans will be covered by health insurance with this bill. It reduces the growth rate of health care costs in America. It provides an affordable option for every American. This is a critically important bill.

The Senator mentioned small companies. I am glad the Senator did because small companies are the ones that are most discriminated against today in our health care system. They pay 20 percent more for the same coverage as a larger company. They do not have options. They do not have a lot of choices about who they can get to insure them. Not only is the cost so high, the annual increases are unpredictable. How do you run a business, if you are a small business owner, not knowing whether your health care cost is going to go up by 10 percent, 20 percent, or 40 percent in the following year? You cannot.

As the Senator knows, we have had small businesses come before us and tell us they are going to have to decide to eliminate their health care. In one case, we had a small business owner who said: Look, I am going to have to give up my business and start to work for a larger company because I can't afford the health care.

We are at a crisis. I do not understand my colleagues on the other side saying they do not even want to have a debate on this issue, they do not even want to vote so we can take up this issue. Instead, they want to protect the private insurance companies and let them continue to make these profits, continue to cause real problems for our consumers.

I have letter after letter from people who are confronting the problems of private insurance today, where they are denying coverage based on preexisting conditions or not covering a specific drug under their policies. There is no effective way to challenge private insurance companies today. This bill will give the consumers of America a chance against our private insurance companies.

Ms. KLOBUCHAR. Mr. President, if the Senator would yield, I see the Senator from Delaware is in the Chamber. Both the Senator from Maryland and the Senator from Delaware serve on the Judiciary Committee, and we have had several hearings in that committee about an issue people do not always think about that hurts the middle class, and that is the money that is being sucked down the fraud tube. Medicare fraud is $60 billion a year, I think.

Mr. KAUFMAN. It is up to $220 billion.

Ms. KLOBUCHAR. Mr. President, $220 billion. This bill will give us the tools. I know I wish to add even more to it on this subject, to go after that money, so that money can go back to help the middle class afford health care.

I yield to the Senator from Delaware.

Mr. KAUFMAN. That is absolutely right. What we are going to do is increase the number of whistleblowers, people who will see health care fraud and report it. We are going to get more prosecutors. We are going to get more FBI people. We are going to get more people to make sure we bring this health care fraud down. That is part of this bill.

But I do not understand—to follow up on what the Senator from Maryland said—how can you say you do not want to debate the bill, when you look at the fact that the alternative is our present health care system, which is totally, completely broke? How can you say you do not want to do it? You say you are fiscally responsible. How can you say you are fiscally responsible when you are not going to do anything about Medicare and Medicaid health costs and the cost of health benefits in this country?

As we have said many times before on the floor, my State is one of the worst cases; that is, in 2016, a family of four making $50,000 a year would be paying $29,000 in health care premiums. They cannot afford $29,000 in health care premiums. So what is going to happen? They are going to have the equivalent of half what they have today. If they can afford $12,000 or $13,000, they are going to have half the program.

I heard my colleagues on the other side talking about rationing. What is going to happen to these people when they are getting half as much health care from these health care companies? And the health care companies are the ones that decide what procedures you can have, when you can have them, and those kinds of decisions. When people have their health care insurance cut by this amount, you have to worry about whether they are going to be able to get the things they need.

Of course, Medicare and Medicaid prices are going through the roof. It is going to bankrupt the country. In 6 or 7 years, Medicare and Medicaid costs will cost more than everything else in the Federal Government. So how you can talk about——

Mr. CARDIN. Will my colleague yield?

Mr. KAUFMAN. Absolutely.

Mr. CARDIN. On the Medicare issue, during the last hour we heard all these people, who for a long time have been trying to privatize Medicare and reduce the program, now saying that Medicare is going to be in jeopardy if this bill moves forward. It is very interesting. The AARP gets it right when it says:

The new Senate bill makes improvements to the Medicare program by creating a new annual wellness benefit, providing free preventive benefits, and—most notably for AARP members—reducing drug costs for seniors who fall into the dreaded Medicare doughnut hole, a costly gap in prescription drug coverage.

This bill strengthens our health care system, strengthens Medicare for the future, and that is what is going to be critically important to our seniors.

I thank my colleague.

Mr. KAUFMAN. I think that is absolutely right. Right now, medical bankruptcies are 60 percent of U.S. personal bankruptcies—a rate 1½ times what it was 6 years ago—because of medical bills. The thing that is striking about this is, 75 percent of the families entering bankruptcy because of medical bills actually have health insurance. Two-thirds of all Americans filing for bankruptcy because of medical bills already have health insurance. We cannot stop that unless we change the system and give people more insurance and give them better insurance and make sure you cannot be denied for preexisting conditions and make sure—the killer—once you get sick—it is bizarre. You get sick, and then the health insurance company comes in and cuts off your health insurance. No wonder so many people are going into bankruptcy.

Ms. KLOBUCHAR. If the Senator would yield, I see the Senator from Massachusetts is in the Chamber, who I think has firsthand knowledge of the importance of this bill, having taken the seat once held by our dear friend Senator Kennedy, who worked so hard to get this bill done, to get health care to the people of his State.

I say to the Senator, maybe he would want to talk about what this would mean to the people of Massachusetts.

Mr. KIRK. I thank the Senator.

I thank Senator KLOBUCHAR for her leadership, as we approach the important moment on voting on a motion to proceed with this debate.

I was appointed by the Governor of the Commonwealth basically in conformity with Senator Kennedy's wishes. He knew how divided this body was over the important health care legislation and the importance of 60 votes so we could proceed to debate the merits of this bill. I am honored and humbled to be standing at his desk, to be one voice and one vote from Massachusetts.

It is a historic moment, and it is a poignant moment. As I reflect on my experience on his staff, as Senator KAUFMAN was on Senator BIDEN's staff at that time, my experience began 40 years ago under the leadership of Senator Kennedy. That was the time he first spoke about the need for national health insurance that would be affordable and accessible to every single American—in hearing after hearing, in speeches on the Senate floor, and in field hearings throughout America, prodding, listening, leading.

I can only reflect on how proud he would be of his colleagues and the leadership of Senator REID and Senator DODD, Senator HARKIN, Senator BAUCUS, all his colleagues who are now uniting in this moment of history to do for the American people what they have waited for for several decades, even since the first utterance of this important health insurance coverage by former President Harry Truman.

Having read through this bill and knowing how proud Senator Kennedy would be of this legislation, I will tell you why he would be. If you look through the bill, what does it do? It saves money. It controls costs. It reduces the Nation's deficit. It stimulates competition. It expands coverage. It strengthens Medicare. It attacks fraud, waste, and abuse. It increases transparency. It eliminates patient discrimination. It promotes flexibility and innovation. It rewards quality and value—not quantity and volume—of health care. It provides affordable, quality health care choices for individuals, families, and small businesses across America.

It introduces, through Senator Kennedy's leadership, a provision which provides long-term services for the elderly and the disabled.

Mr. CARDIN. Mr. President, will the Senator yield for one moment?

Mr. KIRK. Before I do, I say to the Senator from Maryland, there is one large, major question. If this bill promises to do all these things, for the life of me, I cannot understand how 1 of the 100 of us could go home for Thanksgiving and be able to explain to middle-class families, who are stretched and looking for health security and financial stability, that he or she would not vote even to debate the merits of this legislation.

Mr. CARDIN. I was going to comment, listening to the Senator, at the desk that was Senator Kennedy's desk, how proud he would be of the statements the Senator is making here this evening. Senator Kennedy was our champion for middle-income families in America. He understood they needed a voice in the Senate, and he was their strong, passionate voice.

This bill speaks to middle-income families. It is what Senator Kennedy fought his whole career for here in the Senate, to do something that would help middle-income families.

As the Senator points out, we need to bring down the cost of health care. Health care costs are rising three times faster than wages. Senator Kennedy understood better than any of us that Americans are falling farther and farther behind because of the health care issues, because of health care costs. Private insurance companies can make lots of money if health care costs go up. They are not losing. It is the middle-income families who are getting hurt by the system.

He understood that small businesses could not survive unless we figured out a way to deal with the health care issues. And as to people on Medicare—most people on Medicare are from middle-income families. We need to protect Medicare for the future. That is why, again, I get very concerned when I hear what we have heard over the last hour in the discussions, because one of the principal reasons we need to bring this bill forward on the floor of the Senate tonight is to strengthen Medicare, to make sure it is there for the future, to make sure it stays strong, and to make sure we expand benefits, as we do under this bill.

I thank the Senator because those of us who have heard Senator Kennedy speak on the floor of the Senate know how sorely missed he is here, and we are proud you are representing that vote here on the floor of the Senate tonight.

Mr. KIRK. Mr. President, I thank the Senator from Maryland very much.

Ms. KLOBUCHAR. Mr. President, if the Senator would yield, I also see the Senator from Rhode Island in the Chamber. Rhode Island is a State that has one of the highest unemployment rates right now in the country, and it certainly is a State that would welcome this kind of reform. And also on the issue we have been talking about, Medicare, the Senator from Rhode Island has long fought for seniors.

As to Medicare, as has been pointed out, if we do nothing, it is going to go in the red by 2017. The seniors I know who are 65 want to live to be 95 and still have Medicare. People who are in their fifties want to make sure Medicare is there for them when they are 65. That is why it is so important we make these smart reforms, to raise the quality of the care, and to make sure we preserve and save Medicare. And that is what this bill is about.

I yield to the Senator from Rhode Island.

Mr. REED. Mr. President, I thank the Senator from Minnesota. I want to add my comments to that of the Senator from Maryland and the Senator from Delaware to commend the new Senator from Massachusetts. He not only carries on the great work of Ted Kennedy, but he does it with the same passion and eloquence.

What struck me in this legislation—and reminiscent of Senator Kennedy—is that this legislation will provide real help to real people. It is about solutions, not slogans.

Let me illuminate, if I may. Premium relief. What is troubling so many middle-class families? They are too wealthy to qualify for direct public assistance in terms of the Medicaid Program, but they are not wealthy enough to pay for insurance.

This legislation will cap family outlays on medical insurance premiums. Families making under $88,000 will pay no more than 10 percent of their income on premiums. They will be given direct assistance through the tax system. There will be a rebate. So people now, rather than staring at 20 percent, 15 percent, 18 percent increases, will at least know there is a cap. And perhaps if we do our work well enough, the whole system will begin to reduce below the 10-percent mark, and everyone will benefit.

It is also notable that real families worry about many things. They worry about educating their children. They want them to be educated, but they also recognize as full-time students in higher education, they can stay on the family health care plan. It is interesting to note that decisions made about education are tied into health care, and also, in fact, as to where you work, if you should keep your job you do not like because you have health care or go on, whether you strike out to start a new business because you have this brilliant idea or stay in your current position because there is health care there. But what this bill does, again, is provide real help for real people and allows families to keep their children on their health care plan until they are 26 years old.

It also reforms dramatically the insurance system. Again, we listen to many of the complaints: Oh, we don't want a government-run health care system; we don't want bureaucrats telling us what to do. The irony, of course, as you mentioned, and Senator SCHUMER did, too, is that one of the most popular health care programs in this country is Medicare, which is government run. One of the other most popular health care programs in this country is run through the Veterans' Administration, which is a government agency. The least popular programs are private health insurance, where everyone has complaints—doctors, patients, providers. This legislation will prevent lifetime limits that insurance companies dictate. It will also do many other things.

So let me conclude because I appreciate very much—and if the time allows, I have a question for the Senator from Massachusetts. But this is a bill that when you move past all of the rhetorical smokescreens—because, frankly, most of our colleagues on the other side don't want to do anything. They didn't want to do it in 1993 and 1994; they didn't want to do it in 1933 and 1935; and they still don't want to do it—this legislation helps real people with solutions not slogans about nationalization and bureaucrats.

Ms. KLOBUCHAR. The Senator from Delaware.

Mr. KAUFMAN. I was presiding yesterday for I don't know how many hours. When you listen to what is said on the Senate floor by the other side, they are talking about a model where there is no competition. Any tax on an insurance company is going to be passed on to the consumer. What kind of a business—I don't know anybody in business who, if they get an increase in cost, they just pass it on to the consumer. Right? I mean, we have a law of supply and demand the last time I checked. But every single one got up and talked about the cost and said this is going to hurt the consumer. It is not going to hurt the insurance companies because they are just going to pass it on to us. The reason they are going to pass it on to us is kind of obvious.

Here is a list, a small list, that lists all the States in America and how much of their insurance is tied up in two or less companies. Do you know what you have to do? You have to get down to No. 40, Oregon, because the first 39 States on this list, two insurance companies make up over 50 percent of the market in their State. How can you have competition when you have so much of the business tied up in just one entity?

The way you can tell there is not competition? You don't have to have an advanced degree in economics to figure out there is no competition. How do you know there is no competition? Every January, my premiums go up. The only other thing I know that I get that goes up every January is my cable bill, right? There is no competition in cable. You either take cable or you don't. They say there is competition. So every year, whether it is January, February, or March my cable bill goes up. And every year, just like clockwork, my health insurance premiums go up. So clearly, there is not competition.

That is why a public option is so important. We have to have a public option so there is competition not only in the top 39 States where one firm has over 50 percent—two firms have over 50 percent of the business—but in all 50 States.

That is what this bill does. It is amazing to think on the other side, the support they have for competition, and I believe they do and I know them and I respect them and they all are concerned about competition—except every once in a while they kind of turn a blind eye to the fact of how powerful competition is. Competition is valuable and powerful in keeping costs down and increasing benefits and quality of care—only when there is actually competition. So we are going to have to have competition. This bill will actually do it.

Ms. KLOBUCHAR. If the Senator will yield, I think we have been joined by the Senator from North Carolina, who is a member of the HELP Committee and I know has a background in business and understands a little bit about competition.

So how does she see this as being a problem? I know in the State of the Senator from Maryland there is limited competition, and in a number of our States one or two providers—Minnesota is an exception, but one or two providers dominate the market, jacking up the prices.

The Senator from North Carolina.

Mrs. HAGAN. I think one of the key points is the fact that this bill is going to eliminate discrimination based on gender and preexisting conditions. I have two children right now who are in their midtwenties. My daughter is paying more per month for health insurance than her brother. Yet it is the exact same policy. The same with preexisting conditions. How many people do we know who have a condition such as diabetes or asthma, or a woman who has had a C-section who is, therefore, denied from getting health insurance? We have to be sure we correct this, and that is what this bill does.

Let me give a couple of examples. So many people in North Carolina I have heard from have some of these situations. Recently, I got an e-mail from a family in Greensboro. It is a working family. The husband has Graves disease, which is a treatable condition, but he can't obtain health insurance because of this condition. Without health insurance, his life is gravely in danger. He repeatedly uses the emergency room for care.

To make matters worse, he has a 2-year-old son who has hemophilia and has to be taken to the emergency room every time he bumps his head, which sometimes can cost, for a 2-day supply of medicine, $4,600. The family makes too much money to qualify for Medicaid and, obviously, with these preexisting conditions, health insurance is way out of reach for them. It is heartbreaking for this family. What the father has decided to do is to purchase life insurance instead of trying to get health insurance, and he is 29 years old.

Ms. KLOBUCHAR. If the Senator will yield, I think what the people will be shocked to find out is that I think in eight States domestic abuse is actually a preexisting condition. You talk about gender discrimination. If a woman is a victim of domestic abuse, she will basically not be able to get certain insurance policies. Is that right?

Mrs. HAGAN. That is right. In all but 12 States, insurance companies are currently permitted to charge women more than men for the exact same policies.

Mr. CARDIN. If the Senator will yield for a moment, as Senator KLOBUCHAR pointed out, if you don't have

competition—and Senator KAUFMAN said the same thing—if you don't have competition, what is your choice? You are going to have to pay the premium.

There was a Washington Post article written about a street in Gaithersburg. Gaithersburg is a growing suburban community not far from here, certainly middle-class families. They think they are doing fairly well. It talked about one street in Gaithersburg, and they gave half a dozen stories about people—real stories—about people having problems with our current system. They talk about Patty, who has private insurance and thought she was in good shape. She talks about having to search a book in order to find out what doctor she could go to to stay in the network because it is too expensive to go out of network, and then she hits her deductible and finds that her fees and copayments come in fast and strange, making it unaffordable for her with her current insurance coverage. She has no other choice. That is the only insurance she can get.

Two doors down the road is Chuck who needs oxygen, needs certain medicines. He had to fight with his insurance company to get the prescription drug covered. He got the prescription drug covered, only to find out the nurse who administered the drug was not covered, and it cost $400—another problem with a private insurance company.

Across the courtyard, Will and Sarah, they have insurance today. They are going to lose it because he just lost his job, and he has no prospect for being able to afford insurance.

The last one is Martha. This is a very interesting one. Martha went to the emergency room for delivery of her child. She needed an epidural. She made sure she went to a hospital that was in-network because she wanted to make sure it was covered. Guess what. That anesthesiologist she had no control over was not in-network and she had to pay all that extra money. Again, no choice. She had no choice in the system. There is no competition.

I know we have Senator KIRK here who is our newest Member. Perhaps the Senator could tell us what he is hearing from Massachusetts. He is a new Member here. I don't know whether he is getting the same stories of what is happening in his State.

Mr. KIRK. Well, it is exactly the same story, with one exception, I would say to the Senator from Maryland, which is that 3 years ago, Massachusetts adopted its own health reform. Now, 97 percent of the people in Massachusetts are covered with health insurance.

As you have said and as the Senator from Rhode Island has said, the best illustrations of the need for health reform are the individuals, the real people. So I will tell my colleagues a story about a young lady. She is a waitress, a 24-year-old girl. Her name is Jessica Wheeler from Somerville, MA. She is a waitress and works part time as an intern. She had dreams of graduate school, but she was concerned about health insurance. We have an exchange in Massachusetts not dissimilar to what is being offered in this legislation where there is increased competition from private insurers and others. She applied to the exchange and was found eligible and enrolled and took out an insurance plan.

Shortly after, she was stricken gravely ill with organ failure and was hospitalized for an extended period of time. She was made well. She has to take a pill every day in order to keep up with her condition, but her coverage was complete. She has applied now to graduate school, and although she probably has her tuition issues stretching her means and so forth, she is free of the concern and need of expensive health care bills; otherwise, she would have been without. So it is just another illustration.

Just one other point on competition that keeps coming back and back, I ask myself: Why do middle-class families save their hard-earned money to buy health insurance? Obviously, the answer is so that they will have coverage if they get sick. Without competition, I will tell you what is going on. Insurance companies—now get this—are denying coverage because people are sick or they say: Well, you reached a certain limit, and we didn't realize you were going to get that sick, so we dropped the coverage.

Ms. KLOBUCHAR. If the Senator could yield, I have exactly the same kind of example where someone wants to buy coverage, they are willing to pay for some coverage, but they can't. They basically are cut out because they are sick.

This is one of the saddest letters. We just got this from Cheryl from Bemidji, MN. She says:

> I am writing to you because I just got off the phone with my daughter Mickey. At first I couldn't understand her because she was sobbing so hard. Her husband had just been told by his boss that they wouldn't be carrying health insurance on their employees any longer. They are a small company in northern Minnesota and it was costing them $13,000 a month. For her, for my daughter, this is a matter of life and death. She has cystic fibrosis. Because it is a preexisting condition, the insurance companies won't touch her unless it is under a group plan such as the one her husband just lost.

She says:

> You need to stand and be my voice, be Mickey's voice. Mickey is a fighter, but she can't keep fighting a system that is so against her. Mickey has already lived longer than any of the doctors expected. I want her to live to see her 5-year-old son become President one day.

That is from a mom in Bemidji, MN.

So I will just ask my colleagues, how can we continue to go down this path where hardworking families—a man who has a job, who is working for a small business, gets cut off from his insurance, and because his wife has cystic fibrosis, they aren't going to be able to afford insurance.

The Senator from Delaware.

Mr. KAUFMAN. I think the reason we use these examples so much is because certain words kind of roll off your lips; words such as ''preexisting condition.''

Here is an example involving Angela in Dover, and she is a bartender, not a waitress. Her income is from tips. She has no health insurance through her employer. She became pregnant. She tried to find private health insurance, but she was declined coverage because pregnancy was considered a preexisting condition.

Now, just do a visual for a minute. This woman has been living off of tips. She is about to have a baby, and there is nowhere she can go to get health insurance. She applied for Medicaid to find prenatal care for herself and her baby, was denied coverage because she earned $200 more than the monthly income limit. I mean, just picture this now, if you were in this situation. She called organizations and clinics and was unable to find a payment plan she could afford.

Midway through her pregnancy, Angela decided to cut back her work hours so she could qualify for Medicaid. She worked all 9 months of her pregnancy and delivered the baby on May 27. The Medicaid coverage she got was especially crucial because she had complications with hyperthyroidism and was able to get the necessary prescriptions to control her condition.

OK. Do we have the picture? How would we like to see ourselves with our spouses or our kids with this kind of a decision? The sad part of the story, as if it is not sad enough, is that Angela was so anxious to ensure that everything possible was done for a healthy baby and the system threw up roadblocks. Pregnancy should not be considered a preexisting condition.

People in this country who are pregnant should not have to worry, in addition to going through the trauma of being pregnant for 9 months and the baby being healthy and all the fears you have and on top of that fear they may go into bankruptcy because they cannot afford to pay for the doctor bills for their baby. This is real stark to me.

We are going to vote tonight on cloture so we can move to a bill that will, once and for all, make sure Angela Austin and all the women similar to her who have the ''preexisting condition'' of pregnancy will only have to worry about their baby and what is going to happen to her and not worry about what she is going to do when the child is 2 and she is in bankruptcy, because so many people are going into bankruptcy.

Ms. KLOBUCHAR. Maybe the Senators can answer this. In these thousands of letters and calls we get from these people, they are asking us to be their voice. They don't want to say we are not going to debate this bill at all, that we are going to put it in a drawer and pretend it didn't exist.

Mr. CARDIN. That is the interesting point. These are all real stories, people who are being denied health care today because of arbitrary practices from private insurance companies or the way our system is currently organized.

The vote tonight is a pretty simple vote. If you think the current system is what you want, OK, I understand why you are voting against cloture. I understand that you say the status quo is fine; we don't even want to debate the issue; we don't care about the people who have been affected by the arbitrary actions of private insurance companies and saying that pregnancy and childbirth is a ''preexisting condition'' or when you are using over-the-counter drugs to keep your cholesterol under control and the insurance company says that was a preexisting condition.

All we are saying tonight is: Is this worthy of debate on the floor of the Senate—a clear vote? Those who vote for cloture say this is worthy. The people who have written us these letters are entitled to have the Senate take up this issue. That is why we point out that there are numerous groups, including the American Medical Association, that say vote for cloture, let's have this debate before the American people.

Ms. KLOBUCHAR. Along those lines, before I yield to the Senator from Massachusetts, I started out talking about the cost issue. I wanted to put in the RECORD the statement of November 5, 2009, from the Mayo Clinic. There have been things said about their position. My friends on the other side have said they ''don't want any part of this bill'' and they ''want nothing to do with it.'' Those are exact quotes. They said they ''are not taking Medicare and Medicaid patients anymore.''

Those are exact quotes. They are all incorrect. I will put this in the RECORD. It is dated November 5, 2009. ''Points of Agreement and Divergence.'' They say:

> We are encouraged by much—including provisions to pay for value in health care, an insurance exchange, individual mandate, subsidies for people to achieve coverage, and pilot projects on accountable care organizations and bundling of payments.

To be fair, they also say they are ''concerned about other areas including a public option that is based on Medicare rates. . . .''

As you know, the options in the House and Senate bills are not based on Medicare rates but negotiated rates. They are concerned about the long timeline for implementation of value provisions, as I am. They are concerned about across-the-board cuts for providers. They neither endorse nor support the bill. To say they don't want any part of the bill is false.

I ask unanimous consent that this material be printed in the RECORD.

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

A PERSPECTIVE ON CURRENT HEALTH REFORM ISSUES FROM MAYO CLINIC

REFORM BILLS: POINTS OF AGREEMENT AND DIVERGENCE

As the House and Senate prepare to bring their final bills to their respective floors, Mayo Clinic would like to highlight the areas of agreement and divergence in the bills and our positions on health care reform. We are encouraged by much—including provisions to pay for value in health care, an insurance exchange, individual mandate, subsidies for people to achieve coverage, and pilot projects on accountable care organizations and bundling of payments.

At this juncture, Mayo Clinic will neither endorse nor oppose entire bills in the House or Senate, but will continue to point out provisions that we think move the country toward patient-centered health care and areas where we have concerns.

While many provisions in the bill are aligned with our recommendations, Mayo Clinic remains concerned about other areas including a public option that is based on Medicare rates, the long timeline for implementation of pay for value provisions and across the board cuts to providers.

It is critically important that we accelerate the timeline to adjust the Medicare payment system to pay for value in order to truly bend the cost curve—especially in light of the growing number of baby boomers reaching retirement age.

These payment reform provisions should not lag behind expanding coverage to more Americans. In any event, we must focus on ensuring the financial viability of health care for the long term to ensure that patients have access to quality care across the country.

SUPPORT HOUSE IOM STUDY OF HIGH VALUE CARE AND GEOGRAPHIC VARIATION

Mayo Clinic supports the provision that was added to the House bill that will charge the Institute of Medicine to study and design new payment methodologies to build value and address geographic variation into the Medicare payment system. The proposal is consistent with Mayo Clinic's focus on creating a mechanism to better define value, measure it, and create new payment methodologies that reward it.

Most of us, as patients or family members, don't stop to think that our doctors and hospitals are generally paid more for doing more tests and procedures—whether or not we need it. Take for example, the story of a patient eventually seen here at Mayo Clinic:

An older gentleman went to an emergency room because he fainted. A CT scan of the heart was done and showed calcification. Urgent heart catheterization was recommended and then bypass surgery was performed. Later, when a stress test was done, an abnormality was found and a second heart catheterization showed a complication—one bypass was blocked. Stents were placed in the heart artery where the bypass was blocked. However, the fainting spells continued. With his issue unresolved, the patient came to Mayo Clinic, where we conducted a lengthy assessment by a team of physicians. It was determined that all he needed was an adjustment of his medications. In the end, the tests, stents, and surgery performed at the other facility were not needed, did nothing to help the patient, but were paid for by Medicare. On the other side, the additional office time spent at Mayo to fully assess patient's situation and ensure proper diagnosis and treatment was not covered by Medicare.

Doctors and hospitals are usually paid more for doing more tests, visits, hospital admissions, and surgeries rather than spending time with the patient and assessing their individual needs. What if instead, the system rewarded doctors and hospitals for spending time with patients, for doing a procedure successfully, for the fact that you leave the hospital without a fall or infection, and for providing excellent service to you while you were under their care.

SUPPORT CANTWELL AMENDMENT TO INCENTIVIZE VALUE IN MEDICARE

We support a similar provision in the Senate Finance Committee bill introduced by Sen. Cantwell that will help move Medicare in the direction of paying for value by creating a value modifier for physician payments that will create incentives around value in the Medicare physician payment formula.

INSURANCE REFORM THAT GIVES ACCESS TO ALL

We believe coverage can be achieved without creating or expanding a government-run, price-controlled, Medicare-like insurance model. A public option that employs a true negotiated rate process is better than a system based on Medicare rates. However, we are concerned that the exchange could be opened to large employers, which could result in a large shift from private to public insurance plans.

We support reforms to the current insurance system that eliminate pre-existing condition exclusions, and create an individual mandate where individuals can purchase private insurance in various ways:

Through employers,

On the individual market,

Through co-operatives, or

Through an exchange model like the Federal Employees Health Benefit Plan (FEHBP).

We also believe that the government should help people afford the insurance through sliding scale subsidies as needed.

ENCOURAGED BY ACCOUNTABLE CARE ORGANIZATION PILOT PROJECT

Mayo Clinic is encouraged by provisions in the House and Senate bills that allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as Accountable Care Organizations (ACOs) and to be eligible to share in the cost-savings they achieve for the Medicare program. Both houses propose to start an ACO pilot program January 1, 2012.

Mayo Clinic believes that under this approach, a group of physicians would be responsible for quality and overall annual Medicare spending for their patients. Different payment models could be tested. For example, physicians would be paid FFS rates, less a withhold, and then receive bonuses for meeting resources use and quality targets over the course of a year. Options should include creating virtual accountable care organizations based on physician-hospital referral relationships. Such an approach would create incentives for physicians and hospitals to work together to provide better value care.

BUNDLING PAYMENTS CAN HELP CONTAIN COSTS

Both the House and Senate bills have provisions to test a system of bundling payments for Medicare Parts A and B. We are

pleased with the pilot projects on Medicare payment bundling. However, we would like to see a more aggressive implementation timetable—not one that starts in 2014 or later, but finishes by 2014—so that we can see more immediate financial results for the Medicare system.

To realize cost savings quickly, Mayo Clinic believes Medicare should start bundled payments for high-cost hospital episodes such as total knee replacement, heart attack, and lumbar disc herniation. Over time, bundled payments could be considered for some chronic conditions as well. The bundled payment should include hospitalization (Part A), physician (Part B) and post-acute care (nursing home, home health care, etc.) services. The outcome would be defined as reasonably attainable improvement in health status in the safest, most cost-effective way and would cover the entire episode of care through the patient's return to function.

The goal is to reduce practice variation and focus on an outcome-based goal. Such a reformed payment model would encourage improved coordination of care among physicians, hospitals and nursing homes, and it would encourage utilization of nursing and other non-physician caregivers.

CMS INNOVATION CENTER TO ENHANCE QUALITY, IMPROVE PATIENT SAFETY

Mayo Clinic also supports the proposal in the Senate Finance Committee bill that calls for the HHS Secretary to create an Innovation Center within the CMS. The Innovation Center will be authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The provision calls for promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions. The collaborative would develop best practices and proven care methods in improved quality and efficiency, as well as assist other health care institutions on how best to employ such best practices and proven care methods.

INDEPENDENT COMMISSION TO EXTEND MEDICARE SOLVENCY

The Senate Finance Committee proposal includes a provision to establish a 15-member Independent Medicare Commission to develop and submit proposals to Congress aimed at extending the Medicare program's solvency and improving its quality. Each year, beginning in 2013, the Medicare Actuary's Office would make projections about whether Medicare's per-capita spending growth rate in two years will exceed a targeted rate. In years when Medicare costs are projected to be unsustainable, the Commission's proposals will take effect unless Congress passes an alternative measure.

Mayo Clinic believes that this commission can insulate many health care decisions from direct political influence in Congress while still being accountable to Congress. We also believe that the commission should have the authority to change the health care payment system with the goal to move away from fee-for-service medicine and toward paying for team-based, coordinated care.

In addition to payment reform, the commission could serve as a trusted national data aggregator, making performance and pricing information publically available so that stakeholders can identify best practices and high performers.

This perspective is written by Jeffrey O. Korsmo, Executive Director, Mayo Clinic Health Policy Center; and Bruce Kelly, Director of Government Relations, Mayo Clinic.

Mr. KIRK. I know time is running short. I want to say one thing about this. We have heard talk about the status quo. Make no mistake, this is a situation with respect to—we assume when we hear the words ''status quo'' that things will remain as they are.

In the area of health care and health insurance, things are not going to remain where they are. The status quo is not the status quo. We either move forward or we fall back. If we don't address or at least debate the merits of the bill and don't move it forward, we all know what is going to happen. The figures are there. The average family premium, which is now over $13,000, in 2016 will double to $24,000. That is not the status quo. That is falling back. Similarly, the number of uninsured will rise from 47 million today to 54 million in 2014. That is not the status quo. That is falling back. Fourteen-thousand people will continue to be dropped from coverage each day. That is not the status quo. That is falling back. I could go on.

There is a reason this bill needs to be debated. It is because the average middle-class working family deserves and needs health care security and financial stability. This bill will bring them that. At least I hope that the Members of the Senate—all 100—would say that, on the merits, this bill and this need should be debated.

Ms. KLOBUCHAR. I thank the Senator from Massachusetts. The Senator from North Carolina is here. I know the people of North Carolina and the people in the South have concerns about the current state of affairs in health care as well.

Mrs. HAGAN. Yes. A lot of what we have been talking about are people who don't have health insurance and who want it enhanced because of preexisting conditions. We have people who are sick and stuck with health insurance.

I received an e-mail from a young North Carolinian who works for AmeriCorps. She was the valedictorian of her high school class. She suffers from a brain abscess. Her illness has put her into debt for the rest of her life. She has health insurance, but it ran out when she hit a $50,000 cap. Her bills far exceed the cap. It is sinking her entire family into debt. She is sick and stuck.

How many people do we know who have a spouse or themselves who have health insurance, and they are working, but they cannot switch jobs because they would lose their health insurance? I have a good friend whose husband has cancer. She wants to change jobs, but she cannot do it because of the condition of her husband. Once again, people are sick and they are stuck. We have to be sure we can have a debate, that we can move forward on health care reform so we can help people.

Mr. KAUFMAN. We are all concerned about the economy. Even with health care reform, I think for every Senator I talk to on both sides of the aisle, their biggest problem is getting people back to work again and getting the economy moving. It is truly tragic when you think so many people are losing their jobs. Under our present system, the way it is structured, when you lose your job, you not only lose the money coming in to you, you lose your health insurance. You lose your self-respect because we are all judged on where we work. That is how people judge us.

As has been said, the longest walk is the walk home to tell your spouse and your kids that you lost your job. The irony of ironies and the thing that makes this so incredible is that you don't just lose your job and self-respect, you lose your health care insurance.

We have a system, and we have to change the system so these people out their right now can maintain their health care insurance and care for their children and their families, as they and everybody in their families go through this very traumatic experience.

Mr. CARDIN. We are running out of time, with only a few more minutes left. I want the people in Maryland and of the Nation to understand what this vote means. We are going to bring an amendment to the floor of the Senate for debate. Any Senator will be able to offer an amendment to how we should advance health care. The Senator from Massachusetts is absolutely correct. We are either going to continue to see our health care system with more people being denied coverage, with the costs escalating much faster than our economic growth, with businesses having to decide to terminate plans—that is what is going to happen—or we can take up health care reform and try to rein in the practices of private insurance companies and provide a way where every American can get access to affordable health care. That is why the American Cancer Society Cancer Action Network says:

> The American Cancer Society Cancer Action Network urges all Senators to vote in favor of allowing critical health care legislation introduced by Senator Harry Reid this week to be debated on the Senate floor. With thousands of cancer patients being denied coverage, charged excessive premiums, and facing exorbitant out-of-pocket costs, it is urgent that the Senate take action now, not later, to protect and extend health coverage to millions of Americans in need.

Last week, Cynthia and Eric Cathcart were here in the Senate. They are two people who are self-employed. They cannot even get an insurance policy to cover their family. They have to have two separate policies, with two

deductibles and two premiums, and they cannot afford it. We must take up this issue for the Cathcarts and the millions of Americans who cannot make it under this current system. Middle-income families are depending upon us tonight.

Ms. KLOBUCHAR. There is a lot of talk about Medicare and our seniors and what this bill does. Think of the woman I talked about who is a fighter, as her mom says, but she cannot keep fighting a system that is so against her. As you pointed out, the advantage of this bill is, it gives our seniors a better playing field with the drug companies paying for their drugs in the doughnut hole. Also, it is my understanding that AARP wants to advance the bill. Certainly, AARP has stood up for seniors for years and years and years. They know we need to preserve Medicare and keep it safe.

Can the Senator comment on AARP?

Mr. CARDIN. AARP not only wants us to advance the bill; they support the bill. They believe this bill will improve the Medicare system, make it stronger, and provide additional benefits, particularly in reducing the dread Medicare doughnut hole. They want the Members of the Senate to vote to allow this bill to come to the floor.

Ms. KLOBUCHAR. Maybe we should end with the Senator from Massachusetts, the home State of Ted Kennedy, having the last word of this very interesting colloquy, in which we heard from the Senators from North Carolina, Rhode Island, and Maryland.

Mr. KIRK. I thank the Senator. I am honored to be a Senator in this body. Back home, they think I am the 60th vote. I would like to believe we would have a more enlightened full body and that 60 would be a number we would pass through.

The American people are looking forward to debate on this issue. I think they believe they deserve many of the aspects that are contained in the bill. On behalf of my constituents in Massachusetts and those who, for so many years, revered and loved and elected and reelected Senator Kennedy—I think they all, as we do, have him in our minds and hearts tonight, and we hope we can advance this bill to the American people, knowing his spirit and years of work are a reminder of our obligation.

I hope we will have a successful vote this evening. That will provide an opportunity for the American people to hear a debate and perhaps allow corrections by whatever amendments may be needed, so we proceed, keeping in mind, as is true in all legislation, we cannot let the perfect be the enemy of the good. The good is something our people have been waiting for, for decades. The time is now. Let the debate begin.

I thank the Chair and yield the floor.

Ms. KLOBUCHAR. I thank the Senator. I believe our hour has ended. We yield the floor.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. BENNETT. I ask unanimous consent that during the next hour, those Senators who come to the floor may be allowed to proceed in a colloquy.

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

Mr. BENNETT. I came to the floor early so I could listen to what my Democratic friends have had to say. I found it quite enlightening, and I have a few comments with respect to it.

They have been debating vigorously against the status quo. They have been giving us examples, heart-tugging, real-life examples of people who are finding difficult problems in the situation as it now exists—as if the debate were between the status quo and doing something.

The debate is between the solution that has been offered by the majority leader and other solutions, which people on this side of the aisle have been trying to bring forward through the entire time and have not been allowed to come forward.

We recognize that things need to be done to fix problems with respect to the health care situation. We realize the legislation we have been living with for all these years needs to be amended. We have been unable to get any of our ideas to come forward. Now we are told there is such urgency to deal with the status quo that we must pass this bill, and we must pass it virtually without amendment.

I would like to point out, as I have done before, if there is such urgency with respect to the challenges we have in health care, why do we wait until 2014 to have those changes come? We have heard all these examples coming on the Democratic side of the aisle of people who have terrible problems under their health care plan. We must act, we must act immediately, and the act will be to say to all of these people: We will solve your problem in 2014. We will delay all of these reforms we are talking about until 2014.

I made that point the other day, and the Senator from Maryland said, no, some parts of this bill will begin immediately. And he is exactly right. The parts of the bill that would begin immediately are the taxes. We will start taking in money in 2010 if this bill passes. The annual pharmaceutical manufacturers fee would drive up the price of everybody's drugs, an annual nondeductible $2.3 billion fee. That will begin in 2010. The medical device manufacturers fee, another $2 billion, will begin in 2010. The medical insurance provider fee, that will begin in 2010. The cosmetic surgery fee, that will begin in 2010. In 2011, there will be a limit on contributions and in 2013 a high-cost insurance excise tax. All the taxes are front-loaded, but all of the reforms they promise this bill will bring to all of the people whose stories they told us will not take place until 2014. The status for them will remain quo. For all of these attacks on the status quo, the one change we will get is they will start charging the taxes but they will not start delivering any kind of health care reform until 2014.

Why are we delaying until 2014? Not because they do not think people need it but because they realize that if they start spending at the same time they start taxing, the score they will get out of the Congressional Budget Office will point out the true cost of this bill. And it is the true cost of this bill that is the kind of thing we need to be debating and talking about rather than listing story after story. My State is full of them, and I am just as sympathetic as anybody of people who have problems with the present health care system. That is a false debate.

We all realize, all 100 of us realize that something has to be done to make the health care system better. This is not, should we do nothing; this is a debate about what should be done. The proposal we have from the majority leader is not the answer to the problems we face.

Mr. KYL. Mr. President, I wonder if I may interrupt to ask, when the Senator said this is not the approach, the approach taken by the Democratic leader, among other things, because of the cost of it—my colleague from Arizona is here, and I think no one takes second place in this body to him in carefully looking at the cost of every bill we have on this floor. He frequently proposes amendments to reduce the cost of the bills.

I wonder if my colleague from Arizona agrees with my colleague from Utah and is aware of the respected columnist David Broder who wrote in today's Washington Post—actually, it is for publication tomorrow—a column, the title of which is ''A Budget Buster in the Making.''

Mr. McCAIN. Mr. President, I say to my colleague, not only is David Broder's column this morning important, but he is probably the most respected columnist in America. He talks about it in far more eloquent terms than I can.

I ask my friend from Arizona—a very unusual event happened today. The majority leader, I guess proceeding on the concept, the age-old tried tactic of ''shoot the messenger,'' came to the floor of the Senate and excoriated David Broder, of all people, probably the most respected columnist. I might say, Mr. Broder from time to time has written an article or two or more that has been critical of me, but he always had my respect. For the majority leader, who cannot rebut the facts in David Broder's column, to come to the floor and excoriate one of the most respected columnists in America is remarkable.

One of the things, I say to my friend from Utah, is that I do not think Americans really understand the scam that is going on here of beginning to collect taxes. Tax increases and Medicare cuts of approximately $1 trillion begin 40 days from now. In other words, on the first of January, according to this plan, Americans will begin experiencing cuts in Medicare and increases in taxes, 40 days from now. But then it will be 208 weeks and 1,460 days before any benefits from the legislation come about.

Tell me, isn't that like a couple goes to buy a house and they say: OK, you can have the house for X amount. And by the way, you have to start making the payments now and for the next 4 years before you can move into the house. Is there anybody who would agree that is nothing but a scam on the American people? I do not think the American people truly understand the reason why—and why would they do that? To disguise the real cost of this $2.5 trillion bill. That is why they do it. I think Bernie Madoff went to jail for this kind of behavior.

Mr. BENNETT. I say to my friend from Arizona, he reminds me of a real-life experience of a husband who at Christmastime came back to his wife and presented her with a brilliant Christmas present that she had not been expecting. She said to her husband: How could we afford this because the only amount we had in our Christmas budget was—pick a number—$200, and this is obviously worth more than $200.

He said: Oh, don't worry about it. I paid $200 for it.

She said: How in the world did you get $200?

He said: The department store agreed to take the other $1,000 in payments later on.

That is exactly what is happening here. We are making a downpayment and telling ourselves that the total cost is covered as outlined by the Congressional Budget Office.

Mr. MCCAIN. Again, it is so important that we read this hernia-inducing bill, that we understand the details of it. Specifically in these cuts, which are going to take place in 40 days—40 days from now; Happy New Year, America—in 40 days, it will cut $135 billion from hospitals, it will cut $120 billion from 11 million seniors on Medicare Advantage.

I would like to pause there for a moment. Senator KYL and I represent the State of Arizona. We have thousands and thousands—and I am going to get the number before this debate is over—of seniors who are on Medicare Advantage. They are going to cut out the Medicare Advantage Program and tell the American people that if you like your insurance policy you have, you can keep it? How does that work? Then there is $15 billion going to be cut from nursing homes, $40 billion from home health agencies, and $8 billion is going to be cut from hospice care—my God, hospice care, $8 billion.

Here we are telling the American people that we are going to fix health care in America, and the way we are going to pay for the massive government takeover of health care is through cuts. It is terrible on its face, but does anybody really believe these cuts are going to take place? Does anybody really believe the doctors are going to be cut $247 billion in the next 10 years? Does anybody believe we are going to cut $247 billion—or whatever it is—from Medicare? We are not. Why are we not? Because we are a loving, caring nation. We are not going to tell our seniors that they are not going to receive a high quality of Medicare.

Of course, this latest mammogram incident where a board, not unlike the one that is envisioned in this bill, said that women over 40 should not have mammograms—by the way, I have a close friend, Carly Fiorina, who has just recovered from chemotherapy. What would her situation be today if she had not had a mammogram? Women all over America are rising up about it. If you think that is bad, wait until you get this legislation.

By the way, while my friends are standing, I would like to say please sit down, I have shocking news. The three Senators we were worried about—the Senator from Louisiana, the Senator from Arkansas, and the Senator from Nebraska—shocking news. They are going to vote for this bill to move forward. That was an issue of tremendous speculation with the media. I certainly did not know that with all the protestations we had from those three Senators that, by golly, they were thinking long and hard. Guess what. So, OK.

Mr. BENNETT. I say to my friend from Arizona, and then I will yield to my friend from Tennessee, Senator MCCAIN just asked a question: Does anybody really believe these cuts will take place?

I share with him an experience I had driving home from the Senate just this week. I was listening to the radio, and the first story on the radio was this vote coming up. The Senate is going to vote at 8 o'clock on Saturday. The second story was that the House of Representatives just passed a doc fix of $200 billion. So we already have action by the House of Representatives proving that the comment by Senator MCCAIN is exactly right. Before this bill even gets passed, they are reversing the cuts over in the House of Representatives. Senator REID tried to do it here before we got to this bill, and we voted him down. So the House is going to take care of it, and they will ping-pong the bill over here.

There is no question that these cuts will not take place.

My friend from Tennessee wishes to comment.

Mr. ALEXANDER. Mr. President, I see the Republican leadership in the Chamber. It seems as if every other word we hear coming from the other side is that this vote tonight is historic. I agree, it is historic. But I think my view of why it is historic is a little different from their view.

I wonder if my colleagues would not agree with me that this bill is historic in its arrogance? It is historic in its arrogance to think that we in Congress are wise enough to take this entire complex health care system, that serves 300 million Americans and is 16 percent of our economy, and think we can write a 2,074-page bill and be wise enough to change it all at once. It is historic in its arrogance by dumping 15 million low-income Americans into a medical ghetto called Medicaid, which none of us or any of our families would ever want to be a part of for our health care. It is historic in its arrogance by sending the States, that are going broke, a big chunk of the bill for what we have just done. It is historic in its arrogance because it tells Americans that the bill costs $849 billion and then thinks we are not smart enough to read the print and figure out that the real cost is $2.5 trillion when it actually is implemented. It is historic in its arrogance by telling us that paying for reimbursement for physicians is not an important part of a health care bill. It is historic in its arrogance because it cuts and taxes grandma's Medicare, which according to the trustees will be broke by 2015 to 2017, and then spends it on somebody else other than grandma. The bill is arrogant because its telling us it will reduce premiums for most Americans, when, in fact, it increases premiums for most Americans.

So People say: Where is the Republican health care bill? My answer to that is, don't expect Senator MCCONNELL to come rolling in here with a wheelbarrow with a 2,074-page budget-busting, debt-ridden, arrogant piece of legislation because that is not what we believe in.

What we need to do as a Congress is re-earn the trust of the American people by setting a clear goal of reducing health care costs, showing some humility, and starting to move step by step in that direction. I hope during this hour that we have a chance to talk about the specific steps to reduce health care costs that we Republicans have offered day after day to no avail.

Mr. KYL. Mr. President, if I can interrupt my colleague and compliment him on the phrase ''arrogance.'' Maybe ''hubris'' is another word. To think we are smart enough in Washington to figure out what is best for 300 million Americans is truly arrogant.

A question posed by my colleague from Arizona a moment ago: Do they really think they can whiz this by the American people with regard to it not adding to the deficit, for example? Good question.

I want to get back to that Broder piece my colleague from Arizona quoted. There is actually a survey that answers that question. It turns out the American people are pretty smart about this. The question in this Quinnipiac poll read:

President Obama has pledged that health insurance reform will not add to our Federal budget deficit over the next decade. Do you think that President Obama will be able to keep his promise? Or do you think that any health care plan that Congress passes and President Obama signs will add to the Federal budget deficit?

Answer: Less than one-fifth of the voters, 19 percent to be exact, think he will keep his word. Nine out of 10 Republicans, 8 out of 10 independents said that whatever passes will add to the torrent of red ink and by a margin of 4 to 3 even Democrats agreed that this is likely.

That is why, Broder says at the end:

By a 16 point margin the majority of this poll said that they oppose the legislation moving through Congress.

So while it is true they are rather arrogantly trying to contend there will not be any big budget deficit from this, the reality is the American people have broken the code they will. One of two things will happen. My colleague from Arizona put his finger right on it. Either we will make cuts in Medicare, for example, that we have never had the political ability to make in the past, in which case our seniors will be hurt, or else, as David Broder said, this bill will truly be a budget buster.

Neither of those results are very sanguine outcomes to an attempt to transform or reform our health care.

Mr. McCONNELL. Will the Senator from Arizona yield for an observation?

Mr. KYL. Absolutely.

Mr. McCONNELL. I certainly share the views of Senator McCAIN that letting these cuts stand is not likely. On the other hand, the President of the United States said he would veto any measure seeking to reverse these cuts. So we have a Hobson's choice: Either the cuts will occur in which case seniors will be devastated or they will not occur, as the Senator from Arizona has pointed out, and the deficit will balloon further.

Mr. McCAIN. Did the majority leader happen to notice that the AARP has now endorsed this bill? It has endorsed a bill that will cut people, 300,000 of them in my State, from their Medicare Advantage Program, that would cut $15 billion from nursing homes, that would cut $8 billion from hospices, and that AARP, which, by the way, I understand gets some $60-some million out of this deal—I say to the senior citizens in my State: Take your AARP membership card, cut it in half, and send it back to AARP because they have betrayed you.

Mr. BENNETT. If I could make the comment, Mr. President, among the people who do not believe these changes would not occur is CBO itself. CBO itself agrees this is smoke and mirrors. They do it in very polite language, but let me share with you the language. They say:

These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next 2 decades, which is often not the case for major legislation.

That is about as gentle a way as CBO can put it. They don't believe this thing is going to stand without these kinds of changes. Yes, they have come forward because their computers say: You put the numbers in this way, this is the result you get. But human beings are saying that is not what is going to happen over the next two decades.

Mr. KYL. If my colleague will yield, Broder, in his column as to this estimate of budget deficit, he says it depends upon two big gambles.

Will future Congresses actually impose the assumed $420 billion cuts to Medicare, Medicaid and other Federal health care programs? They never have.

Mr. McCAIN. Also, I would like to follow up on what the Senator from Tennessee has said because, particularly from some quarters on the other side of the aisle, we have been attacked: Where is the Republican plan?

A very important article was written by Robert Samuelson in the Washington Post on November 16—again, one of the most respected economists in America.

I don't lay off these opinions of my own on them, but the fact is, when you have highly respected people like Robert Samuelson, one of the most respected economists in America, I quote from his column—the title is ''Obama Care, Buy Now, Pay Later.'' That is the title of it. He says—which I think is directly in consonance with what the Senator from Tennessee said:

[A] prudent society would embark on long-term policies to control health costs, reduce government spending and curb massive future deficits.

Then he goes on to say:

So what do they do? Just the opposite. Their far-reaching overhaul of the health care system—which Congress is halfway toward enacting—would almost certainly make matters worse. It would create new, open-ended medical entitlements that threaten higher deficits and do little to suppress surging health costs. The disconnect between what President Obama says and what he's doing is so glaring that most people could not abide it.

That is strong language from an economist. I think what the Senator from Tennessee is saying, and what we are trying to say is, let's go forward. Let's have malpractice reform. That is nowhere in this monstrosity. Why don't we encourage health savings accounts and expand them? Why don't we let people go across State lines to get health insurance policies of their choice? Why don't we reward wellness and fitness? There is a long list of amendments, of fixes to the long-term costs of health care that we could control, that we could enact tomorrow on a bipartisan basis. They do not add to the deficit. In fact, what they do is control health care costs, which is what is wrong with health care in America.

The quality of health care in America is outstanding. It is the cost. We could be working together step by step, as the Senator from Tennessee says, with a long list. I am sure he will add to them the ones I just gave out to control health care costs in America. We stand willing to do it.

After this bill fails, because the American people overwhelmingly are beginning—it may pass the Senate. It may pass the House. It will not pass.

Then why don't we sit down together for a change, Republicans and Democrats, and move step by step to fix the health care problems in America?

Mr. ALEXANDER. The Senator from Arizona is exactly right.

There is no Senator in the Chamber who has a better record of working across party lines on bipartisan steps in the right direction than the Senator from Arizona. But going to Mr. Samuelson's comment—I was talking to a businessman this morning.

I said: If you had a problem in your company, would the first thing you would do is to tear the whole company down and start over again? Or if the football team had lost two or three games, would you blow up the stadium and run everybody off? No, that is not the way you do it.

The person I was talking to said: What I would do, I would identify the problem, I would test the solution, I would phase it in, and I would make sure we can afford it.

The American people know that. I think they are sitting up there looking at us saying: What are these guys doing? Two-hundred-fifty million of us have health care policies, 85 percent. We would like for the rest of America to have that opportunity too. But we know we can't afford that until we get the costs down.

Why don't we do as the Senator from Arizona suggested, let's move step by step in the right direction to re-earn the trust of the American people by reducing costs?

He said: Why haven't we done that? One of those steps is to allow small businesses to pool their resources and purchase a health plan, which the Congressional Budget Office has said would allow nearly 1 million more employees of small businesses to be covered. Their rates would be lower than they are paying today. It would save $1.4 million of Medicaid. This is what the Congressional Budget Office said. So it would reduce costs, increase insurance coverage, and lower premiums. The reason we are not considering it is because when we brought it up, the Democrats said no. They filibustered it. They didn't come across the aisle and say

that is a pretty good idea; let's put that together with two or three of ours, and we will reduce costs.

I say to Senator BENNETT of Utah, you have founded a company. You have run a company. If you were having a problem with the cost of a product or some other fundamental problem, is the first thing you would do, is to think you were wise enough to tear the whole thing down and start over again? Or if you called in a consultant and he recommended that to you, what would you say to him?

Mr. BENNETT. Obviously, I would not respond in the way the folks across the aisle have responded to this health care crisis. The example the Senator has given is a valid one. That is not how you deal with it.

The other point I would make is that if I had a serious problem that was causing difficulty for the survival of the company, I would not put the solution off for 4 years while I raised prices on the existing products to try to pay for it. I would try to do what I could to get the fix upfront as soon as possible.

As both Senators have pointed out, we Republicans have fixes that could start now and don't have to wait until 2014 in order to get a good CBO score.

Mr. MCCAIN. Along those lines, again, about this Madoff-type budgetary procedure, I am not that good at math. I am sure the Senator from Tennessee is. Help me out.

We have $1 trillion that they want to make in offsets, right, in this 10-year plan. If you started the program at the same time that you enacted the savings, that would be $1 trillion, right? That would be $2.5 trillion. So the deficit, if you used correct accounting procedures—in other words, you bring in the benefits at the same time you start paying for it—you would end up with a $1.5 trillion deficit to the budget? Does that make sense?

Mr. ALEXANDER. It sounds right to me. It is another part of the arrogance of this bill, which is to say we are not smart enough to figure it out. The majority is saying the 10-year cost of the bill is $849 billion, but it doesn't start counting until the fifth year, and Senator REID thinks the American people are not smart enough to figure that out. That is part of the arrogance of the bill.

Mr. MCCAIN. If the benefits kicked in at the same time the taxes did, you would be talking about a $2.5 trillion cost.

Mr. ALEXANDER. That is $2.5 trillion, right?

Mr. BENNETT. I point out the CBO makes the same point at these 10 years. Again, quoting the CBO letter, talking about the 10 years following, when you have the full 10 years of expenditures instead of just 5 or 6 years of expenditure, it says:

> Under the legislation federal outlays for health care would increase during the 2010–2019 period, as would the federal budgetary commitment to health care.

So those who are saying this is going to be a saving to the government and you are going to turn the cost of health care—turn the cost curve with respect to health care down, the CBO has said: No, that is not the case. The Federal commitment would go up in those years.

Again, by delaying the implementation of the expenditure while implementing immediately the implementation of the revenue, they are creating the kind of financial chicanery that, as Senator MCCAIN has said, put Bernie Madoff in jail.

Mr. MCCAIN. Could I bring up another issue to the Senator from Tennessee and the Senator from Arizona and Utah. A New York Times article this week stated: ''Drug Makers Raise Prices in Face of Health Care Reform.''

> Even as drugmakers promise to support Washington's health care overhaul by shaving $8 billion a year off the Nation's drug costs after the legislation takes effect, the industry has been raising its prices at the fastest rate in years.
>
> In the last year, the industry has raised the wholesale price of brand-name prescription drugs by about 9 percent, according to industry analysts. That would add more than $10 billion to the nation's drug bill, which is on track to exceed $300 billion this year. By at least one analysis, it is the highest annual rate of inflation for drug prices since 1992.

So the moral of the story is, you lie down with dogs and you get fleas. So they cut a deal with the administration to cut drug costs, and guess what. With inflation zero, no inflation, they have decided to raise costs by more than 8 percent. Oh, the Consumer Price Index has fallen by 1.3 percent. The Consumer Price Index has fallen by 1.3 percent, and the prescription drugs have increased in cost by 9 percent.

What does this do to seniors? Seniors are not going to get a COLA in Social Security this year because the consumer price index has fallen—which is the indicator as to whether cost of living adjustments are given to Social Security recipients. So what does the drug industry do? Without inflation, they raise the cost of prescription drugs by some 9 percent at a time when Americans are hurting more than ever. Shame on the drug industry. Shame on those people, and shame on the administration for cutting a deal with them.

Mr. KYL. Mr. President, I see our other colleague from Utah here. I know that during Finance Committee deliberations, he was directly involved in one of the conversations about the drug costs and also has been working on his own ideas for alternative approaches to some of these problems. I will ask a question and then if my colleague from Utah, Senator HATCH, may like to comment further, we would invite that.

Is it the case that the Joint Committee on Taxation, which reported to the Finance Committee, and the Congressional Budget Office both said that not only would the increased taxes on the pharmaceutical industry, the medical device industry, and the insurance industry be passed on to consumers in the form of higher premiums but that overall under the legislation that is before us, for the average family as compared to what prices are today, insurance premiums would actually go up and this was one of the two major reasons, the other being mandated benefits?

Mr. HATCH. The Senator is absolutely right. They even said the premiums of the so-called government plan would be higher than private sector insurance premiums. It is incredible.

I have enjoyed the comments by the distinguished Senators from Arizona, Utah, and Tennessee. If you look at what they are trying to do, they are going to throw out a system that 85 percent of the American people feel is basically OK, because they have not taken care of the 15 percent who don't have insurance. But when you deduct the 6 million people who work for companies that provide insurance but they don't take it—they would rather have the money—and you take out the 11 million people who basically qualify for Medicaid or SCHIP but are not enrolled, and you deduct those who earn over $75,000 a year and can afford their own insurance, and then you take the illegal aliens, the documented workers and undocumented workers, you basically come down to 17 million people who need and deserve our help. We are going to throw the whole system out for 85 percent of the people when we could, through subsidization, help those who deserve help.

It doesn't make sense. What are they thinking over there? I hope it is not that they want to take us to socialism or to Europeanize us, when Europe is trying to get away from Europeanization.

We are rapidly approaching one of the most important votes for all of us in the Senate. This is bigger than any of us, our parties or our ideologies. This is about the future of the greatest Nation in the history of the world. It is about your children and my children. It is about your grandchildren, my grandchildren. Elaine and I have three great-grandchildren and two more on the way. It is about giving the future generation the same opportunities and same sense of pride. It is about every American's way of life.

Every American business will be subject to this. Look at that thing, a 2,074-page edict from Washington. I am going to spend my time before this historic vote to highlight some very important numbers. Every Member of this Chamber should understand what they are voting to advance. Make no mistake, our actions today will not be

without consequences. History and future generations will judge us by what we do here today.

Zero is the number of provisions prohibiting the rationing of health care, not one word prohibiting the rationing of health care. All you have to do is look at some of the things that happened this week and you start to worry about it. How about this? Zero is the number of government-run entitlement programs that are financially sound over the long term. Consider these important numbers: 10.2 percent national unemployment rate, the highest in 26 years; 70, the total number of government programs authorized by this bill, 70 new programs at a time when we are going into fiscal insolvency; 1,697 times the Secretary of Health and Human Services is given authority to determine or define provisions in this bill. We are turning the whole thing over to the bureaucrats here in Washington. More numbers: 2,074 total pages of this bill—look at that—2010, the year Americans start paying higher taxes to support this bill. My colleague from Utah and my colleagues from Arizona and Tennessee have brought that out in no uncertain terms. The year when this bill actually starts is 2014, most of the major provisions of this bill. Some of them don't even begin until 2015. The number $6.8 million is the cost to taxpayers per word in this bill; $8 billion is the total amount of new taxes on Americans who do not buy Washington-defined health care; $465 billion in cuts in Medicare at a time when Medicare faces a $38 trillion unfunded liability to finance more government spending; $494 billion is the total amount of new taxes in this bill.

If you think that is all, I think you have something coming here. According to the Budget Committee, using CBO figures, $2.5 trillion is the real cost of this bill over a 10-year period. Our total national debt will be $12 trillion. These numbers are facts and they are indisputable.

Let me finish by reading an excerpt from a fellow Utahn from Provo who is worried about what this bill will do to our country.

I am writing out of deep concern over the increasing expansion of government. I moved here from Germany 20 years ago. I love America because it is free—free-er than Germany in that I have the freedom to choose among other things how I want to insure my family (we have six children). I'm all for affordable health insurance which requires affordable health care. I am self employed and have been hit hard by the economy. There is a good chance that we would actually benefit from [this bill]. Business has been so bad that we would qualify for free school lunches if we asked for it. But I don't want more government handouts. I don't want the government telling me what kind of insurance I need to have. I don't want the government telling me what services I can receive when I need them. I don't want them taking an ever greater part of my income to help finance government programs such as the ''public option'' and the army of government employees it will take to administer such a program. I do not want more government. I want less. A lot less.

These people from Germany have been living in our country as citizens for 20 years. They know what it was like to have their type of a system. I think we ought to pay attention to that humble person who, in spite of the travails they have, don't want this big, massive government program to become law.

Mr. McCAIN. Mr. President, I thank both Senators from Utah for their thoughtful comments and significant involvement. I wish to return to the issue of what we need to do. I say that because criticism has been leveled at this side of the aisle that we have no plan; therefore, since we have no plan, we should embrace this. The fact is, we have had plans. We have had proposals. We have tried to get them listened to. They range from medical malpractice reform to other free market cost reduction measures that add competition and quality to the health care system. Our objective is affordability and availability.

I want to talk with the Senator from Tennessee about the issue of medical malpractice reform. Here is a huge piece of legislation. Yet I ask my friend from Tennessee, is there any measure in this bill we have been able to detect so far—we have been able to detect $100 million in additional Medicaid benefits for the State of Louisiana, but we haven't been able to determine all of the aspects of this bill. On the issue of medical malpractice reform, physician after physician in America says they have to practice defensive medicine for fear of finding themselves in court. Why is it that we have literally no addressing of an issue that could significantly reduce cost?

As I recall, the CBO said that medical malpractice reform could reduce direct medical costs by some $54 billion over 10 years. There are other estimates that say if we added in the cost of the practice of defensive medicine over prescription medicines and drugs because of fear of finding themselves in court, this could be as much as $200 billion. Yet there is not one significant addressing of the issue of medical malpractice in this legislation. I think that is a testimony to the influence of the American trial lawyers association.

Mr. ALEXANDER. Mr. President, I would say to the Senator from Arizona, that is a part of the problem. But I think of it a little different way. There has been a lot of talk this week about medical care availability for women in America. In Tennessee, in 45 of our 95 counties, there are no OB/GYN doctors. So pregnant women in Tennessee in those counties have to drive 50, 60, 70 or 80 miles for prenatal health care. They might have to check into a hotel for a few days in a big city in order to have their baby.

Mr. McCAIN. Could I add, the mirror opposite of that is the State of Texas which was hemorrhaging medical doctors and care providers and then, after they enacted a very modest malpractice reform, there was a flood of physicians returning to the State of Texas. Isn't that the case?

Mr. ALEXANDER. That is exactly right. In fact, a number of us have offered to the Senate, as a part of the way we would go about reducing health care costs, basically adopting the same kind of provisions they did in Texas which still leaves anyone who is hurt, a complete right to recover from that injury, but makes a major change in the availability of doctors to that patient. And in the case of Tennessee, we were talking about OB/GYN doctors to women who are about to have babies. The Senator from Arizona said that would save at least $54 billion over 10 years. No one doubts that reform of medical malpractice, junk lawsuits against doctors, would reduce costs. The point we are trying to make here is, instead of that historically arrogant 2,074-page bill that presumes we know enough to change every aspect of health care in America, why don't we re-earn the trust of the American people, who have lost a lot of confidence in those of us in Washington, and start taking steps in the right direction to reduce cost? We could do it by adopting our legislation to reduce unwarranted medical malpractice suits. That would be one step.

Mr. McCAIN. Could I revisit with the Senator an issue we talked about a little earlier and with my friend from Utah as well. This is the recent spate of publicity concerning a recommendation that women wait until 50 years of age before—I see our physician Dr. BARRASSO is here also—getting routine mammograms. That ignited a firestorm throughout America and story after story of women who have experienced breast cancer who state categorically that if they hadn't gotten the mammogram when they did, it is possible they would not be alive today.

Now that is a nice academic discussion. But I would ask—maybe Dr. BARRASSO would answer it—isn't that the kind of advisory board this legislation could put into law; that those kinds of mandates could come down, which could literally jeopardize the health and lives of Americans?

Mr. BARRASSO. Mr. President, I would say to my colleague and friend from Arizona, this type of legislation would have cost my wife her life. She is a breast cancer survivor, diagnosed by a routine screening mammogram. She was in her forties when that mammogram was performed. She went through the testing and had the operation. In that age, in her forties, she already had the breast cancer spread from her breast to one of the lymph nodes. It was a screening mammogram that

saved her life. She has had three operations, two bouts of chemotherapy. As a result, she is a survivor—6 years later.

But this piece of legislation says: No, no, do not worry about it. There is not going to be any denial of care. There is not going to be anything like that. But if you turn to page 1,150, it talks specifically about this preventative task force, specifically saying when they make their recommendations there is going to be money that taxpayers are going to pay to tell people what those recommendations are. Then, if you go to page 1,190, it says that if it is not approved, they will deny payment for that service—deny payment. It does not say they might.

Mr. MCCAIN. I say to the Senator, you would not describe that as a ''penal panel''?

Mr. BARRASSO. Some people might.

Mr. KYL. Mr. President, I went back to my office and got the exact pages our doctor colleague has just been talking about—page 1,189 and page 1,190 of the actual bill. My colleague from Arizona asked the question—this entity, this U.S. Preventive Services Task Force; the entity that made the recommendations with regard to mammograms is it possible their recommendations could be used to deny coverage or reduce payments or deny payments?

Well, here is the exact language, if my colleagues would like to hear it. The Secretary of HHS is, of course, the person who implements this. It is not the task force. The task force makes the recommendations, and then the Secretary of HHS issues the regulations. Quoting:

> Notwithstanding any other provision of this title, effective beginning on January 1, 2010,—

That is just a couple months from now—

> if the Secretary determines appropriate, the Secretary may—
>
> (1) modify—
>
> (A) the coverage of any preventive service described . . . to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force. . . .

So there you have modifying the coverage. Then, secondly, as my colleague was just reading:

> (2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.

In other words, they make the recommendation, and they say this does not meet our standards, so she can say, therefore, we are not going to pay for it.

That is taking the recommendations of this task force and translating it into the rationing of health care. This is how rationing begins.

Mr. BENNETT. Mr. President, if I could share with Senators this statistic. We hear a lot of talk about everybody has to be covered. We talk about the United Kingdom, where they have a plan where everybody is covered. The cancer survivor rate for women with breast cancer in the United Kingdom, after diagnosis, is 57 percent. The cancer survivor rate in the United States, where we have people who are not covered, is 67 percent. I do not think we want to move in the direction of bringing that rate down.

Mr. BARRASSO. The reasons for that are they are not doing early enough screening, and even once they are able to find the cancer in Great Britain, how long do they have to wait in line until they actually receive the surgery? The delay of care is the denial of care, and that is what is going to happen under this bill.

I see my colleague from Idaho standing as well because he is familiar with this situation. But I look at this and see the numbers. They said: Well, we don't want to cover this service because it would only save 1 life out of 1,900 women in their forties. Well, in my case, that 1 life out of 1,900 was my wife Bobbi.

I know the Senator from Idaho wants to get involved in this discussion.

Senator RISCH.

Mr. RISCH. Mr. President, as you read these pages, most of it is incomprehensible. But, interestingly enough, the point made by the good Senator from Arizona about the ability of the U.S. Government to cut off health care to people is stated so clearly on page 1,189 of the bill. The title of the provision is ''Authority to Modify or Eliminate Coverage of Certain Preventive Services.'' How much clearer can it be? This bill gives authority to the group that was identified to modify or eliminate coverage of certain preventive services.

Had this bill been in effect in the last week when the recommendations came out on mammograms, American women would be denied coverage for mammograms in the time period that was identified by this group. This is absolutely clear on this. This is just the beginning of the kind of health care rationing you are going to see under this bill. Americans are frightened, and they should be. Health care rationing is coming to America if this bill is passed.

Mr. BENNETT. Mr. President, I would like to share another statistic in this whole circumstance that I think we need to focus on because, back to the Broder column Senator MCCAIN talked about, we are talking about the amount of expenditures and the creation of a new entitlement.

Let's go back to the debate on the budget. We got the numbers that said the projected revenue for fiscal year 2009 was $2.2 trillion. The entitlement spending for 2009 was $2.2 trillion. That means everything we have done in government—our embassies overseas, our military, the national parks, education, whatever it is—absolutely everything in 2009, other than entitlement spending, had to be borrowed money.

What are we doing with this bill? We are going to increase entitlement spending. We are going to increase the role of government that this Congress or future Congresses have no direct control over through the appropriations process. I have been chairman of an appropriations subcommittee. The amount we have control over in the Ag Subcommittee is about $17 billion. The total bill was $80 billion. The rest of that $80 billion was off-limits to the Appropriations Subcommittee because it was on autopilot as entitlement spending.

The entitlement spending for farm subsidies is small potatoes, to use a farm subsidy word, compared to the entitlement spending for health care. So facing the kinds of deficits we are facing, facing the runaway entitlement spending we have, the largest portion of which is entitlement spending for health care, what are we being told to do? Increase the entitlement spending for health care and put future Congresses in an even deeper financial bind by taking even more of the total portion of the Federal budget that is outside the appropriations process and putting it on autopilot. That is the issue we must keep in mind as we look at this whole circumstance.

Mr. MCCAIN. Mr. President, I thank the Senator.

Could I go back, again, and reemphasize with my colleagues and the American people what is very odious about the bill that is before us; that is, the Madoff-style budget gimmickry associated with this legislation. In 40 days—in 40 days—tax increases and Medicare cuts of approximately $1 trillion will begin—in 40 days. That is 6 weeks from now. But any benefits that would accrue from this legislation would begin in 208 weeks—1,460 days.

So why in the world would we approve—and, obviously, we know why it is done. It is to make the budget look better, when it is deception being perpetrated on the American people because we are not telling them the true cost. We are not telling the truth because, if the benefits started at the same time the taxes started, it would be a $2.5 trillion deficit over 10 years.

It is unfair to the American people, who are going to have to foot the bill for this massive piece of legislation—it is unfair to them to tell them they are going to have to start paying the taxes and footing the bill for it and only 4 years later would any benefits come to them. I think that is a really wrong thing to do to the American people.

Do you know what. The American people are beginning to figure it out. Mr. President, 51 to 35, the American people do not want this. The American

people do not want an increase in the deficit. They want the spending stopped, and they are figuring it out. I am afraid my friends on the other side of the aisle may have underestimated the intelligence of the American people.

Mr. ALEXANDER. Mr. President, I would like to thank the Senators from Arizona, Utah, and Idaho. Reading that big bill is very hard to do. So for those who are watching, what we have been trying to do—as Senator MCCAIN and Senator KYL just did—is take specific provisions and discuss them and interpret them.

We have done that with the higher premiums. We have done that with the higher taxes that the bill will require. We have done that with the Medicare cuts. Earlier today we had an hour discussion, led by Senator CORKER, that discussed how the bill would send the costs for Medicaid expansion to States.

We have talked now about what we would do if this bill were to fail, which we hope it does. We think this bill is historic in its arrogance—arrogance that we could turn over this whole system, that we think the American people cannot figure out that the bill costs $2.5 trillion, instead of the $849 billion, as advertised.

What we propose is, we move step by step in the direction of cutting health care costs for individuals and for our government. We have proposed legislation that would reduce junk lawsuits, combat waste, fraud, and abuse, allow small businesses to pool resources to purchase insurance, allow Americans to purchase health insurance across State lines, expand health savings accounts, and promote wellness and prevention.

Mr. BENNETT. Mr. President, I wish to make the point, again, following up on what the Senator from Tennessee has had to say, that the argument we are hearing from the other side is a false argument when they say it is either this bill or the status quo and the Republicans have nothing to offer.

We have been offering proposals all along. I have been immersed in this for 3½ years, cosponsoring, with my Democratic friends, ideas on the way to go forward. Those proposals were not even allowed to be considered in committee. The 2,000 pages we see before us were written without a single Republican knowing where the room was, let alone being in the room. Then we are told: But you stand for the status quo, and the status quo is unacceptable.

I repeat what I said earlier: The way this bill is constructed, the status will remain quo until 2014, as far as benefits are concerned, but the taxes will start immediately. But we all know the revenue that comes from those taxes will not be held in trust to pay for the benefits in 2014. They will go for other things, to pay for the $1.4 trillion deficit we have this year. Then, in 2014, when the expenses start, the money will all have been spent that had been brought in, in the 4 years previously, and, as the CBO says, there will be change.

I yield the floor.

The PRESIDING OFFICER. The time reserved for the Republicans is expired.

Under the previous order, the time until 6:30 p.m. will be controlled by the majority.

The Senator from Michigan.

Ms. STABENOW. Mr. President, it is my pleasure and honor this evening to be here to strongly support this motion, this historic motion to proceed to a historic debate about whether we, as America, the greatest country in the world, are going to make sure all Americans have access to affordable health care insurance. This is something that has been debated for 100 years. Now we have the opportunity, with the House having passed their version, to move forward to this debate where we will have lots of opportunity to offer amendments and to debate honest differences in policy. But in the end, I believe confidently that we will come together to move forward to pass legislation that will save lives, that will save money for the American people, that will protect Medicare, and that will stop insurance abuses happening for families every single day.

I have come to the floor so many times to talk about health insurance reform, as has the distinguished Presiding Officer from Rhode Island. I wish to take just a moment to say thank you to a few people because, as the Presiding Officer knows, we would literally not have this opportunity today if it were not for Senator HARRY REID, our distinguished majority leader. He is a quiet, smart, determined, focused leader who has listened to everyone, who has looked at the work products from the Finance Committee and the HELP Committee and brought together a combined bill that is the best of both. He is going to give us the opportunity to continue to debate and improve it on the floor before final passage. So I thank Senator REID. I know he is passionate about his State of Nevada, and that is his No. 1 love after family, but I think No. 2 is the Senate and the ability to lead and get things done, and I thank him.

I thank Senator BAUCUS for his incredible leadership on the Finance Committee; Senator DODD for his leadership and stewardship in bringing the HELP Committee through with their legislation; Senator HARKIN, Senator WYDEN, and Senator BENNETT, who is on the floor. We are not agreeing on the movement forward on this bill, but there have been 2 years of working on health care that I appreciate, and their efforts together to work on health care.

I thank Senator SNOWE. I don't know if she is going to be with us this evening, but her courageous vote on the Finance Committee is something we desperately appreciate. I know she is going to continue to provide input, and I am hopeful she will be with us on the final vote because her input and her knowledge have been extremely important in this process.

I also thank the memory of a very important Senator named Ted Kennedy, who I know is here in spirit, for 40 years of dedication to this cause.

Finally, I thank President Obama. If not for his vision, we would not be here today. For 8 years under a former President, we did not have the opportunity to get here to this place. We did not have the opportunity to be able to end insurance abuses and truly protect Medicare for the future, to put forward health care reform, to save lives, and to save money. I also thank President Obama for understanding that health care is also about jobs and that we have too many people in this country today who are losing their job, and with that they are losing their health insurance. So it is impossible to talk about health care reform without also talking about jobs because for most families they are connected and one and the same.

I have spoken on the floor so many times on health care cost and access. Frankly, health care is something that brought me to public service 30 years ago; when I was 5, I just want to say that for the record. I led an effort in our community to keep a nursing home open in Okemos, MI, and ever since then have been fighting to get to this debate, to get to this point in terms of affordable health insurance for all Americans.

So tonight, after this vote, we start the real debate. This bill provides a framework for every American to find affordable insurance. Is it everything I would do if I was writing it by myself? Of course not. Every Member can say the same thing. But the Democratic process is coming together with the best ideas and negotiating and doing the best we can to be able to solve as much as we can in the best way possible. I am going to continue to work to make health care truly affordable and will be sponsoring and cosponsoring amendments as we move forward to improve on what I believe is a very good bill. I am confident that at the end, again, we will pass legislation that saves lives, that saves money, that protects Medicare, and that stops insurance abuses.

When we first started this effort, I set up the Health Care People's Lobby on my Web site so that people could share their stories, how they felt about what we should be doing. Should we move forward and act? What should happen? What were their experiences with their health insurance and the companies that cover them now? I have heard so many stories. I wish to thank

everyone—thousands of people—who has shared their story. I want to put a face on this debate and vote tonight by sharing just a couple with you.

When we say saving lives, this is not just a slogan. We are talking about saving lives. Forty-five thousand people have the ultimate rationing every year because they can't find affordable insurance. As a consequence, they lose their lives—45,000 people in the greatest country in the world. We can do better than that, and that is what this bill is about.

I wish to share just one story of a young man, Joe, from Okemos, MI. He is a recent graduate of dental school. He worked very hard, was very bright. He was just between jobs after completing his residency, and we know how long and hard that is, to get to that point. He suddenly fell ill. This was only a few months ago. He called his mom. She urged him to go to the doctor, but because Joe didn't have insurance, he was worried about going to the doctor, so he didn't. He continued to feel worse. His family finally got him to agree to go to the hospital, but by then it was too late. Joe died at age 27 of an aneurism—27 years old—because in America, he didn't have insurance and was afraid he couldn't afford it if he went to a doctor.

This is about saving lives. This is about saving money for businesses that are trying to keep the doors open, that may provide insurance now but are at a point where either the jobs go or they have to stop providing insurance. So people come in, and the owner says: I want to keep you working, but we are not going to be able to have health care for you anymore.

This is about the fact that our country is spending twice as much as any other country on health care and yet sometimes having outcomes that are far worse than we would like to see as it relates to other countries. We are 29th in the world in the number of babies who make it through the first year of life. Of all of the insurance companies a woman can choose from if she goes into the private individual insurance market—59 percent don't provide maternity care, basic care, prenatal care, care for mom and baby during the first year. So that is going to change because of the values we bring to this.

We are going to protect Medicare. Folks don't have to believe us. There is a lot of debate about what is happening in Medicare. I am very proud to say we have received a very strong letter from the AARP supporting a ''yes'' vote this evening to move forward on this debate, and that is critically important for us.

Let me share from the Web site of AARP what they say—the champions for seniors in this country; what they say, not what we say—about what is being done in health care reform.

On their Web site:

> Myth: Health care reform will hurt Medicare.
>
> Fact: None of the health care reform proposals being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for Medicare services.
>
> Fact: Health care reform will lower prescription drug costs for people in the Medicare Part D coverage gap or doughnut hole so they can better afford the drugs they need.
>
> Fact: Rather than weaken Medicare, health care reform will strengthen the financial status of the Medicare program.

That is why AARP has written a letter urging us all to vote yes on the motion this evening we will be voting on, because we are strengthening Medicare for the future.

Then let me speak to the question of insurance reforms because the reality is that the majority of people have insurance. The majority of us so far have insurance through our employer, and we hope that as we bring down the costs and save money, that, in fact, we will be able to make sure people are going to be able to continue to have the coverage they are paying for today. So we are talking about insurance abuses and stopping those insurance abuses.

I wish to share a couple of stories from individuals who have found themselves in a very difficult situation. I realize my time has come to an end, so I will be brief, but I do want to share just a couple of stories in conclusion.

From the newspaper recently: Benjamin French, a young boy in Michigan, was born with his right arm missing below the elbow. In his 12 years, he has been fitted with seven prostheses. His most recent replacement will cost nearly $30,000, and his doctor says he will soon grow out of it. He is a 12-year-old who is growing up, so as he gets an artificial arm, it has to be replaced periodically to be able to grow with him. But according to his insurance company, the boy is ineligible for future coverage of prosthetic devices because he has already spent his lifetime maximum benefit. That is going to stop. We are going to eliminate those lifetime caps that get in the way of a 12-year-old being able to have the artificial arm he needs as he grows up so he can lead a normal life.

I wish to share one other story, and that is from Glen from Sterling Heights. He is 62 years old. He got laid off in December. It doesn't look as if he will be called back. He writes:

> I am too young for Medicare. I have preexisting conditions, so nobody wants to insure me. If I get sick before I can get Medicare, my savings and everything else will be wiped out. This is not the way I pictured retirement was going to be. I raised four children, got them through school, and married; paid taxes and did what I thought was the right and moral thing to do. I didn't create this mess, but I am sure paying for it.

He did the right and moral thing, and that is what we are being asked to do on behalf of the American people.

Vote to move forward tonight. Vote for the debate. Doing nothing is not an option when we are losing jobs, people are losing lives; when we are losing the capacity of the country to be able to provide the health care for our families that we need to provide. It is our turn tonight to vote yes on proceeding to a debate that I believe, working together, will result in legislation on health care that will save lives, save money, protect Medicare, and stop insurance abuses.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. MENENDEZ. Mr. President, for many months the voices of opposition to any health care reform have been loud and clear. They have been shouting at townhall meetings and heard in debates in this Chamber. All too often, we have heard shrill voices raised in anger from those who are either misinformed or who would choose the status quo that benefits insurers at the expense of families. For too long those voices have gone unanswered.

The Patient Protection and Affordable Care Act we are about to consider is our answer. It is loud and it is clear. It is thoughtful and historic. Once again, like so many other pieces of landmark legislation in the last century, it is a product of this side of the aisle.

Those who have chosen to block any attempt at health care reform this year are on the wrong side of history, just as those who came before them had one response to every landmark piece of legislation for the last 80 years. Their response has been a resounding ''no.'' They told us that it is not good for business, that it is socialism, that it stifles free market forces, and that it is too much and it goes too far.

We have heard the same fear mongering and innuendo since the New Deal. There are those who raised the specter of socialism then and said no to Social Security. They said no to unemployment insurance when President Roosevelt proposed it as part of the Social Security Act. They said no when John Kennedy and Lyndon Johnson fought for Medicare. They said no to the Civil Rights Act. They said no to the Voting Rights Act. They said no to the Clean Air and Clean Water Acts. They said no to jobs programs. They said no to increasing unemployment insurance, when people needed it the most. They said no to government oversight of polluters who poison our land with toxic waste, and then they said no to cleaning it up. They have been on the wrong side of history for almost a century on every major piece of legislation that has leveled the playing field for average Americans. They are on the wrong side of history once again.

All we hear from the other side of the aisle is the dim echo of the past, with no plan for the future. Americans are tired of the naysayers, tired of the shrill voices of no, when so much is at stake. It is time to say yes, time to say yes to stopping greedy insurance companies from standing between doctor and patients, time to say yes to ending medical decisions based on risk management and the bottom line rather than on saving people's lives.

This historic legislation, like so many other pieces of legislation debated on this floor, is about people—their lives, their hopes, their health, and their dreams for a better life for themselves and their families. We can be proud of this legislation. I know that when the dust settles and the provisions of this bill become clear, America will be proud of it as well.

This landmark reform legislation includes State-based exchanges creating a fair, open, and competitive marketplace for affordable health care coverage. It includes an amendment I proposed for long-overdue consumer protections for emergency services without having to call your health care provider and get a prior authorization. It requires insurance plans to provide behavioral health treatments, such as those for children who face the challenges of autism, as part of the minimum benefit standards. It encourages investments in youth therapies to prevent, diagnose, and treat acute and chronic disease. There is a tax credit for innovative biotechnology research. It ensures that minor children qualify as exchange-eligible and provides for the availability of child-only health insurance coverage in the exchanges. It stops insurance companies from denying coverage for some preexisting condition, some preexisting health status, or gender. It ends the medical benefits shell game that insurers have played with people's lives.

As soon as this bill passes and the President signs it into law, 1.3 million seniors in New Jersey will receive free preventive care, such as colonoscopies or any other recommended preventive service; 227,000 New Jersey seniors will have their brand-name drug costs in Medicare Part D cut in half; 854,000 New Jerseyans will qualify for tax credits to help them buy health insurance and ease the burden of premiums, deductibles, and copayments; 107,000 small businesses in New Jersey could get a small business tax credit—up to 50 percent of premium. Health care reform will end the hidden tax that gets passed along with the $1.1 billion spent on uncompensated care in New Jersey. It will provide portability, security, and choice through the health insurance exchange for 1.5 million New Jersey residents who don't have health insurance at all.

The bottom line is that Senator REID's merged bill helps New Jersey and America. It is fair, balanced, and fixes a badly broken system. It is truly a historic piece of legislation and will be remembered as such. Yet there are all those who will stand against all of it, those who will stand firmly on the wrong side of history once again, those who will use every legislative tactic to stop this legislation as they tried to stop Social Security and Medicare. I am afraid history is about to repeat itself.

We have seen that the truth has been a victim on the Senate floor today. We listened to some of the most dire predictions, some of the most incredible statements, with figures thrown out there that are astronomical, simply not true, and in defiance of what the nonpartisan CBO said, which we all depend on—Democrats and Republicans. They said this bill actually cuts the deficit by $130 billion in the first 10 years and $650 billion in the second 10 years.

In the face of a health care system that seems to work only for health insurers—certainly not for average Americans—one must ask what, if any, health care reform are my friends on the other side for. What were their predecessors for when Americans were standing in bread lines and needed unemployment insurance? What were they for when they voted against Medicare? What are our Republican colleagues for now? They seem to be for one thing only: protecting the status quo, leaving health care just the way it is, letting insurers make medical decisions, letting insurers collect premiums and then find creative ways to deny coverage.

On the other hand, this bill represents the change America voted for. But as we have seen, change does not come easily. You have to work for it. You have to fight for it. Sometimes, in the face of the naysayers and fear mongers, you need more than the truth, common sense, and even a good plan; you need to fight for what you know is the right thing to do for every American, not the few, not the powerful and the well-connected but everyone.

At the heart of it, this vote we will cast tonight is about change. We can see how hard real, honest, commonsense change is. We must ask ourselves: Do we continue to be the agents of change or do we stand with the status quo that discriminates against hard-working Americans who are denied health coverage because of preexisting conditions? Do we continue to be agents of change or do we stand with the status quo and deny coverage to women when they are pregnant? Do we continue to be agents of change, however hard it may be, or do we continue to deny millions of Americans access to quality, affordable care?

History calls on us to stand on rare occasions for what is fair and just and right for the American people. This is one of those occasions. It requires more than parliamentary maneuvers to slow the process. It requires more than voices raised under the banner of free market values at the expense of fundamental human values. It requires doing what is right for the American people. Only then will we find ourselves on the right side of history. That is what this vote is about.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I thank the Senator from New Jersey for his very strong and poignant statement. I listened to it all. I think he really summed it all up.

Let me add to that by saying we are at a momentous crossroads right now in the history of our country. We are at a time that likens itself to 1935, when this Congress passed the Social Security Act. It is like the time in 1965 when Congress passed Medicare. Both of them were giant steps forward in the health and economic security of the American people. But as much as they are part and parcel of our American life today, both Social Security and Medicare were bitterly opposed in this Senate by conservatives who did not want to change. In fact, one conservative Republican Senator said that passing Social Security would put an ''end to the progress of our great country.'' They attacked Medicare as socialized medicine. As Senator Robert Taft said at that time, ''It is going to Sovietize America if we have Medicare. It is going to be a government takeover.'' Well, here they go again. They are unduly frightening people in this country. We saw it earlier with the death panels—all bogus. It was to instill fear in people.

It is hard to change, but the people of America voted last November overwhelmingly for Barack Obama and for Democrats in the House and Senate because they wanted to change the system. They knew we had to change.

People don't fear change. They know it is tough, but they don't fear it. They don't fear change in our health care system either. What people fear is keeping the present system. That is what I hear. They fear being denied coverage because they have a preexisting condition or one of their children has a preexisting condition and they will not be able to get health care coverage. That is what people fear. They fear they will be dropped from their policy because they have come down with cancer or heart disease or some other chronic illness. They fear that if they have a serious illness, they will have to go into bankruptcy to pay the bills. Sixty-two percent of all the bankruptcies in this country are because of medical causes. Eighty percent of those are people who already had coverage. That is what people really fear.

Another reason I think conservative forces will fail this time is because they believe people who have good health insurance really lack compassion and they don't care about the 46 million other Americans who don't have it. I disagree. People care deeply about those 46 million Americans who don't have insurance. It is a national shame when children don't have access to a doctor.

It is unfortunate that our Republican friends are determined to prevent us from even debating and amending the bill. That is what the vote tonight is about. Republicans and the health insurance industry are joined at the hip, using the same talking points, same distortions, same cooked-up scare tactics.

All I can say is, since the Republicans' goal is to obstruct, obstruct, and obstruct, the people of this country are looking to us, to the Democrats, as they did in Social Security and as they did in Medicare, they are looking to us to move this country forward. So this is a call to arms for our caucus. I hate to put it in those kinds of partisan terms, but what can I do when every single Republican says they want to obstruct and stop this bill? It is now on us, the Democratic caucus, all 60 Members, to come here and stand strong for the American people. Now is not the time to go wobbly in the knees, I say to my friends in the Democratic caucus. Now is the time to stand strong, the time to come to the well at 8 o'clock tonight and move this country forward. It is time to say yes to the American people and no to these fears and unfounded allegations you will hear from the other side. Now is the time to take the next step forward in the real progress of this country.

The PRESIDING OFFICER. Under the previous order, the time until 7:15 p.m. will now be controlled by the Republicans.

The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I wish to be notified when I have spoken 20 minutes, please.

The PRESIDING OFFICER. The Chair will gladly do that.

Mr. GRASSLEY. Mr. President, on November 10, former President Clinton visited the Democratic Senate caucus. It has been widely reported that his message to Senate Democrats was that on health care reform, the worst thing to do is to do nothing.

With all due respect to the former President, that is simply wrong. Mr. Clinton, the worst thing we can do is pass this bill. This is not something I say lightly because there are serious problems with our health care system. There are important steps we need to take to fix the problems in our system. But the excesses of this bill appear willfully ignorant of what is going on outside health care. Those things deal with our economy. Those excesses make this bill far worse than doing nothing.

We are a nation facing challenging economic times. We have seen the auto industry go into bankruptcy. We have seen banks shutter their doors.

I want to refer to a chart of our national debt. The Federal debt has increased by $1.4 trillion since inauguration. This chart shows the growing amount of debt the Federal Government is taking on. The amount of increased debt added since the inauguration is $11,535 per household. The national debt now exceeds $12 trillion for the first time in history.

I wish to show a chart on Federal health spending. As this chart illustrates, this bill bends the Federal spending curve further upward by $160 billion over the next decade. The red area of this chart is that net additional Federal health spending, not according to this Senator but according to the nonpartisan Congressional Budget Office. Americans have rightly lost faith when in the face of the current economic crisis Congress thinks this $2.5 trillion restructuring of the health care system happens to be a good idea.

Perhaps one of the biggest warning signs that this bill will saddle taxpayers with more spending and debt is the fact that the budget fail-safe mechanism was dropped from the bill behind closed doors in the Capitol where this bill was written—and I emphasize "closed doors." The Grassley budget fail-safe mechanism was cut from the bill and lots of budget gimmicks were added.

Former Congressional Budget Office Director Douglas Holtz-Eakin wrote in yesterday's Wall Street Journal that this bill is "fiscally dishonest" and that it uses "every budget gimmick and trick in the book . . . leave out inconvenient spending, back-load spending to disguise the true scale, front-load tax revenue, let inflation push up tax revenues, promise spending cuts to doctors and hospitals that have no record of materializing," and so on.

This bill is simply irresponsible. It is worse than doing nothing.

Let's talk about some of the excesses in the bill. It increases the size of government by a staggering $2.5 trillion when fully implemented. It imposes $½ trillion in new fees and taxes. Imposing these new fees and taxes as the economy is struggling to recover is worse than doing nothing. This $½ trillion in new taxes will hurt small businesses and destroy job creation. It breaks President Obama's campaign promise by increasing taxes on individuals and families making less than $250,000 per year. Adding insult to injury, these fees and taxes will also cause health care premiums to go up beginning next year.

But I don't want you to take my word for it. Both the nonpartisan Committee on Taxation and the Congressional Budget Office have confirmed these taxes and fees will be passed through to the consumers in the form of higher health insurance premiums, and these taxes and fees will start increasing premiums 4 years before most of the reforms in this bill take effect in 2014.

Let's take a look at what happens to Medicare and Medicaid in this bill. Both of these health care entitlement programs are already on perilous financial footing. Both are facing a financial meltdown. This bill adds to that burden.

First of all, the Medicare trust fund started going broke last year. In the year 2008, the Medicare Program began spending more out of the trust fund than was coming in. The Medicare trustees have been warning all of us for years that the trust fund is going broke. They now predict it will go broke right around the corner, about 2017. But rather than work to bridge Medicare's $37 trillion in unfunded liabilities, this bill cuts $½ trillion from that Medicare Program to fund yet another unsustainable health care entitlement program.

Medicare has a major problem with physician payments that will cost more than $250 billion to fix. But this bill ignores that problem by pretending the problem does not exist. This bill would leave future Congresses virtually no way to restructure Medicare to do the doctors fix.

By diverting Medicare resources elsewhere and ignoring major problems such as that one, this bill does worse than nothing.

Then there is Medicaid. The Medicaid Program serves 59 million low-income children and families. It is our health care safety net and it, too, is on very shaky financial ground. The Government Accountability Office has reported to Congress that States are reaching a financial and budgetary crisis with Medicaid. Like Medicare, Medicaid is essentially going broke. The Government Accountability Office models predict that State spending on Medicaid will grow faster than State revenues for at least the next 10 years.

Here is what the Government Accountability Office has said about this situation:

> Since most State and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulation suggest that, without intervention, these governments would need to make substantial policy changes to avoid growing fiscal imbalances.

But this bill does not fix this problem either. Here again, this bill makes the problem worse. This bill adds another $374 billion in spending to the Medicaid Program. It adds 15 million people to the rolls of the worst delivery system in health care. It increases State spending by $25 billion, and that happens to be a hidden tax increase because States will be forced to raise

taxes to pay for this increased cost—another unfunded mandate. By dropping the equivalent of a 10,000-pound weight through to our frayed Medicaid safety net, this bill does worse than nothing. This bill also compounds these long-term entitlement spending problems by creating yet another new entitlement program called the CLASS Act. This one is a voluntary Federal program for long-term care insurance.

I devoted several years of effort to improving long-term care support, particularly for the disabled and the elderly.

I understand the issues that supporters of the CLASS Act want to address. But the CLASS Act is simply not viable in its current form.

The CLASS Act is almost certain to attract people who are most likely to need it. This is known as adverse selection. That will cause premiums to increase and healthier people to drop out of the program. It is a classic insurance death spiral.

On November 13, the administration's own chief actuary confirmed this. The chief actuary issued a dire warning in a report on the CLASS Act in the House bill, which is virtually identical to the Senate version. Quoting the chief actuary:

> There is a significant risk the problem of adverse selection would make the CLASS program unsustainable.

For the first 10 years, the CLASS Act saves money. It saves money at the beginning because it collects premiums before benefits start getting paid out. But some time afterwards, it starts to lose money. We all know what happens from there. It will become the taxpayers' responsibility to rescue the program as it fails. Look at financial struggles of Social Security. Look at Medicare. Look at Medicaid. Now go home and look at your children and grandchildren.

Creating an unsustainable CLASS Act is not a responsible thing to do for our children and grandchildren. By adding the ticking time bomb of yet another unfunded liability to our children and grandchildren through the CLASS Act, this bill, again, does worse than nothing.

Health care is one-sixth of the economy. The American people do not want a bill that makes the economy worse. The nonpartisan Congressional Budget Office, the Committee on Taxation, and even the Office of the Actuary of the U.S. Department of Health and Human Services have told us what the American people already knew: These massive partisan health care reform bills are going to make the problem worse when it comes to the cost of health insurance.

According to a September 22 letter from the Congressional Budget Office to Chairman BAUCUS about the Finance Committee bill, CBO wrote:

> Premiums in new insurance exchanges would tend to be higher than the average premiums in the current law individual market.

So according to CBO, after these bills spend $1 trillion, many of the people struggling to afford their premiums today will actually end up paying more if this bill moves forward and is enacted. By increasing costs when people desperately need Congress to lower costs, this bill does worse than nothing.

It does not have to be this way. When the debate began last year, interested legislators of both parties set forth benchmarks that were no-brainers. Health care reform should lower the cost of premiums. It should make health care more affordable. It should do so without Medicare cuts that jeopardize access to care for seniors. It should do so without overloading the Medicaid safety net until it rips. It should do so without adding to the already unsustainable, unfunded liabilities by creating yet another unsustainable entitlement program. It should have done all those things. That is what we intended to do when we started out.

Instead, this bill threatens the economic recovery. It is $½ trillion of new taxes hurting small business and destroying job creation. It calls for an even bigger and more unsustainable Federal budget. It adds to that burden with a massive new government-run health plan. It makes health care more unaffordable and lowers quality.

I know some people believe we should get on to the bill and try to fix it by amendment. But this 2,000-page bill has many more problems than can be fixed by amendment on the Senate floor.

If you want to improve it, it should be stopped right now and get back together where we were at one time. Democratic leaders and the White House have put together one extreme health care plan after another. After the bailouts for Wall Street and Detroit, a stimulus bill that led to the highest unemployment in 26 years, and the Fed shoveling money out the door without any accountability, this health care reform bill is the straw that broke the camel's back.

What Senate Republicans are trying to say tonight, with tonight's vote, is we don't support reform just for the sake of reform. Changes to the health care system must be responsible and not break the backs of the taxpayers and the job-creating engine in America, small business.

It doesn't make any sense to make major new unsustainable commitments to entitlement spending. Already, Medicare's solvency is in jeopardy and the Reid bill would make things worse for Medicare. Seniors are in a tough situation today with the way the economy has hit their retirement savings. We have to step back and remember it is not our money, it is their money. It is the taxpayers' money we are talking about—$2½ trillion of taxpayers' dollars over the decade when this bill is fully implemented.

Generations of hard-working Americans will be forced to pay the costly price for this bill if it moves forward. It is irresponsible for Democratic leaders to use their filibuster-proof majority in the Senate and their control of the House and the White House to push through such massive legislation, reshaping one-sixth of the American economy. The unintended consequences of this legislation could have a destabilizing effect at just the wrong time as America's economy struggles to recover and working families are doing everything in their power just to hold on.

The late Senator Moynihan often warned about the perils of a majority party pushing through major bills and changes in a partisan way. It is a well-founded warning that Democratic leadership has not heeded—this time, at least. If a bill like this one cannot get support more broadly, then something is wrong with it.

Moreover, grassroots America has spoken out against this legislation. It is alarming how those voices have been disregarded by congressional leaders. President Andrew Jackson made it clear that our duty is to tune in to the common sense of the American people who sent us here. I quote President Jackson:

> Our Government is founded upon the intelligence of the people. I, for one, do not despair of the republic. I have great confidence in the virtue of the great majority of the people, and I cannot fear the result.

Listen to what President Jackson said. Listen to the concerns of the people. They are telling us to reconsider this massive, complicated legislation and take a path that leads to less spending, less taxes, and less debt. Instead of continuing to mortgage the future of our children and grandchildren, we need to get back to basics. Congress should pass commonsense medical malpractice reform to stop wasting so much money on defensive medicine. Congress should empower consumers to shop around for health care and lower costs with competition just like with other services the consumers buy. Congress should make market reforms that help small businesses and the self-employed have greater access to health insurance at an affordable rate.

These issues can be addressed without upending the entire health care system with the result of higher taxes, higher insurance premiums, and deficits and debts that will get in the way of the opportunity that results from the ingenuity and industry of the American people.

If we were sitting around a coffee shop in Springfield, IL, or Little Rock, AR, and we were discussing health care reform and I told them we are talking about a bill that is going to raise taxes,

cut Medicare, raise premiums, and not do anything about costs, they would say that is not health care reform.

I encourage my colleagues to listen to the American people and to send this bill back to the drawing board.

I yield the floor.

The PRESIDING OFFICER (Mr. KOHL). The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, as morning broke over our Nation today, millions of Americans woke to a typical, crisp fall day. It seemed ordinary as shopowners opened their local grocery stores; children filled soccer fields and families made preparations for Thanksgiving holiday. It seemed ordinary. But today is anything but ordinary in the life of our Nation.

We have all heard the phrase and repeated it so many times, that we have almost grown numb to it—America is facing the worst economic crisis since the Great Depression. Think about that for a minute. What that really means is that for every single legislator in this Senate, we are in unchartered territory.

We have never been here before and recent signs of a slow, unsteady and jobless recovery are troubling. And, the American people know it. In a survey from this past week, 82 percent of Americans said that our Nation's economic conditions are poor.

Consider the news reports from just yesterday that 14 percent of all mortgage loans—meaning 7.4 million households—were delinquent or in foreclosure in the last quarter. That is the highest number since the mortgage bankers industry began this survey in 1972.

Consider the unemployment rate—it reached a 26-year high of 10.2 percent in October. We lost 190,000 jobs in just the month of October alone. And, according to the Department of Labor's broadest measure, some 17.5 percent of Americans are without a job entirely or underemployed. We have shed 3.5 million jobs since January of this year and the average work-week is now down to 33 hours for the American worker.

It is against this backdrop that the Senate majority leader has chosen to bring up this health care bill. Health reform is a huge undertaking.

Every one of the 2,074 pages in this bill will have a dramatic impact on the health care of every American. I have to tell you, that is a bridge. This is a bigger problem than anyone can imagine because it will affect every single American. This bill represents a massive government intrusion into the medical care of every American.

Under this bill, the government will review every employer health insurance plan in the Nation to determine if it satisfies all of the government mandated benefit requirements. If it does not, the government will then tax many of those employers.

The government will also now determine whether it believes your health insurance costs too much. It will decide what benefits should be covered and what preventive services you should receive.

Earlier this week, the U.S. Preventive Services Task Force recommended that women under age 50 should not receive annual mammograms. Anyone who was concerned about this decision needs to understand that this bill empowers a task force just like that to determine which preventive services should be covered by every health plan in America.

As one of the only Members of the Senate to sit on both committees of health care jurisdiction, I understand the complexities at work in comprehensive health care legislation. And I understand that this bill gets it wrong.

Instead of taking a step-by-step approach to health reform, identifying consensus reforms where we can fix what is broken and leave what works, the majority leader has chosen a different approach. Without Republican support and without the approval of a growing majority of the American people, Senator REID has chosen to shake nearly 20 percent of our economy in its foundation in attempting to jam through a strictly partisan bill.

This bill will increase our health care costs, do nothing to improve the quality of our care, it will increase our Nation's debt and deficit and it will harm our Nation's tenuous job market.

There is no credible study and there will be no serious, unbiased economist who will say that this bill will create jobs or strengthen our economy. And that is what the people in the most recent election said was mot important.

Recently, in an op-ed in the Wall Street Journal, the dean of Harvard Medical School Dr. Jeffrey Flier gave the current health reforms a ''failing grade.'' Dean Flier wrote about the reform bills being debated in Congress, that ''there are no provisions to substantively control the growth of costs or raise the quality of care. So the overall effort will fail to qualify as reform.''

Dean Flier went on to write:

> In discussions with dozens of health care leaders and economists, I find near unanimity of opinion that, whatever its shape, the final legislation that will emerge from Congress will markedly accelerate national health-care spending rather than restrain it. Likewise, nearly all agree that the legislation would do little or nothing to improve quality or change health-care's dysfunctional delivery system.

I ask unanimous consent that this editorial be printed in its entirety in the RECORD at the conclusion of my statement.

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

[See exhibit 1.]

Mr. ENZI. With ratings of failed reform like the dean of the Harvard Medical School, why are we talking about taking the time to tweak a failure of ideas so we can say we did something. We are not fooling the American people. The voices of August are still echoing and coming from a vast majority.

Other experts have weighed in on the provisions in the Reid bill and their potential impact on jobs. One such provision is the job-killing tax of $28 billion that will disproportionately fall on the backs of small business employers in the form of a mandate on employers to provide Washington government-approved insurance.

This job-killing tax has been studied by the non-partisan score keepers at the Congressional Budget Office as well as nationally recognized economists and health experts. These experts have said that the costs of this new tax will ultimately be paid by the American working men and women.

Businesses that cannot afford to provide health insurance will pass the costs of these new penalties on to their workers in the form of lower wages, reduced hours and jobs cut. Yes, this so-called health reform bill will threaten your jobs and if this vote is successful we will spend weeks debating this bill. And just like committee work so far, the majority will reject real solutions just like they have through the two amendment processes that have been merged to make this flawed bill.

According to one recent study by the Heritage Foundation, this new job-killing tax in the Reid bill will place more than 5 million low-income workers at risk of losing their jobs or having their hours reduced and an additional 10 million workers could see lower wages and reduced benefits. At a time of unprecedented economic peril, the majority has chosen to bring a bill to the Senate that will threaten our Nation's jobs and our economic growth.

This bill will also increase our Nation's growing debt and deficit. Currently, our Nation's debt is greater than $112 trillion and our deficit for fiscal year 2009 was greater than $1.4 trillion. As a percentage of the economy, our deficit is 10 percent of GDP—the highest it has been since the Second World War. Once again, we are not debating this bill in a vacuum. Rather, we are debating this bill at a time when our credit card is maxed out.

I worry about the country that I am leaving for my children and grandchildren. Our Nation is being buried under a mountain of debt, which poses a deadly threat to the future of our Nation.

The Federal Government will spend $1.4 trillion more than it receives in revenue this year. The government will make up that deficit by borrowing more money, mostly from China and other foreign governments.

These levels of debt are not sustainable and, our foreign creditors are beginning to recognize this fact. As our

creditors grow more concerned about our ability to pay our debt obligations, the interest rates we pay will grow. That means that it will soon cost us considerably more to allow Washington to continue to borrow the money it needs to fund its current spending binge.

With our current and growing debt, Congress should be concerned. Think about it—our most fundamental duty as Members of Congress is to wisely manage the power of the purse for our Nation. The Framers wisely put in place a process of appropriations that would be annually checked by the representatives of the American people here in Washington.

In this bill we create yet another stream of mandatory spending in perpetuity—or until it runs out—that is not reviewed by Congress on an annual basis.

I remind my colleagues that our Federal deficit is nearly nine times the size of the deficit just 2 years ago. During the same 2-year period, our Nation lost 8 million private sector jobs. Our total Federal debt is now around 85 percent of GDP. According to David Walker, the former head of the Government Accountability Office, at the end of the fiscal year 2000, the Federal Government had about $20.4 trillion in total liabilities and commitments and unfunded promises for just Social Security and Medicare. That number rose to $56.4 trillion at the end of fiscal year 2008. That is a 176-percent increase in only 8 years. By the end of this year, that number is expected to rise to $63 trillion. With these staggering statistics, it is astonishing we are even debating the creation of a new entitlement obligation forever.

A couple days ago, Majority Leader REID stated that this bill will be deficit neutral, but you have to understand what that means. First, the true cost of this bill is hidden by implementing the massive middle-class tax increases and Medicare cuts in the first year and pushing the massive costs in health care subsidies out to the fifth year. Republican Leader MCCONNELL referred to this gimmick as being akin to paying a mortgage for 4 years before actually moving into the house. I wish to emphasize that a little bit. It is a gimmick. You collect the money to begin with, but you don't provide the benefits until further down the road. Then you say: We covered all those costs. But when you extend it on out, it will not continue to cover those costs. So disaster.

As the only accountant in the Senate, I am shocked to see that what would constitute as fraud in the accounting world seems to be reason to hold a press conference to do a hollow boast. The gimmicks in this bill are stunning, whether it comes to implementation of the tax on so-called Cadillac health plans or the increased taxes or the $464 billion in Medicare cuts—Medicare cuts. We are already having a problem with Medicare solvency. It is going to go broke. We are going to take $464 billion from Medicare. Then we are going to form a special commission and this commission will be able to tell us, on an annual basis, where we can make cuts in Medicare so it doesn't go broke. But let's see, there is a deal with the hospitals that they are not going to be touched. There is a deal with the doctors that they will not be touched; in fact, theirs is going to be increased. There is a deal with PhRMA where they will not be touched. Who does that leave? That means cutting benefits for seniors. They and home health care and nursing homes are the only places you can cut it, if you let those other people off the hook. That is what the bill does.

When it comes to the long-term care provisions in this bill that Budget Committee Chairman CONRAD has referred to as a Ponzi scheme, you have to be a little bit worried. If Washington accounting had to come under the same laws as private business, the administration and Congress would be in jail. To attempt to claim the mantle of fiscal responsibility, the majority leader has jammed 10 pounds of entitlement spending into a 5-pound sack. Again, entitlement means the payments automatically go on forever with no further review or constraint. That is not fiscal responsibility and the American people are not buying it. They know, evidently better than we do, what we are talking about.

A large majority of Americans believe their prescription drug costs will go up under this bill and that the cost of their premiums will go up. They are right. What the CBO score doesn't provide us with and can't provide us with is the cost of this bill to each and every one of us. But we know that cost will be great. The CBO evaluation says it is going to be paid for. Paid for? That is an evaluation of whether it is going to cost the government anything. It is not an evaluation of whether it is going to cost the people anything. The only place to get that money is from the people or, in this case, also stealing it from Medicare. In order for this bill to reduce the deficit, the majority leader has to assume that the Medicare payments to physicians will be cut by 21 percent next year. He also has to assume these payments will be annually cut another 5 percent for the next 9 years.

In order for this bill to reduce the deficit, the majority leader also has to assume that more and more middle-class Americans will pay this new tax on high-cost health insurance plans. According to the Congressional Budget Office, 84 percent of the revenue collected by this new tax will come from Americans earning less than $200,000 in 2019. This reminds me of another tax which was originally intended to target just 155 individuals who made more than $200,000 and did not pay any income tax. Today the alternative minimum tax now hits millions of middle-class Americans, and every year Congress has to enact legislation to prevent it from hitting millions more. This bill is drafted that same way. It will creep up there and catch everybody in increased taxes.

In order to believe that this bill will reduce the deficit, its sponsors must believe that future Congresses will allow millions of middle-class Americans to be subject to these new taxes. While the majority leader claims all these things will happen, the American public isn't fooled.

In this morning's Washington Post, the dean of Washington journalists, David Broder, not a politically conservative columnist and someone often cited by the other side, pointed out that a recent survey found that less than one-fifth of the American people believe that health care reform will be deficit neutral over the next 10 years. By a 16-point margin, the majority in this poll said they opposed the legislation moving through Congress. Mr. Broder called this legislation a ''budget-buster in the making.''

It is difficult to quantify the scope of this bill. I have heard some of my colleagues talk about how many years would elapse in 2½ trillion seconds. I heard some of my colleagues talk about how many cars $2.5 trillion would buy or how many school districts it would fund or how many decades it would fund State budgets across America. I don't think people are understanding how comprehensive this bill is that entails 100 percent of the people. That is the difficulty we in the Gang of 6 had coming to any conclusion because it is so big that as we get into one area and scratch the surface and find out what we don't know, it takes a lot of research time to get there to be able to make basic decisions. But it was easy to cram into a bill and say: This solves it, solves it for $1 trillion. We should never say $1 trillion because that sounds like one, and one is not a very big number.

It is $1,000 billion. We don't know what 1 billion is either, but 1 billion is 1,000 million. So we are talking about a lot of money here.

Perhaps the best way to quantify this bill is, it keeps me up nights and, more importantly, these issues we are debating keep our constituents up at night. I am sure everybody has been hearing from their constituents. We worry immensely about the cost and the obligations we are passing on to our children and grandchildren. Where is this bill taking our country, and will we have the courage in our time to preserve and protect our Nation's great strengths for future generations? These are the questions that keep me up at night,

and I know these concerns are shared on the other side of the aisle. I sense it in conversations I have had with the senior Senator from Delaware and the senior Senator from Nebraska. I sensed it in my work over the summer with the chairman of the Budget Committee. I know they share these concerns on the other side. That is why I believe passionately that we must defeat the motion to proceed on this bill.

I am sometimes an optimist, and I still hope we can start over and get to work on a bipartisan bill that has the trust and support of the American people. Any major piece of legislation that has gone through this body has done so in a bipartisan way. It has been necessary to get the confidence of the American people. They don't have confidence in Congress right now. This bill is not helping.

We say we are spending our children and grandchildren's money. Actually, we are doing that plus spending seniors' money. When you take that Medicare money, that is what you are doing. The seniors have figured it out. That is why it was so raucous in August and ever since. They have been concerned about their future and the promises made to them. We have a system that is going broke, and then we are going to take money from it. We ought to back up and make sure Medicare money goes to Medicare. I know part of that is listed as fraud and abuse. I am always fascinated when government talks about fraud and abuse because we talk about it, but if we have known that these billions of dollars of fraud and abuse were out there, why haven't we been collecting that money? Once we turn it over to the government to do that, it is no longer needed. Well, it is needed to pay the bills, but it is no longer that much of a care because the paid-for has already been taken care of.

There ought to at least be a separate account set up that you have to actually collect the fraud and abuse money before you can spend it, but we are not going to do that.

Every senior can tell you some instances of fraud and abuse that they think are happening, and we have passed those on. I see some effort to collect that but not a lot.

As many of my colleagues know, before I came to the Senate, I was a small business owner. My wife and I owned three small shoestores in Wyoming and Montana. When I was showing someone a shoe and he or she said they didn't like it or couldn't afford it, I didn't try to give them a sales pitch. I knew it was time to try to find another shoe, one they liked and could afford. There is a lesson from this in this health care bill. The people of America are complaining, and we are showing them the shoe we want to show them. They don't want to see that shoe. They said: We thought you were going to lower my costs. Every person out there thought they were going to have the benefit of reduced costs, and they are not seeing it in this bill. They wanted to help out other people, and some of that is in here, to a limited extent. But that isn't the main thing that they expected to have happen from this. Small businesses out there are particularly hurting, and this will react on small businesses, those shoestores all over the United States, the grocery stores, the dry cleaners. This is even going to affect doctors. They are small businesses, for the most part.

So there is a lesson in this story when it comes to reforming health care. It is time to listen to the customers and find the alternative they expected, that they wanted, and they can afford.

Probably the biggest help to me in legislating has been the experience of working in a shoestore. The people tell you what they want, and they have told us what they want. We haven't listened. If you want to make the sale, you better listen. You better see how your inventory matches what they want. We haven't checked the inventory or we have said: We don't have anything in here that you need, but we have some things to take care of other people. That is not going to sell.

We have a big decision to make tonight. It will have a lasting effect on our country, a lasting effect in that if the motion to proceed passes, we are going to debate it for a long time. A bill this size deserves a lot of time. It is necessary. And it is more comprehensive than we are going to be able to get into, no matter how long we debate it.

So the American people are going to be surprised at the time we waste when we could be solving jobs and the economy, which is their biggest concern at the present time.

Mr. President, I yield the floor.

EXHIBIT 1

HEALTH ''REFORM'' GETS A FAILING GRADE

(By Jeffrey S. Flier)

As the dean of Harvard Medical School I am frequently asked to comment on the health-reform debate. I'd give it a failing grade.

Instead of forthrightly dealing with the fundamental problems, discussion is dominated by rival factions struggling to enact or defeat President Barack Obama's agenda. The rhetoric on both sides is exaggerated and often deceptive. Those of us for whom the central issue is health—not politics—have been left in the lurch. And as controversy heads toward a conclusion in Washington, it appears that the people who favor the legislation are engaged in collective denial.

Our health-care system suffers from problems of cost, access and quality, and needs major reform. Tax policy drives employment-based insurance; this begets overinsurance and drives costs upward while creating inequities for the unemployed and self-employed. A regulatory morass limits innovation. And deep flaws in Medicare and Medicaid drive spending without optimizing care.

Speeches and news reports can lead you to believe that proposed congressional legislation would tackle the problems of cost, access and quality. But that's not true. The various bills do deal with access by expanding Medicaid and mandating subsidized insurance at substantial cost—and thus addresses an important social goal. However, there are no provisions to substantively control the growth of costs or raise the quality of care. So the overall effort will fail to qualify as reform.

In discussions with dozens of health-care leaders and economists, I find near unanimity of opinion that, whatever its shape, the final legislation that will emerge from Congress will markedly accelerate national health-care spending rather than restrain it. Likewise, nearly all agree that the legislation would do little or nothing to improve quality or change health-care's dysfunctional delivery system. The system we have now promotes fragmented care and makes it more difficult than it should be to assess outcomes and patient satisfaction. The true costs of health care are disguised, competition based on price and quality are almost impossible, and patients lose their ability to be the ultimate judges of value.

Worse, currently proposed federal legislation would undermine any potential for real innovation in insurance and the provision of care. It would do so by overregulating the health-care system in the service of special interests such as insurance companies, hospitals, professional organizations and pharmaceutical companies, rather than the patients who should be our primary concern.

In effect, while the legislation would enhance access to insurance, the trade-off would be an accelerated crisis of health-care costs and perpetuation of the current dysfunctional system—now with many more participants. This will make an eventual solution even more difficult. Ultimately, our capacity to innovate and develop new therapies would suffer most of all.

There are important lessons to be learned from recent experience with reform in Massachusetts. Here, insurance mandates similar to those proposed in the federal legislation succeeded in expanding coverage but—despite initial predictions—increased total spending.

A ''Special Commission on the Health Care Payment System'' recently declared that the Massachusetts healthcare payment system must be changed over the next five years, most likely to one involving ''capitated'' payments instead of the traditional fee-for-service system. Capitation means that newly created organizations of physicians and other health-care providers will be given limited dollars per patient for all of their care, allowing for shared savings if spending is below the targets. Unfortunately, the details of this massive change—necessitated by skyrocketing costs and a desire to improve quality—are completely unspecified by the commission, although a new Massachusetts state bureaucracy clearly will be required.

Yet it's entirely unclear how such unspecified changes would impact physician practices and compensation, hospital organizations and their capacity to invest, and the ability of patients to receive the kind and quality of care they desire. Similar challenges would eventually confront the entire country on a more explosive scale if the current legislation becomes law.

Selling an uncertain and potentially unwelcome outcome such as this to the public

would be a challenging task. It is easier to assert, confidently but disingenuously, that decreased costs and enhanced quality would result from the current legislation.

So the majority of our representatives may congratulate themselves on reducing the number of uninsured, while quietly understanding this can only be the first step of a multiyear process to more drastically change the organization and funding of health care in America. I have met many people for whom this strategy is conscious and explicit.

We should not be making public policy in such a crucial area by keeping the electorate ignorant of the actual road ahead.

Mr. GRAHAM. Mr. President, the bill we have before us today is a 2,074-page, multi-trillion-dollar bill written in the dark of night. This process brings back the worst of Washington. The substance of the bill raises taxes during a recession, compromises individual health care choices, cuts Medicare to pay for the uninsured and will eventually explode the deficit—the combination of which will jeopardize the finest health care system in the world without lowering costs. Today we are voting on the motion to proceed to the bill and I will vote no because this bill is broken beyond repair. Instead of proceeding to a flawed bill, we should stop and start over.

Despite President Obama's repeated statements that Democrats would legislate in an open and transparent manner, this bill was drafted in secret and Republicans were excluded. As a candidate and now as President Obama, he even went so far as to tell the American people that the negotiations would be broadcast live on C–SPAN. Instead of the change Americans thought they voted for, we have gotten more of the same.

The bill we are moving to consider will cost $2.5 trillion once fully implemented; nearly three times the official CBO score of $848 billion. The Democrats are playing a shell game to hide the true cost of this legislation. With this bill we get 10 years of taxes and only 6 years of programs. While some may claim that the bill is deficit neutral, the Federal Government's financial commitment to health care under this bill actually grows. Health care costs are not contained or reduced, they are simply offset by reductions and tax increases elsewhere in the Federal ledger.

A central premise of this legislation is that Congress will allow nearly half a trillion dollars in Medicare cuts to go into effect. Congress has not had the political will to allow these types of cuts to stand in the past, so why should we believe that future Congresses will not follow suit. Case in point, the ''doc fix.'' When we passed the Balanced Budget Act in 1997, we included a formula to limit the cost growth in physician spending in Medicare. Congress allowed that formula to reduce payments to physicians only once and has not done so again. We leave the flawed formula in place and each year we act to block the scheduled cuts to physician payments instead of fixing the problem. This bill increases doctor payments by half a percent in 2010 and then assumes a 23-percent cut in 2011, budget gimmickry at its finest.

Medicare is currently $36 trillion in the hole, but as we have seen, Congress doesn't have the will to cut Medicare by fifty cents, much less $500 billion. When we tried to rein in Medicare costs in the budget in 2007, we proposed $33 billion in savings and only got two dozen votes.

In a nod to Congress' traditional actions, or lack thereof, Democrats even included an Independent Medicare Advisory Board that can cut Medicare provider payments if Congress fails to act. Cutting an already cash-strapped program is not the way to finance health care for the uninsured.

In addition to the nearly half trillion dollars in cuts contained in this bill, we get a half trillion dollars in new and increased taxes. The bill would tax Americans who choose higher cost insurance plans, it would tax employers for not providing health coverage, it would tax Americans for not buying health coverage, and it would increase the Medicare payroll tax on some Americans to fund a new health care entitlement program. In the midst of the worst recession this country has seen in decades, how can these job-killing tax increases be justified?

I believe the provisions contained in this bill are bad for America. We must work to enact policies that preserve patient access to care, rein in ever increasing costs in the health system while ensuring the viability of current programs, and promote choice. This bill is a budget buster that does none of those things.

Mr. President, I cannot support this bill.

The PRESIDING OFFICER. The Chair recognizes the Senator from Montana.

Mr. BAUCUS. Mr. President, a noted psychologist once said:

To be mature means to face, and not evade, [a] crisis. . . .

Our health care system is in a crisis. This crisis has been decades in the making, and history has made clear that this crisis will not solve itself. It is time for us to face the crisis. It is time for Congress to show mature leadership. It is time for us to reform health care, once and for all.

For years now, we have prepared for this moment. The Finance Committee and the HELP Committee studied the issues thoroughly. We have held nearly 70 hearings, roundtables, and walkthroughs. We have studied this issue very thoroughly and exhaustively. We each produced a blueprint for reform—each committee—and we worked together with Leader REID and President Obama to combine those blueprints into one solid plan. This week, tonight, we have brought that plan to the Senate floor. Tonight, we seek to begin that momentous debate. Tonight, we seek, at last, to face the crisis.

We have a bill that will put Americans, patients, and their doctors back in control. We have a bill that will end harmful insurance industry practices. Under our bill, no longer will insurance companies be allowed to deny you health insurance. No longer will insurance companies be allowed to hike up rates for Americans with preexisting conditions, such as heart disease, cancer, or diabetes. No longer will health insurance companies be able to take away your health insurance or reduce benefits when people get sick. Under our bill, no longer will insurance companies be able to limit the amount of health care you can use in a lifetime. No longer will insurance companies be able to put unreasonable limits on the amount of health care you can use in 1 year. If you pay your bill, the insurance company must renew your coverage and provide your benefits. No longer will insurance companies be able to discriminate based on gender or health status. No longer will insurance companies be able to charge more for women or for people who are sick.

Our bill will also require insurance companies to disclose the share of premiums that goes to medical benefits. That is new and very important. No longer will insurance companies receive tax credits when they use their profits to provide excessive executive paychecks.

Our bill is fully paid for. It is fiscally responsible. It will lower health care costs, and it will reduce the Federal budget deficit.

According to the Congressional Budget Office, our bill will reduce the deficit by $130 billion in the first 10 years. Over the next decade, it will further reduce the deficit by about one-quarter of 1 percent of gross domestic product. That is hundreds of billions of dollars in deficit reduction.

As well, our bill will provide billions in tax cuts for American families and small businesses. Our bill will create new marketplaces called insurance exchanges. Individuals and small businesses will be able, quickly and easily, to view, compare, and buy health insurance plans.

Today, many Americans already receive quality health care coverage through their employers. Many are happy with their current insurance plans. This bill will not change that. We keep the best of our current health care system. People who are satisfied with their current health insurance coverage will be able to keep it. But too many others do not have access to insurance, to quality insurance. For too many, this system is broken.

Under our bill, new exchanges will provide one-stop shops where plans are

presented in a simple, consistent format. Americans will be able to know exactly what they are buying. Insurance companies will have to compete on price and on quality, not on their ability to select the healthiest people or hide restrictions. Americans will be able to count on the health care coverage they buy. And tax credits will help to ensure all Americans can afford quality health insurance.

Small businesses will also have access to exchanges and tax credits. Through small business exchanges, these companies will be able to pool together to spread their risk, increase their leverage, and enhance their choice, just as big companies do.

Members of Congress will be required to buy their health insurance through the same exchanges that people in their own States use—exactly the same. No longer will there be a separate congressional health plan.

Our bill will strengthen Medicare. It will improve benefits for seniors. And it will help to ensure Medicare is sustainable for future generations. Our bill will cut costs, but it will not cut benefits. Our bill will increase Medicare benefits. Our bill will provide seniors with free preventive care and wellness checkups. It will improve care for seniors with chronic conditions. And it will provide a 50-percent discount on brand-name prescription drugs to help close the doughnut hole, the gap in benefits in the Medicare prescription drug program.

Our plan is a good, commonsense answer to the crisis facing American families and businesses.

On this floor, here in the Senate, tonight, we have a historic opportunity to consider this plan. We have the chance to make it even better. We hope to have a full debate. But more important than the process or rhetoric, we have the opportunity, at last, to face the crisis. We have the opportunity to show mature leadership. At long last, we have the opportunity, the historic opportunity, to reform health care, once and for all. History is knocking on the door. Let's open it. Let's begin the debate to improve this bill before us today and provide the service all Americans expect us to perform when they elect us to this office.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, I rise in very strong support of this melded bill, drafted and put together by our distinguished leader, the Patient Protection and Affordable Care Act.

Before I begin with some brief remarks, let me extend my heartfelt thanks to our majority leader for his tireless work and thank MAX BAUCUS of Montana for his tireless work and the members of the committees who have worked over the past many months to bring us to this moment.

Others this evening have spoken with great eloquence, in my view, about the provisions of this bill, what we hope to achieve for our fellow citizens with the adoption of this legislation.

I commend the Senate HELP Committee, which did such heroic work during the writing of our portion of the bill—my colleagues, TOM HARKIN of Iowa, BARBARA MIKULSKI of Maryland, JEFF BINGAMAN of New Mexico, PATTY MURRAY of the State of Washington, and so many others.

I thank my Republican colleagues on that committee as well. While we did not end up with a bipartisan vote at the end of that very long process, we did end up adopting more than 160 amendments offered by my Republican colleagues to that bill, which I think strengthened the legislation, made it a better piece of legislation, and many of which are a part of this legislation this evening.

I also want to pause for a moment, if I can, to recognize a colleague who is here tonight only in spirit, Ted Kennedy. So much has been said and written about his lifelong quest to ensure that every American—every American—has decent health care. Tonight and in the days to come, we will pay him the highest compliment, as our colleague, by fulfilling that quest of achieving the goal all Americans aspire for; that is, a national health care plan that serves every one of our citizens.

I would like to speak briefly, if I could, to the American people who are at home this evening and I suspect are just tuning in to this debate.

This important vote will occur momentarily. Why does this issue and this debate matter? Why are we here on a Saturday evening? But then again, for that matter, why are you watching C–SPAN on a Saturday evening, I might add?

Well, for one thing, health care represents one-sixth of our economy and affects 100 percent, as we all know, of the population of this country. And it is true that skyrocketing health care costs are the single biggest threat to the financial future of our fellow citizens.

But the reason tonight's vote is so historic, beyond those last two points, is that never, ever before—never before—has this body, elected to serve the American people, confronted directly this simple truth: Nothing, absolutely nothing, matters more to you and to your family than the ability to get the health care you need, when you need it, from the doctor you choose, at the price you can afford.

Health care is our most basic need. Health care is the most basic commitment we should be willing to make to each other. No matter what your family finances, no matter what your hopes and dreams are, no matter who you are or where you live or what your job is in America, in our 21st century America, you should be able to get the care you need.

But for too many American families—perhaps your family, as you watch this tonight from your homes—health care has become your most basic fear. If you do not have health insurance, you go to bed every single night knowing that if you wake up sick or your child does, you might not be able to see that doctor or afford one if you can even find one. Even if you have health insurance, you are paying more and more in premiums and getting less and less coverage for your money.

Millions of you are seeing your premiums skyrocket. Yet you lie awake at night—millions do—wondering: What if I lose my job? What if I get sick and find out my policy does not cover the costs and the care I need—or, even worse, your insurance company cancels your policy altogether? What if you run out of benefits and have to pay out of your pocket? I wish I could say these fears are irrational fears, but they are not. There is nothing irrational about those fears. Insurance does not allow you to be sure of anything these days.

Our system, all 100 of us here know, is broken. People are losing their homes because they get sick. People are dying because they cannot afford the cure. This is just not acceptable in our America. That is why we are here on a Saturday night.

If you have watched the news over the past few months, you have probably noticed there is a wide range of opinions on how we should fix things. And that is as it should be. We need all the good ideas we can get, and hopefully this debate will produce that. But if you have also watched the debate in the Senate over the last 2 days, you have probably noticed something else as well. I don't believe a single person in this body has stood up at any point and said we are OK doing nothing at all. Therefore, in the weeks ahead we will have a full and open debate about every provision of this bill.

But tonight's vote is nothing more than a choice—a choice between doing something or doing nothing. I urge my colleagues this evening to join us, hopefully unanimously, to say we should do something. We should do something about this most basic right that all Americans deserve.

I yield the floor.

The PRESIDING OFFICER. The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, the Nation is watching the Senate tonight. The American people know how important this vote is. They have seen the bill the Democratic leaders want to impose upon them, and they want to know where the rest of us will stand.

This bill itself is a massive monument to bureaucracy and spending. But at its core it is quite simple. At a moment when more than 1 of 10 working Americans is looking for a job, at the

time when the Chinese are lecturing us about our debt, this bill—this bill right here—costs $2½ trillion the government doesn't have and cannot afford. It imposes punishing taxes on almost everyone. It raises health insurance premiums on the 85 percent of Americans who already have health insurance. And if that were not bad enough, it slashes Medicare by $½ trillion. Anyone who votes aye tonight is voting for all of these things.

It is a fact: A vote in favor of proceeding to this bill is a vote in favor of adding to the tax burden of the American people in the midst of double-digit unemployment. A vote in favor of proceeding to this bill is a vote to raise health insurance premiums on people who were told—they were told—that they could expect their health insurance costs to go down. A vote in favor of proceeding to this bill is a vote in favor of deep cuts to Medicare for tens of millions of seniors who depend on it totally. A vote to proceed to this bill is a vote to continue the completely out-of-control spending binge this Congress has been on all year. A vote in favor of this bill tells every American family sitting in a waiting room tonight, wondering when they will get to see a doctor or how much it is going to cost: It is not our concern. Worst of all, a vote in favor of this bill is a vote in favor of the spending binge that is leading to a massive and unsustainable, long-term debt that will shackle our children to a future they can't afford.

That is what tonight's vote is all about. If it weren't, none of us would be here on a Saturday night with the Nation watching and waiting to see what we do. They are watching because they know that none of this—none of this—is inevitable.

All it takes is one vote—just one. The simple math is this: If there were one Democrat, just one of our friends on the other side of the aisle, just one who would say no tonight, none of this would happen. The voices of the American people would be heard. We have seen all the surveys. We know how they feel. If one Democrat were to say no tonight, he would be saying no to the premium increases, no to the tax cuts, no to the Medicare cuts—just one on the other side of the aisle. Then we could start over with a commonsense, step-by-step approach to fix the problem that got us here in the first place, and that is that health care costs too much.

That is the sad irony of this whole debate. The problem that got us here is that health care costs are out of control. Yet the neutral, nonpartisan Congressional Budget Office, the scorekeeper around here, says under this bill—this massive bill—health care costs are actually going to go up, not down, and the American people thought that is what this whole debate was about in the first place. So 2,074 pages and trillions of dollars later—2,074 pages and trillions of dollars later—this bill doesn't even meet the basic goal the American people had in mind in what they thought this debate was all about—to lower costs. This bill will actually make the situation worse, and now we are about to vote on it.

We have heard some Senators come to the floor today and say that they oppose this bill, but they don't want to stop the debate. They oppose the bill, but they don't want to stop the debate. Nobody is suggesting we stop the debate. No one. Not a single Senator on this side of the aisle have I heard suggest that we stop the debate. But if we don't stop this bill tonight, the only debate we will be having—the only debate we will be having—is about higher premiums, not savings for the American people; higher taxes instead of lower costs, and cuts to Medicare rather than improving seniors' care. That is what the debate will be about.

The American people and 40 of us in this room sitting on this side of the aisle are not asking to end the debate. That is not what we have in mind, to end the debate. What we want to do is change the debate—not end it, change it—because once we get on this bill, ladies and gentlemen, the basic dimensions will not change. The basic dimensions will not change.

So I ask: Why should we consider a bill we already know the American people oppose? This is not anything anybody is in doubt about. The American people think if you don't like this bill, you have an obligation to try to stop it, and that opportunity will come at 8 o'clock.

I am sure this won't come as a surprise to any Member of the Senate, but it is going to take 60 votes to change this bill. That means the bill as introduced—this bill we are looking at right here—will fundamentally be the bill we will be asked to pass sometime in the future. That is a fact.

After tonight's vote we will all go home and face our constituents. We will have to tell them how we voted on raising their premiums, raising their taxes, and cutting their Medicare. For some of us, that is not going to be a very easy conversation, but it doesn't have to be that way. If you want to lower costs and premiums, then we can work together step by step and pass the commonsense reforms the American people have been asking for all along.

We can end junk lawsuits against doctors and hospitals which drive up costs. We can encourage healthy choices such as prevention and wellness programs which hold down costs. We can lower costs by letting consumers buy coverage across State lines. We can allow small businesses to band together to get lower insurance rates. And certainly we can address the rampant—absolutely rampant—waste, fraud, and abuse that drives up costs. All of those, my colleagues, are changes worth making.

The American people are looking at the Senate tonight. They are hoping we say no to this bill so we can start on a better plan that fixes the problem the American people care about most, and that is cost. They want us to start over. There is nothing about this massive bill they like. They want us to start over. They want us to address their real concerns. All it would take, Mr. President and my colleagues, is one Member of the other side of the aisle—just one—to give us an opportunity not to end the debate but to change the debate in the direction the American people would like us to go.

I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, my dear friend, the Republican leader, has had since Wednesday to read this bill. Obviously he hasn't done so because the facts he is talking about do not exist except in the minds of a few people who don't understand this legislation.

For 200 years we have styled ourselves the world's greatest deliberative body. Deliberation necessarily implies discussion and great issues, necessarily requires great debate. Today we vote on whether to even discuss one of the greatest issues of our generation; indeed, one of the greatest issues this body has ever faced: whether this Nation will finally guarantee its people the right to live free from fear of illness and death which can be prevented by decent health care for all. In the coming weeks, we will finally put people, not insurance companies, in charge of their lives.

The road to this point has been started many times. It has never been completed. Merging two such large and consequential bills has never been done before. It has been an enormous undertaking and we would not be in this position without the unflagging dedication of many Senators and extremely loyal staff members. At the top of the list are Chairmen BAUCUS and DODD who have shown dedication and determination in recent weeks and months that has rarely been seen.

I am proud of every single Senator's input, and I am especially proud of the two most recent classes of Senators. Elected with strong mandates for progress, they have demonstrated a studious approach to our historic endeavor and an unwavering belief that all Americans should be able to afford to live a healthy life.

I wish to explain why we are holding this important vote at this hour. As a matter of principle that I respect, the senior Senator from Arkansas insisted we vote only after Senators had time to read and understand this bill. Senators all have now had ample time to do so. That is because of the chairman of the Agriculture Committee, Senator BLANCHE LINCOLN, of Arkansas.

As I have done many times this year privately, personally, as well as publicly, I again invite my Republican colleagues to join on the right side of history. I, again, invite them to join us, at the very least, in a debate about our future.

Around dining room tables in Nevada and across the Nation, families are agonizing over what to sacrifice next to buy health insurance. They are questioning whether to fill a prescription or go without it and hope for the best. Employers are wondering whether they can afford to provide health care to their employees. They are asking how their businesses can survive while health care costs grow faster than ever. Americans need health insurance reform.

Debate is constant between television commentators and the editorial pages of great newspapers and magazines. The only place where silence is even considered is in the Senate of the United States.

Tonight—finally—we have the opportunity to bring this debate where it belongs. We finally have the opportunity to bring this great deliberation to this great deliberative body. That—and nothing more—is what tonight's vote does. A ''yes'' vote says to America: I know this issue is important to your family and to our country, and the Senate should, at the very least, talk about it.

Let's be real transparent. Beyond all the hype, the hyperbole, and the hyperventilation, that—and nothing more—is what tonight's vote does. A ''yes'' vote says to America: I know this issue is important to your family and to our country, and the Senate should at least talk about it.

Some of my Republican friends would like the American people to think that voting to debate the bill is voting to pass the bill. Any high school civics textbook will tell you that suggestion is absolutely false. Tonight's vote is not the end of the debate, it is only the beginning of the debate.

It is clear by now that my Republican colleagues have no problem talking about health care in press conferences, radio interviews, television interviews, and townhall meetings. My distinguished counterpart, the Republican leader, has given many speeches in this Chamber on the issue of health care reform.

Yet now that we have the actual legislation to debate, to amend, and build on—now that we have a plan on paper and not just wild rumors—will they refuse to debate?

After all, if we are not debating, if we refuse to let the Senate do its job, what are we doing here? If Senators refuse to debate about a profound crisis affecting every single citizen, the Nation must ask, what do you fear? In whose voice do you speak? In whose interest do you vote?

Surely, deliberating health reform cannot be more difficult than deciding, as Americans have to do, whether to pay your mortgage or your medical bills. It can't be more painful than not taking your child to the doctor because it costs too much. It cannot be more humbling than facing your own employees and telling them: I am sorry, you can't count on me for your health insurance next year. You are on your own.

It can't be more upsetting than having an insurance company take away your coverage at the exact moment you need it the most.

My Republican friends, there is nothing to fear in debate. President Kennedy once said:

> Let us not be afraid of debate or discussion. Let us encourage it.

Be not afraid of debate. It is our job, and it is exactly what the legislative process is all about—discussing, amending, improving. We Democrats stand ready to do what needs to be done. We welcome debate, encourage debate.

Does any Senator seriously think the Founders conceived the Senate rules in the hopes that legislation would never be deliberated? Of course not.

Did the Framers of the Constitution explicitly enumerate the powers of the Senate but in truth hope this body would avoid the hardest and most urgent questions of the day? Of course not.

Did our Nation's visionaries build this Capitol Building and design this great Chamber we stand in tonight only so it would remain dark and silent? Quite to the contrary.

Imagine if, instead of debating either of the historic GI bills—legislation that has given so many brave Americans the chance to attend college—this body stood silent. Imagine if, instead of debating the bills that created Social Security or Medicare, the Senate voices had been stilled.

Imagine if, instead of debating whether to abolish slavery, instead of debating whether giving women and minorities a right to vote, those who disagreed had muted discussion and killed any vote.

I say to my Republican Senators, don't try to silence a great debate over a great crisis. Don't let history show that when given the chance to debate and defend your position and work with us for the good of our constituents, you ran and hid. You cannot wish away a great emergency by closing your eyes and pretending it doesn't exist.

There is an emergency that exists, and it exists now. The right response to disagreement is not dismissal, it is discussion. Democracy is discussion. Democracy needs deliberation. Let us debate our differences. On some, we will find common ground; on others, we may not. But let's at least tell America their legislators in the Senate are willing to find where we can come together.

Nobel Prize awardee Andre Sakharov, one of the great thinkers of the past century, knew that when opposing sides come together, some of their ideas can outweigh its parts. Sakharov said:

> Profound thoughts arise only in debate, with a possibility of counter-argument. . . .

So come on, my friends, let us share our ideas in the Senate. Let us legislate. Let us negotiate. Let us deliberate. Let us debate. Our country cries for this debate. Our country deserves this debate. Our country needs this debate.

I extend my great appreciation to the truly tireless men and women at the Senate Finance Committee, Senate HELP Committee, Congressional Budget Office, Senate Office of the Legislative Counsel, Joint Committee on Taxation, the Department of Health and Human Services, the Center for Medicare and Medicaid Services and the White House:

CONGRESSIONAL BUDGET OFFICE

Doug Elmendorf, Director; Holly Harvey, Deputy Assistant Director for Budget Analysis; Kate Massey, Unit Chief, Low-Income Health Programs and Prescription Drugs Cost Estimates; Tom Bradley, Unit Chief, Health Systems and Medicare Cost Estimates; Phil Ellis, Unit Chief, Health Policy Analysis; Jean Hearne, Lara Robillard, Lori Housman, Mindy Cohen, Stephanie Cameron, and the rest of their staffs.

SENATE OFFICE OF THE LEGISLATIVE COUNSEL

Jim Fransen, Bill Baird, Ruth Ernst, John Goetcheus, Kelly Malone, Mark Mathieson, Mark McGunagle, Stacy Kern-Scheerer, Allison Otto, and the rest of their staffs.

JOINT COMMITTEE ON TAXATION

Thomas Barthold, Adam Block, John Bloyer, Tanya Butler, Jim Cilke, Tom Dowd, Robert Harvey, Marjorie Hoffman, Melanie Houser, Deirdre James, Rachel Levy, Julie Marshall, Pam Moomau, John Navratil, Ned Newland, Mary Risler, Cecily Rock, Bernard Schmitt, Chris Simmons, Carrie Simons, Lori Stuntz, Kristeen Witt.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Jeanne Lambrew, Meena Seshamani, Caya Lewis.

CENTER FOR MEDICARE AND MEDICAID SERVICES

Erin Clapton, Ira Burney, Amy Hall, Maria Martino, Isabella Leung, Anne Scott, Nancy DeLew, Sharon Arnold, Allison Orris, Jennifer Snow, Jill Gotts, Chantelle Britton, Molly Long, Adam Aten, Lisa Joldersma, Sylvia Yu, Laura McWright, Greg Jones, Dan Miller, Ariel Novick, Rick Foster.

Program Experts in the following offices/centers (in alphabetical order): Center for Drug and Health Plan Choices (Tim Hill); Center for Medicare Management (Jon Blum, Liz Richter); Center for Medicaid & State Operations (Cindy Mann, Penny Thompson); Office of Clinical Standards & Quality (Barry Straube); Office of E-Standards and Services (Tony Trenkle); Office of Financial Management (Deborah Taylor); Office of General Counsel (Janice Hoffman); Office of Legislation; Office of Research, Development and Information (Tim Love).

THE WHITE HOUSE

Nancy-Ann DeParle, Mike Hash.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. REID. Mr. President, I ask unanimous consent that Senators vote tonight from their desks.

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

Mr. REID. Mr. President, I ask consent that we start the vote 5 minutes early.

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

The PRESIDING OFFICER (Mr. DODD). Under the previous order, the clerk will report the motion to invoke cloture.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to proceed to Calendar No. 175, H.R. 3590.

Harry Reid, Tom Harkin, Jack Reed, Edward E. Kaufman, Jeff Merkley, Roland W. Burris, Daniel K. Akaka, Patty Murray, Richard J. Durbin, Sherrod Brown, Michael F. Bennet, Jeanne Shaheen, Sheldon Whitehouse, Bill Nelson, Mark Udall, Benjamin L. Cardin, Christopher J. Dodd, Patty Murray.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call is waived.

The question is, Is it the sense of the Senate that debate on the motion to proceed to H.R. 3590, the Service Members Home Ownership Tax Act of 2009, shall be brought to a close? The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Ohio (Mr. VOINOVICH).

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 353 Leg.]

YEAS—60

Akaka	Feingold	Lincoln
Baucus	Feinstein	McCaskill
Bayh	Franken	Menendez
Begich	Gillibrand	Merkley
Bennet	Hagan	Mikulski
Bingaman	Harkin	Murray
Boxer	Inouye	Nelson (NE)
Brown	Johnson	Nelson (FL)
Burris	Kaufman	Pryor
Byrd	Kerry	Reed
Cantwell	Kirk	Reid
Cardin	Klobuchar	Rockefeller
Carper	Kohl	Sanders
Casey	Landrieu	Schumer
Conrad	Lautenberg	Shaheen
Dodd	Leahy	Specter
Dorgan	Levin	Stabenow
Durbin	Lieberman	Tester
Udall (CO)	Warner	Whitehouse
Udall (NM)	Webb	Wyden

NAYS—39

Alexander	Crapo	LeMieux
Barrasso	DeMint	Lugar
Bennett	Ensign	McCain
Bond	Enzi	McConnell
Brownback	Graham	Murkowski
Bunning	Grassley	Risch
Burr	Gregg	Roberts
Chambliss	Hatch	Sessions
Coburn	Hutchison	Shelby
Cochran	Inhofe	Snowe
Collins	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Wicker

NOT VOTING—1

Voinovich

The PRESIDING OFFICER. On this vote, the yeas are 60, the nays are 39. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

(Disturbance in the galleries.)

The PRESIDING OFFICER. Expressions of approval are not allowed.

Under the previous order, all postcloture time is yielded back, and the motion is agreed to.

The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2786

Mr. REID. Mr. President, I call up my amendment that is at the desk.

The PRESIDING OFFICER. The clerk will report the amendment by title.

The legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN, proposes an amendment numbered 2786.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

(The amendment is printed in the RECORD of Thursday, November 19, 2009, under ''Text of Amendments.'')

Mr. MCCONNELL. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The majority leader.

MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent that there now be a period for the transaction of morning business, with Senators allowed to speak therein for up to 10 minutes each.

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

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BROWN. I ask unanimous consent that the order for the quorum call be rescinded.

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

HEALTH CARE REFORM

Mr. BROWN. Mr. President, we just did one of the most important things I have ever done in my professional life, and I join my colleagues in noting that. We have taken a major step in doing several things today—in providing health insurance to tens of millions of Americans who don't have insurance, in building consumer protections around 80 percent of Americans who are insured so people will no longer be disqualified from preexisting conditions, no more discrimination based on gender.

As the Presiding Officer knows from his work in Minnesota, women pay significantly higher health insurance premiums than men on average. Those days are behind us. There will no longer be lifetime caps so if somebody gets sick and their cost of treatment—from physician care, from hospital visits—so high, the insurance company chooses to do what they call rescission, cutting their insurance coverage off, those days are behind us, once we move forward with this bill.

Tonight is the first step. Even though none of my Republican colleagues, not 1 of the 39 who voted, not 1 of them wanted to proceed with the debate, clearly the country wanted us to move forward. Now everybody has a fair shot. If they don't like the public option, they can try to get rid of it. If they don't like the way we are paying for it, they can try to change it. If they don't like what we have done with biologics, those opportunities are in front of us now for the next 2 or 3 weeks.

I have come to the Senate floor leading up to this debate, since July, sharing letters from people in my State who have a few things in common. Almost every single letter I get comes from somebody who a year or two ago was pretty satisfied with their health insurance. Then maybe they had a baby with a preexisting condition or they lost their insurance or they owned a small business and 1 person out of 50 employees got cancer and their premiums spiked so high, the insurance was either terminated by the company or it was so expensive they couldn't afford it. Someone got so sick and the costs were so high, the insurance cut them off. In almost every one of these letters, people were generally satisfied with their insurance.

I get letters from a lot of people in their early sixties, people from Springfield to Troy to Zaynesville. These people in their early sixties who have lost their insurance, their job, or they had

a preexisting condition, can't wait to be 65. It is a pretty bad commentary on how we do this when a 62-year-old is so anxious to be 65 so that they have insurance. Then they have the security and the stability of Medicare. Why shouldn't we instead give them the security and the stability of the public option, if that is what they choose, if they are uninsured and in their sixties or forties or any other age.

The last thing I have found in these letters is an overwhelming sentiment in support of the public option. The public option does several things. The public option is only an option. If you want CIGNA or WellPoint or Medical Mutual, a not-for-profit company in Ohio, you can choose that or the public option. The public option, even with these reforms, will help keep the insurance companies honest. Nobody gets eliminated from Medicare because of a preexisting condition. Nobody will lose their health insurance with the public option because of a preexisting condition. Too many times, they have, if they had CIGNA or if they had WellPoint or Blue Cross or Aetna. That is the second reason the public option is so important.

Third, the public option is going to keep costs in check because in southwest Ohio, in Cincinnati, and the three surrounding counties, two insurance companies have 85 percent of the insurance policies.

What does that mean? It means lower quality and higher cost. Put the public option in as a competitor, people in Lebanon and Batavia and Middletown and Butler and Cincinnati don't have to choose the public option, but its very existence will discipline the market. It is good, old-fashioned American competition, and it will mean that the private insurance companies will act better. They will provide better quality at a lower price. That is the whole point of the public option.

Let me share a couple letters this evening. Debbie from Clark County:

In May, I suffered a serious ankle injury. After an ER visit and then a consultation by a specialist, I was told not to bear weight on my foot and that I needed major surgery.

Up until June 1, I was covered by my husband's employer-based plan. His company then changed its insurance policy and stated that any spouse of an employee who worked full time, and had access to insurance, would no longer be covered.

At the time, I was still employed and had access to an employer plan. But shortly after my injury on May 29, I couldn't work, and asked that I be put on my husband's plan.

The insurer initially declined, but after weeks of fighting, they agreed to put me back on his plan, but only during open enrollment in March 2010.

My surgery is critical and needs to be done immediately; I have to wait until March 2010—nearly ten months after my injury.

I have researched private insurance, but we can't afford it. Nor can we afford the surgery without insurance.

We have worked hard and raised our four children to believe that nothing worth having comes easy. But now, I feel like I'm somehow letting my family down.

How can this happen when living in the United States of America?

Debbie is like so many Ohioans and so many Americans who have worked hard, paid their taxes, played by the rules, and something happened with their insurance. They lost their insurance. She was victimized by a set of circumstances that simply shouldn't happen. Under our bill this will not happen. They will not be allowed to take people's insurance away. People will not fall through the cracks. She will be able to get insurance by buying on the insurance exchange. If she chooses to, she could choose the public option.

Robert from Lake County:

In 1986 my wife was terminally ill with cancer and several other illnesses. When I switched jobs and looked for new insurance, we were denied because of her pre-existing condition.

In 2001, when I was 58, I lost my job. When COBRA ran out, I was denied insurance based on my pre-existing conditions of diabetes and heart disease.

I managed to limp through until I turned 65 and became eligible for Medicare.

I'm sure the fear and anxiety I suffered over health insurance hasn't been at all beneficial to my overall health.

We don't think about that in this body. Most of the people we hang around with have insurance. Most of the people we hang around with as Senators don't have a lot of these problems. We certainly have sick relatives and friends who have disabilities and illnesses. But rarely do they have to worry so much before they turn 65 and can get the stability of Medicare, the same stability we want to give people in the public option. When you think about that, think of all the people who have insurance and they go to the doctor or hospital and get a medical treatment. They then apply to their insurance company to get their benefits paid for their expenses. Thirty percent of the time insurance companies deny claims—30 percent of the time, often on appeal to the insurance company, though they will pay the claim on the second round.

Think about putting people through that. You are sick, you have a $14,000 medical bill. You are making $35,000 a year. You can't afford anything close to that. Your insurance company turns you down. You go back and fight with them, you argue with them, or your spouse argues with them. Where does that leave you?

In difficult times with their health, the anxiety makes it even worse. That is why we need to change this model of the private insurance companies finding all kinds of reasons to not insure people with preexisting conditions, to discriminate because of gender and then to refuse to pay claims. That is what the public option will do, inject competition so they would not be able to do that.

The last letter I wish to share is from Shelly from Coshocton County in sort of eastern-southeastern Ohio:

I have no health insurance coverage for myself or my son. My husband is disabled and receives Social Security Disability and Medicare.

My son was born with a congenital heart defect and has already had one open heart surgery. Along with my pre-existing condition, neither of us can afford private coverage. Pre-existing conditions should be illegal for insurance companies to use to delay health care for Americans.

A public option would protect Shelly. She asks for a public option. She says: A public option would protect me from preexisting condition exclusions. That is exactly right. The insurance industry model—you think about how it works.

They first hire a bunch of bureaucrats to keep people from buying insurance if they are sick. So they deny people the ability to buy insurance because they might be expensive, on the one hand. And then, after you do have coverage, and you get sick and you submit a claim, they hire a bunch of bureaucrats on that end to stop you from getting payment, to stop you from getting reimbursed for your claim.

That is why the CEO of Aetna was able to make $24 million last year. That is why insurance companies have seen profits increase 400 percent in the last 7 years. When you have a business model where you hire a bunch of bureaucrats to keep people who are sick from buying your insurance, and on the other end you hire a bunch of bureaucrats to deny payment of their claims, those are companies that are going to make a lot of money.

That is a pretty good business model. It works for them. The CEOs of the top 10 insurance companies in the country average $11 million in pay. It works for them. It works for their shareholders. It works for their profitability. It is not working so well for Shelly. It is not working so well for Debbie from Springfield. It is not working so well for Robert from Wickliffe or Willowick, in that part of Ohio.

So it is clear we have our work cut out for us tonight. It is a major step. I am sorry none of my Republican colleagues wanted to even debate this, wanted to even move forward and put this bill on the floor. But I am confident as we process these amendments, the dozens and dozens of amendments—I know the Presiding Officer has a great amendment on making sure the drug companies that advertise do not get subsidized by taxpayers through a tax deduction, which they do now. There are a lot of amendments that are coming to this floor that will make this bill better.

There are some amendments that will not make it better. But everybody is going to have a free shot—all 100 of us. That is the way this system should

work. That is why open debate is good, even though some of my colleagues did not want us to do that. But that is why, in the next month or two, we are going to get a bill through the Senate, through the conference committee, to the President's desk, and it is going to change Americans' lives.

Those who have insurance, who are satisfied with it, will be able to keep their insurance with consumer protections. It will help small businesses so they can insure their employees. And it will help those people who do not have insurance get some help and get some insurance. The public option will improve the system all up and down in other ways.

Mr. President, I yield the floor.

NSWG TRAVEL

Mr. KYL. Mr. President, I rise today in my capacity as the cochairman of the Senate's National Security Working Group. It is in that capacity I recently traveled on a CODEL with the senior Senator from California.

Pursuant to the requirements of the current Memorandum of Understanding on the Administrative Procedures for the U.S. Senate National Security Working Group, specifically paragraph 6, Senator FEINSTEIN and I have filed in the Office of Senate Security a classified memorandum available to the members of the working group and their designated staffer.

As my colleagues are aware, the NSWG, which is the successor of the Senate's Arms Control Observer Group, was created by the Senate to aid administrations that choose to negotiate arms control treaties. In view of the 67-vote threshold to ratify a treaty, and given the complexity and importance of the subject matter at the heart of arms control treaties, as well as the Constitution's mandate that the U.S. Senate has a role of advice and consent in treaty making, the NSWG exists to provide a forum for an expert group of Senators to have up-to-date information on ongoing treaty negotiations, and to provide the Administration with consultation from the Senate.

This consultative role is important, because the Constitution entrusts the Senate with the responsibility to provide its advice along with, perhaps, its consent to a treaty. This means administrations are supposed to listen to the advice of Senators if they expect to earn the Senate's consent.

The U.S. negotiating team is lead by Assistant Secretary of State Rose Gottemoeller, a highly capable administration official and a gracious host. I thank her for her time and hospitality, as well as for her service.

I urge my colleagues in the NSWG to take the time to study the classified memorandum Senator FEINSTEIN and I have drafted. The issues covered in our memorandum are significant, and, in some cases worrisome. I won't go into detail here—the memorandum is classified and for good reason.

That said, I will ask to have printed four recent articles on the START follow-on treaty negotiations to the RECORD. These articles highlight issues that every Senator should consider.

As my colleagues know, the 1991 START Agreement expires 2 weeks from today. I urge my colleagues to consider what will happen on December 6, the day after the expiration of that agreement. For the first time in 15 years, an extensive set of verification, notification, elimination and other confidence building measures will expire.

The U.S. will lose a significant source of information that has allowed it to have confidence in its ability to understand Russian strategic nuclear forces; likewise, the Russian Federation will lose information about U.S. nuclear forces, almost all of which are strategic, unlike the Russian-forces, which place tremendous emphasis on tactical nuclear forces not covered by the 1991 Agreement or its successor.

Yet, no one appears to know what will come next. According to the reports I will add to the RECORD, there is no plan for what provisions of the 1991 Agreement will be maintained after the 1991 Agreement expires on December 5.

The question of what happens after the 1991 Agreement expires is important. The Russian Federation is already telling us they intend to deploy a new road mobile missile, one which, for the first time, will have multiple independent reentry vehicles. Open source reports indicate this missile will constitute 80 percent of Russian ICBM forces by 2016. This is a significant deployment. Moreover, it confirms that Russia, unlike the U.S., is modernizing its nuclear forces.

How will we monitor this highly destabilizing weapon, the RS–24? According to the article I introduced from the Global Security Newswire by Elaine Grossman, we won't have the entry and exit portals at Votkinsk.

That we don't have answers to these questions is alarming, more so because our negotiators must have known for months that a ''bridge'' would be necessary. Why do I say this? Simple: the Moscow Treaty took the Senate 9 months—287 days—to ratify from the date of its signature. And that was a very limited treaty—it was about two to three pages long.

The START agreement of 1991 took 429 days to ratify on October 1, 1992, after it was submitted to the Senate on July 31, 1991. And by everything we have seen in the press and been briefed on in the National Security Working Group, this new treaty will be almost as complicated, and will include highly significant nuclear force reductions, that will take time for Senators to consider. In fact, the Senate has not had even one hearing on the START process yet.

The administration must have understood this. Yet it spent the first half of the year negotiating a joint understanding that would allow it to show progress towards the President's goal of world without nuclear weapons. According to press reports, only now have the negotiators begun looking at the question of verification.

I was shocked that there had been virtually no talk—and I know this from my conversations with members of both the Russian and U.S. delegations in Geneva—of what happens after December 5 and prior to the possible entry into force of the follow-on agreement when and if it is signed by the two executives. Mr. President, I don't say this lightly, but, this borders on malpractice.

I have said repeatedly that I hope to be able to support the treaty being negotiated now. I have kept an open mind throughout this process. Yet as I learn more about what has been negotiated thus far, and the general process this treaty negotiation has taken, I grow more concerned.

The paramount object of this treaty should have been to extend the verification measure of the 1991 Agreement. But, it appears that the administration's object was to lock in significant nuclear weapons cuts; they achieved that with the July joint understanding. Only recently has verification gotten the attention it deserved all along.

And, now, the Russians may think they have the advantage. That may be why they returned a counter offer a little over a week ago that the U.S. was ''very disappointed about'' in the words of Under Secretary of State Ellen Tauscher. We have entered an end-game where the Russians may feel that the U.S. wants the START follow-on agreement more than they do; even though Russia needs this treaty, needs to lock the U.S. into strategic delivery vehicle reductions as Dr. Keith Payne explained in his testimony before the House Foreign Affairs Committee, only the House so far has held a hearing on START.

I believe the U.S. would have been very well served with a simple 5 year extension of the 1991 Agreement, as the treaty allowed. But, now the President is preparing to head to Oslo to collect his Nobel Peace Prize, one that was apparently based on the President's endorsement of the Global Zero vision. The Russians apparently perceive that the President would be quite embarrassed if he had to pick up his Prize having failed to get a START follow-on completed. In the interest of the United States, I implore the administration not to negotiate against an artificial deadline. There are means to lock in verification and associated activities from the 1991 Agreement after it expires in 2 weeks.

Mr. President, I ask unanimous consent that the four articles to which I referred be printed in the RECORD.

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

NEW RUSSIAN-U.S. ARMS REDUCTION TREATY HAMPERED BY DIFFERENCES

(By Ilya Kramnik)

MOSCOW.—Russia and the United States cannot agree on a new strategic arms reduction treaty to replace the START–1, which will expire on December 5, 2009.

The problems concern control of mobile missile systems, cuts in delivery vehicles, and a connection between the new treaty and limits on the deployment of ballistic missile defense systems.

The START–1 treaty signed in 1991 stipulated the size of mobile missile systems' deployment areas and the number of basing stations for rail missile systems. It also limited the number of missile systems that can be simultaneously deployed outside their deployment sites, and the duration of such deployment.

The liquidation procedures stipulated for mobile missiles are stricter than for silo-based missiles. In particular, mobile missiles must be liquidated together with their delivery vehicles, whereas the cuts for silo- and submarine-launched missiles stipulate only the liquidation of silos and submarines.

Topol is the only mobile intercontinental ballistic missile on combat duty in Russia. The United States decided in the early 1990s that submarine-launched Trident II missiles could replace its land-based mobile systems.

When the silo-based group of missiles was cut in Russia, the focus was shifted to the Topol missiles. The role of mobile systems increased when the Topol-M system was introduced and the RS–24 Yars MIRVed missile, which is heavier than Topol-M and can carry up to ten independently targetable warheads, was created.

Given the current trends, land-based mobile missiles will constitute the bulk of Russia's Strategic Missile Force in the next 20 years. Russia might also deploy new rail missile systems.

In this situation, limits put on the deployment areas and movement of mobile systems will deprive Russia's Strategic Missile Force of its main advantage—mobility, which ensures a degree of safety in case of a first strike. However, the survival of silo-based missiles in a first strike is not assured either, given the growing precision of reentry vehicles.

The U.S. strategic nuclear might is based on the naval element of the nuclear triad, in particular its 14 Ohio-class nuclear submarines armed with 336 Trident II missiles, each with eight individually targeted warheads. It would be useless to try to limit the deployment areas and movement of submarines, because such a limitation cannot be effectively verified.

Another bone of contention is the number of delivery vehicles. Russia has proposed cutting them to 500, whereas the United States sets the limit at 1,000. This explains the big difference in the proposed limitations, between 500 and 1,100 delivery vehicles and 1,500–1,675 nuclear warheads.

The issue of delivery vehicles is closely connected to the ''upload potential,'' which is the number of warheads for cruise missiles carried by heavy bombers that can be stored for potential deployment in a dangerous period. The more delivery vehicles a side's strategic nuclear forces have, the larger the upload potential, which makes strategic arms reductions senseless.

And lastly, the main problem of the new reduction treaty is a connection between strategic nuclear weapons and ballistic missile defense (ABM) systems. Russia insists that the ABM systems should be curtailed, whereas the United States is only prepared to recognize a connection between strategic offensive arms and ballistic defense systems in the preamble to the new treaty.

Unless the sides agree on this issue, the new treaty will be a useless document suiting neither side. This will not please the United States, the economically stronger partner. At present Russia plans to supply 30 new missiles to its strategic nuclear forces annually and may step up the process. If necessary, Russia will be able to maintain its nuclear forces at standards guaranteeing unacceptable damage to the aggressor, irrespective of the ABM systems.

If the sides do not sign the new treaty, or if the treaty does not limit the deployment of ABM systems, this will actually restart a nuclear missile race, even if at a lower level than in the 1950s through 1980s.

The opinions expressed in this article are the author's and do not necessarily represent those of RIA Novosti.

U.S. TREATY-MONITORING PRESENCE AT RUSSIAN MISSILE PLANT WINDING DOWN

(By Elaine M. Grossman)

WASHINGTON.—With the Strategic Arms Reduction Treaty expiring in early December, U.S. inspectors are winding down their nearly 15-year presence in the remote Russian village of Votkinsk.

Roughly 630 miles northeast of Moscow, the town is home to the Votkinsk Machine Building Plant, a weapon factory where the accord allows as many as 30 U.S. personnel to ensure Russian compliance with treaty provisions on nuclear-capable missiles. Moscow uses the facility to manufacture SS–27 Topol-M and SS–26 Bulava ICBMs.

Operating 24 hours a day, the monitoring staff can observe and inspect vehicles leaving the facility by rail or road, according to the U.S. Defense Threat Reduction Agency. The monitors also conduct twice-daily perimeter inspections to verify that missiles cannot leave the facility by any other means.

Washington and Moscow are engaged in intense negotiations to replace the treaty with a new accord that sets lower caps on deployed nuclear warheads and delivery vehicles. However, the envoys have not yet reached agreement. Despite earlier hopes to the contrary, the two nations will be unable to achieve ratification of a new treaty before the old one comes to an end.

Lacking a new agreement that allows for a continued U.S. presence at the Votkinsk facility, the monitors would be forced to move out by Dec. 5, when the 1991 treaty expires.

There is no public indication yet that a new pact would maintain a provision allowing for U.S. inspectors on the ground at Votkinsk.

With the United States not currently producing any new-design strategic missiles, there is nothing for Moscow to monitor at shuttered U.S. production lines. In that the production-monitoring verification measure is now not reciprocal, Moscow no longer finds it useful, even if Washington does, according to nuclear weapons expert Jeffrey Lewis of the New America Foundation.

Lewis has pointed to indications that Moscow wants to jettison any such missile-production monitoring in the so-called ''New START'' agreement.

''The Russians have been saying that for a long time,'' one U.S. Defense Department official told Global Security Newswire last week.

Given clear signals that a Russian change of heart was unlikely, ''we had to [start packing up],'' the official said. ''We had to. You can't just walk away.''

U.S. facilities at the Votkinsk site include a large administrative building and three residential buildings, called Lincoln, Roosevelt and Washington.

Although preparing to depart Votkinsk has been a major undertaking, responsibility for winding down operations has fallen largely to the support staff, freeing inspectors to continue their treaty-controlled mission, officials said.

''We've got monitors there right now . . . and we will continue to monitor until the treaty expires on Dec. 5,'' the defense official said. ''Nobody has suspended it. Nobody would. We've maintained that [monitoring since 1995 when] we sent our first monitors there, and they've been there continuously, 365 days a year, since that point.''

This official and several others interviewed for this article spoke on condition of anonymity. They cited diplomatic and political sensitivities involved in discussing a verification regime under negotiation in the ongoing U.S.-Russian arms control talks.

Asked to describe treaty-verification activities at Votkinsk, a U.S. official would say only that ''the United States has fully implemented its rights under START at Votkinsk and will continue to do so until Dec. 5.''

However, the monitoring process at Votkinsk is based on clearly established rules and is fairly straightforward, other officials said.

From inside a Navy-issued trailer called a ''Data Collection Center,'' the inspectors observe traffic exiting the production facilities through a huge portal, according to those familiar with the setup.

They use red traffic lights to control vehicles, and can exercise treaty rights to inspect cargo if a truck or railcar exceeds a specified length and is potentially capable of transporting a missile, these sources said. U.S. personnel also can record the serial numbers of START-limited missiles, aiding in any subsequent efforts to track deployed missiles under treaty provisions.

The inspections have helped Washington assess Moscow's nuclear-capable missile fleet and remain aware of new missiles under development, officials say.

Under a New START accord, Washington and Moscow each anticipate reducing deployed strategic nuclear warheads to no more than 1,675, U.S. and Russian Presidents Barack Obama and Dmitry Medvedev announced in July. The pact would also cut nuclear-capable delivery vehicles to a level between 500 and 1,100, the leaders said.

Perhaps the greatest challenge in the ongoing negotiations has been finding common ground on how to verify the new numerical limits, experts say. Moscow has resisted a number of measures that it interprets as nonreciprocal, including Washington's interest in tracking Russia's mobile ICBMs, according to reports. The United States fields no such mobile systems for possible monitoring.

Russian negotiators also have opposed renewing START provisions for exchanging missile-test data, called ''telemetry,'' Lewis said early this month on his blog, ArmsControlWonk.com. However, it remains unclear what the U.S. negotiating position has been on this issue, he said.

Interviewed last week, Lewis rued the potential loss of these verification measures under the anticipated New START pact, saying, ''I suspect we're going to lose Votkinsk, but I hope we can hang onto the telemetry.''

Not everyone views Votkinsk monitoring as a valuable verification provision to be sought in a forthcoming treaty.

The basis for exchanging inspectors at U.S. and Russian weapon-production facilities essentially is that ''we think you're cheating and we're here to prove it,'' said one retired nuclear-weapons officer. ''[But] if they're going to do something they don't want us to know about, they'll go and do it someplace else.''

Over the years, it has become increasingly possible to verify missile-test performance and weapon deployments via direct observation or satellite imagery, according to this defense expert and others.

Under the 1991 treaty, ''we put some rather onerous requirements on the Russians because we could,'' said the retired officer. ''If the Cold War is either over or thawing, there are certain things you would not require a counterpart to do.''

Moscow actually never exercised its reciprocal right to continuously monitor a U.S. missile production facility by deploying inspectors, according to a DTRA fact sheet. In April 2001—a year after Thiokol Corp. stopped making Peacekeeper missiles at a plant in Promontory, Utah—the Russian right to maintain such inspectors in the United States came to an end.

That left Votkinsk as the only operating strategic-missile production facility in either nation, and the only site to host continuous monitoring. The START accord also allows for 12 types of intrusive verification measures that include suspect-site inspections to confirm that clandestine weapons production is not occurring, according to the U.S. defense agency.

Even as hosting the only remaining monitoring mission at a production facility has evolved into an irritant for Moscow, it is unclear how useful the U.S. presence at Votkinsk has been for Washington. Intelligence officials have prized the U.S. opportunity to observe Russian manufacturing operations at Votkinsk, but how much militarily useful information has been gleaned is uncertain, some experts said.

For many of the U.S. civilian and military inspectors who served at the remote Russian location, there were apparently few surprises.

''It was very monotonous. We could have months go by without inspecting a missile,'' a former U.S. inspector at Votkinsk told GSN in an interview. ''It all seemed like the whole process was very ridiculous, in a way.''

A photograph posted on a Facebook page for the ''Votkinsk Portal Monitoring Facility'' shows a group of U.S. personnel wearing swimsuits and big smiles, posing on beach chairs in several inches of snow. A Defense Threat Reduction Agency building appears in the background.

''It always felt like an episode from 'M*A*S*H,' '' said the former inspector, referring to the television comedy series about an Army medical unit during the Korean War. ''There's people from all over the country just thrown in there to do this job. It was very surreal at times.''

Military duty officers would cycle through the facility on three- or six-week rotations, this source said. Civilians typically served much longer tours—many on DTRA contract with Raytheon Technical Services, or Hughes before that—on duty for nine-week stretches, with three weeks of leave in between.

Under the START accord, the U.S. government could deliver food and other goods to the inspection and support teams at Votkinsk in two cargo aircraft flights a year.

The defense agency describes a typical inspection team as including a team chief and deputy, two linguists, a weapons specialist and other experts. Government and contracted support personnel include translators, technicians, cooks and medical staff, according to defense officials.

The former inspector said the U.S. team at Votkinsk used relatively little advanced technology for its monitoring operations, and the staff's computers or other electronics could likely be moved using a single cargo aircraft. Most furniture and office supplies would likely be disposed of or left behind, officials speculated.

RUSSIA HINTS AT DELAY IN START II NEGOTIATIONS

WASHINGTON—A report from Interfax news agency has quoted the Russian Foreign Ministry as saying that the provisions of the Strategic Arms Reduction Treaty (START) can remain in force even after it expires on December 5.

To some, the pronouncement looks problematic for the administration of U.S. President Barack Obama, which was hoping to sign a new treaty with Russian President Dmitry Medvedev when Obama goes to Europe to accept his Nobel Peace Prize on December 10.

At a November 15 meeting with Medvedev in Singapore after the close of the Asia-Pacific Economic Cooperation forum, Obama said that the two men's ''goal continues to be to complete the negotiations and to be able to sign a deal before the end of the year.''

He added that he was ''confident'' that with ''hard work and a sense of urgency,'' it could happen.

But as Russian and U.S. weapons negotiators continue to meet in Singapore, it has emerged that a key sticking point is how each country inspects the other's nuclear weapons facilities.

''If you believe the leaks that have been coming out over the past couple of days, the issue is now about disagreements over the systems and processes of how things are checked,'' Fyodor Lukyanov, the editor of the journal ''Russia in Global Affairs,'' told RFE/RL's Russian Service. ''For its part, the Russian side is opposed to the proposals that the Americans have put forward.''

Lukyanov said that one point of disagreement could bring the talks to a crashing halt.

''Nothing is agreed on until everything is agreed on,'' he said.

''WORKING THROUGH ISSUES''

Obama may have been referring to that issue in Singapore when he said he felt ''as if both sides are trying to work through some difficult technical issues but are doing so in good faith.''

Obama and Medvedev met in Moscow in July and agreed to reduce the number of nuclear warheads that each country could possess to between 1,500 and 1,675 within seven years.

Kennette Benedict, executive director of the Bulletin of Atomic Scientists, which focuses on the consequences of nuclear weapons, thinks the statement by the Russian Foreign Ministry about allowing the original START treaty to remain in force is a positive sign from Moscow.

''I take this as a very positive sign because the START Treaty does expire on December 5—and there are provisions for extending it, and the reason it's so important to extend is because it has such robust verification measures in it. We have inspectors now in Russia and they have inspectors here in the United States,'' Benedict said. ''If START I is not extended, then our inspectors would need to leave, Russia and their inspectors would need to leave the U.S., and the trust that we've built may make it more difficult to come to a final agreement.''

Benedict said she expects that Obama and Medvedev will sign a START II Treaty soon, perhaps by the end of the year. The hard part, she said, will be persuading getting the U.S. Senate to ratify it.

DOMESTIC POLITICS

For the past decade, Benedict said, the Senate has been reluctant to ratify any international treaties, regardless of subject matter.

''As I understand it, they think that the United States can go it alone on any number of things, and that we have a right to have as many weapons as we want, and they believe, I guess, that all weapons are useful,'' Benedict said. ''So they think that military might is the best way for the United States to proceed.''

Gary Schmitt, director of advanced strategic studies at the American Enterprise Institute, a private policy-research center in Washington, agreed that Senate ratification will be difficult, but for a more nuanced reason.

''It's not going to be a slam-dunk [in the Senate] because the actual agreement's going to reduce the number of warheads and platforms,'' Schmitt said. ''And if it's really a substantial cut, there'll be a serious debate about what the nature of our deterrent looks like.''

In fact, Schmitt said he's surprised that Obama is acting as if the United States needs a START II Treaty. One of the snags in the negotiations so far, he noted, is that Moscow wants to cut weapons further than Washington does.

''I think one of the problems with the Obama administration's approach was that they actually acted like we needed this arms-control agreement, when, in fact, it was the Russians who were looking for it because, first of all, it costs a lot of money to develop new weapons, and the second thing is that a lot of what they have is extremely old and should be taken out of commission,'' Schmitt said. ''Somebody was telling me that at the most recent military parade in Moscow they were driving some of the missiles by and they were noticeably rusty, which is not what you want when you have ICBMS.''

Ultimately, Schmitt said, it is good news that both Russia and the United States aren't arbitrarily standing by the December 5 deadline.

Give the two sides plenty of time to talks, he said, because both sides can easily live with an extension of START I.

RUSSIA NOT PREPARING INTERIM AGREEMENT AT START TALKS

MOSCOW, NOV. 17.—The United States and Russia are not preparing some interim agreement on strategic offensives weapons, the Russian Foreign Ministry said.

''According to the instructions that were given our delegation is working on a new agreement on the reduction and limitation of strategic offensive weapons and not some interim documents,'' Russian Foreign Ministry spokesman Andrei Nesterenko said at a briefing in Moscow on Tuesday.

Nesterenko was commenting on the statement by U.S. presidential aide Michael McFaul that Moscow and Washington need to prepare an interim agreement on strategic offensive weapons, as the main agreement will not be ratified by December 5 when the current one expires.

CHANGES TO S. CON. RES. 13 PURSUANT TO SECTION 301(a)

Mr. CONRAD. Mr. President, section 301(a) of S. Con. Res. 13, the 2010 budget resolution, permits the chairman of the Senate Budget Committee to adjust the allocations of a committee or committees, aggregates, and other appropriate levels and limits in the resolution, and make adjustments to the pay-as-you-go scorecard, for legislation that is deficit-neutral over 11 years, reduces excess cost growth in health care spending, is fiscally responsible over the long term, and fulfills at least one of eight other conditions listed in the reserve fund.

I find that the Patient Protection and Affordable Care Act of 2009, an amendment in the nature of a substitute to H.R. 3590, fulfills the conditions of the deficit-neutral reserve fund to transform and modernize America's health care system. Therefore, pursuant to section 301(a), I am adjusting the aggregates in the 2010 budget resolution, as well as the allocation to the Senate Finance Committee.

I ask unanimous consent that the following revisions to S. Con. Res. 13 be printed in the RECORD.

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

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

[In billions of dollars]

Section 101	
(1)(A) Federal Revenues:	
FY 2009	1,532.579
FY 2010	1,623.888
FY 2011	1,944.831
FY 2012	2,145.835
FY 2013	2,322.917
FY 2014	2,560.488
(1)(B) Change in Federal Revenues:	
FY 2009	0.008
FY 2010	−42.098
FY 2011	−143.800
FY 2012	−214.558
FY 2013	−192.420
FY 2014	−73.170
(2) New Budget Authority:	
FY 2009	3,675.736
FY 2010	2,910.707
FY 2011	2,842.766
FY 2012	2,829.808
FY 2013	2,983.128
FY 2014	3,193.867
(3) Budget Outlays:	
FY 2009	3,358.952
FY 2010	3,021.741
FY 2011	2,966.921
FY 2012	2,863.655
FY 2013	2,989.852
FY 2014	3,179.417

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

[In millions of dollars]

Current Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays	1,166,970
FY 2010 Budget Authority	1,237,336
FY 2010 Outlays	1,237,842
FY 2010–2014 Budget Authority	6,857,897
FY 2010–2014 Outlays	6,857,305
Adjustments:	
FY 2009 Budget Authority	0
FY 2009 Outlays	0
FY 2010 Budget Authority	12,500
FY 2010 Outlays	11,500
FY 2010–2014 Budget Authority	−33,100
FY 2010–2014 Outlays	−38,400
Revised Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays	1,166,970
Pt 2010 Budget Authority	1,249,836
FY 2010 Outlays	1,249,342
FY 2010–2014 Budget Authority	6,824,797
FY 2010–2014 Outlays	6,818,905

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BUNNING (for himself, Mr. NELSON of Nebraska, Mr. BROWNBACK, Mr. BURR, Mr. CASEY, Mr. CHAMBLISS, Ms. COLLINS, Mr. ENZI, Mr. INHOFE, Mr. ISAKSON, Mr. JOHNSON, Mr. ROBERTS, Mr. THUNE, and Mr. VITTER):

S. 2816. A bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs and to allow the adoption credit to be claimed in the year expenses are incurred, regardless of when the adoption becomes final; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. REID:

S. Res. 359. A resolution to make temporary appointments to the Select Committee on Ethics; considered and agreed to.

By Mr. DODD (for himself, Mr. CORNYN, Mr. KERRY, Mr. LUGAR, Mr. LIEBERMAN, Mr. KIRK, Mrs. SHAHEEN, Mr. MENENDEZ, Mr. BROWNBACK, Mr. MCCAIN, Mr. BROWN, Mrs. FEINSTEIN, Mr. WICKER, Mr. VOINOVICH, Mr. ISAKSON, Mr. BOND, Mr. CASEY, Ms. MIKULSKI, and Mr. FRANKEN):

S. Res. 360. A resolution honoring the Prime Minister of India, Dr. Manmohan Singh, for his service to the people of India and to the world, and welcoming the Prime Minister to the United States; considered and agreed to.

ADDITIONAL COSPONSORS

S. 2097

At the request of Mr. BROWNBACK, his name was added as a cosponsor of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BUNNING (for himself, Mr. NELSON of Nebraska, Mr. BROWNBACK, Mr. BURR, Mr. CASEY, Mr. CHAMBLISS, Ms. COLLINS, Mr. ENZI, Mr. INHOFE, Mr. ISAKSON, Mr. JOHNSON, Mr. ROBERTS, Mr. THUNE, and Mr. VITTER.

S. 2816. A bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs and to allow the adoption credit to be claimed in the year expenses are incurred, regardless of when the adoption becomes final; to the Committee on Finance.

Mr. BUNNING. Mr. President, today is National Adoption Day, and there could be no more fitting day to introduce legislation that will help American families achieve their dream of adopting a child.

For too many families, the high cost of adoption makes this dream difficult and sometimes impossible to reach. That is why Congress acted in 2001 to strengthen the adoption tax credit and make welcoming a child into a family more affordable. Unfortunately, this important tax relief will expire at the end of next year.

The legislation I am introducing today with Senator BEN NELSON, the Adoption Tax Relief Guarantee Act, will permanently extend and improve the 2001 adoption incentives. By easing this financial burden, we will encourage the development of more stable families and provide a brighter future for countless children for years to come.

The Adoption Tax Relief Guarantee Act will allow adoptive families to receive a tax credit of up to $10,000 and guarantees the maximum $10,000 credit for families who adopt children with special needs. This legislation will help middle-income families break the financial barriers and successfully adopt a child, especially those children with special needs who are in particular need of a loving home. In addition, this bill will allow families to receive the credit in the year an adoption expense is paid or incurred. Currently, those who adopt a child must wait until the following taxable year before receiving a tax credit for an adoption expense. This important change will expedite financial relief, putting money back into the pockets of middle-income families who struggle through the lengthy and costly adoption process.

I am pleased that Senators from both sides of the aisle have cosponsored this

legislation, and that it has received endorsements from the National Council for Adoption and RESOLVE: the National Infertility Association, the National Council for Adoption, and the American Academy of Adoption Attorneys. The adoption tax credit and assistance programs have already helped countless children and families by making adoption more affordable. We owe it to future generations of children in need to make these provisions permanent.

Our entire society benefits when children are placed with loving, permanent families. I urge my colleagues to support critical legislation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2816

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Adoption Tax Relief Guarantee Act''.

SEC. 2. REPEAL OF APPLICABILITY OF SUNSET OF THE ECONOMIC GROWTH AND TAX RELIEF RECONCILIATION ACT OF 2001 WITH RESPECT TO ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

Section 901 of the Economic Growth and Tax Relief Reconciliation Act of 2001 is amended by adding at the end the following new subsection:

''(c) EXCEPTION.—Subsection (a) shall not apply to the amendments made by section 202 (relating to expansion of adoption credit and adoption assistance programs).''.

SEC. 3. ALLOWANCE OF ADOPTION CREDIT IN YEAR OF EXPENSES.

(a) IN GENERAL.—Paragraph (2) of section 23(a) of the Internal Revenue Code of 1986 (relating to allowance of credit) is amended to read as follows:

''(2) YEAR CREDIT ALLOWED.—The credit under paragraph (1) with respect to any expense shall be allowed for the taxable year in which such expense is paid or incurred.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to expenses paid or incurred in taxable years beginning after December 31, 2010.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 359—TO MAKE TEMPORARY APPOINTMENTS TO THE SELECT COMMITTEE ON ETHICS

Mr. REID submitted the following resolution; which was considered and agreed to:

S. RES. 359

Resolved, That (a) for matters before the Select Committee on Ethics involving Preliminary Inquiry Case Number 20711, the Senator from Arkansas (Mr. Pryor) shall be replaced by the Senator from Maryland (Mr. Cardin).

(b) The membership of the Select Committee on Ethics shall be unchanged with respect to all matters before that Committee other than the matter referred to in subsection (a).

SENATE RESOLUTION 360—HONORING THE PRIME MINISTER OF INDIA, DR. MANMOHAN SINGH, FOR HIS SERVICE TO THE PEOPLE OF INDIA AND TO THE WORLD, AND WELCOMING THE PRIME MINISTER TO THE UNITED STATES

Mr. DODD (for himself, Mr. CORNYN, Mr. KERRY, Mr. LUGAR, Mr. LIEBERMAN, Mr. KIRK, Mrs. SHAHEEN, Mr. MENENDEZ, Mr. BROWNBACK, Mr. MCCAIN, Mr. BROWN, Mrs. FEINSTEIN, Mr. WICKER, Mr. VOINOVICH, Mr. ISAKSON, Mr. BOND, Mr. CASEY, Ms. MIKULSKI, and Mr. FRANKEN) submitted the following resolution; which was considered and agreed to:

S. RES. 360

Whereas, on August 15, 1947, India became a sovereign, democratic nation;

Whereas the Prime Minister of India, Dr. Manmohan Singh is now the honoree of President Barack Obama's historic first State Dinner;

Whereas India is the world's largest democracy, embracing and upholding fundamental liberties and freedoms, justice, and the rule of law;

Whereas the 2009 parliamentary elections in India were the world's largest democratic election to date;

Whereas India is a multi-ethnic, multi-cultural, and multi-religious society that promotes tolerance, diversity, and equality;

Whereas the 100,000 Indians who are studying in the United States and the 2,500,000 Americans of Indian descent living in the United States, including Nobel Laureates, artists, business leaders, journalists, and public servants, have contributed enormously to the rich social, political, and economic fabric of the United States;

Whereas cooperation between the United States and India in the areas of science and technology, our advancement of security and defense, and our commitment to clean energy continue to strengthen the bond between the two countries and enhance mutual admiration;

Whereas India serves as a pivotal and effective partner in ensuring international peace and security and is the third largest contributor of personnel to United Nations peacekeeping missions;

Whereas, since the liberalization of India's economy in 1991, bilateral trade has increased and benefitted both India and the United States;

Whereas, the market economy in India has contributed to increased economic opportunities, reduced poverty, and accompanying stability; and

Whereas a strong relationship between the people and governments of the United States and India, based on mutual trust and respect, will enable the countries to more closely collaborate across a broad spectrum of interests, such as global peace and prosperity, counterterrorism, defense, nonproliferation, economic prosperity, energy and climate change, education, scientific research, outer space, public health, and agriculture: Now, therefore, be it

Resolved, That the Senate—

(1) warmly welcomes the Prime Minister of India, Dr. Manmohan Singh, on his official state visit;

(2) believes that together, the governments of India and the United States can bring immense benefits to their people and make enormous contributions to addressing the global challenges of the 21st century;

(3) looks forward to the continuing progress in relations between India and the United States; and

(4) appreciates the contributions of Americans of Indian descent and desires closer relations between the people of the United States and the people of India.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2788. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2789. Mr. COBURN (for himself, Mr. VITTER, Mr. BURR, and Mr. HATCH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2788. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. _____. INCREASED TRANSPARENCY.

(a) SCORING AND SUMMARY.—It shall not be in order in the Senate or the House of Representatives to vote on final passage on a bill, resolution, or conference report unless a final Congressional Budget Office score and Congressional Research Service summary report on policy changes in the bill, resolution, or conference report has been posted online on the public website of the body 72 hours before such final vote.

(b) ADDITIONAL REQUIREMENTS.—The information required to be posted by subsection (a) shall also include—

(1) an affidavit that the policy summary of the Congressional Research Service adequately reflects the measure signed by the Majority and Minority Leaders; and

(2) signed affidavits from every member of the body attesting that they have read the measure.

(c) WAIVER AND APPEAL.—

(1) WAIVER.—This section may be waived or suspended in the Senate or House of Representatives only by an affirmative vote of 3/5 of the members, duly chosen and sworn.

(2) APPEAL.—An affirmative vote of 3/5 of the members of the Senate or House of Representatives, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this subsection.

(d) PUBLIC AVAILABILITY OF AMENDMENTS.—Each amendment offered in the Senate or House of Representatives shall to be posted online on the public website of the body as soon as practicable after the amendment is offered.

SA 2789. Mr. COBURN (for himself, Mr. VITTER, Mr. BURR, and Mr. HATCH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 156, line 4, strike all through page 157, line 7, and insert the following:

(D) REQUIREMENT OF MEMBERS OF CONGRESS TO ENROLL IN THE PUBLIC OPTION.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, all Members of Congress shall be enrolled in the community health insurance option when established by the Secretary.

(ii) INELIGIBLE FOR FEHBP.—Effective on the date on which the community health insurance option is established by the Secretary, no Member of Congress shall be eligible to participate in a health benefits plan under chapter 89 of title 5, United States Code.

(iii) EXCEPTION.—Notwithstanding clauses (i) and (ii), if a Member of Congress resides in a State which opts out of providing a community health insurance option, that Member may be enrolled in a health benefits plan under chapter 89 of title 5, United States Code, during any period which that State has opted out.

(iv) EMPLOYER CONTRIBUTION.—

(I) IN GENERAL.—The Secretary of the Senate or the Chief Administrative Officer of the House of Representatives shall pay the amount determined under subclause (II) to the appropriate community health insurance option.

(II) AMOUNT OF EMPLOYER CONTRIBUTION.—The Director of the Office Of Personnel Management shall determine the amount of the employer contribution for each Member of Congress enrolled in a community health insurance option. The amount shall be equal to the employer contribution for the health benefits plan under chapter 89 of title 5, United States Code, with the greatest number of enrollees, except that the contribution shall be actuarially adjusted for age.

(v) DEFINITIONS.—In this subparagraph:

(I) COMMUNITY HEALTH INSURANCE OPTION.—The term ''community health insurance option'' means the health insurance established by the Secretary under section 1323.

(II) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Jacqueline Lampert, a Democratic Policy Committee staffer, be granted floor privileges for the consideration of H.R. 3590.

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

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate proceed to executive session to consider, en bloc, Executive Calendar Nos. 532, 533, 534, 553, 554, and 558; that the nominations be confirmed en bloc; the motions to reconsider be laid upon the table en bloc; that no further motions be in order; that any statements relating to the nominations be printed in the RECORD; that the President be immediately notified of the Senate's action, and the Senate resume legislative session.

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

The nominations considered and confirmed en bloc are as follows:

DEPARTMENT OF JUSTICE

Kenyen Ray Brown, of Alabama, to be United States Attorney for the Southern District of Alabama for the term of four years.

Stephanie M. Rose, of Iowa, to be United States Attorney for the Northern District of Iowa for the term of four years.

Nicholas A. Klinefeldt, of Iowa, to be United States Attorney for the Southern District of Iowa for the term of four years.

THE JUDICIARY

Christina Reiss, of Vermont, to be United States District Judge for the District of Vermont.

Abdul K. Kallon, of Alabama, to be United States District Judge for the Northern District of Alabama.

EXECUTIVE OFFICE OF THE PRESIDENT

Daniel I. Gordon, of the District of Columbia, to be Administrator for Federal Procurement Policy.

NOMINATIONS OF JUDGE CHRISTINA REISS AND ABDUL KALLON

Mr. LEAHY. Mr. President, I am pleased that today the Senate will consider and confirm Judge Christina Reiss to a seat on the U.S. District Court in Vermont. Judge Reiss will be the first woman to serve on that Court.

As the senior Senator from the State of Vermont, I was honored to recommend Judge Reiss to President Obama for this post. She has considerable criminal and civil experience, and is extremely qualified. For the past 5 years, she has been a State trial court judge in Vermont—a position to which she was appointed by Governor Jim Douglas, a Republican, and confirmed unanimously. She formerly was a partner in two Vermont law firms. Judge Reiss earned her B.A. from my alma mater, Saint Michaels College, and earned her J.D. with high honors from University of Arizona College of Law, where she was editor-in-chief of the law review.

Judge Reiss has been nominated to fill the vacancy created when my good friend, Judge Garvan Murtha, announced his intention to take senior status on the court. It is the first vacancy on this court since 1995, when the Senate confirmed Judge Murtha and Judge William Sessions. Judge Reiss will make an excellent addition to that court. She has already demonstrated as a state court judge her ability to relate to litigants of many backgrounds, and knows how important it is for judges to possess an understanding of the effects of legal rulings on people's lives.

In making this recommendation, I looked to Vermont's Judicial Nominating Commission, a practice I started with the late Senator Robert Stafford, a Republican, and a practice I have continued to follow. The Commission that helped select Judge Reiss was comprised of a nine member non-partisan panel appointed by me, Senator SANDERS, and the Vermont Bar Association, and we were aided in the selection process by input from Congressman PETER WELCH. The non-partisan, merit-driven process is a good fit for our approach to government in Vermont.

Senators of both parties have clearly seen that Judge Reiss has all of the qualities that are important on the Federal bench. Earlier this week, Judge Reiss's nomination was reported from the Senate Judiciary Committee without dissent in a voice vote. I am confident that Judge Reiss is the right person for this position.

The Senate will also consider and confirm Abdul K. Kallon to the Northern District of Alabama, the home state of the Ranking Member of the Judiciary Committee. Mr. Kallon's nomination has the support of both Senator SESSIONS and Senator SHELBY, and was reported out of the Senate Judiciary Committee this week with approval by voice vote.

I congratulate Judge Reiss, Mr. Kallon and their families on their confirmations today.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will now return to legislative session.

UNANIMOUS CONSENT AGREEMENT—EXECUTIVE CALENDAR

Mr. BROWN. Mr. President, as in executive session, I ask unanimous consent that at 11:30 a.m., Tuesday, December 1, the Senate proceed to executive session to consider Calendar No. 487, the nomination of Jacqueline Nguyen to be a U.S. district judge for the Central District of California; that debate with respect to the nomination be limited to 30 minutes, equally divided and controlled between Senators LEAHY and SESSIONS or their designees; that upon the use or yielding back of time, the Senate proceed to vote on confirmation of the nomination; that upon confirmation, the motion to reconsider be considered made and laid

upon the table; no further motions be in order; the President be immediately notified of the Senate's action, and the Senate then resume legislative session.

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

HUMAN RIGHTS ENFORCEMENT ACT OF 2009

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 209, S. 1472.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (S. 1472) to establish a section within the Criminal Division of the Department of Justice to enforce human rights laws, to make technical and conforming amendments to criminal and immigration laws pertaining to human rights violations, and for other purposes.

There being no objection, the Senate proceeded to consider the bill, which had been reported by the Judiciary committee with amendments, as follows:

[Strike the parts printed in boldface brackets and insert the part printed in Italic]

S. 1472

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Human Rights Enforcement Act of 2009''.

SEC. 2. SECTION TO ENFORCE HUMAN RIGHTS LAWS.

(a) REPEAL.—Section 103(h) of the Immigration and Nationality Act (8 U.S.C. 1103(h)) is repealed.

(b) SECTION TO ENFORCE HUMAN RIGHTS LAWS.—Chapter 31 of title 28, United States Code, is amended by inserting after section 509A the following:

[''§ 509B. Section to enforce human rights laws

[''(a) Not later than 90 days after the date of the enactment of the Human Rights Enforcement Act of 2009, the Attorney General shall establish a section to enforce human rights laws within the Criminal Division of the Department of Justice.

[''(b) The section is authorized to—

[''(1) identify individuals who are suspected of committing serious human rights offenses under Federal law;

[''(2) take appropriate legal action, including prosecution, denaturalization or extradition, against the individuals identified pursuant to paragraph (1); and

[''(3) coordinate any such legal action with the United States Attorney for the relevant jurisdiction.

[''(c) The Attorney General shall consult with the Secretary of Homeland Security and the Secretary of State in making determinations regarding the prosecution, removal, denaturalization, extradition, or exclusion of naturalized citizens or aliens who are suspected of committing serious human rights offenses under Federal law.

[''(d) In determining the appropriate legal action to take against individuals who are suspected of committing serious human rights offenses under Federal law, the section shall take into consideration the availability of criminal prosecution under the laws of the United States for such offenses or in a foreign jurisdiction that is prepared to undertake a prosecution for the conduct that forms the basis for such offenses.

[''(e) The term 'serious human rights offenses under Federal law' includes—

[''(1) violations of Federal criminal laws relating to genocide, torture, war crimes, and the use or recruitment of child soldiers under sections 1091, 2340, 2340A, 2441, and 2442 of title 18, United States Code; and

[''(2) genocide, torture, extrajudicial killings, Nazi persecution, or the use or recruitment of child soldiers, as described in subparagraphs (E) and (G) of section 212(a)(3) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(3)).''.**]**

''§ 509B. Section to enforce human rights laws

''(a) Not later than 90 days after the date of the enactment of the Human Rights Enforcement Act of 2009, the Attorney General shall establish a section within the Criminal Division of the Department of Justice with responsibility for the enforcement of laws against suspected participants in serious human rights offenses.

''(b) The section established under subsection (a) is authorized to—

''(1) take appropriate legal action against individuals suspected of participating in serious human rights offenses; and

''(2) coordinate any such legal action with the United States Attorney for the relevant jurisdiction.

''(c) The Attorney General shall, as appropriate, consult with the Secretary of Homeland Security and the Secretary of State.

''(d) In determining the appropriate legal action to take against individuals who are suspected of committing serious human rights offenses under Federal law, the section shall take into consideration the availability of criminal prosecution under the laws of the United States for such offenses or in a foreign jurisdiction that is prepared to undertake a prosecution for the conduct that forms the basis for such offenses.

''(e) The term 'serious human rights offenses' includes violations of Federal criminal laws relating to genocide, torture, war crimes, and the use or recruitment of child soldiers under sections 1091, 2340, 2340A, 2441, and 2442 of title 18, United States Code.''.

(c) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of the title 28, United States Code, is amended by inserting after the item relating to section 509A the following:

''Sec. 509B. Section to enforce human rights laws.''.

SEC. 3. TECHNICAL AND CONFORMING AMENDMENTS.

(a) GENOCIDE.—Section 1091 of title 18, United States Code, is amended—

(1) in subsection (a)—

(A) by striking '', in a circumstance described in subsection (d)''; and

(B) by striking ''or attempts to do so,'';

(2) in subsection (c), by striking ''in a circumstance described in subsection (d)'';

(3) by striking subsection (d) and (e); and

(4) by inserting after subsection (c) the following:

''(d) ATTEMPT AND CONSPIRACY.—Any person who attempts or conspires to commit an offense under this section shall be punished in the same manner as a person who completes the offense.

''(e) JURISDICTION.—There is jurisdiction over the offenses described in subsections (a), (c), and (d) if—

''(1) the offense is committed in whole or in part within the United States; or

''(2) regardless of where the offense is committed, the alleged offender is—

''(A) a national of the United States (as that term is defined in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101));

''(B) an alien lawfully admitted for permanent residence in the United States (as that term is defined in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101));

''(C) a stateless person whose habitual residence is in the United States; or

''(D) present in the United States.

''(f) NONAPPLICABILITY OF CERTAIN LIMITATIONS.—Notwithstanding section 3282, in the case of an offense under this section, an indictment may be found, or information instituted, at any time without limitation.''.

[(b) IMMIGRATION AND NATIONALITY ACT.—Section 212(a)(3)(E)(ii) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(3)(E)(ii)) is amended by striking ''ordered, incited, assisted, or otherwise participated in conduct outside the United States that would, if committed in the United States or by a United States national, be genocide, as defined in section 1091(a)'' and inserting ''has engaged in genocide in violation of section 1091''.**]**

(b) IMMIGRATION AND NATIONALITY ACT.—Section 212(a)(3)(E)(ii) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(3)(E)(ii)) is amended by striking ''conduct outside the United States that would, if committed in the United States or by a United States national, be''.

(c) APPLICABILITY.—The amendments made by subsections (b), (c), and (d) of the Child Soldiers Accountability Act of 2008 (Public Law 110–340) shall apply to offenses committed before, on, or after the date of the enactment of the Child Soldiers Accountability Act of 2008.

(d) MATERIAL SUPPORT FOR GENOCIDE OR CHILD SOLDIER RECRUITMENT.—Section 2339A(a) of title 18, United States Code, is amended by—

(1) inserting '', 1091'' after ''956''; and

(2) striking '', or 2340A'' and inserting '', 2340A, or 2442''.

Mr. LEAHY. Mr. President, I am always looking for ways in which we can improve the investigation and prosecution of international human rights abusers, including those who seek safe haven in the United States. That is what led me to develop and fight for several years to enact the Anti-Atrocity Alien Deportation Act, which became law in 2004. That is what I did in supporting and implementing legislation for the Convention Against Torture. That is what I have done in my work on the State and Foreign Operations Appropriations Subcommittee.

It is vital that the United States reclaim its historic role as a world leader on issues of human rights. President Obama and Secretary Clinton are working hard to make that a reality. I worked in the last Congress to create the Judiciary Subcommittee on Human Rights and the Law, and to reconstitute it again this Congress. I have worked closely with Senator DURBIN as he has ably chaired it.

This country should not provide a refuge for those who commit human rights violations. Congress took an important step when we passed the Anti-

Atrocity Alien Deportation Act. That statute closed loopholes in our immigration law, making it easier to keep out perpetrators of human rights abuses, and to deport those who are already here. It established by statute the Office of Special Investigations, OSI, within the Department of Justice, an office that previously existed only under the discretionary authority of the Attorney General. The Anti-Atrocity Alien Deportation Act expanded OSI's mission from denaturalizing Nazi war criminals, to investigating, extraditing, or denaturalizing any alien who participated in genocide, torture, or extrajudicial killing abroad. This law has prompted, among other accomplishments, the deportation of Kelbessa Negewo to Ethiopia, where he is now serving a life sentence for torture and multiple killings.

The Human Rights Enforcement Act of 2009, a bill which I was pleased to cosponsor, builds on the foundation created by the Anti-Atrocity Alien Deportation Act. It seeks to improve our ability to identify and prosecute human rights abusers. It proposes consolidating two sections within the Department of Justice: the Office of Special Investigations, and the Domestic Security Section, which is charged with criminally prosecuting human rights abusers.

This bill also amends a section of the Immigration and Nationality Act that makes those who ordered, incited, assisted, or otherwise participated in genocide, as defined in section 1091(a) of title 18, United States Code, inadmissible, and therefore ineligible for the protection of our asylum laws. This bill does not alter our intent, which the Supreme Court has repeatedly recognized, that asylum laws are meant to implement our obligations under the 1967 United Nations Protocol Relating to the Status of Refugees. Like our asylum laws, that international treaty bars those who have committed a crime against peace, a war crime, or a crime against humanity from qualifying as a refugee.

During its last term, in Negusie v. Holder, the Supreme Court, in an 8–1 decision, held that nearly identical language barring those who ''ordered, incited, assisted, or otherwise participated in the persecution'' of others from the benefits of our asylum laws did not automatically disqualify those whose conduct was coerced or otherwise the product of duress. Individuals who have been forced to commit such crimes under duress have been determined to be exempt from that bar by both the United Nations High Commissioner for Refugees Handbook and by nations that have interpreted the Refugee Convention and Protocol. This bill is consistent with that interpretation.

It is vital that the United States reclaim its historic role as a world leader on issues of human rights. We can support the work of President Obama and members of his cabinet, who are working hard to make that a reality. I am pleased that the Senate will pass the Human Rights Enforcement Act of 2009.

Mr. BROWN. Mr. President, I ask unanimous consent the committee-reported amendments be agreed to, the bill, as amended, be read a third time and passed, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements be printed in the RECORD.

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

The committee amendments were agreed to.

The bill (S. 1472), as amended, was ordered to be engrossed for a third reading, was read the third time, and passed, as follow:

S. 1472

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Human Rights Enforcement Act of 2009''.

SEC. 2. SECTION TO ENFORCE HUMAN RIGHTS LAWS.

(a) REPEAL.—Section 103(h) of the Immigration and Nationality Act (8 U.S.C. 1103(h)) is repealed.

(b) SECTION TO ENFORCE HUMAN RIGHTS LAWS.—Chapter 31 of title 28, United States Code, is amended by inserting after section 509A the following:

''§ 509B. Section to enforce human rights laws

''(a) Not later than 90 days after the date of the enactment of the Human Rights Enforcement Act of 2009, the Attorney General shall establish a section within the Criminal Division of the Department of Justice with responsibility for the enforcement of laws against suspected participants in serious human rights offenses.

''(b) The section established under subsection (a) is authorized to—

''(1) take appropriate legal action against individuals suspected of participating in serious human rights offenses; and

''(2) coordinate any such legal action with the United States Attorney for the relevant jurisdiction.

''(c) The Attorney General shall, as appropriate, consult with the Secretary of Homeland Security and the Secretary of State.

''(d) In determining the appropriate legal action to take against individuals who are suspected of committing serious human rights offenses under Federal law, the section shall take into consideration the availability of criminal prosecution under the laws of the United States for such offenses or in a foreign jurisdiction that is prepared to undertake a prosecution for the conduct that forms the basis for such offenses.

''(e) The term 'serious human rights offenses' includes violations of Federal criminal laws relating to genocide, torture, war crimes, and the use or recruitment of child soldiers under sections 1091, 2340, 2340A, 2441, and 2442 of title 18, United States Code.''.

(c) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of the title 28, United States Code, is amended by inserting after the item relating to section 509A the following:

''Sec. 509B. Section to enforce human rights laws.''.

SEC. 3. TECHNICAL AND CONFORMING AMENDMENTS.

(a) GENOCIDE.—Section 1091 of title 18, United States Code, is amended—

(1) in subsection (a)—

(A) by striking '', in a circumstance described in subsection (d)''; and

(B) by striking ''or attempts to do so,'';

(2) in subsection (c), by striking ''in a circumstance described in subsection (d)'';

(3) by striking subsection (d) and (e); and

(4) by inserting after subsection (c) the following:

''(d) ATTEMPT AND CONSPIRACY.—Any person who attempts or conspires to commit an offense under this section shall be punished in the same manner as a person who completes the offense.

''(e) JURISDICTION.—There is jurisdiction over the offenses described in subsections (a), (c), and (d) if—

''(1) the offense is committed in whole or in part within the United States; or

''(2) regardless of where the offense is committed, the alleged offender is—

''(A) a national of the United States (as that term is defined in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101));

''(B) an alien lawfully admitted for permanent residence in the United States (as that term is defined in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101));

''(C) a stateless person whose habitual residence is in the United States; or

''(D) present in the United States.

''(f) NONAPPLICABILITY OF CERTAIN LIMITATIONS.—Notwithstanding section 3282, in the case of an offense under this section, an indictment may be found, or information instituted, at any time without limitation.''.

(b) IMMIGRATION AND NATIONALITY ACT.—Section 212(a)(3)(E)(ii) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(3)(E)(ii)) is amended by striking ''conduct outside the United States that would, if committed in the United States or by a United States national, be''.

(c) APPLICABILITY.—The amendments made by subsections (b), (c), and (d) of the Child Soldiers Accountability Act of 2008 (Public Law 110–340) shall apply to offenses committed before, on, or after the date of the enactment of the Child Soldiers Accountability Act of 2008.

(d) MATERIAL SUPPORT FOR GENOCIDE OR CHILD SOLDIER RECRUITMENT.—Section 2339A(a) of title 18, United States Code, is amended by—

(1) inserting '', 1091'' after ''956''; and

(2) striking '', or 2340A'' and inserting '', 2340A, or 2442''.

MAKING TEMPORARY APPOINTMENTS TO THE SELECT COMMITTEE ON ETHICS

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 359 submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 359) to make temporary appointments to the Select Committee on Ethics.

There being no objection, the Senate proceeded to consider the resolution.

Mr. BROWN. Mr. President, I ask unanimous consent that the resolution be agreed to and the motions to reconsider be laid upon the table.

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

The resolution (S. Res. 359) was agreed to, as follows:

S. RES. 359

Resolved, That (a) for matters before the Select Committee on Ethics involving Preliminary Inquiry Case Number 20711, the Senator from Arkansas (Mr. PRYOR) shall be replaced by the Senator from Maryland (Mr. CARDIN).

(b) The membership of the Select Committee on Ethics shall be unchanged with respect to all matters before that Committee other than the matter referred to in subsection (a).

ORDER TO MAKE APPOINTMENTS

Mr. BROWN. Mr. President, I ask unanimous consent that notwithstanding a recess or adjournment of the Senate, the President of the Senate, the President of the Senate pro tempore, and the majority and minority leaders be authorized to make appointments to commissions, committees, boards, conferences, or interparliamentary conferences authorized by law, by concurrent action of the two Houses, or by order of the Senate.

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

HONORING THE PRIME MINISTER OF INDIA

Mr. BROWN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 360, which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

A resolution (S. Res. 360) honoring the Prime Minister of India, Dr. Mahmohan Singh, for his service to the people of India and to the world, and welcoming the Prime Minister to the United States.

There being no objection, the Senate proceeded to consider the resolution.

Mr. BROWN. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 360) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 360

Whereas, on August 15, 1947, India became a sovereign, democratic nation;

Whereas the Prime Minister of India, Dr. Manmohan Singh is now the honoree of President Barack Obama's historic first State Dinner;

Whereas India is the world's largest democracy, embracing and upholding fundamental liberties and freedoms, justice, and the rule of law;

Whereas the 2009 parliamentary elections in India were the world's largest democratic election to date;

Whereas India is a multi-ethnic, multi-cultural, and multi-religious society that promotes tolerance, diversity, and equality;

Whereas the 100,000 Indians who are studying in the United States and the 2,500,000 Americans of Indian descent living in the United States, including Nobel Laureates, artists, business leaders, journalists, and public servants, have contributed enormously to the rich social, political, and economic fabric of the United States;

Whereas cooperation between the United States and India in the areas of science and technology, our advancement of security and defense, and our commitment to clean energy continue to strengthen the bond between the two countries and enhance mutual admiration;

Whereas India serves as a pivotal and effective partner in ensuring international peace and security and is the third largest contributor of personnel to United Nations peacekeeping missions;

Whereas, since the liberalization of India's economy in 1991, bilateral trade has increased and benefitted both India and the United States;

Whereas, the market economy in India has contributed to increased economic opportunities, reduced poverty, and accompanying stability; and

Whereas a strong relationship between the people and governments of the United States and India, based on mutual trust and respect, will enable the countries to more closely collaborate across a broad spectrum of interests, such as global peace and prosperity, counterterrorism, defense, nonproliferation, economic prosperity, energy and climate change, education, scientific research, outer space, public health, and agriculture: Now, therefore, be it

Resolved, That the Senate—

(1) warmly welcomes the Prime Minister of India, Dr. Manmohan Singh, on his official state visit;

(2) believes that together, the governments of India and the United States can bring immense benefits to their people and make enormous contributions to addressing the global challenges of the 21st century;

(3) looks forward to the continuing progress in relations between India and the United States; and

(4) appreciates the contributions of Americans of Indian descent and desires closer relations between the people of the United States and the people of India.

ORDERS FOR MONDAY, NOVEMBER 30, 2009

Mr. BROWN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 2 p.m., Monday, November 30, 2009; that following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate proceed to a period for the transaction of morning business until 3 p.m., with Senators permitted to speak therein for up to 10 minutes; that following morning business, the Senate resume consideration of H.R. 3590, with Senator REID or his designee permitted to offer the first amendment to the Reid substitute; further, that Senator MCCONNELL or his designee be permitted to offer the next amendment to the substitute, with no other amendments in order during Monday's session.

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

PROGRAM

Mr. BROWN. Mr. President, there will be no rollcall votes during Monday's session. The next rollcall vote will occur at noon on Tuesday, December 1, on the confirmation of the nomination of Jacqueline Nguyen to be a U.S. district judge for the Central District of California.

ADJOURNMENT UNTIL MONDAY, NOVEMBER 30, 2009, AT 2 P.M.

Mr. BROWN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate adjourn under the provisions of H. Con. Res. 214.

There being no objection, the Senate, at 9 p.m., adjourned until Monday, November 30, 2009, at 2 p.m.

CONFIRMATIONS

Executive nominations confirmed by the Senate, Saturday, November 21, 2009

EXECUTIVE OFFICE OF THE PRESIDENT

DANIEL I. GORDON, OF THE DISTRICT OF COLUMBIA, TO BE ADMINISTRATOR FOR FEDERAL PROCUREMENT POLICY.

THE ABOVE NOMINATION WAS APPROVED SUBJECT TO THE NOMINEE'S COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

DEPARTMENT OF JUSTICE

KENYEN RAY BROWN, OF ALABAMA, TO BE UNITED STATES ATTORNEY FOR THE SOUTHERN DISTRICT OF ALABAMA FOR THE TERM OF FOUR YEARS.

STEPHANIE M. ROSE, OF IOWA, TO BE UNITED STATES ATTORNEY FOR THE NORTHERN DISTRICT OF IOWA FOR THE TERM OF FOUR YEARS.

NICHOLAS A. KLINEFELDT, OF IOWA, TO BE UNITED STATES ATTORNEY FOR THE SOUTHERN DISTRICT OF IOWA FOR THE TERM OF FOUR YEARS.

THE JUDICIARY

CHRISTINA REISS, OF VERMONT, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF VERMONT.

ABDUL K. KALLON, OF ALABAMA, TO BE UNITED STATES DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF ALABAMA.

SENATE—*Monday, November 30, 2009*

The Senate met at 2 p.m. and was called to order by the Honorable MARK R. WARNER, a Senator from the Commonwealth of Virginia.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray:

O God, the hope of all the ends of the Earth be in our midst today. Endue our lawmakers with a spirit of wisdom that will bring peace and prosperity within our borders. Lord, keep them from disunity, ignited by selfish fires, that will hinder Your purposes in our world. Pardon and overrule what has been left undone or done amiss as You strengthen all that has been worthily achieved. Bless and keep us, and make Your face to shine upon us, as You give us Your peace. We pray in Your merciful Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable MARK R. WARNER led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, November 30, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable MARK R. WARNER, a Senator from the Commonwealth of Virginia, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. WARNER thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, there will be a period of morning business until 3 o'clock today. At that time, the managers of the bill will be here. Until that time, Senators will be allowed to speak for up to 10 minutes each as in morning business.

At 3 p.m., the Senate will resume consideration of the health care legislation. Today, the majority will offer the first amendment and the Republicans will offer the next amendment to the substitute. No other amendments, by virtue of the order that was entered before the Thanksgiving recess, will be in order today.

There will be no rollcall votes during today's session, and the next vote will occur at noon tomorrow on the confirmation of the nomination of Jacqueline Nguyen to be a U.S. District Judge for the Central District of California.

HEALTH CARE REFORM

Mr. REID. Mr. President, the next few weeks will tell us a lot about whether Senators are more committed to solving problems or creating them. We have before us a historic occasion. That is where we are—a time in history where we have never been before—with the chance to ensure the well-being of both our fellow citizens and our recovering economy. We have before us the opportunity to relieve the suffering of many and prevent even worse pain in the future.

But if we are to seize this opportunity, this debate must be on facts, not fear. We must remain focused on how we can best help the American people and the American economy, and we must avoid the temptation to drown in distractions and distortions. In other words, we must do our jobs.

Last week, my counterpart—the distinguished Republican leader, Senator MCCONNELL—called the health care crisis manufactured. The American people would beg to differ. I have said on this floor before, on several occasions, that last year 750,000 people filed for bankruptcy. That is true. I said previously that half the people who filed bankruptcy filed because of medical expenses. But we have learned of a report that came out last week which states that number is too small; that, realistically, it is about 70 percent of the people who file for bankruptcy file because of health care costs.

I have also said on this floor that half the people who filed for bankruptcy because of medical expenses did so even though they had insurance. We learned last week that number is also too small; that it is 62 percent. That means 62 percent of the people who filed for bankruptcy because of medical expenses were already insured. Is that a crisis in America—750,000 people filing for bankruptcy and about 70 percent of them filing because of health care costs, with 62 percent of those who filed for bankruptcy because of health care costs having health insurance? What a sad commentary on the present state of the health care delivery system in our country.

This weekend the assistant Republican leader said we should go back to square one. In fact, his exact quote was: ''There is no way to fix this bill.'' That is what we do. We are legislators. I have been in Congress a long time. I have been fortunate to get things passed and never, ever have I gotten the legislation I wrote passed the way it was written. With rare exception that happens.

I would say to my friend, the junior Senator from Arizona, that Republicans have had a seat at the table from the very beginning of the health care debate. An example of that was in the HELP Committee, where 161 of the amendments Republicans offered in that committee were made a part of the bill that was reported out of that committee. So when you hear someone say there is no way to fix this bill, you have to look at the underlying statements this gentleman has made in the past: Basically, there is no problem with health care; things the way they are, are just fine; the fact that 750,000 people filed for bankruptcy last year, 70 percent because of health care costs, not important.

That is exactly what the legislative process is all about—changing things, working on things, trying to improve them, taking out things you don't like, debating, amending, and improving. Democrats stand ready to do so. I hope my Republican colleagues recognize that, even if the party leaders deny it.

As we round the latest turn along this journey, I renew my plea to this body—to Senators, Democrats, and Republicans: Let us discuss the specifics of this bill, not the whispers and wild rumors. While we disagree at times, let us at least agree that doing nothing is

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● This ''bullet'' symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

not an option. While each of us may not say yes to each word of this bill as it currently reads, let us at least agree that simply saying no isn't enough.

We will do this work transparently, and we will do this work tirelessly. That may mean debating and voting late at night. It definitely means, I say to everyone within the sound of my voice, the next weekends—plural—we will be working. I have events this weekend that I will have to postpone; some will have to cancel. That is the way it will have to be with everyone. There is not an issue more important than finishing this legislation.

I know people have things they want to do back in their States and rightfully so. I know people have fundraisers because they are running for reelection. I know there are other important things they have to do. But nothing could be more important than this. We notified everybody prior to the break we would be working weekends. Our cloakroom did so by e-mails. We have transmitted this message time and time again. So we are going to have to work Saturdays and Sundays.

This crisis—and, yes, it is a real crisis—is simply too hazardous to our country and to its health not to work as much and as long as we have to. This is a good bill we have before us. It saves lives, saves money, and saves Medicare.

The evidence about this continues to pour in. Just a few days ago an MIT economist—one of the Nation's foremost economists—a man by the name of Jonathan Gruber, analyzed our bill and concluded it will help Americans pay less and get more. He found that while the cost of private insurance continues to rise at extremely rapid rates, those who use the new health care insurance changes we propose will save hundreds, and in some cases thousands, of dollars per year per person.

I am gratified we have already taken health insurance reform further than at any point in American history, but I am not satisfied and will not rest until we finish the job. Health care fairness will come if we dedicate the coming weeks to solutions, not scare tactics.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. McCONNELL. Mr. President, I wish to reiterate the point the majority leader made—that he is anticipating us being in on the weekends—and to underscore why that seems to be necessary, which is because the majority is intent on passing this health care bill that the American people oppose. We know that from all of the surveys.

In addition to that, there are a number of things that actually must be done this month: We have a debt ceiling expiring, or needing to be expanded, according to the administration; we have not passed appropriations bills; there are tax extenders that expire at the end of the year; there are PATRIOT Act provisions that expire at the end of the year. There are many things we must do this month. Yet we are going to spend an enormous amount of time working on a bill the American people wish we would not pass this month.

Let me, first, welcome everybody back—Senators and staff—after what, hopefully, was a restful and happy Thanksgiving. I actually worked Monday and Tuesday of last week, and I had a chance to spend a good deal of time out in my State of Kentucky with a number of folks. I must tell you nobody was shy about telling me what they thought about the health care bill. Nobody was shy about it. They had obviously been paying a lot of attention to it. Many had focused on the vote to proceed to this 2,074-page bill, Saturday a week ago. Many people have an opinion. So far, not a single, solitary Kentuckian did I run into—admittedly, this is anecdotal—but not a single, solitary one said anything other than you have to stop that health care bill. I assured them we were going to do the very best we could to either dramatically change it by amendment or, hopefully, on a bipartisan basis, keep this 2,074-page bill from passing.

A lot of people I met had that kind of observation. I expect it is pretty similar across the country. Kentuckians want to know how spending trillions of dollars we don't have on a plan that raises health insurance premiums and taxes on families and small businesses is good for health care or for jobs or for the economy, for that matter. The fact is, Americans feel like they have been taken for a ride in this debate, and they are beginning to realize what administration officials meant when they said a crisis was a terrible thing to waste. Early this year, they said: A crisis is a terrible thing to waste.

The notion that we would even consider spending trillions of dollars we don't have in a way the majority of Americans don't even want is proof this health care bill is completely and totally out of touch with the American people. It is now perfectly clear what happened. The administration and its allies in Congress have wanted to push government-run health care for many years, and they view the economic crisis we are in as their moment to do it. So they sold their plan as an antidote to the recession, even though their plan would only make things worse. But now Americans are beginning to see the truth behind the rhetoric. No one believes—no one—that trillions in spending, taxes, and debt will do anything but kill jobs and darken the economic prospects of struggling Americans and their children.

The administration's health care plan will not alleviate the situation we are in. Instead, it would punish struggling Americans at a moment when all they want is a little help.

Proponents of this bill couch their efforts with the refrain that history is calling. I think they have got it half right. Someone's calling all right, but it is not history. It is the American worker. He is wondering where the jobs are. It is the middle-class family wondering how Congress could try to pass a scheme that won't do anything to control costs. It is one of the roughly 40 million seniors wondering when Medicare became a piggy bank to fund more government and higher premiums.

I have enumerated the specifics about the Medicare cuts in this bill before: nearly $135 billion in cuts to hospitals, $120 billion in cuts to Medicare Advantage, nearly $15 billion in cuts to nursing homes, more than $40 billion from home health agencies, early $8 billion from hospices—hospices. Nearly one-half trillion dollars in cuts: this is what some have audaciously started referring to as ''Saving Medicare.'' I don't know what's more preposterous: saying that this plan ''saves Medicare,'' or thinking that people will actually believe you.

Arthur Diersing gets it. He is a constituent of mine from Versailles, KY. Here's what he had to say about this plan. He wrote:

> I . . . agree that there are some things in the health care system that need to be fixed or improved. But let's work on the most important 5–6 issues rather than turn the whole system upside down, and run up the cost for all of us and take away from us seniors.

Mr. Diersing knows what he is talking about. He knows this bill doesn't reflect the views of the American people. Americans have been asking us to cut costs, not raise them. They want the kinds of step-by-step reforms that would actually make a difference, without bankrupting the country and without further expanding the role of the government in their lives. Americans don't want this bill to pass. Instead, they want us to earn their trust with the kind of commonsense reforms Republicans have been talking about all year and which our friends have brushed aside.

Americans want us to end junk lawsuits against doctors and hospitals that drive up costs. And yet there is not a serious word about doing so in the 2,074 pages of the Democrat bill. Americans want us to encourage healthy choices like prevention and wellness programs. And yet Democrat leaders couldn't come up with a serious word about these kinds of reforms in 2,074 pages.

Americans want us to lower costs by letting consumers buy coverage across

State lines. They want us to let small businesses band together to negotiate lower insurance rates. And yet Democrats have ignored both of these ideas, despite having 2,074 pages to include such ideas.

Americans also want us to address the rampant waste, fraud, and abuse in the current system before we create an entirely new government program. And yet Democrats don't seriously confront this problem in their 2,074 page monument to more government, more taxes, more spending, and more debt.

Americans are fed up with big-government solutions that drive up taxes and debt and which only seem to create more problems, more abuse, and more fraud.

In the face of this, our friends on the other side of the aisle appear determined to plow ahead with their plans. They don't seem to care that Americans are telling them to stop and start over and fix the problem, which is health care costs.

Democrat leaders may think they hear history calling. But the sounds they should be hearing are the voices and the concerns of ordinary Americans. The American people will be heard in this debate, I assure you. In a democracy, public opinion should not be and never is irrelevant.

At the beginning of the health care debate, we were told this $1 trillion experiment would actually lower premiums for American families. Yet just this morning, this very morning, the independent Congressional Budget Office provided an analysis showing that the Democratic bill will actually increase premiums for American families. That is the CBO this morning. It indicated this will actually increase premiums for American families. So a bill that is being sold as a way to reduce costs actually drives them up.

The bottom line is this: After 2,074 pages and trillions more in government spending, massive new taxes and one-half trillion dollar cuts in Medicare, most people, according to the Congressional Budget Office—most people—will see their insurance premiums go up. This is not what the American people are asking for, and it certainly is not reform.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. There will now be a period for morning business until 3 p.m. with Senators permitted to speak for 10 minutes each.

The Senator from Florida is recognized.

HEALTH CARE REFORM

Mr. NELSON of Florida. Mr. President, when we start the debate on the health bill, I will be exceptionally eager to take the floor and to address some of the points the Republican leader has just addressed.

Most of us went home. As the minority leader said, most of us heard from our constituents who were not bashful about expressing their opinions. It is interesting that a lot of those opinions I heard were from the people who are just reeling in agony because they are in the middle of some medical procedure such as chemotherapy and suddenly they get a notice from their insurance company that they are canceled or they are desperate to get health insurance coverage and have been terminated from their job where they had it, and then an insurance company tells them they will will not insure them because they have a preexisting condition.

I do not believe there is anybody in America who is satisfied with the way the overall health care and health insurance industry delivery system is giving us our health care. Whenever it is said this bill that is before the Senate now is going to increase the cost, let's remember our costs are already increased by the people who do not have insurance who end up at the most expensive place, which is the emergency room, since they have not had any preventive care when they are in an emergency. All of the rest of us pay for it. On average that is $900 to $1,000 that is tacked on to our insurance policies we are paying as a hidden tax to pay for all those whom, if brought into the health insurance system, we would not be paying for.

I will save the rest of my remarks until we get on the health bill.

THE ECONOMY

Mr. NELSON of Florida. Mr. President, I want to take this time to talk about this terrible economic recession. To those people, by the way, who do not have a job, it is not a recession, it is a depression. The times are difficult economically all over this country but especially in my State of Florida which has an unemployment rate that is well above the national average, and there are pockets in Florida where the unemployment rate is exceptionally soaring, such as southwest Florida. It is this continued economic devastation from home foreclosures, business closings, and high unemployment rates that is threatening the prosperity of the country and particularly States such as mine, Florida.

For example, in southwest Florida, we learned last week that another local bank had been shut down by Federal regulators. It is the sixth bank failure to hit that region this year. On the housing front, numbers were released that indicate Fort Myers still has a long way to go to climb out of the housing mess. While the positive news was that foreclosures had declined 20 percent from September to October, the area still ranks fifth in the country in foreclosures.

We need to continue the steps to get the housing market back on its feet. One of those steps we did included the $8,000 tax credit for first-time home buyers. That goes through next spring. Most recently, we took one step further when we passed a $6,500 tax credit for existing homeowners who sell their home and want to buy another. That has spurred home sales.

We need to stabilize the prices, which remains the top priority. We also need to keep the pressure on the banks, the lenders, to work with folks who are losing their homes.

Many places across the Nation, and specifically Florida, are responding to the crisis by adopting mandatory mediation as an alternative to foreclosures, thereby forcing banks to modify mortgages and avoid a foreclosure altogether.

A great success story is a program in Philadelphia where borrowers can keep their homes in a program that is being looked upon as a model for the rest of the Nation. Under a plan put in place by the city's civil court, no property can be foreclosed in that court and sold by the sheriff until the mortgage company sits down with the homeowner to try to find a solution.

Unlike the administration's effort to stem foreclosures, which relies on giving incentives to mortgage companies to encourage them to work with homeowners—a program that has not worked as the Obama administration has intended—the Philadelphia program, in contrast, is not a voluntary program. Mortgage companies are forced to participate. While that Philadelphia program will not result in every troubled homeowner getting the outcome they are looking for, making those lenders come to the table is a step in the right direction. But if we are going to bring back health to our banking and financial system, we are going to have to fix the problems that are driving our community and regional banks to insolvency. The crisis in residential and commercial real estate values, home foreclosures, and nonperforming commercial real estate loans is wiping out those regional and local bank balance sheets.

In response, those regional banks are desperately hanging on to their deposits and other assets. I wish I didn't have to say this, but the Obama administration, particularly Secretary Geithner, has not done a good job in leading our banking system and real estate markets to recover. Their response to the collapse in residential real estate was a tepid loan modification program which in most cases

kicked the can down the road for the few underwater homeowners who were fortunate enough to qualify. Their response to the crisis in commercial real estate has been absent altogether. The consequence is that the commercial real estate market is on the verge of its own collapse as creditors are reluctant to refinance commercial projects.

Half way through the year, Florida banks had over $5 billion of commercial real estate loans in default. Commercial real estate makes up over one-third of the assets of Florida banks. These growing liabilities are putting the brakes on bank lending in Florida, and they are hurting creditworthy small businesses and prospective home buyers. It is a vicious downward spiral that is not easily broken. One thing is clear: The Troubled Asset Relief Program has not been the answer.

When then-Secretary of the Treasury Hank Paulson, the former head of Goldman Sachs, first proposed TARP, there were a number of us on this floor who opposed and voted against it. I thought it was massive and a wasteful bailout of the Wall Street banks with zero accountability and no meaningful reform. What have we found out about it? Of the $700 billion that Congress appropriated for TARP, over $220 billion has yet to be loaned out and only some $70 billion has been repaid. I believe we should end the program once and for all and return those funds to the U.S. Treasury to prevent us from falling deeper into fiscal debt and a fiscal black hole. Bringing the deficit under control would then help stabilize interest rates. It would hold borrowing costs down, and it would reduce the growing debt burden on future generations. That still leaves roughly $400 billion of TARP funds outstanding.

Bank of America, Citigroup, and Wells Fargo need to repay the TARP funds that have propped them up for more than a year. They need to stand on their own feet. Banks such as Goldman Sachs that have repaid their TARP funds still owe a tremendous debt to American taxpayers. Goldman Sachs, Merrill Lynch, and a slew of other banks all profited from the dollar-for-dollar taxpayer bailout of AIG's credit default swaps, those insurance policies. Under that AIG bailout, the most outrageous of all the bailouts, $70 billion of American taxpayer funds was put at risk to ensure that speculators in credit default swaps were fully protected. The head of Goldman Sachs recently apologized for his firm's reckless behavior and pledged to commit $500 million for small business lending. That sounds like a serious commitment, until we consider that Goldman Sachs has set aside $17 billion for year-end bonuses. So while Main Street is tightening its belt and preparing for a lean holiday season, Wall Street is still living high on the hog. That must change.

As banks repay their TARP loans, we need to consider how we use those funds, how we reform the financial sector. To get us back on track, we will have to be creative and find new solutions to ensure that businesses have access to the capital they need to grow, prosper, and hire new workers.

I have a few suggestions. First, we need to scrap the trickle-down TARP model and start working from the bottom up. We need to focus on access to capital for small businesses and ways to shore up residential and commercial real estate values. TARP has focused far too much on the largest Wall Street banks at the expense of community and regional banks, the backbone of finance in Florida. We need to increase Federal support and assistance to community banks and credit unions.

Second, we need to look at other ways to improve access to capital such as promoting direct lending by the Small Business Administration.

Third, we need a flexible approach to dealing with underwater homeowners, those whose value is now less than the value of their mortgage, which is so typical in the State of Florida. A flexible approach would be like the one in Philadelphia which is undertaking to require mediation and loan modifications.

These are a few suggestions I have in this very tough economic time.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Arizona.

Mr. KYL. I ask unanimous consent to speak up to 20 minutes in morning business.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. KYL. Mr. President, I rise to talk about the health care legislation because in a few minutes the official debate in the Senate will commence. The American people will have before them the full panoply of arguments both for and against the legislation. They will make their judgment about whether we are in fact carrying out their will.

According to public opinion surveys, the will of the American people is that this bill should not pass. According to a relatively new Rasmussen poll, by an 18-point margin, Americans say this bill should not pass. By 56 to 38, they oppose it. In terms of people in the middle, the independents or other voters not identified with either political party, the percentage of people who oppose the legislation is even greater. More than 3 to 1, Independents oppose this legislation. The majority believes it will both increase their costs and decrease the quality of health care. It is for these reasons that I indicated before—and I will say it again—I don't think this bill can be fixed. In fact, I don't think the majority will allow it to be fixed. That is why, along with my Republican colleagues, I believe we should start over and attack the problems that face our country in a more realistic way, in a step-by-step approach, first to win back the confidence of the people and then to provide elements of relief to each of the problems we face, rather than trying to tackle the entire health care system, the government programs, the private programs, the insurance, the physicians, the hospitals, trying to do it all in one giant bill that results in massive government takeover, over $1 trillion—in fact, $2.5 trillion—in expenditures, massive new debt, more taxes, higher insurance premiums, all of which will result in, ultimately, the rationing of health care which is, to me, the most dangerous part of this entire exercise.

Somehow or other, we could probably pay the expense of this. Somehow or other we will survive. But we won't survive the life-and-death decisions that are made every day by patients, doctors, and families, if the government begins intruding between the patient and the physician, begins making decisions about what kind of health care we can have, what kind of health care the government will allow payment for and the like. Those become life-and-death decisions. That is why Americans feel so strongly and personally about this debate and about the decisions we are about to be making here.

Let me address something the distinguished majority leader said a moment ago, and then I wish to talk a bit about Medicare as one of the aspects of this insurance debate.

The majority leader said that Republicans have had a seat at the table. I am on one of the two major committees, the Finance Committee. I think one amendment was adopted. It was an amendment offered by a Republican and a Democrat on the committee. There were well over 100 amendments that Republicans offered that were all shot down, defeated, largely on party-line votes. I say to my distinguished friend from Nevada that maybe we have a seat at the table but it is a little like the kids table at Thanksgiving dinner where you are told to mind your manners and keep the noise down. That is the way Republicans feel about our role at the table in fashioning this legislation.

The majority leader himself would acknowledge that after the two committees in the Senate acted, he went behind the closed doors of his office and, along with representatives from the White House and a couple of other Democratic Senators, no Republicans at all, legislation was developed in his office that he then presented here on the Senate floor just before the Thanksgiving recess. That is how the legislation got developed. It was without Republican participation.

We will have a chance to amend this bill. Maybe he will prove me wrong. Maybe he will demonstrate that we can fix this bill.

I do, with all deference, disagree with his comment that the motivation of Republicans is to do nothing. Of course, he frequently says doing nothing is not an option. Nobody is arguing about doing nothing. Republicans have presented some very good ideas to do something, to do a lot of somethings. Our ideas have been rejected. Let's don't get into false debate about doing something or nothing and the only alternative is the bill that is on the Senate floor. There are alternatives, and I will discuss one group of alternatives we have presented in a moment.

There will be a good test to see whether in fact we can amend this bill or if my prediction that there is no way to fix it will turn out to be true. That has to do, first and foremost, with what this bill does to Medicare, the program we have developed for seniors. Let me go over some of the Medicare cuts in this bill and then ask my Democratic colleagues if they are willing to join Republicans in restoring these provisions of Medicare—in other words, in striking these cuts—if they are willing to join Republicans in that effort. Then maybe the majority leader is right. Maybe we can fix this bill. If they are not willing to do that, then I resubmit that this bill can't be fixed, and it can't because our Democratic friends won't allow it to be fixed.

Here are the ways this bill cuts Medicare benefits for seniors: $137.5 billion is cut from hospitals that treat seniors; $120 billion is cut from Medicare Advantage. I will return to Medicare Advantage in a moment. That is the private insurance company that somewhere around a quarter to a third of seniors take advantage of. Well over a third of the seniors in Arizona, approaching 40 percent of Arizona seniors, participate in the Medicare Program, the benefits of which are substantially cut. Continuing, $14.6 billion is cut from nursing homes; $42.1 billion from home health care, $7.7 billion from hospice care. That is a total of $464.6 billion in Medicare cuts. Seniors know we can't make these kind of cuts without jeopardizing the care they receive. That is the concern I have. We are not talking about cuts in the abstract. We are talking about delay and denial of care for American citizens. These folks wonder how it is fair or justifiable to cut the health care that has been promised to them in order to pay for some kind of new government entitlement.

I receive letters and phone calls every day. I have quoted from many of these letters. Many of them have to do with the proposed cuts in Medicare, in particular to Medicare Advantage.

I mentioned the percentage. In numbers, it is about 329,000 Arizonans—329,000 Arizonans—a third of a million who enjoy Medicare Advantage plans. That is over 37 percent of overall Medicare beneficiaries in my State of Arizona. They know $120 billion in Medicare Advantage cuts will hit our State and, specifically, their coverage very hard. They worry that under the Reid bill, they will lose the low deductibles and the low copayments they enjoy under Medicare Advantage and many of the other benefits I mentioned a moment ago.

They worry about losing the choices they have, which is one of the nice things about the Medicare Advantage plan, and the extra benefits, including things such as eyeglasses, hearing aids, dental benefits, preventative screening, free flu shots, home care for chronic illnesses, prescription drug management tools, wellness programs, medical equipment, and access to physical fitness programs. These and many more are the kinds of benefits that are included in the Medicare Advantage Program, and they will lose many of these benefits under the legislation that is before us right now.

I think they have a right to be concerned about losing these benefits. If there is any doubt about this, incidentally, the Congressional Budget Office, which is a nonpartisan entity which serves both Democrats and Republicans here—it calls it straight; sometimes they give answers we do not like, but they provide the analysis of the costs and benefits—and the Congressional Budget Office has confirmed that under the Democrats' bill, Medicare Advantage beneficiaries will lose, and they will lose big. In fact, they will lose more than half their extra benefits under Medicare Advantage.

Well, my senior citizen constituents do not like that, and they have let me know about that. Let me share a couple letters—just excerpts from letters from two of my constituents. The first is from Surprise, AZ:

> My mother is on Medicare Advantage, and I don't know what she would do without it.
>
> The poor and middle class are already hurting much more than government officials realize. We are on fixed incomes, and have already cut back to bare minimum. What happened to ''government for the people, by the people?''

Another constituent from Gold Canyon, AZ, writes:

> I have been on Medicare for 11 years and have been subscribing to a Medicare Advantage plan for the past 6 years. It has been excellent, and has provided substantial savings for us. Now we understand that the government is dropping its support of the plan. Please try to stop this. It is very important to many senior citizens in Arizona.

These constituents of mine, these senior citizens, know Medicare cuts will hurt seniors' care, and those who try to suggest otherwise are simply wrong. The Congressional Budget Office, as I have said, has confirmed it.

One of the newspapers on Capitol Hill, Politico, recently provided a helpful summary of an actuarial report on the Democrats' health care plan, prepared by the Centers for Medicare and Medicaid Services. That is CMS. That is the outfit out of the Department of Health and Human Services that actually runs Medicare. According to page 8 of the report, as Politico summarizes, the Democrats' bill:

> . . . reduces Medicare payments to hospitals and nursing homes over time, based on productivity targets. The idea is that by paying institutions less money, they will be forced to become more productive. But it's doubtful that many institutions can hit those targets, which could force them to withdraw from Medicare.

We hear it all the time: physicians dropping or not taking any new Medicare patients; entities that are no longer going to be able to serve Medicare patients because they are not getting paid enough by the government for them to even break even.

This report I am quoting from—the CMS report—according to Politico, says that by 2014, Medicare Advantage enrollment will plunge 64 percent—we are not talking about just a few folks—from 13.2 million down to 4.7 million because of the ''less generous benefit packages.''

One of the reasons this is being done is because those on the left do not like private competition for the government program, Medicare. What I think they fail to appreciate is what my constituents have appreciated, which is this private alternative to regular Medicare provides additional benefits, additional health protections. If they are willing to pay a little bit more for those benefits, why shouldn't they be allowed to take advantage of those benefits? No. Those on the left say: We don't want any private insurance companies competing to get Medicare patients. We want that to be strictly a government program.

Well, if folks like it, why shouldn't they be allowed to keep it? Remember what the President said: If you like your insurance company, you get to keep it. No, that is not true, according to this. Medicare Advantage enrollment will plunge from 13.2 million to 4.7 million because of the ''less generous benefit packages.'' So I guess it is not true: If you like it, you get to keep it.

The Washington Post—a newspaper here in Washington—wrote an article about the Center for Medicare and Medicaid Services report, the same one I have been quoting here, and the headline was ''Bill Would Reduce Senior Care.'' Well, that says it in a nutshell. The story goes on to tell us: ''A plan to slash . . . Medicare spending—one of the biggest sources of funding for President Obama's proposed overhaul of the nation's healthcare system—would sharply reduce benefits for some senior citizens.''

''Would sharply reduce benefits.'' So the Medicare cuts, as proposed by the

majority, do, in fact, jeopardize seniors' benefits. The majority leader says we can amend the bill, and that is hypothetically correct, of course.

Let's see how many of our Democratic colleagues are willing to join Republicans in striking these Medicare cuts, the cuts I have just now been referring to. If we do not do that, then I will repeat what I have said before, which is that we should start over because it is clear this bill is not going to be fixed and starting over would mean taking some of the Republican suggestions.

Let me talk about one of these suggestions. My colleague from Florida was talking about the sorry state of real estate in his State of Florida, and I could have added my State of Arizona as well. I agree with much of what he had to say about that. But he also noted, with regard to health care, there is a subsidy in what those of us with private insurance pay because of the care that is given to others who cannot always pay for all of it. That is true.

I would add, there is also a subsidy for what we pay in insurance premiums because of the government programs, such as Medicare and Medicaid, which, likewise, do not pay for all the benefits they provide. In fact, they only pay doctors and hospitals somewhere in the neighborhood of 70 to 80 percent of their cost, and we have to make up the difference in that in the private insurance premiums we pay. So increasing insurance premiums is, to a large degree, the fault of the U.S. Government, not the insurance companies.

The Democrats say the answer is yet another government program, and they even have a government insurance program in the legislation they have introduced. Their other answer is to write insurance policies. They actually specify in the bill what policies have to include. These are called government mandates. What is the effect of these proposals? Is this the right way to go or is there a better idea?

Again, the Congressional Budget Office, which the distinguished minority leader referred to a moment ago, in its most recent report said—and it said the same thing to the Finance Committee—the premiums for private insurance under this Democratic legislation will, what, go up. The average family is going to pay more in insurance premiums under this legislation, not less.

What was the whole idea here? The whole idea of health care reform was to reduce the cost of health care, to reduce our insurance premiums. They are skyrocketing. My colleagues on the other side of the aisle say: Small businesses cannot afford to buy insurance for their employees; my constituents cannot afford their health insurance premiums, which are increasing in price. All that is true. They are increasing. So what should we be doing? We should be lowering them, not raising them. This legislation, according to the Congressional Budget Office, increases insurance premiums.

What about the Republican alternative, the alternative that was presented in the House of Representatives by the House Republicans? That alternative, according to the Congressional Budget Office, reduces average insurance premiums by $5,000 a year. So on the one hand, you have the Democratic proposal, which increases insurance premiums; on the other hand, you have the Republican proposal, which decreases premiums.

There is a study by a private consulting firm, Oliver Wyman, which breaks this down by State. The reason I am excited about this Republican idea is the average family in Arizona would see its premiums go down annually by over $7,400. So think about that. On the one hand, you have insurance premiums going up, under the Democratic legislation; under the other, you have insurance premiums going down, on average, somewhere in the neighborhood of anywhere from $3,300 to, in my State, up to $7,400. I think the average is somewhere between $3,000 and $5,000.

The point is, you can cut insurance premiums with better ideas coming from Republicans, and I just ask my colleagues: Why wouldn't you do that as opposed to the complicated, costly, government-run kind of program you are trying to institute under this legislation, which, according to CBO, would raise insurance premiums?

That is why the American people, by a significant margin, say: Do not pass this bill, why they appreciate it would raise their costs, it would reduce the quality of their health care, and why, therefore, my colleagues and I are going to try our best to persuade our Democratic colleagues to amend the bill. But if at the end of the day they are not willing to buy some of these good Republican ideas and instead insist on pushing right ahead with their legislation, at the end of the day, we will have to say: We are sorry, it does not appear this bill is going to be fixed and, therefore, we are going to follow the wishes of the American people and see to it that it does not pass.

I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

ORDER OF PROCEDURE

Mr. REID. Mr. President, the Senator from Minnesota is here. She has a brief statement to make. I ask unanimous consent that she be allowed to speak for 5 minutes and then we go to the bill.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from Minnesota.

DETENTION IN IRAN

Ms. KLOBUCHAR. Mr. President, I come to the floor to call attention to the situation of three citizens of the United States—Shane Bauer, Sarah Shourd, and Josh Fattal—who have been detained by the Government of Iran for nearly 4 months. One of these individuals, Shane Bauer, comes from my home State of Minnesota, and so the safe return of these three young Americans is of particular importance to me.

On July 31 of this year, Shane, Sarah, and Josh—who shared a common passion for travel and discovery—were on a hiking trip in a peaceful region in northern Iraq, when they reportedly accidentally strayed across the poorly marked border between Iraq and Iran and were surrounded by Iranian border guards.

Since then, Shane, Sarah, and Josh have been held in near isolation in a Tehran prison and have been allowed no contact with their families in the United States.

Despite repeated requests by the Swiss Government, which represents U.S. interests in Iran, the three have been denied regular consular access required by the Vienna Convention. They have been denied repeated requests to be able to speak with their families via telephone, and they have been denied public information on any charges they may face.

In the 4 months they have been detained, the three have been allowed only two meetings with Swiss consular officials and have been denied due process and access to legal representation.

Even more alarming, Iranian officials have recently declared the three may be charged with espionage, a charge that is not only baseless but also completely at odds with who Shane, Sarah, and Josh are as individuals.

Shane, Sarah, and Josh made a simple mistake in accidentally crossing the border, and their continued detention is unwarranted and unreasonable. Since the three were detained, I have gotten to know Shane's mother Cindy and other members of the hikers' families. During our conversations, I have learned what a remarkable person Shane is and how he is dedicated through his work to bringing the world closer together through photo journalism.

Shane grew up in Onamia, MN, a small town in the central part of our State, and he graduated from the University of California at Berkeley. Prior

to being detained in Iran, Shane was living with Sarah in Damascus. He has traveled around the Middle East as a free-lance journalist, reporting from Syria, Iraq, Darfur, Yemen, and Ethiopia. His writing and award-winning photographs have been published in the United States, the United Kingdom, Canada, and throughout the Middle East.

His latest trip with Sarah and Josh brought him to the Kurdistan region of Iraq, which is known for its scenic hikes among mountainous waterfalls. This is hardly the background of someone who would deliberately enter Iran in hopes of committing espionage.

A few weeks ago, I met with Shane's mom Cindy and members of Sarah and Josh's families in my office in Washington. As a mother, I can only imagine how difficult this ordeal must be for all of them. They have had no contact with their sons or their daughter. Yet I have been overwhelmed by their resolve. They are pursuing every avenue they can find to demonstrate to the Iranian Government that their children made a simple mistake and clearly deserve to be released.

I came away from our meeting even more committed to seeing that Cindy and Shane, along with Sarah and Josh and their families, are united as soon as possible. As we all know, Iran is in the center of many pressing foreign policy challenges we currently face. I, along with my colleagues, will address those, but Shane, Sarah, and Josh have absolutely nothing to do with these international fights. They have nothing to do with what is going on in Iran or Iran's differences with other countries. This is strictly a humanitarian case. I urge Iranian officials not to politicize it or seek to use the three hikers as diplomatic pawns. There is no cause for their continued detention, and nothing will be gained by prolonging it any further. Iran's leaders should demonstrate the necessary compassion by immediately releasing Shane, Sarah, and Josh and allowing them to return home to their families. In the meantime, they should at the very least allow them to speak to their families in the United States over the telephone.

I thank my friend, the Ambassador to Switzerland, and Swiss officials for their work in this area. It has been 122 days since Shane, Sarah, and Josh were first detained; 122 days in captivity, apparently just for straying over a line on a map when they were on a hike. We will continue to work with the families, with the State Department, and Swiss officials to do everything we can to bring Shane home to Minnesota.

Thank you, Mr. President. I yield the floor.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The legislative clerk read as follows:

A bill, (H.R. 3590), to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

The ACTING PRESIDENT pro tempore. The majority leader.

Mr. REID. Mr. President, today is the beginning of one of the most important debates in the history of our country. Today is the beginning of one of the most historic times in the Senate. Our two chairmen, Senators BAUCUS and DODD, have spent months of their lives working on the legislation that allows us to be where we are today. We now have before us a bill that saves money, saves lives, and saves Medicare. It is a bill, if you add in Medicare recipients, that will insure 98 percent of the people in America.

Mr. President, I note the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. REID. Mr. President, one of the major goals of the Patient Protection and Affordable Care Act is to lower Federal health care costs and reduce the deficit. Our bill does that. According to the nonpartisan Congressional Budget Office, this legislation would not add a penny to the Federal deficit. In fact, it will reduce the deficit over both the short term and the long term, over the long term by as much as $650 billion.

In developing this bill with the Finance and HELP Committees, we were determined to ensure that the legislation not only would reduce our deficit and our debt but that it would do so without relying on additional surpluses in the Social Security trust fund. This legislation would increase revenues in the trust fund as workers' wages rise. But those revenues are supposed to be for Social Security, so we didn't touch a penny of them—they are all used for Social Security and nothing else.

Likewise, about $70 billion in revenues over the first 10 years of this bill flows from premiums paid into the new long-term care insurance program known as the CLASS Act. Several Members came to me and argued that none of these funds should be used for other purposes. I agreed. After all, these premiums would be used to build up a fund that later would be used to pay benefits. So, as with Social Security, we didn't use any of the CLASS surpluses for other programs.

I think it is important that as the Senate considers changing the legislation, we maintain our commitment to protecting Social Security and CLASS surpluses. In both cases, all additional revenues are dedicated to pay benefits. Diverting them to other purposes would not be fiscally responsible, and it wouldn't be fair to Social Security or to people who paid their CLASS premiums in good faith.

To help ensure we remain true to this commitment, I now ask unanimous consent that all amendments to the pending bill be considered out of order unless they are consistent with the following two principles: The additional surplus in the Social Security trust fund generated by this act should be reserved for Social Security and not spent in this act in any other fashion; and No. 2, the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in any other manner in this act.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. ENZI. Reserving the right to object, neither of these requests are the requests I was just talked to about a minute and a half ago, so I object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. Mr. President, I think what he saw a minute and a half ago is essentially the same thing, but I will recite this again.

I ask unanimous consent that no amendment be in order to the Reid substitute amendment 2786 or a subsequent substitute amendment and H.R. 3590 if the additional surplus in the Social Security trust fund generated by this act would be expended on other provisions of this act and not reserved solely for Social Security, and the net savings generated by the CLASS program in the underlying substitute amendment and any subsequent substitute amendment are reserved solely for the CLASS program provisions of this act.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. ENZI. Mr. President, in the weeks this has been sequestered without us being able to review it and now having something that is not understandable in the short period of time we have to do it here, I have to object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. Mr. President, I am sorry my friend objected. It is not too difficult to comprehend that any Social Security surpluses should be reserved for Social Security. It is not too difficult to comprehend that all monies related to the CLASS Act would be reserved for paying benefits for that. So I am disappointed that my friends on the other side of the aisle are not interested in making sure Social Security monies are not used and/or CLASS Act monies are not used for anything other than those two programs.

Mr. President, I have another unanimous consent request.

The process for developing this legislation has been very transparent. In fact, the hearings held in the Finance Committee were done very publicly, and that is an understatement. For weeks and weeks, members of that committee couldn't walk out of the room without being questioned by the press. The press was present at most of their meetings. So both the HELP and Finance Committees marked up their legislation in public markups. Republican and Democratic members of both committees offered numerous amendments, all of which were available to the public. Republican and Democratic members voted for or against those amendments in a public and transparent way, and each committee member can be held fully accountable to their constituents for all of those votes.

The merged bill before us is entirely consistent with the provisions produced in those public markups. The bill has been fully available on the Internet for about 2 weeks. So each and every American has had the opportunity, if they wanted, to read the text of the legislation and to communicate their views with their Senators.

One of the main reasons we have gone the extra mile in ensuring a fully transparent process is because of the leadership of Senator BLANCHE LINCOLN of Arkansas. From the very start of this debate, she has made clear to me that a transparent process and debate on this critical issue is a top priority of hers. To that end, Senator LINCOLN said she would not allow a vote on the motion to proceed to this bill unless it had been available to the public for a reasonable period of time. She was joined by virtually everyone on this side of the aisle to that effect. They were right. The people did deserve a chance to see the bill before that vote, so we were sure to give them that chance. The Senator deserves credit for that, and I appreciate her standing up on that issue.

She believes—and I agree—that we can do more on the transparency front as this bill moves forward to the next stage of this process; therefore, Senator LINCOLN has asked me to propound on her behalf a unanimous consent request.

I ask unanimous consent that no amendment be in order to the Reid substitute amendment No. 2786, a subsequent substitute amendment, or H.R. 3590 unless the text or Internet link to the text of the amendment is posted on the home page of the official Senate Web site of the Member of the Senate who is sponsoring the amendment prior to the amendment being called up for consideration by the Senate and the amendment is filed at the desk. Further, that this unanimous consent agreement shall be in effect for the duration of the consideration of H.R. 3590.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. ENZI. Mr. President, in light of some of the trust problems and transparency problems we have, and while it appears to lead to greater transparency, we can also see ways that this can limit the ability for the minority to offer amendments. Therefore, I object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. Mr. President, this is not a good way to start this debate. No. 1, there is an objection to the moneys in Social Security being protected and, No. 2, to the moneys in the CLASS Act being protected. That was also objected to.

Finally, Senator LINCOLN's request, which I support 100 percent, indicating that amendments should be filed on a Member's Web site—that doesn't sound too outlandish—and filed at the desk before they are offered, sounds pretty fair and square to me. I am disappointed this is the way the debate started.

Mr. President, there is an order before the body that there will be two amendments in order today. One will be offered by the Democrats and one will be offered by the Republicans. The one to be offered by the Democrats will be offered by the distinguished Senator from Maryland, BARBARA MIKULSKI, who I had the good fortune of serving with in the House of Representatives. She and I came here together in 1986 when we were elected to the Senate. She is a Senator I have such great respect and fondness for. We have been literally together and, because of our seniority, I am always one step behind her. Frankly, most people are a step behind the Senator from Maryland. The amendment she is going to offer is very sound and good. She will explain it in detail. It expands women's health services. We had a consternation about mammograms a couple weeks ago, and this will put that all to rest.

I express my deep appreciation for the leadership of the Senator from Maryland on this issue and on so many other issues she is involved in.

As I have indicated, the managers of the bill on our side will be Senators BAUCUS and DODD. We look forward to a rigorous debate. With the consent of my friend from Wyoming, I ask that the Senator from Maryland be recognized.

Mr. ENZI. Mr. President, I was hoping I would have a chance to comment on the things I had to object to so I can give a more full explanation. I am happy to wait.

Mr. REID. Mr. President, there is no need to cut the Senator off. I have indicated to my staff earlier today that there is no one easier to get along with in the Senate than the Senator from Wyoming. I would never, ever cut him off intentionally. If there is anything he wishes to say, he should say it. If the Senator from Maryland will withhold for a moment, the Senator from Wyoming wishes to speak for a brief period of time.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I cannot be brief on what just happened here. I will let the Senator go ahead. Frankly, I am a little upset about what has happened—combining a couple of unanimous consent agreements so that part of it would be acceptable and part would not be, leaving out the most important one, which is that we wouldn't take Medicare money from Medicare, and then not having much time to consider, or to rewrite, or to do anything with those. I have a lot of comments I wish to make on that, plus a general statement on the bill, which fits in with what just happened. I will defer to the Senator from Maryland.

The ACTING PRESIDENT pro tempore. The Senator from Maryland is recognized.

AMENDMENT NO. 2791 TO AMENDMENT NO. 2786

Ms. MIKULSKI. Mr. President, I have an amendment at the desk.

The ACTING PRESIDENT pro tempore. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Maryland (Ms. MIKULSKI), for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN, proposes an amendment numbered 2791 to amendment No. 2786.

Ms. MIKULSKI. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To clarify provisions relating to first dollar coverage for preventive services for women)

On page 17, strike lines 9 through 24, and insert the following: ''ance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

''(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

''(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the

Centers for Disease Control and Prevention with respect to the individual involved; and

''(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

''(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.''.

''Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.''.

Ms. MIKULSKI. Mr. President, before I go into the contents of my amendment, I thank the Senator from Wyoming for his unfailing courtesy to allow me to proceed to offer my amendment. I have worked with the Senator from Wyoming on the Health, Education, Labor and Pensions Committee, and have often valued his sound counsel and steady hand as we have moved complex legislation. His considerable experience as an accountant and his commitment to the stewardship of Federal funds have often added to the consideration of legislation. As we move forward on both debating and refining the health care reform bill before us, I look forward to working with him. Again, I thank him for his courtesy.

I also want to acknowledge the Democratic leader and wish to support him for bringing something called the ''merged'' bill to the floor, which took the best elements of both the Finance Committee and the HELP Committee and brought them forth.

I believe the overriding bill before us is an excellent bill. No. 1, it expands universal access to health care that will now cover over 90 percent more Americans. It will end the punitive practices of insurance companies, particularly in the area of gender, age discrimination, and preexisting conditions. It also stabilizes and makes Medicare secure and, at the same time, it begins to bend the cost curve by following innovative practices related to quality control and prevention.

I think the overriding bill is an excellent one. I congratulate the manager of the bill on the floor, the Senator from Montana, Mr. BAUCUS, chairman of the Finance Committee, for the excellent work his committee did, for bringing in a great bill that establishes new ideas, such as medical homes, emphasizing primary care and prevention, and at the same time accomplishing the objectives I have mentioned.

However, as I reviewed the bill, I felt we could do more to be able to enhance and improve women's health care. That is what my amendment does. The essential aspect of my amendment is that it guarantees women access to lifesaving preventive services and screenings.

This amendment eliminates one of the major barriers to accessing care in the area of cost and preventive services. It does it by getting rid of, or minimizing, high copays and high deductibles that are often overwhelming hurdles for women to access screening programs. We know that screening is important and early detection is important because it saves lives. But it also saves money. It does it by reducing the top diseases that are killing women today, or certainly impairing their lives.

Today, according to the CDC, the top killers of women are cancer—breast cancer, cervical cancer, colorectal cancer, ovarian cancer. Also upfront and high on the list is lung cancer which, if identified early, can be treated with less invasive procedures and with lower costs. Another top killer of women is heart and vascular disease. And then there are the silent killers that often go undetected, such as diabetes, which can result in terrible consequences, such as the loss of an eye, the loss of a limb, or the loss of a kidney.

We now have screenings that are proven to detect these diseases early. Guaranteed access to these screenings, as I said, will save money and lives.

If we look at where women are today, we find women often forgo those critical preventive screenings because they simply cannot afford it, or their insurance company won't pay for it unless it is mandated by State law. Many women right now don't have insurance at all—seventeen million women in the United States of America are uninsured—or when they are insured, they have to pay large out-of-pocket expenses.

Three in five women have significant problems paying their medical bills. Women are more likely than men to neglect care or treatment because of cost. Fourteen percent of women report they delay or go without needed health care. Women of childbearing age incur 68 percent more out-of-pocket health care costs than men, simply because of the maternity aspect.

Women are often faced with the punitive practices of insurance companies. No. 1 is gender discrimination. Women often pay more and get less. For many insurance companies, simply being a woman is a preexisting condition. Let me repeat that. For many insurance companies, simply being a woman is a preexisting condition. We pay more because of our gender, anywhere from 2 percent to over 100 percent. A 25-year-old woman is charged up to 45 percent more than a 25-year-old male in the same identified health status. A 40-year-old woman is charged anywhere from 2 percent to 140 percent more than a 40-year-old man with the same health status for the same insurance policy.

What does my amendment do? It guarantees access to those critical preventive services for women to combat their No. 1 killers. We will provide these services at minimal cost.

The overall cost of my amendment has been scored by CBO. It says the cost is $1 billion. The majority leader, the Democratic leader, has provided opportunities to meet this cost. This amendment eliminates this big barrier of copayments and deductibles.

Let's talk about the benefit package. This benefit package is based on HRSA recommendations. It is based also on the recommendations of CDC. If this amendment passes, women will have access to the same preventive health services as the women in Congress have. If this passes, again, the women of America will have access to the same preventive services that we women in Congress have.

What does that mean? It means a mammogram, if your doctor says you need it; screening for cervical cancer, if your doctor says you need it; that check on diabetes, if your doctor is worried about you; and along with the symptoms related to menopause, there are other things, such as a loss of weight; and they may want to know at this juncture if you have diabetes. If you know that at 40, you are less likely to need kidney dialysis when you are 60.

The pending bill doesn't cover key preventive services, such as annual screenings for women of all ages to focus on our unique health needs. We know that for many people—for example, there are 15 million people in America with diabetes, and half are women. Often pregnant women with diabetes don't get the proper prenatal care. Heart disease is one of the top two leading causes of death in women—cancer and heart disease. Every year, over 267,000 women die from heart attacks. Women are generally unaware of their heart risks.

My amendment would, again, ensure heart disease screening for women. Remember that famous study that said ''take an aspirin a day to keep a heart attack away.'' It was done on 10,000 male medical residents, and not one woman was included. Thanks to a bipartisan effort, Bernadine Healy, NIH, and the women of the Senate, supported by the good guys of the Senate, were able to get that screening for women, get that evaluation. We know we manifest things differently than guys do. Now we are on our way to detection—if you can afford to have a doctor and if you can afford to have the screening.

My amendment also guarantees screenings for breast cancer—yes, for mammograms. We don't mandate that you have a mammogram at age 40. What we say is discuss this with your doctor. But if your doctor says you need one, you are going to get one.

Studies have found mammogram screening decreases breast cancer among women by over 40 percent. Regular Pap smears reduce cervical cancer by 40 percent. This year, over 4,000 women will die of cervical cancer.

My amendment does focus on women's health needs. Keeping a woman healthy not only impacts her own life but that of her family. It impacts her ability to care for her child or an aging parent.

Early detection saves money by treating diseases early. Screening tests for breast and cervical cancer cost about $150, but the treating of advanced breast cancer is over $10,000 and can even go much higher. The treating of early stages of cervical cancer is $13,000 and can go much higher.

My amendment also leaves the decision of which preventive services a patient will use between the doctor and the patient. The health reform debate is focused on what you should have when. We agree. Decisions should be made in doctors' offices, not in the office of a Member of Congress or the office of an insurance executive. The decision about what is medically appropriate and medically necessary is between a woman and her doctor.

The authors of the bill have done a very good job in protecting women in many areas. This actually refines and improves this particular issue. That is why I support the overall health reform bill providing universal access to health care for over 90 percent of the American people, ending those punitive practices of the insurance companies, stabilizing and strengthening Medicare, and improving quality in public health by using innovation and preventive services and quality. We can pass a health reform bill.

I conclude by saying that we will end the confusion about what is needed in the area of preventive health services for women when our coverage is often skimpy and spartan. We want to make sure what we do enables us to have access to these comprehensive services.

I hope this amendment is adopted unanimously. I believe good people on both sides of the aisle will believe in its underlying premise: that early detection and screening save lives and save money.

Often those things unique to women have not been included in health care reform. Today we guarantee it and we assure it and we make it affordable by dealing with copayments and deductibles in a way CBO believes is fiscally achievable. In the long run, I think by doing this it will mean a lot to families, and it will mean a lot to the Federal budget.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, before I give a statement on the bill, I wish to compliment the Senator from Maryland for standing up for and essentially helping the health care of women. As she has pointed out, women are discriminated against today in America in various ways. Her amendment addresses some of that discrimination. I very much appreciate that. I know all women in the country do. I do, too. I have a mom. I have sisters. I have women in my family, and I very much care.

I don't know if she made this point, but about 80 percent of health care decisions made for families are made by women. It is all the more important women are not discriminated against, partly because they make so many decisions that affect health care for Americans, but second, women themselves are often discriminated against. Some States have gender ratings which discriminate against women. In other States a preexisting condition is a factor that discriminates against women.

I thank the Senator from Maryland. She has hit the nail on the head. It is another reason this health care reform is going to mean so much for so many Americans. I personally very much thank the Senator from Maryland.

In the Presidential campaign of 1912, Theodore Roosevelt's platform said:

> We pledge ourselves to work unceasingly in State and Nation for . . . the protection of home life against the hazards of sickness . . . through the adoption of a system of social insurance adapted to American use.

Today, nearly a century later, we are closer than ever to enacting meaningful health care reform.

As in Teddy Roosevelt's time, we seek protection against the hazards of sickness. Of necessity we seek a system uniquely adapted to American use. And recognizing the daunting task still ahead of us, we pledge ourselves to work unceasingly to get the job done.

In the years since Teddy Roosevelt, some of our Nation's greatest leaders signed up for this job. But at the same time, we have never faced a greater need to get the job done than we do today.

Why is that? Basically because health care costs are skyrocketing out of control. Every day American businesses are forced to cut benefits for their workers. Why? To remain competitive in the global marketplace. Every 30 seconds another American files for medical bankruptcy. Just think of that. Every 30 seconds another American files for medical bankruptcy. Every year, about 1.5 million families lose their homes because of health care costs. Our system is in crisis.

We have a historic need and we have a historic opportunity. We have an opportunity to enact groundbreaking reform that will finally rein in the growth of health care costs and help bring financial stability back to American families and businesses.

Unfortunately, there are some who stand in the way. Unfortunately, there are some who are spreading misinformation about how health care reform will work. On this very floor I have heard arguments that health care reform is about the government trying to take over health care. That is false.

The truth is, health care reform is about allowing patients and doctors to take back control of health care. We need to allow patients and their doctors together to take back control from the big insurance companies.

Our plan would not increase the government's commitment to health care. But don't just take my word for it. The nonpartisan Congressional Budget Office says:

> [D]uring the decade following the 10-year budget window, the increases and decreases in the federal budgetary commitment to health care stemming from this legislation would roughly balance out, so that there would be no significant change in that commitment.

That is right, health care reform will not increase the Federal Government's budgetary commitment to health care.

I have also heard it argued that health care reform will increase the budget deficit. That, too, is false—plainly, patently false.

The bipartisan Congressional Budget Office says our plan would reduce the Federal deficit by $130 billion within the first 10 years—reduce the deficit in the first 10 years. That trend would continue, the CBO says, over the next decade. During the next decade, CBO says our bill would reduce the deficit roughly $450 billion. That is nearly one-half trillion dollars in deficit reduction, according to the Congressional Budget Office, in the second 10 years.

I have also heard it argued that health care reform will raise taxes. That, too, is false. In fact, health care reform will provide billions of dollars in tax relief to help American families and small businesses afford quality health insurance—tax cuts.

The Joint Tax Committee—again bipartisan and which serves both the House and the Senate—tells us, for example, that our bill would provide $40 billion in the tax cuts in the year 2017 alone—$40 billion in tax cuts in the year 2017. The average affected taxpayer will get a tax cut of nearly $450. The average affected taxpayer with an income under $75,000 in 2017 will get a tax cut of more than $1,300.

Let me repeat that. The average affected taxpayer with income under $75,000 in 2017 will get a tax cut of more than $1,300. They will also get a tax cut in earlier years, but it ramps up to that amount in 2017.

In the same vein, I have heard claims that health care reform will result in an increase in higher costs for Americans. That, too, is false.

Health care reform will not result in higher costs for Americans. Health care reform is fundamentally about

lowering health care costs and making quality health care affordable for all Americans. Lowering costs is what health care reform is designed to do, lowering costs; and it will achieve this objective. How? In many ways.

First, health care reform will end abusive practices by insurance companies. Reform will stop insurance companies from denying coverage or hiking up rates for those with a preexisting condition. We stop that in this legislation. That will lower costs. Reform will stop insurance companies from dropping coverage or reducing benefits for those who get sick.

Those reforms protect consumers, and they will protect Americans and reduce premium costs for Americans who are sick. These reforms will also help lower costs for small businesses and their employees. Right now, if one employee in a small business gets sick—just one—insurance companies can double the premiums they charge the whole business. I know that is true. I have heard that time and time again from small business owners in Montana. That is just because one employee gets sick, the insurance companies jack up premiums, double the premiums they otherwise would charge the whole business. That is just wrong. We stop that in this legislation.

How else do we lower costs in this bill? Health care reform will provide billions of dollars in tax credits and reform will limit out-of-pocket costs such as copayments that insurance companies are able to charge. We limit them. This will also help to ensure Americans can afford their total health care costs and not just their premiums.

That is very important. Premiums and out-of-pocket costs are both addressed by this bill. It limits growth in premiums and also limits growth in out-of-pocket costs. So total cost—premiums plus out-of-pocket costs—for Americans will be lower under this legislation than otherwise would be.

Third, health care reform will work to repeal the hidden tax of more than $1,000 in increased premiums that American families pay each year in order to cover the cost of caring for the uninsured.

Today, millions of Americans without health insurance are too often forced to turn to emergency rooms to get the care they need, and then health care providers shift the cost of that care to other Americans with health insurance. People with insurance, therefore, pay higher premiums. By providing quality, affordable health insurance to millions more Americans, health care reform will reduce this hidden tax and reduce premiums for all Americans—$1,000 per year per family due to uncompensated care. That is that hidden tax. This bill will virtually stop that hidden tax, stop that additional $1,000 that goes to average family premiums.

How else do we reduce health care costs? By providing affordable health care to more Americans which will increase the number of Americans in the insurance market. Why? What is so good about that?

One reason is more people will have health insurance. But also it will spread the risk of paying for an accident or disease more broadly. Spreading the risk more broadly should lower premium rates for everybody. It is a basic tenet of insurance.

Fifth, health care reform will reduce costs by cutting administrative redtape. That is no small item. Today, insurance companies spend a lot of time and money finding ways to discriminate against people. They spend time and money to find ways to drop coverage, and insurance companies pass those administrative costs on to all Americans in the form of higher premiums. The figure I heard is about 18 percent of American health care dollars is administrative costs. This legislation would dramatically reduce that percentage to a much lower number. We don't know to exactly what level yet but a much lower level. About 18 percent of total health care dollars go to pay administrative costs. That is not the case in other countries. They pay 4 to 5 percent in other countries. We have to get that down in America, and health care reform will significantly achieve that result.

Health care reform will outlaw this discrimination, and also reform will eliminate those administrative costs that go along with it. Furthermore, health care costs will work to streamline administrative procedures across the board by requiring standard enrollment forms and marketing material through insurance exchanges. That, too, will help streamline procedures. That, too, will help reduce administrative costs for providing for standard enrollment forms and also standard marketing materials through insurance exchanges. That is going to lower administrative costs and make it much easier for a person to shop and know which policy is best for him or her. With the other reforms we are making competition is more on the basis of price not just underwriting, a fancy term for denying because of a preexisting condition and putting in all those extra escape clauses insurance companies often provide in small print. In a letter released today, the Congressional Budget Office said:

> Compared with plans that would be available in the nongroup market—

And they are referring there to the individual market—

> under current law, nongroup policies under the proposal would have lower administrative costs.

Let me say that again. Compared with plans that would be available in individual markets—individuals seeking insurance—under current law, individual policies under the proposal would have lower administrative costs.

Lower, not higher. Lower.

Six—another way to reduce costs. Health care reform creates insurance exchanges where consumers can easily shop and compare plans to find the right coverage. Exchanges will make it easier for Americans to choose the most efficient plans, and that will reduce their costs and put pressure on insurance companies to offer lower cost, higher quality plans.

Seven—still another way this bill reduces costs. Small business insurance exchanges will allow small companies to pool together to spread their risk and increase their buying power. More pooling available for small business insurance exchanges—this will allow small businesses to negotiate lower rates and provide more quality insurance plans with lower premiums to their employees.

Eight. Health care reform will strengthen oversight and enforcement measures to cut down on fraud, waste, and abuse in the health care system. Fraud, waste, and abuse are estimated to cost our health care system more than $60 billion every year. This bill will help reform our system to reduce fraud, waste, and abuse, which eats up way too many health care dollars.

Nine. Health care reform will move the focus of our system toward efficiency and value with payment incentives that reward quality care—not quantity and volume but reward quality care, reward outcomes. Over the long run, paying doctors and other health care providers for quality instead of quantity will reduce health care costs.

Ten. Health care reform will lower costs by working to change the focus of our health care system from treating sickness to promoting wellness. The big problem we have today is that we treat sickness. We don't spend enough time promoting wellness. Reform will make critical investments in policies that promote healthy living and help prevent costly chronic conditions that drive up costs throughout the system.

These are just 10 examples of how health care reform will reduce health care costs and lower premiums for American consumers. There are many more, but these are those 10, as I said. On the other hand, without reform; that is, without passing this legislation, costs are guaranteed to continue to skyrocket out of control.

Since Congress failed to enact health care reform in the 1990s, health care premiums have risen eight times faster than wages. Consider that. Since the last time we attempted to pass health care reform—and failed—in the 1990s, health care premiums have risen eight times faster than wages. And if we don't reform our health care system now, premiums will increase 84 percent in the next 7 years. And that is just

premiums. What about out-of-pocket costs? Those, too, will increase at a rate much faster than wage increases.

Today, health care coverage costs the average American family more than $13,000 a year, according to the Kaiser Family Foundation. If current trends continue without reform, the average family plan will cost more than $30,000 a year in the next 10 years. That is up from $13,000 today to $30,000 10 years from now. And businesses could see their health care costs double in that same time. Without reform, our Nation's long-term fiscal picture is almost certainly unsustainable.

As Peter Orszag said when he was Director of the Congressional Budget Office:

> Rising health care costs represent the single most important factor influencing the Federal Government's long-term fiscal balance.

He was right. Without reform, instead of working to reduce our national deficit and stabilize the Federal budget, we will see total health care spending nearly double to encompass one-fifth of our gross domestic product in less than 10 years. And the Congressional Budget Office projects entitlement spending will double by the year 2050.

Without reform, millions of uninsured Americans will continue to suffer. A Harvard study found that every year in America, lack of health care coverage leads to about 45,000 deaths. People without health insurance have a 40-percent higher risk of death than those with private health insurance. You have a 40-percent higher chance of death if you don't have health insurance compared with those who do. That is 46 million Americans at risk today because they do not have health insurance. A recent Johns Hopkins study found that children without insurance have a 60-percent higher risk of death than those with private health insurance—a 60-percent higher risk of death than those with private health insurance.

Another recent Harvard study found that the risk of dying from car accidents and other traumatic injuries is 80 percent higher for those without insurance—80 percent higher. The risk of dying from car accidents and other traumatic injuries is 80 percent higher if you don't have health insurance. In the greatest country on Earth, no American should die simply because they do not have health insurance.

So, Mr. President, we are at a crossroads in history. We have a historic opportunity to enact meaningful health care reform that will work to stabilize our economy and provide quality, affordable health care coverage for millions of Americans. We are not the first to be here, but we have come further than ever before.

We laid the groundwork in the Finance Committee and the HELP Committee. We held many hearings and countless hours of meetings on health care reform. Each committee crafted meaningful legislation and held exhaustive markups where we incorporated amendments from both sides of the aisle. We produced balanced, meaningful legislation, and I am proud—I am very proud—of the work both committees accomplished. Now we have one health care plan before us in the Senate, two basic bills merged together. We have an opportunity to debate that plan and offer amendments to make it even better. Then we will be called upon to vote.

The health care of our Nation is depending on us. The health care of our economy is depending on us. History itself is depending on us to answer the call. I am confident we will. I am confident we will at long last answer the call of history. I am confident we will soon enact meaningful health care reform that will lower costs and bring quality, affordable coverage to millions of Americans.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. ENZI. Mr. President, as I mentioned earlier following the unanimous consent requests the leader made—who then introduced Senator MIKULSKI so that she could do her amendment, which kept me from commenting on the unanimous consent requests he made—I have to say I think those unanimous consent requests would have to be put in the category of a stunt. Unanimous consent usually means the two leaders have gotten together and negotiated some kind of agreement that we would abide by during this time. There was no agreement on this. Yet they went ahead and did the unanimous consent request solely so they could get the objection.

Nobody here, I am sure, wants to use Social Security money for anything except Social Security. So the real key to the stunt was the second one, which is the net savings generated by the CLASS program. That is a long-term care program that wound up in the Health, Education, Labor, and Pensions Committee bill.

The flaw with that particular amendment was that it collected money for 10 years without spending any and then it wound up with a huge liability. So we put in a little provision that it had to be actuarially sound because, quite frankly, it is not very good accounting to collect $70 billion in exchange for a $2 billion—excuse me, $2 trillion—I get the b's and the t's mixed up here, because we are talking about real money here—a $2 trillion bill. That is how much we are going to have to pay out over the next 10 years to cover the $70 billion we accept in payments for this new kind of insurance that would be provided. That kind of insurance is provided—it is provided in the private sector—but for considerably more than what they were providing for in the CLASS Act.

So that was to bring a little more attention to it, and I want to bring a little more attention to it because I want people to take a closer look at the way that winds up. It is a good idea that is not paid for, and it is not paid for in such a way that it winds up, once again, adding to the deficit but in some cagey ways.

As for having the amendments posted on the Web site before they are given, I hope the initial version is posted on the Web site by everybody before they do it. But one of the things that happens on this floor is that occasionally a good idea can be built on by somebody from the other side or even somebody from your own party, and when that happens you can modify the amendment. I am not sure that agreement wouldn't have prohibited any modifications to amendments, which is kind of what we ran into in the Finance Committee when we were trying to do amendments.

So good ideas—they need a lot more work. And to just throw those out at the beginning and to have about 1½ minutes' notice that they are going to be thrown out—I just don't think that is the right way to go about this whole process.

I have been working on the Nation's broken health care system ever since I entered the Senate more than 12 years ago, and I had high hopes this would be the year the Democrats and the Republicans of the Senate would work together to provide health insurance to every American. I urged my colleagues to start with a blank piece of paper and develop a bipartisan bill that up to 80 Members of the Senate could support.

Unfortunately, the majority leadership had other ambitions, because the bill being debated today is a testament to a partisan ideological vision. It appears that the drafters of this bill took to heart the sentiments expressed by the Speaker of the House, who earlier this year said, "We won the election, we write the bills." And for a number of weeks, the majority leader closed his door and wrote this bill on his own terms without any input from many of his colleagues or anybody on this side of the aisle.

This is a deeply flawed bill that fails to address the real needs of the American people. Americans overwhelmingly want reforms that will help lower their health care costs. Instead, this bill will spend $2.4 trillion when it is fully implemented and contains numerous provisions that will actually drive up the costs millions of Americans pay for their health care.

It is important to understand how we got here. At the beginning of this process, the majority staff of the HELP Committee decided they were going to draft a partisan bill based on the reforms that had recently been adopted

in Massachusetts. Republicans were shut out of the process during the drafting of the HELP Committee bill. Rather than working to resolve the difficult issues, the drafters of the bill included over 200 separate instances where the bill gave the Secretary of Health and Human Services the authority to make important decisions about the types of health care plans millions of Americans can receive. Rather than confronting and debating these important policies—getting to the details, and the devil is always in the details—the majority empowered unelected government bureaucrats to make decisions that will affect the health care of every single American.

As a result of this partisan process, we were forced to file hundreds of amendments. The chairman and other Democratic members of the committee have repeatedly commented on the numerous amendments accepted by the majority during the markup. At the same time, they ignored the reality that most of these amendments were merely technical corrections which were necessary because the underlying bill was hastily written and filled with numerous drafting errors. Unfortunately, nearly all of the accepted Republican amendments merely tinkered around the edges. Almost all of the substantive alternative-idea amendments suffered the failing fate of the party-line vote. In 12 days of markup at HELP, we had 45 rollcall votes on Republican-sponsored amendments and only 2 prevailed.

After the markup, the majority refused to release a final copy of the bill for over 2 months, denying the American people the chance to see what they had done. Once we finally got a copy of the bill, we learned that majority staff had unilaterally made numerous changes to the bill, in some cases undoing agreements that had been worked out by Members on issues such as prevention and wellness.

While this was happening, there were also ongoing bipartisan negotiations, led by Senator MAX BAUCUS. And I have to congratulate him for the process he started and got people involved in and for his persistence and the amount of time he put into it. This dwindled down to a Gang of 6. The Gang of 6 discussions were not an honest attempt to try to develop a bipartisan health care bill that would offer real solutions to the problems that face our health care system.

Ultimately, these negotiations failed to produce a bipartisan bill. I do not believe the failure was due to a lack of effort on the part of the participants but, rather, we were unsuccessful because the Democratic leadership chose to impose arbitrary and unrealistic time deadlines on the process that we commented on. The deadline slipped a few times, moved up a week, and then became finalized. The decision was made that it was more important to move fast than it was to get it right, and the decision ultimately doomed our efforts.

This, in turn, led to another partisan markup where the Finance Committee rejected most GOP health reform ideas. Proposals such as medical liability reform were rejected on jurisdictional grounds, while the chairman unilaterally included Democratic provisions that were clearly within the jurisdiction of other committees. Republican amendments were voted on and then unilaterally changed at the eleventh hour—actually, 1:30 in the morning—by amendments offered by the chairman.

The two bills were then merged, merged in secret, with no input from the many Republicans who want to enact a bipartisan health bill. We now have a 2,074-page bill that reflects many of the worst provisions from both the HELP and the Finance Committee bills.

We did not need to end up here today with Republicans opposing a partisan health care reform bill. The Senate should develop legislation that will impact one-sixth of our Nation's economy and affect the health of every American.

The former chairman of the Senate Finance Committee, Daniel Patrick Moynihan, a Democrat from New York, once provided the following perspective on how the Senate should consider major policy changes. He said:

> Never pass major legislation that affects most Americans without real bipartisan support. It opens the doors to all kinds of political trouble.

Chairman Moynihan noted that absent such bipartisan support, the party that didn't vote for it would feel free to take shots at the resulting program whenever things go wrong and a large segment of the public would never accept it unless it was an overwhelming success. Chairman Moynihan understood a partisan legislative process guarantees that any glitches that occur in implementing the bill would provide ammunition for future attacks; thereby, further undermining public support of the new policies. There will, unfortunately, be plenty of glitches if this bill is ever enacted.

The Reid bill will impose $493 billion in new taxes, and many of them go into effect immediately. At same time, most Americans will not see any insurance reforms or other potential benefits from this bill until at least 2014. That leads to some interesting accounting.

The Reid bill will kill jobs and cut wages. The Congressional Budget Office has told us the employer mandates in this bill will likely result in lower wages and higher unemployment. These job and wage cuts would hit low-income workers, women, and minorities the hardest. It is hard to believe that with unemployment at a generational high, Democrats would even consider putting more jobs on the chopping block. The Reid bill mandates that Washington bureaucrats ration care. The bill lays the groundwork for a government takeover of health care, giving Washington bureaucrats the power to prevent patients from seeing the doctor they choose and obtaining new and innovative medical therapies.

I think that is attested to by the first amendment we have, the amendment by the Senator from Maryland, because her amendment preempts the provision in the bill that allows the U.S. Preventive Services Task Force to determine what preventive services should be covered. This amendment recognizes the problems associated with government bureaucrats determining what benefits should be covered. The majority realized it had a political problem when the U.S. Preventive Services Task Force said that women aged less than 50 years old should not have annual breast screening exams. This amendment doesn't do anything to protect patients who might be denied access to preventive tests in the future, such as prostate exams, colonoscopies, Pap smears, and so on, if bureaucrats decide to deny access.

This bill also shows how this will never be a truly science-based process. Bureaucrats will always have to respond to political pressure for powerful constituencies.

I guess we are part of the powerful constituencies. If we decide something should or should not be in there, that eliminates the science-based part of it.

I understand what they are trying to do. In the HELP Committee, when we were doing the markup, we did numerous amendments around this clinical effectiveness research, to see what it was supposed to eliminate from the health care for the person, separating them from their doctor by making these science-based decisions.

We did a series of amendments and found there, evidently, are a lot of things they are hoping will be precluded from people being able to get. I invite people to take a look at those amendments. We may have to try those again to see exactly where this process is going. I appreciate the Senator from Maryland making an attempt to solve a part of the problem, but I am having a little trouble with the reading of the amendment itself. At any rate, enough of that.

The Reid bill spends millions—billions. There is that word again. The Reid bill spends billions of taxpayer dollars on new pork-barrel spending. The bill would build new sidewalks, jungle gyms, and farmers' markets and creates a $15 billion slush fund for additional pork-barrel projects, a real deviation from what the Appropriations Committee has ever allowed.

This bill also fails to achieve the commonsense goals Republicans and

Democrats share. This bill even breaks many of the promises President Obama has made about health care reform. President Obama repeatedly called for a health care bill that will reduce costs. This bill will actually drive up health care costs for millions of Americans as a result of new mandates and taxes. President Obama has also said that if Americans like the insurance they have, they can keep it. Under the bill, millions of Americans will lose their employer-provided health insurance.

President Obama promised not to raise taxes on individuals earning less than $250,000 per year. The bill would impose several new taxes on people who make considerably less than $250,000 a year.

President Obama said the health care reform would not increase the deficit. This bill will not increase the deficit only if you believe certain things. This bill will not increase the deficit if you believe Medicare payments to physicians will be cut by 40 percent over the next decade. I don't think anybody believes that.

The bill would reduce the deficit only if you believe Medicare payments to other providers will be slashed to levels that endanger patients' ability to get the care they need. No one believes that.

The bill will also reduce the deficit if you believe Congress will allow a massive new tax to be imposed on middle-class tax payers. I hope no one believes that.

If you don't believe Congress will allow all these things to happen, then you can't believe this bill will reduce the deficit. President Obama, in his remarks to the American Medical Association this summer, acknowledged the need to address our out-of-control medical liability. Rather than addressing this issue, this partisan bill preserves the costly, dangerous, duplicative medical malpractice system.

President Obama finally said no Federal dollars will go to pay for abortion. According to the National Right to Life and the Conference of Catholic Bishops, the Reid bill fails this requirement as well.

Despite all these failures, it is still not the worst health care bill in Congress. The Wall Street Journal got it right when they described the House-passed bill as the worst bill in America. Even if the Senate passed the bill before us today, it would still have to go to conference with the House bill and any final bill would have to move toward several provisions in the House bill and poll after poll suggests that the American people are opposed to this bill, let alone the wild one from the House.

If we cannot defeat this partisan bill and get back to work for the American people and write a bill that garners the support of both parties, doing it step by step so we can assure, for instance, the seniors that Medicare money will only be spent on Medicare—that is one of the pieces that ought to have been in that unanimous consent I started talking about. That is not going to happen, though. They are going to take a bunch of money out of there.

I think this legislation fails to meaningfully address these goals and will stick the American people with a bill we cannot afford. I believe we can do better, and we owe it to the American people to do so.

I yield the floor.

The PRESIDING OFFICER (Mrs. HAGAN). The Senator from Connecticut is recognized.

Mr. DODD. Madam President, let me begin, if I may, by congratulating the majority leader and my colleague and dear friend from Montana, Senator BAUCUS, and members of the Finance Committee as well as the members of the HELP Committee. As I said before, I am sort of an accidental participant in all this, in the sense that the person who should be standing at this desk and at this podium as the chairman of the HELP Committee is, of course, our deceased colleague from Massachusetts. I was filling in for him during the months of his illness and managing the markup of the bill that produced part, half—whatever the percentage is—of the combined legislation. All our colleagues know, whether you agreed or disagreed with him, he considered this issue to be what he called the passion of his public life, to make a difference for all Americans when it comes to their health care. So I know it is with a sense of sadness that, on the day on which we begin this historic debate and discussion, he is not here to participate—at least physically. We sense his presence, of course, those of us who had the privilege of serving with him for so many years, as Senator BAUCUS and I did, and worked with him on these many issues. Of course, our colleague from Wyoming, Senator ENZI, and Senator GRASSLEY did as well over the years. I thank all members of the committee.

It was a laborious undertaking. The Presiding Officer was very much a part of that as well, during those many hours we gathered in the Senate caucus room—the Russell caucus room now named the Kennedy caucus room—in some 23 sessions, over many hours. But that was only the culmination of an effort that began a long time ago.

Actually, the business of writing this bill began months and months earlier. My colleague from Montana can appreciate the hours I know I spent in meetings in his office, late into the evening, long before a markup began. Long before any formal conversations and discussions, there was a significant reaching out to our colleagues, to try to bring us together and develop what we all hoped to be the case and still can be the case; that is, a consensus bill, a bipartisan bill on health care.

I know as a matter of fact here, beginning last fall, Senator Kennedy, when he did have his strength, met on countless occasions with members of the minority to try and navigate the minefield of health care ideas, to see if it couldn't be possible to put together that kind of a consensus bill.

I know our committee began a long process, beginning last winter, to try to begin, long before the markup of this summer, to draft such a proposal, having what they call a walk-through of legislation, going through the various ideas and listening.

It was with some regret that I say this idea that the bill somehow being jammed down people's throats, with little or no thought given to other people's ideas and thoughts, is not borne out by the facts. I have been here for many years. I have been through many markups over three decades in this body on various committees. This effort was and still remains an effort to try to bring us together about this issue, which has such a massive impact on not only the individuals of our Nation who go through the fear every day of wondering whether the coverage they have will be adequate; and if they don't have that coverage, whether an illness or tragedy could befall them that could wipe out everything they have—not only today but for the rest of their lives.

This journey begins. My hope is, before we have finished the task, we will find that common ground that we each bear responsibility to try and achieve.

Before we left for the Thanksgiving holiday, the Senate held a landmark vote on whether we should even debate health care. I must say a lot of attention was given to that. There must be a lot of confusion in the minds of many Americans, wondering why we had to debate whether we could debate. The one issue this body is known for is endless debate. We are not limited, under our rules of the Senate, at least not formally limited, by how much time we can consume when we want to talk. The filibuster is a unique practice which only the Senate has. So we had to vote as to whether we could actually have a vote. We had a debate on whether we could have a debate on the subject matter that is obviously of great concern, whether you agree or disagree.

I think all Americans agree the present system needs a lot of work. The vote we took simply stated that after decades of inaction, despite the efforts of others over the years, this time the Senate would not fail to deliver the change the people we represent across America want and need.

We now begin that long, overdue conversation over exactly what change should look like in the area of health care. There are, as has been made clear

over the past months, many different opinions on the subject matter, almost as many as there are Members of this body. I hope my fellow Senators are ready to share their thoughts, listen to the ideas of their colleagues and, most importantly, join together to act. The legislation we present for debate is designed to fix the things that are wrong with our system, while protecting and strengthening the things that are great about health care in America. As I have heard my colleague from Montana say on so many occasions, we are not out here to design or copy what goes on in Canada or Europe or Australia or New Zealand or any other country around the world. We are here to design an American health care plan, an American plan, one we are forging after listening to health care providers, our constituents, and others who have great interest in the debate and discussion and who bring very valuable facts to the table, as all of us, individually, even those not on the committee, have listened over many weeks and months—in fact, over many years that we have been debating this subject matter.

Our long history of innovation and discovery—cures, vaccines, and treatments, discovered and produced right here in our own country, that have saved countless lives here and around the world—is something for which every American ought to be proud. Our legislation, this combined bill, encourages that innovation so more groundbreaking medical discoveries can be made in America.

In fact, one of the debates that occurred in the HELP Committee, as my colleague and the Presiding Officer may recall, was on an amendment offered by Senator HATCH—no technical amendment—dealing with how to create a pathway for the Food and Drug Administration to approve follow-on biologics and how many years of exclusivity innovators should receive for their original product. We had a heated debate in the committee. It went on for a day or so. In a divided vote, the Hatch amendment was approved with bipartisan support for this very critical and important issue. No technical change, I might add, a significant part of this bill.

Our legislation recognizes that we do best by our citizens when the public and private sectors work together. It has been our history in so many areas, not just in this area.

Medicare, the ironclad commitment to take care of our seniors, dating back to 1965, when Members who preceded us in this Chamber, in a heated debate that went on for days, heated debate over whether we would have a health care program for seniors, decided not on a partisan vote but nearly as much, that there ought to be something called Medicare. It took the poorest sector of our population, the elderly, and lifted them out of poverty. Because we said: After their works on behalf of all of us, their defense of our Nation in two world wars, and their contribution coming out of a depression, we ought to be able to do better by them when it comes to their health care needs, Medicare was established. And despite what some critics have said, this legislation protects and strengthens Medicare. I hope even our friends who have taken to labeling government-run programs such as Medicare as socialist takeovers will join us in keeping this important promise to our seniors.

Of course, Americans are justifiably proud of and happy with our workforce of dedicated health professionals, the doctors, specialists, primary care physicians, compassionate nurses, dedicated medical technicians, and family doctors all across the Nation who make a difference every single day in serving the people of our Nation. This legislation is designed to guarantee that you can get the care you need when you need it from the doctor you like. Meanwhile, it will help that physician spend less time filling out redundant paperwork and more time taking care of you and your family. It will help you spend less time fighting with your insurance company and more time getting better and getting back on your feet again.

There are many things to like about our health care system in the United States. This legislation doesn't change them. There are many things that are wonderful about our health care system. I think it is important at the outset to acknowledge that and to understand, again, the quality of innovation that occurs, the compassionate work done by health care providers in every community. In my State, there are 31 hospitals, all nonprofit hospitals, in the State of Connecticut. I have visited all of them over the years, but I have gone back recently and almost completed a round of going to see them all about this bill, sitting down with rural hospitals in northeastern Connecticut to major urban hospitals in Bridgeport and Hartford. I wish I could take everyone with me to see what everyone does. I know this is the case in other States where people do a remarkable job every day. If you show up in a hospital, they treat you. No one gets turned away. It is a wonderful thing about our health care system, the people who work in them every single day, reaching out to try and make a difference in the lives of these individuals, and how frustrating it is for these health care providers.

I met with a group of ophthamologists in Hartford. One doctor was telling me how a family came to him the other night with a child that clearly needed a medical device and technology and knowing what a difference it could make for her. Yet that insurance company said: No, you can't do it; we don't provide that kind of coverage. The frustration that doctor expressed because he couldn't provide what that family needed. They didn't have the resources financially to pay for it, and they were being turned down. That child could not get that help. Under our bill that won't happen, if we can get this legislation done. Examples like that child happen every day across this great country of ours.

The high cost of health care has bankrupted millions of families. The system, in many ways, despite its strengths, is broken in too many places as well. Without reform, health care will continue to eat up larger and larger shares of budgets—the Federal budget, State budgets, business budgets and, of course, family budgets. Budgets, particularly family and business budgets, are at breaking points. The high cost of health care has bankrupted millions of families, shuttered the doors of businesses, forced States to make impossible choices, and put unimaginable strain on the Federal bottom line. If we don't address the skyrocketing cost of health care, more and more families, more and more businesses could lose everything and our deficit will explode. As bad as it is today, it gets worse if we do nothing.

That is the bigger picture. But the reality of our broken system can be captured by the tragedies that play out in American homes every single day. As we have discussed, tens of millions of our fellow citizens who don't have health insurance at all go to bed every single night knowing that if they wake up sick or their children wake up ill or in need of medical care, they might not be able to see a doctor to get the medical care they need. Many of these Americans don't have insurance because they can't get insurance, they have a preexisting condition, and no insurance company wants them on their rolls.

There are even more Americans who do have insurance but can't be sure of anything these days when it comes to their health care. They are paying more and more in premiums, twice what they paid even a decade ago. Yet they are getting less and less and less coverage for their money. They lie awake at night wondering, what if I lose my job, as many have over these last number of weeks and months, what if I get sick and find out my policy doesn't cover the care I need or, even worse, my insurance company cancels my policy altogether. What if I run out of benefits and have to pay out of my pocket. These are not irrational fears. They are anything but irrational fears. Millions of our fellow citizens have them every single day, and these nightmares come true for far too many of our citizens. People lose their homes because they get sick. People die because they can't afford care.

This does not happen to the 8 million of us who are Federal employees, all of

us who serve in this body and the 435 who serve in the other body. Like all Federal employees, we have a special marketplace. Every year each one of us gets to choose from a long menu of insurance options. We sit down. We pick a plan that makes sense for us and our families, and we know the coverage we have chosen will be there when we need it. Every American should have the same opportunity as the people who represent them in the Halls of Congress. That is what our bill tries to do.

For too long health insurance has been a seller's market. Depending upon where you live, you may or may not have more than one option or two options to choose from. Sometimes there aren't any good options at all. You pay whatever the insurance companies want to charge you, and you get whatever coverage they feel like giving you. You are covered only until they decide they don't want to cover you any longer. By the way, if you lose your job, or if you want to change your job, if you want to start a business, if you want to move, you could lose your coverage entirely.

Our bill is designed to help you get a better deal and empowers every American family to pick the plan that works for them, creating a real marketplace, like the one Federal employees have, that members of congress have, with multiple insurance companies competing for your business and a real choice for you and your family. If you like what you have now, great, keep it. If you don't, you will have more and better options to consider. If you are one of the millions of uninsured Americans who has been denied coverage because of a preexisting condition, you will immediately have access to affordable coverage so that you will have insurance while this marketplace is being established. In that marketplace, you will finally have a chance to find affordable insurance that works for you and your family. No matter who you are or which plan you choose, you will have less expensive options. Insurance will be available regardless of your age or your health. And once you have it, the insurance company won't be allowed to take it away. You stay covered even if you lose your job, even if you move, even if you get sick.

On the day this bill is enacted, health insurance becomes a buyer's market, not a seller's market. That is as American as apple pie, having choices, good old competition out there. So little of it exists today. Our bill is designed to promote and create more of it. When businesses have to compete for your business, we all do better. Businesses do well and, obviously, the consumer has better choices. As other pieces of the legislation begin to take effect, our health care system will become less expensive and more responsive to the needs of the American people. Because American families and businesses literally can't afford more of the status quo, our bill makes health care more affordable.

According to the Congressional Budget Office, if you are buying health insurance in the individual market under the senate bill, premiums may be up to 20 percent lower than equivalent coverage today. According to CBO, if you are buying health insurance in the individual market, you could see premium costs be as much as 20 percent lower than what they are today. If you are working for a small business, according to CBO, your premiums may be up to 11 percent lower than what they are today. And according to the Congressional Budget Office, if you work for a large employer, which five out of six Americans do, your premiums could be lowered by as much as 3 percent. In every single category—individuals, small businesses, as well as large employers—premium costs come down under our bill, according to the Congressional Budget Office.

Compare that to the status quo of doing nothing or defeating this bill. I can't speak for every State, but I suspect these numbers are probably pretty much true across the country. In Connecticut, in the year 2000, a family of four paid on average around $6 to $7,000 a year in health care premiums. Today that same family in my State, 9 years later, is paying over $12,000 for that same coverage. And if we do nothing in the coming days, those numbers will jump to around $24 to $25,000 in 7 years and as much as $35,000 in 10 years.

Compare that with what we offer here in this bill. The CBO says we can actually lower premium costs in the individual market, the small group market, and the large group market. That is what is in this bill. That is why it is deserving of our support.

Because investing in keeping people well is more cost effective than waiting to treat them when they get sick, this legislation puts a focus on prevention. Let me pay a particular tribute to Senator TOM HARKIN, now chairman of the HELP Committee, who spent a long time on the prevention piece of this bill, as I know the Finance Committee did as well, combining efforts to encourage more effort in reducing the tremendous problems that are associated with four or five illnesses that consume about 70 or 75 percent of the health care dollar. You can't wipe them out altogether, but by working on prevention, dealing with obesity, smoking, cardiovascular problems, you can make a difference in those areas alone.

I know my fellow members of the HELP Committee, we passed legislation—and my good friend MIKE ENZI was a part of this and a strong supporter on the floor of this body—when for the first time in America history, the Food and Drug Administration can now regulate tobacco products. They can regulate mascara, cat food, dog food, men's cologne, all of those things get regulated, but tobacco did not. We changed that. We finally have regulation of the sale, marketing, and the production of tobacco products by the Food and Drug Administration. That is $180 billion a year in health-care related costs. Four hundred thousand people die every year from smoking-related products; 3,500 young people today will start smoking in the United States; 1,000 will become addicted for life, 3,500 a day just in that one area. If we can reduce people's dependency on those products, if we can get people to quit, if we can stop children from starting in the first place, what a difference that can make for people all across the country. From diabetes screenings to quit smoking programs to mammograms, you will be able to get preventive care at no cost to you under this bill. That we do right off the bat so you can stay well even if your family is not wealthy.

Because our seniors should be able to afford the prescriptions they need to stay healthy, this bill will shrink the Medicare Part D doughnut hole, giving seniors a 50-percent discount on medications. That is a huge savings to our people. Because 200 million American adults don't have insurance protection in place to handle the cost of long-term services and supports, our bill creates a new program that will give American families peace of mind, help working people who are also taking care of a loved one, and save Medicaid dollars in State and Federal budgets.

Because we need our small businesses to do what they do best—create jobs—our bill alleviates their burden by providing a tax credit to help them cover the cost of providing health care to their employees, as so many of them want to do. And because a buyers' market depends on educated buyers, our bill will empower consumers by eliminating the fine print in insurance policies. You will be able to make an apples-to-apples comparison when shopping for health insurance.

Again, according to the Congressional Budget Office, families and businesses will save money because this new marketplace will bring down administrative costs, ensuring you get the most out of your premium payments and increased competition for your business—competition that is increased even further with a strong public option as well.

The analysis confirms that if you like the plan the way it is, the bill explicitly provides that you will be able to keep it. In fact, just so we are clear, let me quote from the CBO, the Congressional Budget Office, analysis released today. I quote them:

> [I]f they wanted to, current policyholders in the nongroup market would be allowed to keep their policy with no changes, and the premiums for those policies would probably

not differ substantially from current-law levels.

The CBO estimates that as the marketplace gets up and running, the deficit will go down by $130 billion in the first 10 years after this bill passes and by $650 billion more in the second decade.

This bill lets you keep your insurance if you like it, this bill protects seniors, this bill gives families more choice, and this bill saves money.

While I hope we can keep our facts straight, let me say at the outset that I expect this to be a full, open, and at times passionate debate in this Chamber, as it should be. This is an issue that represents a full one-sixth, as you have heard already, Madam President, of our economy, and it affects every single one of our citizens. Still, I understand that no matter how patiently and thoroughly we discuss this issue, some will, of course, insist we are attempting to rush through a piece of partisan legislation. Again, let's get our facts straight. Thus far, between the two committees responsible for drafting this bill, we have held more than 100 bipartisan meetings, devoted more than 20 days toward the amendment process, considered more than 400 amendments, and, despite what I have heard, we accepted 170 amendments offered by the minority, including some very substantive ones. Clearly, there were technical ones. I am not suggesting otherwise. But to suggest that all of these were such is not to portray an accurate picture of what occurred. The legislation we will now debate was made available online 72 hours before even a procedural vote was cast.

Well, Madam President, I am committed to ensuring every Senator has the opportunity to offer his or her suggestions. That is what we did in our committee. It took a long time. But while people may not have been happy with the final outcome, I believe people ought to have an opportunity to be heard and their ideas to be vetted here and to engage, I hope, in a civil debate, a passionate but civil debate, not to engage in the ad hominem personal attacks that too often have contaminated debate but, rather, you ought to stand or fail based on the soundness of your ideas.

My dear friend Ted Kennedy spent a lifetime, as I said at the outset of these remarks, fighting for every American's right for decent health care. It is a cause I know we all support. This is our chance to get it right.

This moment calls for commonsense problem-solving that cuts the cost of health care, protects patient choice, and ensures every American gets the care they need when they need it, from the doctors and providers of their choice.

This moment calls for compassion. We must finally hear the cry of the child whose ear infection goes untreated because his or her parents cannot find jobs and cannot afford a doctor; the voice of the small business owner who must choose between laying off workers and cutting off health benefits for them; the call of future generations who will see the rising tide of health care costs become a tsunami if we do not act in these days.

Perhaps most of all, this moment calls for courage. This bill does not necessarily guarantee a tickertape parade or a lot of applause lines. There are some very tough choices in this bill.

With the possible exception of the public option and a few other items, I suspect that if the roles were reversed here and we were sitting in the minority and our friends on the other side were in the majority, frankly, the bill we would be considering today might not be substantially different because, frankly, the options are not unlimited as to how to deal with costs and increased access and prevention. Yes, there are differences. I accept that and understand that. But the kinds of choices Senator BAUCUS and his committee made, and the ones we considered in our committee, were ones I believe most of my colleagues believe generally have to be dealt with: the quality of care, strengthening our workforce, dealing with the delivery system, increasing prevention and wellness in this country. What steps do we take? We can differ over this item or that, but I believe we generally believe these are items that must be part of a significant health care proposal. So I suspect these bills, were the roles reversed, might not be substantially different. It might not be that different.

Perhaps most of all, it is important we find the means to come together. The road we are on, the status quo, leads to ruin, in my view, for our economy and for our fellow citizens. The road to reform is a long and difficult one, but we have taken so many unprecedented steps just to come to this place. It is time now to finish the job.

So I am prepared—as I know our leader is and as I know my friend from Montana, the chairman of the Finance Committee, is, as are the members of that committee, as I believe most of our colleagues here—we would like a legacy to be left long after we have departed this Chamber that will say that in the first decade of the 21st century, when faced with the daunting challenge of doing something positive to increase the availability, increase the quality, and decrease the cost of health care in America, this Congress rose to the challenge and met its obligations. I feel optimistic we can achieve that.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I have a few small matters here before I yield to my friend from Iowa.

First, I cannot thank my colleague from Connecticut enough. He has worked so hard as the former chairman of the HELP Committee and now as a very active participant in the HELP Committee, along with Chairman HARKIN. I cannot thank him enough. The Senator from Connecticut has worked on health care in such a constructive way. I deeply appreciate his efforts.

Before I give up the floor, I wish to pay my strongest compliments to my colleague from Iowa, Senator GRASSLEY. Senator GRASSLEY is one heck of a guy. He represents his State, in my judgment, very, very well. As I am sure the Presiding Officer knows—certainly my colleague from Connecticut knows—we have worked very closely together, Senator GRASSLEY and I, on a nonpartisan basis as much as we possibly can because we both think—and I know most people think—good legislation is legislation where you work together, not where you are fighting each other.

Senator GRASSLEY and I started out trying to get this bill put together on a bipartisan basis working together. As it turned out, we did not quite get there. But I know in the end he would very much like to find a way to vote for health care reform, as most Members of the Senate would.

I am an optimist. I think most of us in this body are optimists. I have not given up yet. Who knows how this is going to evolve? Who knows what the amendments are going to be? Who knows what the votes are going to be in the next several weeks or so? But I am looking for an opportunity where Senator GRASSLEY and other very constructive Senators will join us, all together, in a way, with a little give and take here, perhaps, to find a solution.

So I just want to end by saying how much I appreciate the Senator. He does a super job.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, I thank the Senator from Montana for his kind remarks. He does describe the situation very well, particularly one where there was a very close working relationship during the summer and up until the middle of September, when people in this body felt we were not moving fast enough to get a product before the body, and so some of us were shoved to the side, not by Senator BAUCUS but by other people in this body.

I also compliment Senator DODD from this standpoint—that as I look at this 2,074-page bill we call health care reform, that as he described parts of this bill, I think you get a broad consensus that the things he talked about should be done. But that does not describe everything in this bill and it does not describe the opposition that comes to a certain part of this bill now, not only by Members of the body, but if you follow polls and town meetings

around the country, you find a lot of the people are having second thoughts about the words ''health care reform.''

I would suggest to you, if you were in a coffee shop in any small town of the United States and they were talking about health care reform, and I came into that coffee meeting and I said: The bill before the U.S. Senate is going to raise premiums, it is going to raise taxes, it is going to take hundreds of billions of dollars out of Medicare, and it is not going to do anything about the inflation of health care, I will bet you that people at the end of that would say: Well, that doesn't sound like health care reform to me.

Even though Senator DODD describes a lot of things that are neither Democratic nor Republican nor even bipartisan, there is kind of a consensus that these things ought to be done. He describes it accurately. But, still, a lot of goals that were sought by those of us who were negotiating these things over a period of several months—that we ought to have it be revenue neutral—and on the 10-year budget window, it is revenue neutral. But, remember, that is 10 years of increased taxes and 6 years of program to make that happen. So you raise the question, if it was 10 years of expenditures and 10 years of income, would it be revenue neutral? Well, obviously not. And it does not do anything about health care inflation. Those are two goals that were sought over a long period of time. This 2,074-page bill does not do that.

I believe the people of the United States think our country has the best doctors and nurses in the world. But as Senator DODD pointed out, there is widespread agreement that the health care system in America does have problems. Costs are rising three times the rate of inflation. Americans are uninsured. Millions more fear losing their insurance in a weak economy and because of preexisting conditions. Doctors are ready to close their doors over high malpractice costs and low government reimbursement. So everybody says we need health care reform. Everybody agrees on that very much.

But, today, the Senate begins debate on a bill—2,074 pages—that would make a bad situation worse. It is unfortunate that early efforts to reach bipartisan solutions in Congress deteriorated into leadership-driven, partisan exercises.

The bills in Congress slide rapidly down the slippery slope to more and more government control of health care. They contain the biggest expansion of Medicaid since it was created 43 years ago. They impose an unprecedented Federal mandate for coverage, backed by enforcement authority of the Internal Revenue Service. They increase the size of government by $2.5 trillion when fully implemented. They give the Secretary of Health and Human Services extraordinary powers to actually define benefits for every private health plan in America and to redefine those benefits annually. They create dozens of new Federal bureaucracies and programs to increase the scope of the Federal Government's role in health care. That is a lot of power over people's lives, and it is concentrated here in Washington, DC, in the Federal Government.

The excesses of the bill appear willfully ignorant of what is going on in the rest of the economy outside of health care. These excesses make the bill far worse than doing nothing.

At this point in our Nation's history, we are a nation facing very challenging economic times—some people would say the great recession, not quite the Great Depression; other people would say the worst recession we have had since 1982. What have we seen? We have seen the auto industry go into bankruptcy. We have seen banks shutter their doors.

I have a chart that is up. We call it the wall of debt chart. The Federal debt has increased by $1.4 trillion just since inauguration. This chart shows the growing amount of debt the Federal Government is taking on. The amount of increased debt added just since the inauguration is $11,500 per household. It now exceeds $12 trillion for the first time in history.

Within 5 years, the Obama administration's policies will more than double the amount of debt held by the public, and by 2019 it will more than triple the debt. That is not according to this Senator but according to the Congressional Budget Office and the White House Office of Management and Budget. Already, foreign holdings of U.S. Treasurys stands at nearly $3.5 trillion or 46 percent of the Federal debt held by the public. In other words, people outside of this country are holding 46 percent of our Federal debt.

At the beginning of this debate, one of the key promises of health care reform was—and I said this previously, but I will repeat it now—that it would bring down Federal health costs. This needs to be done before health spending sinks the Federal budget and saddles the taxpayer.

I have another chart, a health spending chart or, more accurately, a Federal health spending chart. As this chart illustrates, this bill bends the Federal spending curve further upward by $160 billion over the next decade. The red area of this chart, emphasizing the red area of the chart, shows net additional Federal health spending—again, not according to this Senator but according to the Congressional Budget Office.

Americans have rightly lost faith when, in the face of the current economic crisis—the ''great recession''—Congress thinks this $2.5 trillion restructuring of our health care system is a good idea.

The Reid bill also includes a government-run plan. A government-run plan would drive private insurers out of business and lead to a government takeover of the health care system. From rationing health care to infringing on doctor-patient relationships, a government-run system would guarantee U.S. taxpayers a staggering tax burden for generations to come.

The government cannot be a regulator, a funder, and a competitor at the same time without doing a great deal of damage to what the private sector has been doing for 60-some years. A government-run plan is not necessary for health care reform unless perchance the goal is to put in place the power of the Federal Government to drive down costs by—how? Not just driving them down but the consequences of that: rationing care and slashing payments to providers. These problems are bad enough, but much worse is that this bill—this bill—fails to solve the fundamental problems in health care. None of them take serious steps to reduce costs in health care.

The bills will cause health care premiums for scores of people to go up, not down. An analysis just released this very day by the Congressional Budget Office confirms our worst fears about the impact this bill will have on people's health insurance premiums. According to the Congressional Budget Office, the new benefit mandates and regulatory changes will actually increase costs of nongroup health insurance for individuals and families by 10 to 13 percent. That means millions of people who are expecting lower costs as a result of health care reform will end up paying more in the form of higher premiums. For large and small employers that have been struggling for years with skyrocketing health insurance premiums, the Congressional Budget Office concludes this bill will do little, if anything, to provide relief.

In fact, they cover their increased premiums they cause by spending even more on subsidies because of the increased premiums. So what happens? They do this by handing over close to $500 billion in hard-earned taxpayer dollars directly to health insurance companies. That sure doesn't sound as though this bill is actually reforming the market. The nonpartisan Congressional Budget Office analysis makes clear the Reid bill is not fixing the problem.

The Reid bill also imposes new fees and taxes that will be pushed directly to the consumer. These new fees and taxes will total about one-half trillion dollars over the next few years. On the front end, these fees and taxes will cause premium increases beginning next year when they go into effect, and those new fees increase premiums—for 4 years; they are there for 4 years—before most of the reforms take effect in 2014.

Then after forcing health premiums to go up, the legislation makes it mandatory to buy health insurance. Let's

think about mandatory health insurance. The Federal Government is a government of limited powers under the 10th amendment. To my knowledge—and I think I know a lot about U.S. history—never in 225 years has the Federal Government said you had to buy anything. You don't have to buy—you buy what you want to buy in America, but not when this 2,054-page bill goes into effect. Then you will buy health insurance.

Somebody is going to throw at us: Well, the States make you buy car insurance, and probably most States do. My State of Iowa does. But under the 10th amendment, the State governments have a lot of power the Federal Government doesn't have.

The Reid bill also makes problematic changes to Medicare. It imposes higher premiums for prescription drug coverage on seniors and the disabled. The Reid bill creates a new independent Medicare board with broad authority to make further cuts in Medicare, and this bill makes that commission permanent. The damage this group of unelected people could do to Medicare is, in fact, unknown.

What is more alarming is that so many providers got exempted—they have political power, so they got exempted from the cuts this board would make—that it forces the cuts. Then what happens? They fall directly and disproportionately on seniors and the disabled.

Sooner or later, it has to be acknowledged that by making this board permanent, those savings are coming more and more—are going to bring more and more cuts to Medicare. That is a good example of the philosophical differences between the two sides in this body, and as the country divides itself more against this 2,054-page bill than for it, but still a large number of people in America support going in this direction. So those are philosophical differences between the two sides.

There are alternatives. Some of us want to reduce the overall cost of the legislation. We want to try to reduce the pervasive role of government, make it harder for undocumented workers to get benefits, allow alternatives to the individual mandate and harsh penalties, and add medical malpractice reforms. I bring a little bit of emphasis to medical malpractice reform because at my town meetings throughout this past year and particularly during the month of August people would say: Why don't you first try to save money in health care costs by taking on the lawyers and doing medical malpractice reform? But, instead, the prevailing view is to move millions of people from private coverage into public coverage and create new government programs that cover families making close to $90,000. Yet, even with all of these changes, after raising one-half trillion dollars in new taxes, cutting one-half trillion dollars in Medicare, imposing stiff new penalties for people who don't buy insurance, and increasing costs for those who do—after all of these changes, the Congressional Budget Office says there are still 24 million people who will not have health insurance under the Reid bill.

I don't think this is what the American people had in mind when the President and the Congress promised to fix the health care system.

It is not too late for bipartisan legislation, so I have the hope that Senator BAUCUS just expressed before I spoke that builds on common ground to improve coverage, affordability, increased quality, and decreased costs. So here are some more alternatives. I have worked for years on bipartisan legislation that would transform Medicare from paying for volume of services provided to the quality of care delivered. There is also widespread support for stronger rules on insurance companies to make coverage more affordable and accessible, especially for small businesses and for people who aren't offered coverage by their employers, and for reforms to stop denials of coverage due to preexisting conditions. Tort reform would reduce abusive lawsuits that drive up costs and surely limit access to doctors. The nonpartisan Congressional Budget Office estimates that comprehensive medical liability reform would reduce Federal budget deficits by roughly $54 billion over the next 10 years. It would save even more when nonfederal health spending is taken into account. That would mean lower premiums for individuals and families.

So far the Democratic leaders in Congress have little interest in creating an environment where doctors don't have to engage in defensive medicine just to keep their practices open because somebody might sue them. The medical community should continue to make the case for reasonable reforms that will cut down on unnecessary medical tests that serve no purpose except to reduce malpractice premiums and to protect against frivolous lawsuits.

On several occasions, Republicans tried to take the legislative substance in a whole different direction. We tried to ensure the President's pledge not to tax middle-income families, seniors, and veterans was carried out. However, we were rebuffed at every step of the way. Republicans' efforts to provide consumers with a lower cost benefit option were consistently defeated. That means despite the promise, a lot of people are not actually going to be able to keep what they have as they were promised in the last Presidential campaign.

The Democratic leaders in Congress are advancing their extremist health care reform bills with a bare minimum of votes to do the job. I disagree with that approach. Health care is one-sixth of the economy. That is as large as the entire British economy. The legislation Congress is considering will affect every American at every level of health and at every stage of employment. When the debate began last year—in fact, it was just this month of November that I remember 8 or 10 of us from different committees met with a solemn pledge. We were going to work together in a bipartisan way to get this job done. We met again for the next 6 months several times, but it just didn't work out.

But when that debate began last year, interested legislators of both parties set benchmarks that were no-brainers:

Health care reform should lower the cost of premiums. It should reduce the deficit. It should bend the growth curve in health care the right way—downward. The Reid bill doesn't do any of these things.

It is not too late to start over. I guess Senator BAUCUS has put forth that invitation. I hope it materializes. If both sides can set aside some philosophical differences, and if the Democratic leaders are willing to refocus on the principles that brought us to the table months ago, I believe we can produce health care reform that improves the quality of life for Americans who are suffering under the current health care system and doesn't degrade the quality of life for everyone else.

But it is not the entirety of this 2,074-page bill. These issues can be addressed without upending the entire health care system, with the result of higher taxes, higher insurance premiums, and deficits and debt that will get in the way of opportunities that result from the ingenuity and productivity and industry of the American people.

I get back to that coffee shop meeting, where people are discussing health care reform. As I walk into that coffee meeting and I tell them that this 2,074-page bill increases taxes, increases premiums, takes 400 or more billion dollars out of Medicare, and it doesn't do anything about controlling costs, according to the Congressional Budget Office, that group again will say: That doesn't sound like health care reform to me.

As we start this debate this week, I urge my colleagues to listen to the American people. The Reid bill is in the wrong direction.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

MOTION TO COMMIT

Mr. MCCAIN. Madam President, I ask unanimous consent to send to the desk at this time a motion to commit with instructions.

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

The clerk will report the motion.

The legislative clerk read as follows:

The Senator from Arizona [Mr. McCAIN] moves to commit the bill H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that do not include the following:

(1) Medicare Advantage cuts totaling −$118.1 billion.

(2) Medicare Advantage payment changes totaling −$1.9 billion.

(3) Provider cuts totaling −$150.0 billion.

(4) The establishment of the Independent Medicare Advisory Board totaling −$23.4 billion.

(5) Reporting requirements for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs totaling −0.2 billion.

(6) Penalties to hospitals totaling −1.5 billion.

(7) The expansion of CMS spending totaling −1.3 billion

(8) A Medicare shared savings program totaling −4.9 billion.

(9) Hospital penalties totaling −7.1 billion.

(10) A revision to the Medicare Improvement Fund totaling −22.3 billion.

(11) Home health care cuts totaling −42.1 billion.

(12) Hospice payment changes totaling −0.1 billion.

(13) Medicare disproportionate share hospital payments changes totaling −20.6 billion.

(14) Cuts to advanced imaging services totaling −3.0 billion.

(15) A revision of the payment for power-driven wheelchairs totaling −0.8 billion.

(16) Cuts for certain medigap plans totaling −0.1 billion.

(17) A reduction in the part D premium subsidy for high-income beneficiaries totaling −10.7 billion.

(18) Outpatient prescription drug cuts in long-term care facilities totaling −5.7 billion.

(19) Changes to preventive services in Medicare totaling −0.7 billion.

(20) A limitation on the Medicare exception to the prohibition on certain physician referrals for hospitals totaling −0.7 billion.

(21) Comparative effectiveness research totaling −0.3 billion.

(22) The elimination of indexing for part B premiums totaling −25.0 billion.

And reflects the Sense of the Senate that any savings to the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) by reason of the provisions of, and amendments made by, sections 6401, 6405, 6407, and 6410 should be used to strengthen the Medicare program under title XVIII of such Act.

Mr. McCAIN. Madam President, simply put, this motion to commit would be a requirement that we eliminate the one-half trillion dollars in Medicare cuts that are envisioned by this bill—one-half trillion dollars in cuts that are unspecified as to how, and one-half trillion dollars in cuts that would directly impact the health care of citizens in this country—Medicare Advantage cuts totaling $118 billion; an independent Medicare advisory board that would cost $23 billion; an expansion of Medicare hospital penalties totaling $7.1 billion; home health care cuts totaling $42.1 billion; and hospice—of all the things—payment changes. The list goes on and on.

All of these are cuts in the obligations we have assumed and that are the rightful benefits people have earned—particularly our senior citizens—across this Nation. This eliminates one-half trillion dollars in cuts to Medicare that are cuts that are unspecified.

I eagerly look forward to hearing from the authors of this legislation as to how they can possibly achieve one-half trillion dollars in cuts without impacting existing Medicare programs negatively and eventually lead to rationing of health care in this country. That is what this motion is all about. This motion is to eliminate those unwarranted cuts. All of us know there are enormous savings in fraud, abuse, and waste that can be identified. No expert I know of believes that would come up to one-half trillion dollars. Hospitals are cut by $105 billion. Nursing homes are cut by $14.6 billion. Hospices are cut by $7.6 billion.

These are not attainable cuts, without eventually rationing health care in America and rationing health care for our senior citizens, who have earned these benefits, and we have guaranteed them these benefits.

For the life of me, how the AARP can support this 2,000-page legislation is beyond my imagination. Seniors all over America, including Arizona, including the 330,000 senior citizens in my State who are under the Medicare Advantage Program, which will be drastically cut by some $120 billion, are outraged. The more they find out about it, the more angry they are becoming.

Here we are, as my colleague from the great State of Iowa, a leader on health care, articulated, with a totally partisan measure before the Senate, in which no Member on this side of the aisle has been consulted in any way. I point out that, historically, there has never been a major reform implemented by the Congress of the United States unless it is bipartisan in nature, and I don't believe the American people want this 2,000-some-page monstrosity, which is full of all kinds of provisions that they are either unaware of, or even in the study of this legislation, many of us have also become unaware of. But fundamentally, the Bernie Madoff/Enron accounting that has been going on with this bill is dependent upon envisioning one-half trillion dollars in cuts that are not attainable. If they are attainable, it would mean a direct curtailment and reduction of the benefits we have promised the senior citizens of this country. That is not acceptable.

What this motion to commit does is send it back to the Finance Committee: Come back with another bill. Only this time, don't put the cost of it on the backs of senior citizens of this country. Don't do it. It was back last summer, 3 months before he was elected President, on a campaign stop not far from Washington, DC, now-President Obama vowed not only to reform health care but to do it in a new way. He said:

> I am going to have all the negotiations around a big table, televised on C–SPAN, so that people can see who is making arguments on behalf of their constituents and who are making arguments on behalf of the drug companies or the insurance companies.

Americans wanted to believe this would be true. Republicans offered to work with the majority on our ideas. But that was rejected. So what has happened? Business as usual. Let me read from a report of this past weekend about business as usual:

> The Associated Press has moved a story saying that health care lobbyists and other interests have made 575 visits to the White House between January and August. The report is based on records released by the White House on Wednesday.
>
> The timing of the release smells of a classic Washington tactic—dumping bad news on the getaway day before a long weekend. Clearly, the White House, which prides itself as being the most transparent administration in the history of the world, hopes this nugget gets lost over the four-day Thanksgiving weekend.

AP's Sharon Theimer:

> Top aides to President Barack Obama have met early and often with lobbyists, Democratic political strategists and other interests with a stake in the administration's national health care overhaul, White House visitors records obtained Wednesday by the Associated Press show.

All of my fellow citizens watching, I urge you to call the White House and say you want to have an appointment to meet with the President or members of the administration in the White House. Five-hundred-seventy-five special interests were able to get in. Why can't you? Give them a call. Tell them you want to meet with the members of the administration. That is what 575 lobbyists have been able to do. Give them a call.

Continuing to quote:

> The records show a broad cross-section of the people most heavily involved in the health care debate [except for average citizens] weighted heavily with those who want to overhaul the system.

It talks about who were among them.

> The list also includes George Halvorson, chairman and CEO of Kaiser Health Plans; Scott Serota, president and CEO of Blue Cross and Blue Shield Association; Kenneth Kies, a Washington lobbyist who represents Blue Cross/Blue Shield, among other clients; Billy Tauzin, head of PHARMA, the drug industry lobby; and Richard Umbdenstock, chief of the American Hospital Associations.
>
> Several lobbyists for powerful health care interests, including insurers, drug companies, and large employers also visited the White House complex, the records show.

Again, citizens, why don't you call the White House and ask for an appointment? The lobbyists and special interests—big donors—get it. They are not ambassadors. They are lobbying the White House on this issue.

Health care reform should have been about both sides sitting down together and fixing what is broken, reducing health care costs, while preserving the highest quality health care in the world.

Somewhere in the course of this debate, in the process of this legislation, we have lost sight of the fundamental problem with health care in America, and that is the cost of health care in America, not the quality. This legislation will destroy the quality and the availability, if the cuts envisioned in this legislation—this Enron accounting measure, where the first 4 years after this legislation—suppose this legislation were signed on the 1st of January by the President of the United States. Immediately benefits will begin being cut. Immediately taxes will go up. Guess what. None of the benefits will be given to any American citizen for 4 years. That is how you get deficit neutrality. That is how you get deficit neutrality.

If you started giving the benefits at the same time you raise the taxes, you have got about $1.3 trillion in deficit in a $2.5 trillion bill—a $2.5 trillion piece of legislation. Here we are with the highest deficits in history, with deficits and debt as far as the eye can see, with a stimulus package that has done so well that we now have 10.2 percent unemployment, and many predict it will go even higher. Wall Street is doing fine, and lobbyists are doing fine. Mr. Tauzin, the PhRMA lobbyist, is doing fine. I understand his salary is a couple million dollars a year, not to mention all the other perks. But the average citizen, including the 330,000 citizens of my State, who have the Medicare Advantage Program, are going to see it cut and cut over and over again—about $120 billion worth.

So what happened? The White House engaged in the tradition of handing out favors to special interests, including PhRMA, AARP, and AMA. Shame on AARP and shame on the AMA. We know there are many commonsense reforms that Americans want.

By the way, in this monstrosity, find me any significant, real medical malpractice reform. The threat of medical malpractice causes physicians to practice defensive medicine. The CBO estimates it would be roughly a savings of $54 billion over 10 years. That does not take into consideration the cost of defensive medicine that doctors have to practice because of fear of being sued.

I ask the distinguished chairman of the committee: Where is any meaningful medical malpractice reform in this 2,000-page bill? Where is it?

I had a townhall meeting the other day in Arizona, as I do quite frequently. There were a lot of doctors, nurses, and caregivers who came. I asked them: What do you do about medical malpractice reform? Every one of them said: We practice defensive medicine. We prescribe additional tests and procedures. We have to do it because we will find ourselves in court by the trial lawyers.

Do not underestimate, I say to my friends, the many special interests and their influence in this legislation, but do not underestimate the stunning success of the American Trial Lawyers Association that has made sure there is no provision in this bill that has to do with medical malpractice reform.

By the way, if there is an example, it is called the State of Texas. The State of Texas enacted meaningful and yet not draconian medical malpractice reform. Premiums have gone down. Cases have gone down. Doctors are flooding back into the State of Texas. It has worked.

We are going to hear from the other side that there may be demonstration projects, there may be this, there may be that. The demonstration project is the State of Texas. That is all we have to do. It has already been proven.

Instead of a reform which could save tens if not a couple hundred billion dollars, what are we going to do? We are going to cut hospitals by $505 billion, nursing homes by $14.6 billion, hospices by $7.6 billion, and the list goes on and on, up to one-half trillion dollars. My motion will send it back to the Finance Committee and tell them to remove these unnecessary, unneeded, unwanted, harmful cuts in the Medicare system, which will not allow us to fulfill our obligation to the senior citizens of this country.

Buried in this partisan legislation, as I mentioned, are 10 years of tax increases and Medicare cuts, a total over $1 trillion. Using CBO numbers, this stack of partisan legislation costs $2.5 trillion over its 10-year implementation.

Let me put this in different terms for you. Suppose you want to buy a house. You go and buy the house, but the terms of the contract of purchasing the house say you have to make payments on the house for the first 4 years and then after 4 years you can move in. That is why this is Bernie Madoff accounting. It is a sham. It is a sham. It is a sham to make people pay taxes and have their benefits cut for 4 years and then only after 4 years do the benefits kick in. That is the way, with this kind of accounting, they get to deficit neutral. It is crazy. It is crazy.

The increased taxes and Medicare cuts begin impacting Americans and our economy in 32 days, if this is passed. Let me repeat this. Starting in January 2010, just 1 month from now, the majority begins tax increases and Medicare cuts, starting in January, and incredibly delays implementation of this bill for 4 years. That is 1,460 days and 208 weeks of new taxes and Medicare cuts before implementation. That is playing games with the American people.

If they were not playing games by delaying implementation of the bill 4 years after the tax increases and Medicare cuts, we would not even be discussing this pile of legislation because it would be scored as adding over $1 trillion to our deficit.

If the other side wanted to be honest and reject the Madoff-Enron accounting, they would be talking about the first 10 years of real costs and the first 10 years of their tax increases and Medicare cuts.

The respected dean of the Washington press corps, David Broder, pointed this out just last week in his column in the Washington Post entitled ''A Budget-Buster in the Making.'' By the way, the majority leader then felt compelled to come down and trash one of the most respected columnists in America whom I don't need to take the time to defend; he can defend himself and so will many others who have great respect for David Broder.

David Broder's column said:

It's simply not true that America is ambivalent about everything when it comes to the Obama health plan.

The day after the Congressional Budget Office gave its qualified blessing to the version of health reform produced by Senate Majority Leader Harry Reid, a Quinnipiac University poll of a national cross section of voters reported its latest results.

. . . by a 16-point margin, the majority in this poll said they oppose the legislation moving through Congress.

Broder went on to say:

I have been writing for months that the acid test for this effort lies less in the publicized fight over the public option or the issue of abortion coverage than the plausibility of its claim to be fiscally responsible.

This is obviously turning out to be the case. While the CBO said that both the House-passed bill and the one Reid has drafted meet Obama's test by being budget-neutral, every expert I have talked to says that the public has it right. These bills, as they stand, are budget-busters.

Here, for example, is what Robert Bixby, the executive director of the Concord Coalition, a bipartisan group of budget watchdogs, told me: ''The Senate bill is better than the House version, but there's not much reform in this bill. As of now, it's basically a big entitlement expansion, plus tax increases.''

These are nonpartisan sources, but Republican budget experts such as former CBO director Douglas Holtz-Eakin amplify the point with specific examples and biting language. Holtz-Eakin cites a long list of Democratic-sponsored ''budget gimmicks'' that made it possible for the CBO to estimate that Reid's bill would reduce federal deficits by $130 billion by 2019.

Perhaps the biggest of these maneuvers was Reid's decision to postpone the start of subsidies to help the uninsured buy policies from mid-2013 to January 2014—long after taxes and fees levied by the bill would have begun.

Even with that change, there is plenty in the CBO report to suggest that the promised budget savings may not materialize. If you read deep enough, you will find that under the Senate bill, ''federal outlays for health care would increase during the 2010–2019 period''—not decline. The gross increase would

be almost $1 trillion—$848 billion, to be exact, mainly to subsidize the uninsured. The net increase would be $160 billion.

But this depends on two big gambles. Will future Congresses actually impose the assumed $420 billion in cuts to Medicare, Medicaid and other federal programs? They never have.

Why don't we tell the truth to the American people and take these supposed cuts out of this bill? Tell them the truth about what it costs and tell them the truth that this is a dramatic expansion of entitlements, but at the same time those presently eligible, those senior citizens, such as the 330,000 who are under the Medicare Advantage Program in my home State of Arizona, will not see that program maintained. You cannot reach these kinds of savings, these kinds of reductions, these kinds of cuts without impacting existing programs. I know of no expert who says it will who is an objective observer. I believe Dr. COBURN, Dr. BARRASSO, and others in the medical profession will say the same thing. Every time Congress has enacted so-called cuts in Medicare or contemplated it, they have never taken place.

That doctor fix? We took care of that problem. We just took it out of the bill. But you know what we are going to do about the doctor fix. Every year we are going to delay it, delay it and delay it and it will never happen. That has been the history of the so-called doctor fix since its beginning.

And will this Congress enact the excise tax on high-premium insurance policies (the so-called Cadillac plans) in Reid's bill? Obama has never endorsed them, and House Democrats—reacting to union pressure—turned them down in favor of a surtax on millionaires' income.

The challenge to Congress—and to Obama—remains the same: Make the promised savings real, and don't pass along unfunded programs to our children and our grandchildren.

That means taking this legislation back, taking out these cuts in Medicare and programs that are vital to the citizens of this country and come back with a realistic—a realistic—piece of legislation that has malpractice reform, the ability to go across State lines to get the health insurance policy of your choice, rewards for wellness and fitness, expansion of health savings accounts, and medical malpractice reform.

There are many cost-saving measures we can enact to bring the cost of health care in America under control and preserve quality. Instead, we are doing the opposite.

If you are going to make these kinds of cuts—the $420 billion in cuts to Medicare and Medicaid and other Federal health programs—then you are going to impact the provision of health care in America.

Americans have been clear overspending has to stop, nor do the American people believe empowering Washington bureaucrats in a new Federal health care entitlement is health care reform. The other side disregards the message from the American people all across the country, and the bill does the opposite.

I wish to talk just for a minute about a provision in this bill that is very important; that is, the transfer of power, the massive transfer of power in this bill to the Secretary of Health and Human Services. This is a huge transfer. ''HHS would become federal giant under Senate plan'' by Susan Ferrechio:

A quick search of the Senate health bill will bring up ''secretary'' 2,500 times.

That's because Health and Human Services Secretary Kathleen Sebelius would be awarded unprecedented new powers under the proposal, including the authority to decide what medical care should be covered by insurers as well as the terms and conditions of coverage and who should receive it.

I wish to repeat that. In this bill, the Secretary has the ''authority to decide what medical care should be covered by insurers as well as the terms and conditions of coverage and who should receive it.''

We saw a little precursor of that the other day with, for example, recommendations concerning mammograms. A board recommended that women under 50 should not get routine mammograms. Of course, the response was incredible and justified. Women all over America are now alive today because they had mammograms prior to the age of 50. The Secretary of Health and Human Services said that would not be carried out, et cetera. We are creating a situation where the Secretary of Health and Human Services and a board would decide that.

''The legislation lists 1,697 times where the Secretary of Health and Human Services is given the authority to create, determine or define things in the bill,'' said Devon Herrick, a health care expert at the National Center for Policy Analysis.

For instance, on Page 122 of this 2,079-page bill, the secretary is given the power to establish ''the basic per enrollee, per month cost, determined on average actuarial basis, for including coverage under a qualified health care plan.''

The HHS secretary would also have the power to decide where abortion is allowed under a government-run plan, which has drawn opposition from Republicans and some moderate Democrats.

And the bill even empowers the department to establish a Center for Medicare and Medicaid Innovation that would have the authority to make cost-saving cuts without having to get the approval of Congress first.

''It's a huge amount of power being shifted to HHS, and much of it is highly discretionary,'' said Edmund Haislmaier, an expert in health care policy and insurance markets at the Heritage Foundation, a conservative think tank.

Haislmaier said one of the greatest powers HHS would gain from the bill is the authority to regulate insurance. States currently hold this power, and under the Senate bill, the federal government would usurp it from them. This could lead to the federal government putting restrictions and changes in place that destabilize the private insurance market by forcing companies to lower premiums and other charges, he said.

''Health and Human Services doesn't have any experience with this,'' Haislmaier said. ''I'm looking at the potential for this whole thing to just blow up on people because they have no idea what they are doing. Who in the Federal Government regulates insurance today? Nobody.''

''The health care reform legislation would rely on the U.S. Preventive Services Task Force for recommendations as to what kind of screening and preventive care should be covered. Last week, the group, which operates under HHS, drew sharp criticism for advising that mammograms should begin at age 50, a decade later than the current standard.''

''Critics of the bill said this was an example of how the new bill could empower HHS to alter health care delivery, but Democrats argue they would rather have the government making these decisions.''

That is the key to it. They would rather have the government making these decisions. If you like the way the post office is run, you will love the way HHS runs health care in America.

I understand the amendment of the other side may address some of this, but under the Reid bill the Senate moved to consider, beginning in 32 days, the language from the bill on page 1,189 authorizes the Secretary to modify benefits under Medicare pursuant to task force recommendations. As I mentioned, how many women would have died if the coverage provisions guiding the new Federal plan under mammograms had been implemented? Then, on the following page, 1,190, the Secretary is authorized to deny payment for prevention services that the task force recommends against. So if this unelected panel changes the preventive recommendation for some other type of cancer, the Federal Government plan would not cover it. I don't think the American people want their health coverage decisions coming from a panel in Washington.

The Reid bill drives up costs and premiums. Just today the CBO released its assessment of what will happen to health insurance premiums under the new entitlement compared with premiums today. The CBO dealt a blow to claims the health care bill introduced by Senator REID will lower premiums when they released an analysis showing that premiums will go up significantly in the individual market. Premiums for individuals without employer-sponsored coverage would increase 10 to 13 percent or $2,100 per family in 2016. The Democrats' bill therefore requires individuals to purchase insurance that is more expensive than would be available under current law. For small businesses and employers, the bill largely preserves the status quo and does little if anything to lower the cost. In fact, CBO estimates that under the Reid bill the average family with employer-sponsored coverage will soon pay more than $20,000 per year for health insurance.

President Obama said the following during the campaign:

I have made a solemn pledge that I will sign a universal health care bill into law by the end of my first term as President that will cover every American and cut the cost of a typical family's premium by up to $2,500 a year.

Well, CBO's analysis shows that the President is breaking that pledge by both failing to achieve universal coverage and raising premiums, just as it contradicts an analysis by MIT economist John Gruber released by the White House this weekend claiming that individual premiums would go down. In fact, even with the generous assumptions made by CBO in a number of areas, premiums will either go up or remain unchanged.

From the CBO report just today, CBO says premiums in the individual market would be 10 percent to 13 percent higher in 2016 than under the current law. Average premiums would increase by $300 for an individual policy and by $2,100 for a family policy. The new benefit and coverage mandates actually drive up premiums by 27 to 30 percent, and this increase is offset by other factors, such as new administrative efficiencies.

CBO says that little more than half of enrollees in the individual market would receive a government subsidy. However, the bill before us would still require nearly 14 million Americans to purchase unsubsidized insurance that is more expensive than they have today.

President Obama has promised that seniors will not see a reduction in benefits. In fact, he said recently:

People currently signed up for Medicare Advantage are going to have Medicare with the same level of benefits.

How did he get there? How do you get there when you are cutting Medicare Advantage by $120 billion? There is no math—old or new—that gets you to no change in the benefits that they have under Medicare Advantage and yet cutting $120 billion. Traditional Medicare doesn't offer coordinated benefits that can improve the quality of care. Traditional Medicare doesn't have many of the aids or benefits for our seniors.

President Obama has also promised several times, "If you like what you have, you can keep it." The American people took those words as a promise that if they had a health benefit they were happy with, they could keep it. I want to make sure we are helping the President keep his promise. I want to help him keep his promise by sending this bill back, taking out the cuts that are in it on Medicare, on the $105 billion cuts to hospitals, nursing homes by $14.6 billion, hospices cut by $7.6 billion, Medicare Advantage by $120 billion. I want to send it back to the Finance Committee and come back with a bill that the American people can believe in that will preserve the solemn obligations we have made to our senior citizens.

Medicare Advantage provides the only choice in the Medicare Program allowing an option for seniors who want additional benefits or a better option. Medicare Advantage is working for nearly 11 million seniors to give them a choice about their health care and better benefits. As I mentioned, 330,000 beneficiaries in my State of Arizona are in Medicare Advantage, and they will see benefit reductions or their plan disappear. Eighty-nine percent of seniors need and have some form of supplemental coverage on top of Medicare to provide protections against out-of-pocket costs or additional benefits. Many low-income Americans and minorities rely on Medicare Advantage as their supplemental coverage.

Some have claimed that cutting the "extra payments" to Medicare Advantage plans reduces insurance company profits. Under Federal law, that is simply not the case. The fact is, 75 percent of those "extra payments" go directly to better benefits for seniors under current law. The other 25 percent goes back to the Federal Government. Unfortunately, those extra benefits will be taken from seniors who are enrolled in Medicare Advantage.

This bill contains $120 billion in direct cuts to private Medicare plans. Common sense says you can't do that without affecting benefits. The Congressional Budget Office thinks so as well. CBO assumes the Reid bill will cut benefits by more than half, from an average of $98 in additional benefits to $41 a month.

I see one of my colleagues is waiting to speak, but I hope the American people will understand what we are trying to do. All we are trying to do is send this back to be reworked, to be fixed on a bipartisan basis, and not to force $400-some billion in cuts and benefits that we have promised the American people. We want to send it back and come out with a bipartisan approach. Sit down, for the first time, Republicans and Democrats, have the C–SPAN cameras rolling—the way the President promised he would a year ago last October.

Let's sit down together and figure out how we can fix this.

The best way to fix it is to preserve the quality of health care in America and bring down the cost, not to pass a 2,074-page monstrosity that is full of the measures that would impair the ability, particularly of our senior citizens, to keep the benefits they have earned and we have promised them.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. CASEY. Madam President, I rise to speak about health care, as we begin the debate in the Senate. I am grateful we are finally at this point where the Senate at long last will be debating our health care bill. It has been a long time in coming. Some of us have waited years, some have waited for decades to be at this point in our history.

On the Senate floor now is the Patient Protection and Affordable Care Act, and we are going to be discussing various aspects of that over the next couple of weeks.

I am reminded, as I rise today, of something Hubert Humphrey said a long time ago. He said the test of the government is how it treats those in the dawn of life—our children—those in the shadows of life—those who have challenges in their life, as we try to help them—and those in the twilight of life—older citizens across America. In large measure, we will be talking about each of those Americans in one way or another and a lot of other Americans as well. I rise to speak of our children but also to spend a couple of moments talking about older citizens, especially in light of some of the arguments made most recently on the Senate floor.

I will start with our older citizens. I come from the State of Pennsylvania where in our little State, with more than 12 million Pennsylvanians, we have almost 1 million Pennsylvanians over the age of 65. We have a very high number of Pennsylvanians on Medicare and also a lot of families who rely upon that kind of health care coverage, as we have for many generations. So when we speak of those in the twilight of life, we speak of many Americans who are covered by Medicare.

I want to make a couple of points about the bill that is on the floor now. First of all, with regard to older citizens, a couple of basic points on which I will provide a little more background. First of all, this bill, as it relates to Medicare, will protect Medicare's already guaranteed benefits. The bill also reduces premiums and copays for older citizens. It will ensure that older citizens can keep their own doctor or doctors with whom they have developed a relationship, on whom they have come to rely, and in whom they have confidence. So we want to make sure they can keep their own doctors.

The bill keeps Medicare from going bankrupt in 8 years by stopping waste, fraud, and abuse and by other provisions as well. The bill provides new preventive and wellness benefits—something we have talked about for every age group, but we are finally going to do something about it to give people better health care options.

The bill also, as it relates to older citizens, lowers prescription drug costs. We will talk more about that. We have had a lot of discussion over the last couple of years about the so-called doughnut hole. That is a very nice-sounding way of describing falling into a period of coverage, if you are an older citizen getting prescription drug coverage, where you have to pay the whole

freight, so to speak. This bill provides relief for those who are in that so-called doughnut hole with regard to Medicare prescription drug coverage.

Finally, this bill keeps older citizens in their homes and limits those who would be compelled, if they didn't get additional help, to go into nursing homes. Some do. Some choose to do that. But we want to provide more opportunity for people to stay in their homes, if they can.

In terms of preserving Medicare without the changes made in this bill, Medicare is going broke in 8 years—not 18, not 80, but 8 years—if we do nothing. Older citizens will have trouble accessing their doctors if we don't take action. Older citizens will have trouble affording prescription drugs if we don't take action. Finally, without reform, cost sharing for older citizens will increase to completely unaffordable levels.

Next, we have to make sure older citizens across America have the opportunity to continue to receive guaranteed protection for hospital stays, access to doctors, home health care, nursing home, and prescription drug coverage. We have to make sure we extend the life of the Medicare trust fund beyond 2022. Without reform, we cannot extend the Medicare trust fund beyond 2022. Without reform, we do not have the opportunity to ensure that trust fund will be there for older citizens across America. Finally, health reform will not interfere with any medical decisions made by patients and their doctors.

Let me step back a moment and reflect upon what we are talking about with regard to Medicare: Protecting our seniors, protecting their benefits. It is interesting to note this whole debate started January of 2009, in a fully engaged way, when staffs of all relevant committees were working on this, month after month. Then it went into the summer, working on health care reform in the Health, Education, Labor, and Pensions Committee and the Finance Committee, improving bills, changing the bills. Now we have one bill that is the result of all that work. So this has been going on for months and months.

I keep hearing criticisms from my Republican colleagues on various aspects of the bill. There is nothing unusual about that. It is natural to have a decision and a debate. We are starting that today, at least on the floor. But we have been having a debate over many months. My point is that on the one hand you have the legislation that resulted from work by the two committees into one bill, so you have the Patients Protection and Affordable Care Act on the floor and you have had basically the ideas contained in that being discussed for many months. But what we have not seen, what I have been waiting for and have not seen, is a bill by the other side.

In other words, when we were working in June and July in the HELP Committee or when the Finance Committee was working all summer and into the fall, you would think that one of the results from that would be that Democrats had a point of view and they produced a bill; Republicans had a point of view. But they did not produce a bill. So you basically have a choice before the American people: the bill before us, which will change and which will be amended. I have some things I would want to change. But the answer cannot be let's go back to square one, where we were a year ago or 5 years ago or 10 years ago and just cancel this and try to start over. This is the result of many years of work, especially many months of work by people at the staff level and Senators across the board.

Unfortunately, the other side does not have a plan, so I can only conclude they want to stay with the status quo. They think where we are in health care is OK; that we should stay where we are, maybe tinker with it a little bit but not change much. I think that is unacceptable. Too many people I run into, in Pennsylvania especially, have said to us: Please provide some protections for me. We are talking about individuals who have health care. Provide some consumer protections. Make sure the Medicare trust fund will always be there. Help me with this doughnut hole problem. This is the problem too many seniors run into when they cannot pay for prescription drugs at a certain point in the delivery of that benefit.

I do not think the response of doing nothing or staying where we are is acceptable. That is one of the reasons why we have to make sure we focus on changes or debates about this bill, not going back to where we were in January or where we were 5 years ago and basically doing nothing year after year about health care and saying it is OK to stay where we are.

We have a long way to go. But I think it is also important to point out this is not just a debate between Republicans and Democrats. We have had groups, across the board, that are neutral arbiters that weigh in on public policy but are not representing a Democratic point of view or a Republican point of view. The AARP said on November 20 of this year:

> Opponents of health reform won't rest. They are using myths and misinformation to distort the truth and wrongly suggest that Medicare will be harmed. After a lifetime of hard work, don't seniors deserve better?

So says the AARP, just a couple of weeks ago—not even a couple of weeks ago, 10 days ago. The AARP also said on November 18, 2 days earlier:

> The new Senate bill makes improvements to the Medicare program by creating a new annual wellness benefit, providing preventive benefits, and most notably for AARP members, reducing drug costs for seniors who fall into the dreaded Medicare donut hole [that I spoke about earlier] a costly gap in prescription drug coverage.

That is the AARP weighing in on not a concept, not a theory but the bill in front of us.

The American Medical Association, on that same day, November 20, 2009:

> We are working to put the scare tactics to bed once and for all, and inform patients about the benefit of health care reform.

I could go on from there, but we have ample evidence that there is strong support for the ways this bill will strengthen Medicare.

I wish to move to the second topic I was going to cover today and that is the other end of Hubert Humphrey's test of government, what we do and what the test is of our Government as it relates to those in the dawn of life. I spoke of older citizens a moment ago. At the dawn of our life are children.

It has been a topic and a focus of mine since the very beginning of this debate, which for me began last spring when I was working in the Health, Education, Labor, and Pensions Committee before our work this summer on the bill. The Patient Protection and Affordable Care Act, which is the bill before us today, deals with many aspects of our health care system. One of them is how we take care of our children. I have come back to this issue over and over. I have had just a basic test for this legislation. It is very simple. It is four words: No child worse off, especially and importantly, children who are low income and are particularly vulnerable, therefore, and children with special needs. So "no child worse off" should be the foundation of what we do in this bill for our children.

That is particularly true for those who are vulnerable, as I said before; they are vulnerable or children with special needs. That is the foundation of what we should be doing, the foundation for a guiding philosophy. The way I look at this, every child in America, no matter who they are, no matter what circumstance, every child in America is born with a light inside them. For some, that light is boundless because of their circumstance, because of their ability, because of advantages they have. Their potential is unlimited and that light burns very brightly without any help from anyone else. That is some children.

Then there are other children who have a light inside them and are deserving of our care and protection and advocacy. We have a lot of people around here who get besieged by lobbyists for different points of view, but very rarely do we have the same kind of lobbying power, the same kind of power in our system to stand for children. So we have to do that if an interest group will not. There are plenty who have advocated strongly for our children, but they don't get enough attention in my judgment.

There are some children who are born with a light inside them that does not

burn very brightly because of their own circumstances or limitations or because of particular vulnerabilities that they have. They are the ones for whom we have to fight the hardest. They are the ones we have to stand up to the special interests for because they cannot do it for themselves. They don't have a voice sometimes in this debate unless the Senate stands up for them.

I believe no matter what the light is inside a child, no matter what the limit or whether it is unlimited potential, we have to make sure that potential is reached, the full potential—not most of it, not some of it, the full potential of every child, the full burning of that light inside them.

There are two programs that work well to do that. They are Medicaid and the Children's Health Insurance Program. Thank goodness both these programs came along: Medicaid, some 40 years ago, and Children's Health Insurance Program less than the last 15 years.

We have the opportunity to listen to people who come up to us on the street or who send us an e-mail or who send us a letter. It just so happens one of my constituents in Pennsylvania sent us a note the other day, literally 2 days ago, November 28. I will not give away her identity, but I will give you a general sense of what her challenge is.

She wrote to us talking about her two children who are covered by the Children's Health Insurance Program in Pennsylvania. By the way, Pennsylvania is one of the first States that put into place this program, almost 20 years ago, back in 1992–1993.

She wrote and said she was concerned that the House, in their bill, had made some changes that would adversely impact her situation. She said:

We qualify for free Children's Health Insurance Program benefits in Pennsylvania but my husband's income is greater than the 150 percent of the Federal poverty level which means our children wouldn't qualify for the coverage under the House's proposed plan.

Then she says:

This has us terrified.

She goes on to talk about what she and her husband are trying to do to make ends meet. She says:

Our water bills will increase and we are nervously awaiting the annual increase in heating.

I will not go through the whole letter, but suffice it to say we have a program in place now, the Children's Health Insurance Program, that works for families right now. Now we are engaged in a great debate on health care on the floor of the Senate and we deal with programs such as the Children's Health Insurance Program. What we have to make sure about is that we do nothing in this process to injure or harm or set limits on what we can do with a program that we know works.

This is a program which is good for a child, to make sure he or she reaches the full potential of that light inside them. This is good for his or her family. Imagine the peace of mind that a mother or father has in the course of the day, whether they are going off to work or whether they are home, to know their child has health care. Yet we have some families, some parents, terrified even with the coverage they have, worried that coverage will not remain in effect for their children. So we have to make sure that rule is followed: No child worse off in America. We want to fix what is broken and build upon what works.

I wish to make sure, as we go through this, we have a sense of what the difference is between these benefits and what can happen down the road. One of the things that will have an adverse impact on our health care system, generally, but in particular on a program such as the Children's Health Insurance Program, will be the skyrocketing cost of coverage. The share of household incomes spent on premiums is climbing. The New America Foundation reports that in 2008, household income spent—on the side, ''percent of median household income spent on health care''—is 26.3 percent. That is far too high as of 2008.

With no action, if we stay where we are, go down the same road we are on, the status quo, don't change anything, let's start over and keep scratching our head about this, here is what is going to happen by 2016, 7 years away. That median household income dedicated to health care will skyrocket to 45 percent nationally.

Unfortunately, in Pennsylvania, it goes up over 51 percent instead of 45 percent, so that is the ''do nothing'' path right now. Do nothing, and we can guarantee that those costs are going to keep going up and up.

I said before we know the Children's Health Insurance Program works. By the way, when that bill passed and when it was reauthorized, we had help from both sides of the aisle—sometimes not enough help but we have had help supporting that program. We know this program works because we can see it from the results achieved by our children because of this program.

Let's compare this to some other challenges in the economy. The national poverty rate. In 2007, a little more than 37 million Americans were in poverty, 12.5 percent of the population. In 2008, it was up to 13 percent. So the poverty rate went up from 2007 to 2008. The child poverty rate went from 18 percent to 19 percent, almost 1 million more kids in 1 year falling into poverty because of changes in the economy. People without health insurance, 2007 versus 2008, that has gone up. It may only be 15.3 to 15.4, but look at the overall number, from 45.7 to 46.3. Everything is going up. We would expect that, as tragic as that is, when times are bad. The national poverty rate is up, the child poverty rate up, and the uninsured rate is up.

What has not gone up between 2007 and 2008 is the number of uninsured children: 8.1 million in 2007 were covered; 7.3 million kids covered in 2008. That is good news, that the number of uninsured children is actually going down from roughly 8 to 7 million. That is good news. Why is that happening? It is not magic. If we didn't have a Children's Health Insurance Program, that number would be going up just as the other numbers. Why is the uninsured number for children going down? One basic reason—and we could point to maybe a few others—is because we have a program called the Children's Health Insurance Program which works and which, fortunately, we reauthorized a couple of months ago. Thank goodness we did that, or more and more children would fall into poverty. We are on a path now to go from the number of children who are insured, to get that number that is now in the double figure millions, to get that to 14 million children, to have that uninsured number keep going down and cover more and more children. In a couple of years, we will have the opportunity to say that in America, we have 14 million kids covered. What we have to do is make sure we have a successful program that works for the child, for their family, and for our society. Because guess what. We are going to have a better economy because of the Children's Health Insurance Program. If we invest in a child early, they get health care, and they will learn better. When they learn better, they will be doing better in school and have a better job and have a higher skill level. This whole debate about children's health insurance isn't just a nice thing to do; it is how we compete around the world in a tough economy. It is how we build a skilled workforce in a tough economy. It is how we build strong families.

This isn't just some nice program. This has real results for our economy, for gross national product growth, economic growth, for a skilled workforce. Fill in the blank. You could add 10 themes to that in terms of the impact of the legislation. But you have to be careful. In the midst of this health care reform debate, we have to make sure we don't do what some have urged which is to take the Children's Health Insurance Program, this program that we know works, and drop that into the health insurance exchange that will be created as a result of this bill. The exchange is a good idea to cover a lot of people. It just happens to be a bad idea when it comes to merging or putting the Children's Health Insurance Program in there. It needs to remain a stand-alone program.

One of the reasons why we can say we are at that point where it is a stand-alone program still is because during the debate in the Finance Committee,

Senator ROCKEFELLER of West Virginia ensured that we kept the Children's Health Insurance Program out of the exchange and that the program would continue until 2019. Unfortunately, the House doesn't have the same provisions, and we want to make sure we do that by the end of the debate.

I filed an amendment today to make sure that children are protected by health care reform, so we can truly say that no child is worse off as a result of our health care reform bill. In a nutshell, this amendment will strengthen and safeguard health care for children in CHIP from now until 2019 and beyond with whatever changes the future of health care reform brings.

I will provide a couple of highlights. It continues funding through 2019. It ensures that children have access to the essential care they need. It streamlines and simplifies enrollment. The amendment also provides financial incentives for States to increase enrollment of eligible but uninsured children and calls for a study of children under the Children's Health Insurance Program compared to coverage of children under the so-called insurance exchange.

These are just some highlights of my amendment. I will be talking more about it.

I conclude with this thought. I know Senator BAUCUS was here a moment ago, chairman of the Finance Committee, who has worked very hard on this bill, this program, the Children's Health Insurance Program, and on the health care reform bill overall to protect our kids. I return to this letter I got 2 days ago from a mother, in essence commending the benefits of this program, that this program gives her peace of mind. What we have to do is make sure we keep the Children's Health Insurance Program intact and, if anything, strengthened over time so this mother doesn't have to worry again, so she doesn't have to be ''terrified'' of changes that will adversely impact her two children, especially in the midst of a bad economy but even if it were not.

I thank the Chair and yield the floor.

The PRESIDING OFFICER (Mrs. SHAHEEN). The Senator from Wyoming.

Mr. ENZI. Madam President, I thank the Senator from Pennsylvania for his comments. I certainly hope no one who is listening thinks that anybody wants to make any child worse off. That is a basic premise, and I appreciate his pointing out the way the House makes some children potentially worse off.

I want to constrain my comments to the Medicare amendment because I think that is one of the key parts of this whole bill. The Senator from Pennsylvania mentioned that there wasn't a Republican bill. Actually, there are four Republican bills, and there is one bipartisan bill out there that meets all of the goals the President put out. When we were going through the HELP Committee amendment process, we put one of those out, and it was voted down with one vote. We said: That didn't work very well. There were a lot of good ideas in there. They ought to have to consider every one of those.

We have been putting our ideas out one at a time so that hopefully the other side will glean something out of the amendment that will be worthwhile to be a part of the bill. All the good ideas couldn't be on one side of the aisle.

We began the day with kind of a stunt which, of course, was to have the leader propose a unanimous consent. He proposed that the Social Security money ought to stay with Social Security. I don't think there was any problem with that. But then he proposed that CLASS Act money ought to stay with the CLASS Act. That is a fund that isn't even actuarially sound to begin with. It is just a piece of the bill that is already in existence around here. He left out what he should have put in that unanimous consent request. He should have said Medicare money should be reserved for Medicare. That would have relaxed a lot of seniors. But it would have been untrue and impossible to pass this bill if that were the UC, because Medicare money is going to expansion of new programs outside of Medicare. That is what is upsetting seniors. And it ought to.

Medicare, as everybody has said, is going broke. That is a government option that is going broke. Well, never mind. But Medicare is going broke. We all agree on that. So why would we take $464 billion out of Medicare to use on other programs and then recognize that Medicare is going broke and throw in a special commission that will come to us once a year and suggest cuts to Medicare? That is not a bad idea, but some side deals have been made in this whole thing that keep that from being a very realistic option either. The hospitals can't be cut any more. The doctors, we are going to have to fix that, and that is where some of the phony accounting comes in.

The pharmaceuticals, the little deal they made for the doughnut hole, that will provide extra help to seniors through the doughnut hole, but it has to be on brand name products. We know that generics are a lot less expensive and a lot of seniors switch to generics, especially when they get to the doughnut hole and have to make decisions on their own and they want to save a few dollars. But that will not be a possibility under this bill because of the deal that was made with the pharmaceuticals. They are going to pay their percentage on brand name products only. Why would they do that? If they can get you to use brand name products through the doughnut hole, when the government starts paying again, you will still use the brand name.

One of the ideas with health care is to get a little skin in the game with everybody so people are making good choices on health care. How much of a good choice are you going to make if you don't have to make a choice and you can keep on doing what you have been doing, whether it is the best choice for you, whether it is even what the doctor agrees with, and whether it is a whole lot more expensive for the government to keep Medicare going?

I rise to support the McCain motion to commit this bill and eliminate its Medicare cuts. Senator REID's bill cuts $464 billion from the Medicare Program. These cuts will eliminate benefits for Medicare patients. They will make it harder for them to see doctors and other providers and will threaten the survival of hospitals, nursing homes, and home health agencies. Don't take my word for it. The administration's own chief actuary recently reviewed the House bill with its similar levels of Medicare payment cuts and reached the same conclusion I just said.

Richard Foster, chief actuary at the Centers for Medicare and Medicaid Services, CMS, wrote that if these cuts were to take effect, many providers ''could find it difficult to remain profitable and might end their participation in the program.'' He also noted that this could jeopardize Medicare beneficiaries' access to care. I have heard similar messages from doctors, home health aides, and nursing home owners back in Wyoming. They are all concerned about the one-half trillion dollars in Medicare cuts and what it will do to their ability to treat Medicare patients.

I have heard from folks at the Baggs Senior Center, the Star Valley Senior Citizens, the Southwest Sublette County Pioneers Senior Citizen Center, and from other Wyoming nursing homes about how the $15 billion in Medicare cuts to nursing home payments will devastate their ability to provide care for seniors in Wyoming. Many of these nursing homes are small businesses. They struggle to make payroll every month and deal with an ever increasing burden of government regulations. We have never cut those back. They tell me how their Medicare payment rates have already been reduced and how the additional cuts in the bill could force them to close their doors.

Connie Jenkins, executive director of the Star Valley Senior Center, recently wrote to me about the important role nursing homes play in rural towns in Wyoming. She noted that ''in a rural state such as ours, closure of nursing homes would mean families travelling farther to visit [their] loved ones and in some cases loss of access altogether.''

In rural States—and we are about as rural as you can get; we have the least

population in the Nation, and we have a lot of land mass—there is a lot of distance between towns. If the nursing home in your town closes down, it is a long way to the next nursing home. The Reid bill would also cut $135 billion in Medicare payments to hospitals. In a State such as Wyoming, with an older population, between 40 to 50 percent of our hospital revenue comes from Medicare. Medicare already pays a fraction of what private insurers pay, and the cuts in this bill will undermine those hospitals' ability to continue to operate. I have heard from several Wyoming hospital executives that because of the payment cuts in this bill, they are going to need to ask their people to work fewer hours and take pay cuts.

They also said they may need to lay some folks off and to find ways to scale back the services they offer to their patients. They do not want to compromise the care they provide, but the payment cuts in this bill will not leave them a choice.

The Reid bill also cuts nearly $8 billion in payments to hospice care. Hospice care helps to relieve the suffering of people who are dying from diseases such as cancer. These are terminal patients, terminal patients who, of course, are not going to be cured. But the hospice is intended to help manage the pain and other symptoms of the patients with the terminal illness, and working with the families, much on a volunteer basis.

According to National Hospice and Palliative Care Organization, the cuts in the Reid bill, combined with prior regulatory cuts, would reduce Medicare payments to hospice providers by 14.3 percent through 2019. According to a June 2008 report from the Medicare Payment Advisory Commission, hospices already operate with narrow profit margins that average just 3.4 percent.

Smaller nonprofits and hospices in rural areas such as Wyoming already operate with negative profit margins. Many depend on charitable fundraising to keep their doors open and to enable them to keep treating patients. Yet the Reid bill would further cut their Medicare payments by $8 billion. This will force many hospices to close, which will threaten dying seniors' access to that type of care.

The Reid bill also cuts more than $40 billion in Medicare payments to home health agencies. According to the analysis done by one industry association, this level of cuts could put nearly 70 percent of all home health agencies at risk of having to close their doors. I want to say that again. The $40 billion in Medicare cuts to home health agencies, according to an analysis done by one industry association, could put nearly 70 percent of all home health agencies at risk of having to close their doors.

There are a lot of people who are out of nursing homes because they are getting home health care. If we eliminate home health care, we drive up the cost of care. If the Senate passes this bill, it will mean that Medicare patients may not be able to get the skilled nursing care, the physical and speech therapy, and the assistance that home health aides provide with many daily activities, such as dressing, bathing, helping patients live more fully with a disability.

The Medicare cuts in the Reid bill are not limited to slashing payments to hospitals and other providers. The bill also cuts $120 billion from the 11 million seniors on Medicare Advantage. These cuts make a mockery out of President Obama's promise that if you like what you have, you can keep it. As a result of these cuts, millions of Medicare beneficiaries will lose the benefits currently provided by Medicare Advantage plans.

Supporters of Senator REID's bill have tried to gloss over the impact these Medicare Advantage cuts will make, arguing they will only result in a loss of ''extra benefits.'' For the seniors who have come to rely on Medicare Advantage plans to provide things such as flu shots, eyeglasses, hearing aids, and protections against catastrophic costs, these are not extra benefits but items and services they depend on.

We all agree Medicare needs to be strengthened and reformed. Its financing is unsustainable. The Hospital Insurance Trust Fund, which pays for hospital services, will be insolvent in 2017. The physician payment formula, which calls for Medicare payments to doctors to be cut by more than 40 percent over the next 10 years, is fundamentally broken. We know that. We even had a vote on that in this Chamber. We said it had to be paid for.

Let's see, $464 billion coming out of Medicare. Medicare is what is being affected by the doctors' payments. Why wouldn't we use some of that? But it is a lot of money. It is a lot of money, but it is not as much money as we are taking out of Medicare.

Unfortunately, the Reid bill does nothing to fix these problems. Instead, it cuts one-half trillion dollars from Medicare to create a brandnew entitlement program for the uninsured. This approach fails to address the real problem facing Medicare; and that is the physician formula. Instead, it uses the same gimmick that Congress has repeatedly used to fix this problem and provides a temporary fix in 2010, which will actually lead to steeper cuts in subsequent years.

Physicians have grown increasingly frustrated by Congress's repeated failure to replace the current payment formula. We kind of like to keep them hanging on a year at a time. I think it is a little bit of a hostage situation, but that is the way Washington works. It should not be that way. We should redo the formula. If we do not address this problem soon, many more physicians are going to decide it is not worth it to continue to treat Medicare patients.

The Congressional Budget Office has estimated that truly fixing the physician payment formula could cost upwards of $250 billion, yet the Reid bill does not address this problem.

Spiraling costs associated with medical liability lawsuits directly increase Medicare costs. These costs are calculated directly into payment formulas for providers such as physicians. In addition, physicians and hospitals order billions of dollars in extra tests and procedures to protect themselves from the threat of potential lawsuits.

We know that enacting commonsense medical liability reforms directly reduces the liability insurance premiums doctors pay. We have seen the results in States such as Texas, where physicians liability insurance premiums have decreased every year since the State-enacted reforms, with average liability rates dropping a total of 27 percent.

The Reid bill does nothing to address the problems of medical liability. Instead of including reforms that would help reduce Medicare costs and extend the solvency of the program, the only thing the Reid bill does is include a meaningless sense-of-the-Senate resolution on liability reform. That will not pay the bills.

We owe it to the 43 million people who depend on Medicare to reject the arbitrary cuts in the Reid bill. We need to come up with better solutions that will not endanger their ability to see a doctor or to get care at a hospital or a nursing home. Yes, if we do not pay the doctors, the doctors will not take them because in Medicaid they already will not take 40 percent of the patients; and in Medicare it is 20 percent already. A lot of people are being asked, when they call a doctor, if they are a Medicare patient. It is my contention if you cannot see a doctor, you do not have any kind of insurance at all. We do not take care of that problem, so we do need to come up with a better solution that will not endanger their ability to see a doctor or to get care at a hospital or a nursing home or to have home health care.

I believe we can do better. If the Senate passes this motion to commit, we can develop bipartisan reforms that will eliminate the unsustainable payment cuts and address the underlying problems facing the Medicare Program.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, I am not in favor of doing nothing. The previous Democratic speaker, Senator CASEY, said if we do nothing, costs will go up. I think the fact is, if you look at CBO's analysis, it says costs will go up even more if this bill, this 2,074-page

bill, passes. So I want to spend some time because there has been some obfuscation on what this Congressional Budget Office letter to Senator BAYH means.

This morning, the nonpartisan Congressional Budget Office sent a letter to Senator BAYH providing a very detailed analysis of what health insurance premiums will look like as a result of this 2,074-page bill. I have the letter from the Congressional Budget Office right here, if anybody wants to read it in detail.

Like many of us, Senator BAYH wants to know if the Reid bill is addressing our constituents' No. 1 priority: costs. I think if you were to have a Saturday morning coffee club meeting in almost any of the small towns of America, and they were discussing health care reform—and emphasis upon the word ''reform''—and I walked into that meeting, and if I told them under this 2,074-page Reid bill that costs were not going to be brought under control, taxes were going to go up, premiums were going to go up, and we were taking $400 billion out of Medicare to set up a new health care program, they would probably unanimously respond: Well, that does not sound like health care reform to me.

A lot of Senators are concerned about costs because that is what we are hearing from the grassroots of America. Everyone, from the dean of Harvard's Medical School to even the New York Times, has said this bill does not sufficiently address the rising cost of health care. But before today, we were still all anxiously waiting to hear what the Congressional Budget Office has now said about that issue of rising costs. Well, today, CBO has spoken loudly and clearly. The Reid bill not only fails to bring down costs, it will actually raise costs for millions of Americans. I think that bears repeating. The Reid bill will make health insurance more expensive. Families will end up paying 10 to 13 percent more as a result of this 2,074-page bill.

Some proponents of the bill are trying to spin this, what they consider unfortunate news, and tell the American people that taxpayer-funded subsidies will actually offset these cost increases. In fact, tonight some Members have already been saying that this CBO analysis shows costs will come down.

But I want to make it very clear CBO says that is not the case. Well, this may be true; if you take $500 billion of taxpayers' hard-earned money and give it out in subsidies directly to insurance companies, sure, some people may end up paying less for health insurance. But this argument fails to recognize two big underlying problems.

First, most Americans will not qualify for any subsidies. They will end up paying higher premiums. In fact, 160 million Americans who stay in employer-based plans will not see any help. In fact, despite all the rhetoric about how employers cannot afford the status quo, CBO says this bill does little, if anything, to lower costs for employers. Maybe that is why the National Federation of Independent Businesses, the U.S. Chamber of Commerce, and a host of other business groups, oppose this 2,074-page bill.

The nonpartisan Congressional Budget Office goes on to say that 14 million people who cannot get coverage through an employer will not get any help either, but they will see a 10- to 13-percent increase in premiums. And, of course, an intrusive new insurance mandate will be enforced by the IRS if you do not do what has never been done in the 225-year history of America. Never has the Federal Government said any American had to buy anything. Now you have to buy insurance. If you do not buy it, pay the IRS more money. Some people are going to say: Well, you have to buy car insurance. But under the tenth amendment, the State governments have any powers that are not prohibited by the Federal Constitution to them.

So families who would have paid $13,100 under current law will actually pay more than $15,000 as a direct result of this 2,074-page bill. And people in employer-based coverage will be paying more than $20,000 a year for health insurance in 2016.

The second big problem is this: Health insurance premiums are still more expensive in the Reid bill than they would be under current law. The government is cutting Medicare and raising taxes to offset the increases. So instead of addressing the underlying issue of cost, as was promised, this bill enacts policies that drive up costs by close to 30 percent, and then hands over close to $500 billion in hard-earned taxpayer dollars directly to health insurance companies to offset the increases.

Well, you might not believe the spin. In fact, you better not believe the spin because the nonpartisan Congressional Budget Office has confirmed it. This bill fails to drive down the cost of health insurance premiums. It simply drives up prices with a bunch of arbitrary regulatory reforms, very cutely shifting the cost on to the American people in the form of higher taxes and massive Medicare cuts. So, once again, don't take my word for it. Read what the nonpartisan Congressional Budget Office says. They have confirmed what we have been hearing for months: The Democratic leadership bill means higher costs for millions of Americans.

I yield the floor.

Mr. ENZI. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. DURBIN. Madam President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

ADDITIONAL STATEMENTS

TRIBUTE TO PAT VEZINA

• Mr. BEGICH. Madam President, today I wish to recognize a milestone for my constituent Pat Vezina. On Friday, December 4, 2009, Pat will mark the 50th anniversary of her arrival in the State of Alaska. Alaska became a State in January 1959 and Pat made it her home less than a year later, one of thousands of people who have built our State over the last half century.

Pat was born in Wallsend, Northumberland, England, on June 4, 1931, to Clement and Constance Boothroyd. She grew up in Jesmond, Northumberland, and was evacuated for a short time during World War II before returning home to live with her parents for the duration of the war. After attending nursing school in Leeds, England, she emigrated to Canada and then to Alaska

Pat worked as a registered nurse in the labor and delivery department at Providence Hospital, one of Alaska's finest institutions. She began her Alaska nursing career at ''Old Providence'' hospital where hundreds of new Alaskans, including me, were born. After marrying and having two children of her own, she returned to nursing at ''New Providence'' where she worked for 30 years before her retirement in 1996.

Pat has an abiding love for the beauty of Alaska. She enjoys walking on the beaches of Homer, buying summer flowers for her garden in the greenhouses of the Matanuska Valley, picking berries at Sheep Mountain Lodge, and an afternoon with a friend at Summit Lake Lodge. She is loved by her children Karen and John and by the close friends she has made over the last 50 years.

Madam President and colleagues, please join me in honoring and recognizing Pat Vezina on the 50th anniversary of her arrival in Alaska.•

RECOGNIZING THE 169TH FIGHTER WING

• Mr. DEMINT. Madam President, Senator GRAHAM joins me today to congratulate the men and women of the

169th Fighter Wing stationed at McEntire Joint National Guard Base, SC, for their outstanding service in defending our Nation and for their great achievements at the 2009 Falcon Air Meet.

It has been 8 years since the attacks of 9/11 and the record of continuous operations for the 169th is an inspiration to us all. Shortly after the attacks, McEntire personnel deployed to Southwest Asia, directly participating in combat operations in support of Operation ENDURING FREEDOM, pounding al-Qaida and Taliban insurgents. Later, the 169th FW mobilized and deployed as part of what became Operation IRAQI FREEDOM. The Swamp Foxes flew more than 400 combat missions, performing the Suppression of Enemy Air Defenses mission and flying numerous precision bombing missions over Iraq.

However, when the 169th isn't defending freedom, they are winning awards and bringing home trophies. We are especially proud of the 169th's accomplishments at the 2009 Falcon Air Meet, a multinational F–16 competition. The Swamp Foxes represented the United States against other Nation's fighter crews. They finished first in four of five competition categories, earning the Large Force Employment Trophy, Scramble Launch and Intercept Competition, Weapons Load Competition, Top Overall Maintenance Award, and was recognized with the Top Overall Competition Award. These are impressive achievements that bring great credit upon the 169th.

On behalf of the people of the State of South Carolina and our great country, Senator GRAHAM and I want to salute the outstanding work of the 169th.

We are amazed by their stories, and humbled by the immense burdens they have shouldered. Their dedication, and their families' sacrifices are an inspiration, and our country owes them a debt of gratitude for their patriotic service.●

REMEMBERING MALCOM SHERMAN

● Ms. MIKULSKI. Madam President, I wish to pay to tribute the life and legacy of Malcolm Sherman.

Malcolm Sherman was part of that extraordinary generation that fought for America during World War II, and then fought for what America stands for during the rest of his life.

He joined the Marines after the Japanese attack on Pearl Harbor and served during the Guadalcanal campaign. When he returned home, he built a family with his beloved wife Mimi, and he built a career in real estate.

He truly lived his life according to the Jewish principle of ''tikkun olam''—the repair of the world through the pursuit of social justice. He worked for peace and civil rights throughout his life. He also was a leader in the effort to ending segregation and discrimination in housing. Perhaps his greatest legacies are his children and grandchildren, who live by his principles of service.

I ask that an obituary of Mr. Sherman written by Frederick Rasmussen of the Baltimore Sun be printed in the RECORD.

The information follows.

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

[From the Baltimore Sun, Nov. 21, 2009]

MALCOLM SHERMAN: FORMER ROUSE CO. EXECUTIVE BATTLED BLOCKBUSTING IN BALTIMORE NEIGHBORHOODS IN THE 1950S AND 1960S

(By Frederick N. Rasmussen)

Malcolm ''Mal'' Sherman, a former Rouse Co. executive and real estate agent who battled blockbusting and worked tirelessly for integrated neighborhoods during the 1950s and 1960s, died Thursday of pneumonia at the Broadmead retirement community in Cockeysville. He was 87.

Mr. Sherman was born in Philadelphia and spent his early years there. After the death of his father in 1927, he was sent abroad to a boarding school in Lausanne, Switzerland, where he lived until returning to New York City in 1932.

After graduating from Horace Mann School in New York City, Mr. Sherman attended the University of North Carolina at Chapel Hill.

He dropped out of college and enlisted in the Marine Corps two days after the Japanese attack on Pearl Harbor.

Mr. Sherman was wounded while serving as a master sergeant during the Guadalcanal campaign and was honorably discharged at war's end.

He was a founder of the United Nations Veterans League, which worked for world peace.

After the war, Mr. Sherman and his wife, the former Miriam ''Mimi'' Heller, whom he married in 1943, moved to San Francisco, where he was a salesman for Paul Masson Wines.

In 1949, Mr. Sherman moved to Baltimore to be closer to his wife's family. He earned his real estate license and established Mal Sherman Inc. Realtors. His staff consisted of 18 men and 18 women, at a time when there were few women in the business.

''I always had an interest in houses and land,'' Mr. Sherman said in a 1999 interview with the Maryland Realtor. ''I thought I could help people make a decision. I wanted to help families find a better quality of life. It was a way for me to combine business and social work all in one.''

In the early days, Mr. Sherman confronted anti-Semitism and segregated neighborhoods.

''As a Jewish real estate broker, I was not allowed to show property east of Falls Road,'' he recalled in the interview.

In 1953, when Mr. Sherman tried to stabilize a neighborhood that was undergoing blockbusting, he appealed to white residents to stay.

They rebuffed his plea and refused to do business with him because of his integrationist views.

Even after the Supreme Court's Brown v. Board of Education decision in 1954 that declared ''separate but equal'' unconstitutional, discrimination in real estate continued.

In 1960, Mr. Sherman decided it was time to hire African-American real estate agents and brought Lee Martin, a Morgan State graduate, into his company.

While working for Baltimore Neighborhoods Inc. in the early 1960s, Mr. Sherman began to push fair-housing issues and in a news conference said he would sell to anyone ''regardless of race, creed, or color.''

When baseball great Frank Robinson came to Baltimore to play for the Orioles in 1966, he instructed Mr. Sherman to find a home for him and his family in a white neighborhood.

''He didn't want to be segregated,'' Mr. Sherman recalled in an interview. After persuading the white neighbors to accept Mr. Robinson, Mr. Sherman was still attacked by a local builder for ''breaking the block.''

President John F. Kennedy appointed him to the Equal Opportunity for Housing in America Committee.

Mrs. Sherman, who died in 2005, joined her husband in his quest for open housing and civil rights.

''All that black people wanted was the right to buy or rent anyplace, regardless of race, creed or color, and once given that right, they didn't necessarily inundate and run to the neighborhoods that they had been barred from,'' Mr. Sherman told The Sun in 2001.

He was later joined by other local brokers such as Russell T. Baker and Bill Wilson in the push for fair-housing laws that finally became a reality in 1968 when Congress passed legislation, but his crusade took a toll on his firm.

''Because he felt so strongly about these issues, it eventually put him out of business. It was a terrible thing to have happened,'' said Sandy Marenberg, president of MEI Real Estate in Baltimore.

''Mal held to his views all the way until the end of his life. He was a real hero and mentor in the Baltimore real estate community,'' Mr. Marenberg said.

In 1967, Mr. Sherman was named residential land sales director for the Rouse Co., and three years later was promoted to director of sales and land marketing in Columbia.

Mr. Sherman was named Rouse Co. vice president in 1971 with responsibilities for all residential land sales and helped steer Columbia toward racial diversity.

When he went to work for the Rouse Co., Mr. Sherman found a boon companion in Jim Rouse, the company founder, who shared his views.

''We were combating a trend, and Jim was frightened. He didn't want it [Columbia] to come out like the city,'' Mr. Sherman recalled in a 2000 interview in The Sun. ''He wanted all of the people mixed all over the place; that was the social goal.''

''He was a charismatic man always trying to help someone. He discriminated against no one,'' said James Holechek, a retired Baltimore public relations executive.

''It was a personal testimony when he was sought out and hired by Jim Rouse. To me, Mal Sherman was always Mr. Real Estate in Maryland,'' he said.

A liberal Democrat and an anti-war activist, Mr. Sherman found himself on the Nixon White House's enemies list after founding Businessmen Against the Vietnam War.

That's ''great news'' he told The Sun in 1973. ''It's the best thing I have to tell my son about myself. I feel better about this than any kind of honor that could come to me,'' he said.

After leaving the Rouse Co. in the early 1970s, Mr. Sherman went to work for Phipps Land Co. and later Ackerman & Co., a real estate firm based in Atlanta. He returned

from Atlanta in 1981 when he was appointed Baltimore-Washington area regional vice president for the firm.

Mr. Sherman continued working as a real estate consultant after leaving Ackerman. He retired in 2001.

''He was arguably the wisest, most caring adviser and thinker in the Baltimore real estate world,'' said Martin L. Millspaugh Jr., who was the first chief executive of Charles Center-Inner Harbor Management Inc.

''His life made a difference over many years, in ways that will become even more apparent as time goes by,'' Mr. Millspaugh said.

He was a former president of the Real Estate Board of Greater Baltimore and in 1999 was awarded the Maryland Real Estate Board Life Achievement Award. Recently, he was honored for his civil rights work by the National Association of Realtors.

A former resident of the Colonnade in Homewood, Mr. Sherman was a member of the Baltimore Hebrew Congregation.

Services will be held at 1 p.m. Sunday at Sol Levinson and Bros., 8900 Reisterstown Road, Pikesville.

Surviving are two daughters, Wendy R. Sherman of Bethesda and Andrea Sherman of Dobbs Ferry, N.Y.; and two grandchildren. His son, Douglas Sherman, died in 1981.●

REMEMBERING ROYAL J. ''BUD'' WOOD

● Mr. THUNE. Madam President, today I mourn the loss of Royal J. ''Bud'' Wood, of Warner SD. Bud passed away on November 19, 2009, at the age of 87.

Born and raised in Warner, Bud will be remembered as a man who committed his life to his family and community. Bud celebrated his life with his wife Dorothy, his 4 children, 12 grandchildren, and 6 great-grandchildren. His passion for his faith, family, and friends was unwavering as he spent much of his time at church and family activities.

Although Bud was extremely dedicated to his family, he will also be remembered for his service to the State of South Dakota. I got to know Bud when his wife Dorothy managed Senator James Abdnor's office in Aberdeen. Elected to the South Dakota House of Representatives in 1966, Bud was one of the longest serving representatives, working for the people of South Dakota for 26 years. While a member of the State legislature, he served in many different capacities including: assistant majority leader, speaker pro tempore, speaker of the house, along with vicechairman of the Legislative Research Council and chairman of the Local Government Study Commission and Local Government Standing Committee. Bud also served on the Presidential Task Force for both President Ronald Reagan and President George H.W. Bush.

Beyond his political career, Bud was a talented auctioneer at Hub City Livestock Auction for 25 years. He was on the board of directors for the South Dakota Wheat Growers, the Warner Elevator Board, and at one time a church council member at St. John's Lutheran Church in Warner.

Bud was a man who was always willing and determined to help out his neighbor. A mentor, confidant, and friend, he selflessly impacted his community in a positive way.

Today I wish to celebrate the life of an extraordinary public servant and leader. As we mourn the loss of this great South Dakotan, I extend my thoughts, prayers and best wishes to Bud's family, friends, and loved ones.●

TRIBUTE TO THOMAS KURT JAROS

● Mr. THUNE. Madam President, today I recognize Thomas Kurt Jaros, an intern in my Washington, DC, office, for all of the hard work he has done for me, my staff, and the State of South Dakota over the past several months.

Kurt is a graduate of Downers Grove South High School in Downers Grove, IL. Currently he is attending the Biola University, where he is majoring in philosophy and political science. He is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Kurt for all of the fine work he has done and wish him continued success in the years to come.●

TRIBUTE TO DENNIS D'AQUILA

● Mr. THUNE. Madam President, today I recognize Dennis D'Aquila, an intern in my Washington, DC, office, for all of the hard work he has done for me, my staff, and the State of South Dakota over the past several months.

Dennis is a graduate of Wantagh High School in Wantagh, NY. Currently he is attending the Catholic University of America, where he is majoring in politics. He is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Dennis for all of the fine work he has done and wish him continued success in the years to come.●

TRIBUTE TO DYLAN KESSLER

● Mr. THUNE. Madam President, today I recognize Dylan Thomas Kessler, an intern in my Washington, DC, office, for all of the hard work he has done for me, my staff, and the State of South Dakota over the past several months.

Dylan is a graduate of Roncalli High School in Aberdeen, SD. Currently he is attending the Hillsdale College, where he is majoring in English. He is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Dylan for all of the fine work he has done and wish him continued success in the years to come.●

TRIBUTE TO BRITTNI PALKE

● Mr. THUNE. Madam President, today I recognize Brittni Jo Palke, an intern in my Washington, DC, office, for all of the hard work she has done for me, my staff, and the State of South Dakota over the past several months.

Brittni is a graduate of MACCRAY in Clara City, MN. Currently she is attending the Southeastern University, where she is majoring in journalism. She is a hard worker who has been dedicated to getting the most out of his internship experience.

I would like to extend my sincere thanks and appreciation to Brittni for all of the fine work she has done and wish her continued success in the years to come.●

TRIBUTE TO ALELI PARDO

● Mr. THUNE. Madam President, today I recognize Aleli Marie Pardo, an intern in my Washington, DC, office, for all of the hard work she has done for me, my staff, and the State of South Dakota over the past several months.

Aleli is a graduate of Carrollton School of the Sacred Heart in Miami, FL. Currently she is attending the George Washington University, where she is majoring in political science. She is a hard worker who has been dedicated to getting the most out of her internship experience.

I would like to extend my sincere thanks and appreciation to Aleli for all of the fine work she has done and wish her continued success in the years to come.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mrs. GILLIBRAND:

S. 2817. A bill to amend part D of title V of the Elementary and Secondary Education

Act of 1965 to provide grants to schools for the development of asthma management plans and the purchase of asthma inhalers and spacers for emergency use, as necessary; to the Committee on Health, Education, Labor, and Pensions.

By Mr. LEMIEUX:

S. 2818. A bill to amend the Energy Conservation and Production Act to improve weatherization for low-income persons, and for other purposes; to the Committee on Energy and Natural Resources.

By Mrs. FEINSTEIN:

S. 2819. A bill to amend the Poultry Products Inspection Act, the Federal Meat Inspection Act, and the Federal Food, Drug, and Cosmetic Act to require processors of food products to certify to the applicable Secretary that the processed food products are not adulterated; to the Committee on Agriculture, Nutrition, and Forestry.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. BENNETT (for himself and Mr. HATCH):

S. Res. 361. A resolution commending Real Salt Lake for winning the 2009 Major League Soccer Cup; to the Committee on the Judiciary.

By Mr. SHELBY (for himself, Mr. VITTER, Mr. COCHRAN, Mr. CORNYN, Mrs. HUTCHISON, Mr. ISAKSON, Mrs. SHAHEEN, and Mr. WICKER):

S. Res. 362. A resolution expressing the sense of the Senate that the Secretary of the Treasury should direct the United States Executive Directors to the International Monetary Fund and the World Bank to use the voice and vote of the United States to oppose making any loans to the Government of Antigua and Barbuda until that Government cooperates with the United States and compensates the victims of the Stanford Financial Group fraud; to the Committee on Foreign Relations.

By Mr. VOINOVICH (for himself and Mr. BROWN):

S. Res. 363. A resolution honoring the life and service of breast cancer advocate, Stefanie Spielman; to the Committee on the Judiciary.

By Mrs. SHAHEEN (for herself and Mr. DURBIN):

S. Res. 364. A resolution supporting the observance of National Diabetes Month; considered and agreed to.

ADDITIONAL COSPONSORS

S. 254

At the request of Mrs. LINCOLN, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 254, a bill to amend title XVIII of the Social Security Act to provide for the coverage of home infusion therapy under the Medicare Program.

S. 332

At the request of Mrs. FEINSTEIN, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. 332, a bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

S. 354

At the request of Mr. WEBB, the name of the Senator from Massachusetts (Mr. KIRK) was added as a cosponsor of S. 354, a bill to provide that 4 of the 12 weeks of parental leave made available to a Federal employee shall be paid leave, and for other purposes.

S. 436

At the request of Mr. CORNYN, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 436, a bill to amend title 18, United States Code, to protect youth from exploitation by adults using the Internet, and for other purposes.

S. 456

At the request of Mr. DODD, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 456, a bill to direct the Secretary of Health and Human Services, in consultation with the Secretary of Education, to develop guidelines to be used on a voluntary basis to develop plans to manage the risk of food allergy and anaphylaxis in schools and early childhood education programs, to establish school-based food allergy management grants, and for other purposes.

S. 461

At the request of Mrs. LINCOLN, the names of the Senator from New Hampshire (Mrs. SHAHEEN) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 461, a bill to amend the Internal Revenue Code of 1986 to extend and modify the railroad track maintenance credit.

S. 510

At the request of Mr. DURBIN, the names of the Senator from Iowa (Mr. HARKIN) and the Senator from Wyoming (Mr. ENZI) were added as cosponsors of S. 510, a bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the safety of the food supply.

S. 619

At the request of Mrs. FEINSTEIN, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 678

At the request of Mr. LEAHY, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of S. 678, a bill to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, and for other purposes.

S. 781

At the request of Mr. ROBERTS, the name of the Senator from Delaware (Mr. CARPER) was added as a cosponsor of S. 781, a bill to amend the Internal Revenue Code of 1986 to provide for collegiate housing and infrastructure grants.

S. 795

At the request of Mr. HATCH, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 795, a bill to amend the Social Security Act to enhance the social security of the Nation by ensuring adequate public-private infrastructure and to resolve to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation, and for other purposes.

S. 823

At the request of Ms. SNOWE, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. 823, a bill to amend the Internal Revenue Code of 1986 to allow a 5-year carryback of operating losses, and for other purposes.

S. 870

At the request of Mrs. LINCOLN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 870, a bill to amend the Internal Revenue Code of 1986 to expand the credit for renewable electricity production to include electricity produced from biomass for on-site use and to modify the credit period for certain facilities producing electricity from open-loop biomass.

S. 987

At the request of Mr. DURBIN, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 987, a bill to protect girls in developing countries through the prevention of child marriage, and for other purposes.

S. 1008

At the request of Mr. THUNE, his name and the name of the Senator from Oregon (Mr. WYDEN) were added as cosponsors of S. 1008, a bill to amend title 10, United States Code, to limit requirements of separation pay, special separation benefits, and voluntary separation incentive from members of the Armed Forces subsequently receiving retired or retainer pay.

S. 1067

At the request of Mr. FEINGOLD, the names of the Senator from Minnesota (Ms. KLOBUCHAR) and the Senator from Iowa (Mr. HARKIN) were added as cosponsors of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1217

At the request of Ms. STABENOW, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1217, a bill to amend title XIX of the Social Security Act to improve

and protect rehabilitative services and case management services provided under Medicaid to improve the health and welfare of the nation's most vulnerable seniors and children.

S. 1317

At the request of Mr. LAUTENBERG, the names of the Senator from Connecticut (Mr. LIEBERMAN), the Senator from Michigan (Mr. LEVIN), the Senator from Rhode Island (Mr. WHITEHOUSE) and the Senator from New York (Mrs. GILLIBRAND) were added as cosponsors of S. 1317, a bill to increase public safety by permitting the Attorney General to deny the transfer of firearms or the issuance of firearms and explosives licenses to known or suspected dangerous terrorists.

S. 1353

At the request of Mr. LEAHY, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 1353, a bill to amend title 1 of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits.

S. 1458

At the request of Ms. LANDRIEU, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1458, a bill to encourage the development and implementation of a comprehensive, global strategy for the preservation and reunification of families and the provision of permanent parental care for orphans.

S. 1535

At the request of Mrs. FEINSTEIN, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1535, a bill to amend the Fish and Wildlife Act of 1956 to establish additional prohibitions on shooting wildlife from aircraft, and for other purposes.

S. 1756

At the request of Mr. HARKIN, the names of the Senator from Washington (Mrs. MURRAY) and the Senator from Illinois (Mr. BURRIS) were added as cosponsors of S. 1756, a bill to amend the Age Discrimination in Employment Act of 1967 to clarify the appropriate standard of proof.

S. 1799

At the request of Mr. DODD, the names of the Senator from Missouri (Mrs. MCCASKILL) and the Senator from Minnesota (Mr. FRANKEN) were added as cosponsors of S. 1799, a bill to amend the Truth in Lending Act, to establish fair and transparent practices related to the marketing and provision of overdraft coverage programs at depository institutions, and for other purposes.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1927

At the request of Mr. DODD, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1927, a bill to establish a moratorium on credit card interest rate increases, and for other purposes.

S. 2097

At the request of Mr. THUNE, the name of the Senator from Wyoming (Mr. BARRASSO) was added as a cosponsor of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2740

At the request of Mrs. MURRAY, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 2740, a bill to establish a comprehensive literacy program.

S. 2757

At the request of Mr. MENENDEZ, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 2757, a bill to authorize the adjustment of status for immediate family members of persons who served honorably in the Armed Forces of the United States during the Afghanistan and Iraq conflicts and for other purposes.

S. 2779

At the request of Ms. KLOBUCHAR, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 2779, a bill to promote Department of the Interior efforts to provide a scientific basis for the management of sediment and nutrient loss in the Upper Mississippi River Basin, and for other purposes.

S. 2781

At the request of Ms. MIKULSKI, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2787

At the request of Ms. COLLINS, her name was added as a cosponsor of S. 2787, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

S. CON. RES. 39

At the request of Mr. MENENDEZ, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. Con. Res. 39, a concurrent resolution expressing the sense of the Congress that stable and affordable housing is an essential component of an effective strategy for the prevention, treatment, and care of human immunodeficiency virus, and that the United States should make a commitment to providing adequate funding for the development of housing as a response to the acquired immunodeficiency syndrome pandemic.

S. RES. 71

At the request of Mr. WYDEN, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. Res. 71, a resolution condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights.

S. RES. 337

At the request of Mr. BYRD, the names of the Senator from Washington (Mrs. MURRAY), the Senator from Pennsylvania (Mr. SPECTER), the Senator from Wyoming (Mr. BARRASSO), the Senator from Ohio (Mr. BROWN), the Senator from Montana (Mr. BAUCUS) and the Senator from Montana (Mr. TESTER) were added as cosponsors of S. Res. 337, a resolution designating December 6, 2009, as ''National Miners Day''.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. FEINSTEIN:

S. 2819. A bill to amend the Poultry Products Inspection Act, the Federal Meat Inspection Act, and the Federal Food, Drug, and Cosmetic Act to require processors of food products to certify to the applicable Secretary that the processed food products are not adulterated; to the Committee on Agriculture, Nutrition, and Forestry.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce the Processed Food Safety Act. When enacted, this bill will make one very important principle clear: It is the producer's responsibility to produce safe food, it is not the consumer's responsibility to make their food safe.

This legislation gives food producers and anyone else who modifies our food two options: They can take an additional ''kill-step'' to eliminate all verifiable traces of pathogens within each ingredient they have added to the product, or they can certify to the Secretary of Agriculture that each of the ingredients used to make our food contains no verifiable traces of pathogens.

One would think that this is common sense. Wouldn't any company producing or modifying our food take the time, and the care, to make sure that their product was safe for us to eat?

Unfortunately not. Today, more than 100 years after the publishing of Upton Sinclair's ''The Jungle,'' much of our food is still produced by companies that put their profits over the health of their customers.

On any given week I can open up the newspaper and find another heartbreaking story about the serious health effects of food-borne illnesses from tainted products. Anyone who visits the Web sites of the USDA or the

FDA can see that recalls are not a rare occurrence.

In the last month the USDA has recalled: Roast beef in Iowa due to the presence of undeclared allergens; canned soup in Pennsylvania due to the undeclared presence of egg in the product; beef tongues in Nebraska and Wisconsin because of improperly removed tonsils, which, when consumed, increase the risk of contracting Mad Cow Disease; and hundreds of thousands of pounds of ground beef in California, New York, and Massachusetts due to the presence of E. coli 0157—the deadliest strain of this common pathogen.

The FDA this month has recalled: Dove ice cream bars in 19 States including California for the undeclared presence of peanuts, a potentially deadly allergen; Jelly Belly Jelly Beans were also recalled due to the presence of peanuts and peanut butter in their product; apple and carrot pouches in California that may contain a spore that can lead to botulism; vegetarian spring rolls in Maine, which were found to have meat products. The uninspected meat could have contained any number of food-borne pathogens; pre-made sandwiches in North Carolina due to concerns about the presence of Listeria. These bacteria can cause serious illness, pregnancy complications and even death; salted herring in New York because of the possible presence of the spore that can lead to botulism; and dried plums in Texas, found to contain traces of lead.

Simply put, the state of our food supply is alarming. And without serious reform and leadership from this Congress, things will not get any better. That is why today I am introducing the Processed Food Safety Act.

As I said, this bill will require companies that process any kind of food, from ground beef to frozen pot pies, to test their finished products and their ingredients to make sure that they are safe to eat and pathogen free.

I mentioned ground beef and frozen pot pies, two very different items, because both of these seemingly unrelated products have been the subject of two recent exposés in the New York Times.

On October 4, 2009, writer Michael Moss highlighted the disturbing realities in the ground beef industry, at each step in the process. He found slaughterhouses don't take time to properly remove intestines and fecal matter which then contaminate meat with E. coli. These slaughterhouses then sell to grinders who agree not to test their product for contaminants. Meat grinders purchase scraps from a variety of slaughterhouses across the country and across the globe. They then combine their scraps in a way that makes it virtually impossible to trace back their ingredients for public health purposes. Federal agencies offer regulations and guidance, but they fail to compel the industry to comply with their safety standards.

Each individual oversight is a problem, but together, they represent a clear, systematic failure of the overall food safety system.

This story makes it abundantly clear that the companies producing our ground beef spend more time worrying about how to avoid testing for pathogens than they spend trying to make their products safe.

The New York Times ran another story on May 15 that highlights serious concerns about frozen chicken pot pies.

The newspaper discovered that ConAgra, a frozen food giant which produced and sold over 100 million pot pies last year, decided to make consumers responsible for killing pathogens in their products instead of taking the responsibility themselves.

As consumers, we expect that producers of these frozen meals have properly cleaned and washed their ingredients before repackaging them for sale. We expect that these frozen entrees are ready for consumption—just ''heat and eat,'' the popular advertising motto tells us.

However, as this story points out, companies have actually tried to shift this burden to the consumer by requiring very specific, often burdensome cooking instructions which require the use of a meat thermometer to test the temperature of a product in several different places.

What is even more shocking is that the authors found that it was virtually impossible to meet the cooking specifications put on the box by ConAgra.

On the outside of the box, the cooking instructions state that the product must reach 160 degrees in several places as tested by a meat thermometer, before the product is safe to eat.

However the New York Times found that even after using a higher power microwave than recommended by ConAgra, and cooking the product for an additional 1 minute and 30 seconds, 30 percent longer than recommended, parts of the pot pie did not reach the temperature recommended by ConAgra to kill pathogens within their product.

When asked if a sample of their product that was cooked above and beyond their recommendations was safe to eat even though it did not reach the recommended temperature, the company conceded that it was not safe for human consumption.

Other frozen food products from Nestle, Swanson, and Hungry-Man were also tested to see if their cooking directions were clear, simple, and adequate. Not surprisingly, the New York Times found that their tests on these products yielded similar results.

Increasingly, food producers are using consumer cooking instructions as a method to deflect responsibility for the safety of their product. These companies effectively said that it was up to the consumer to kill potentially deadly doses of E. coli and Salmonella in their frozen meals.

Under current law, food producers are allowed to get away with this. That is why I am introducing the Processed Food Safety Act.

The bill will dean up the food industry by: amending the Poultry Products Inspection Act, the Federal Meat Inspection Act and the Federal Food, Drug and Cosmetic Act to prohibit the sale of any processed poultry, meat or FDA-regulated food that has not undergone a pathogen reduction treatment or been certified to be virtually pathogen free; doing away with loopholes in current laws that allow for producers to add coloring, synthetic flavorings and spices to their products without informing the consumer; and banning the sale of food that has not undergone these rigorous inspections and safety procedures.

The Processed Food Safety Enhancement Act will force companies to produce safe foods. And, it will let consumers know that their health is more important than the financial interests of the food industry.

Some may argue that this bill will be too expensive, because the inspections and tests required by this bill may raise the cost of food. I believe that these concerns are short-sighted.

The Centers for Disease Control and Prevention estimate that food-borne illnesses sicken up to 76 million people, cause 325,000 hospital visits, and cause more than 5,000 deaths each year. The CDC estimates that these illnesses annually cost American taxpayers up to $6 billion.

By another metric, the USDA food-borne illness cost calculator estimates that Salmonella cost the United States $2.6 billion in 2008, and E. coli 0157 cost $478 million.

By implementing more rigorous safety standards for our food, the Processed Food Safety Act may actually result in a substantial cost savings to the average American consumer.

But that misses the point. This bill, and this problem cannot be measured in dollars and cents. Food-borne illnesses kill up to 5,000 people every year. In this day and age, this is simply unacceptable. We cannot let this go on.

Food producers must be held responsible for the safety of their products. In the early 1900s Congress acted forcefully to prohibit the most egregious violations in food production. Today, 104 years after ''The Jungle'' was published, it is time for Congress to again take up this important fight.

The Processed Food Safety Act puts the responsibility for food safety back where it belongs. This legislation protects consumers and keeps our food safe.

I am proud to introduce this legislation, and I urge my colleagues to support this important, commonsense bill.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2819

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Processed Food Safety Act of 2009''.

SEC. 2. POULTRY SAFETY.

(a) DEFINITION OF MISBRANDED.—Section 4(h) of the Poultry Products Inspection Act (21 U.S.C. 453(h)) is amended—

(1) in paragraph (5)—

(A) by inserting ''(A)'' after ''(5)'';

(B) by striking ''showing (A) the name'' and inserting the following: ''showing—

''(i) the name'';

(C) by striking ''distributor; and (B) an accurate'' and inserting the following: ''distributor;

''(ii) subject to subparagraph (B), an accurate''; and

(D) by striking ''count: *Provided*, That under clause (B) of this subparagraph (5), reasonable'' and inserting the following: ''count; and

''(iii) an accurate description of each cut of poultry or poultry product contained in the package or other container; and

''(B) except that under subparagraph (A)(ii), reasonable'';

(2) in paragraph (7)(B), by striking ''(other than spices, flavoring, and coloring)''; and

(3) in paragraph (9)(B), by striking ''; except that spices, flavorings, and colorings may, when authorized by the Secretary, be designated as spices, flavorings, and colorings without naming each''.

(b) PROHIBITED ACTS.—Section 9 of the Poultry Products Inspection Act (21 U.S.C. 458) is amended—

(1) in paragraph (5), by striking the period at the end and adding ''or''; and

(2) by adding at the end the following:

''(6) sell, transport, offer for sale or transportation, or receive for transportation, in commerce, any poultry or poultry product that is capable of use as human food, unless the person (including any slaughterer, poultry products broker, renderer, processor, reprocessor, retail food store, or official establishment) affirmatively certifies to the Secretary that—

''(A) each ingredient in the poultry or poultry product that was added, modified, or otherwise handled by the person has undergone a pathogen reduction treatment in accordance with requirements of the Secretary that will reduce the presence of pathogens of public health concern and other harmful food borne contaminants; or

''(B) the person has tested and certified that each ingredient in the poultry or poultry product that was added, modified, or otherwise handled by the person contains no verifiable traces of pathogens.''.

(c) PHASE-IN PERIOD.—Paragraph (6) of section 9 of the Poultry Products Inspection Act (as added by subsection (b)(2)) shall not apply until the date that is 18 months after the date of enactment of this Act.

SEC. 3. MEAT SAFETY.

(a) DEFINITION OF MISBRANDED.—Section 1(n) of the Federal Meat Inspection Act (21 U.S.C. 601(n)) is amended—

(1) in paragraph (5)—

(A) by inserting ''(A)'' after ''(5)'';

(B) by striking ''showing (A) the name'' and inserting the following: ''showing—

''(i) the name'';

(C) by striking ''distributor; and (B) an accurate'' and inserting the following: ''distributor;

''(ii) subject to subparagraph (B), an accurate''; and

(D) by striking ''count: *Provided*, That under clause (B) of this subparagraph (5), reasonable'' and inserting the following: ''count; and

''(iii) an accurate description of each cut of meat or meat food product contained in the package or other container; and

''(B) except that under subparagraph (A)(ii), reasonable'';

(2) in paragraph (7)(B), by striking ''(other than spices, flavoring, and coloring)''; and

(3) in paragraph (9)(B), by striking ''; except that spices, flavorings, and colorings may, when authorized by the Secretary, be designated as spices, flavorings, and colorings without naming each''.

(b) PROHIBITED ACTS.—Section 10 of the Federal Meat Inspection Act (21 U.S.C. 610) is amended—

(1) by striking ''**SEC. 10.** No person'' and inserting the following:

''SEC. 10. PROHIBITED ACTS.

''No person'';

(2) in subsection (c)—

(A) by striking ''in commerce (1) any'' and inserting the following: ''in commerce—

''(A) any'';

(B) by striking ''which (A) are capable of use as human food and (B) are'' and inserting the following: ''that—

''(i) are capable of use as human food; and

''(ii) are''; and

(C) by striking ''(2) any'' and inserting the following:

''(B) any'';

(3) by redesignating subsections (a) through (d) as paragraphs (1) through (4), respectively, and indenting appropriately;

(4) in paragraph (4) (as so redesignated), by striking the period at the end and inserting ''; or''; and

(5) by adding at the end the following:

''(5) sell, transport, offer for sale or transportation, or receive for transportation, in commerce, any meat or meat food product that is capable of use as human food, unless the person, firm, or corporation (including any slaughterer, meat broker, renderer, processor, reprocessor, retail food store, or official establishment) affirmatively certifies to the Secretary that—

''(A) each ingredient in the meat or meat food product that was added, modified, or otherwise handled by the person, firm, or corporation has undergone a pathogen reduction treatment in accordance with requirements of the Secretary that will reduce the presence of pathogens of public health concern and other harmful food borne contaminants; or

''(B) the person, firm, or corporation has tested and certified that each ingredient in the meat or meat food product that was added, modified, or otherwise handled by the person, firm, or corporation contains no verifiable traces of pathogens.''.

(c) PHASE-IN PERIOD.—Paragraph (5) of section 10 of the Federal Meat Inspection Act (as added by subsection (b)(5)) shall not apply until the date that is 18 months after the date of enactment of this Act.

SEC. 4. FOOD SAFETY.

(a) PATHOGEN REDUCTION TREATMENT.—Chapter IV of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by adding at the end the following:

''SEC. 418. PATHOGEN REDUCTION TREATMENT.

''(a) IN GENERAL.—The Secretary shall promulgate regulations requiring each facility registered under section 415 to apply pathogen reduction treatments to each food, as the Secretary determines appropriate, that such facility manufactures, processes, packages, or holds for consumption in the United States.

''(b) CERTIFICATION.—The Secretary shall promulgate regulations requiring each facility described in subsection (a) to certify to the Secretary that—

''(1) each food manufactured, processed, packaged, or held (including each ingredient of such food that is added, modified, or otherwise handled) by such facility contains no verifiable traces of pathogens; or

''(2) each food leaving such facility has received pathogen reduction treatments, as required by the regulations promulgated under such subsection.''.

(b) PHASE-IN PERIOD.—The requirements under section 418(b) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a)) shall not apply until the date that is 18 months after the date of enactment of this Act.

(c) TECHNICAL AMENDMENT.—Section 402 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 342) is amended by adding at the end the following:

''(j) If the facility has not provided a certification required under section 418.''.

(d) LABELING WITH RESPECT TO SPICES, FLAVORING, AND COLORING.—Section 403 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343) is amended—

(1) in paragraph (g), by striking ''(other than spices,'' and inserting ''(including spices,'';

(2) in paragraph (i), by striking ''; except that spices, flavorings, and colors not required to be certified under section 721(c) unless sold as spices, flavorings, or such colors, may be designated as spices, flavorings, and colorings without naming each'';

(3) in paragraph (k), by striking ''The provisions of this paragraph and paragraphs (g) and (i) with respect to artificial coloring shall not apply in the case of butter, cheese, or ice cream.''; and

(4) in paragraph (x), by striking ''Notwithstanding subsection (g), (i), or (k), or any other law, a'' and inserting ''A''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 361—COMMENDING REAL SALT LAKE FOR WINNING THE 2009 MAJOR LEAGUE SOCCER CUP

Mr. BENNETT (for himself and Mr. HATCH) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 361

Whereas on November 22, 2009, Real Salt Lake (RSL) won the Major League Soccer Cup in front of 46,011 fans in Seattle, Washington;

Whereas RSL overcame substantial obstacles to outplay and outlast the formidable Los Angeles Galaxy in the championship game;

Whereas RSL began the second half trailing the Galaxy by a score of 1-0 and were also without starter Will Johnson and key playmaker Javier Morales;

Whereas Robbie Findley scored for RSL in the 64th minute to tie the game at 1-1;

Whereas RSL won by a score of 5-4 in the seventh round of penalty kicks on a shot by Robbie Russell;

Whereas RSL goalkeeper Nick Rimando made more saves than any other goalkeeper in the 2009 Major League Soccer (MLS) playoffs, as he stopped 2 penalty kicks during the final shootout and was named the MLS Cup Most Valuable Player;

Whereas RSL head coach Jason Kreis, at age 36, became the youngest manager to win a MLS title;

Whereas the MLS Cup victory capped off an improbable season for RSL, as the team accumulated an 11-12-7 record during the regular season but went on to become the first franchise in professional sports history to win a championship after finishing the regular season without a winning record;

Whereas the victory in the championship game was the second straight shootout win for RSL, after beating the Chicago Fire in the Eastern Conference Championship by a score of 5-4 on penalties;

Whereas RSL defeated the defending MLS champion Columbus Crew in the Eastern Conference Semifinals, winning 4-2 on aggregate;

Whereas Salt Lake City, Utah, has been home to RSL since the team's founding in 2005;

Whereas the people of the State of Utah have provided stalwart support for RSL and deserve to celebrate this championship, which is the first professional sports crown in the State of Utah since 1971; and

Whereas the players of RSL are good role models to young athletes for their hard work, tenacity, and determination in the face of difficult obstacles, and have served as outstanding representatives for the State of Utah both on and off the field: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates Real Salt Lake for winning the 2009 Major League Soccer Cup;

(2) recognizes the achievements of the players, coaches, and staff whose hard work and dedication helped Real Salt Lake win the championship; and

(3) respectfully directs the Secretary of the Senate to transmit an enrolled copy of this resolution to Real Salt Lake for appropriate display, as well as owner Dave Checketts and head coach Jason Kreis.

SENATE RESOLUTION 362—EXPRESSING THE SENSE OF THE SENATE THAT THE SECRETARY OF THE TREASURY SHOULD DIRECT THE UNITED STATES EXECUTIVE DIRECTORS TO THE INTERNATIONAL MONETARY FUND AND THE WORLD BANK TO USE THE VOICE AND VOTE OF THE UNITED STATES TO OPPOSE MAKING ANY LOANS TO THE GOVERNMENT OF ANTIGUA AND BARBUDA UNTIL THAT GOVERNMENT COOPERATES WITH THE UNITED STATES AND COMPENSATES THE VICTIMS OF THE STANFORD FINANCIAL GROUP FRAUD

Mr. SHELBY (for himself, Mr. VITTER, Mr. COCHRAN, Mr. CORNYN, Mrs. HUTCHISON, Mr. ISAKSON, Mrs. SHAHEEN, and Mr. WICKER) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 362

Whereas thousands of investors, many of them in the United States, lost billions of dollars that they invested in fraudulent Stanford International Bank certificates of deposit;

Whereas Allen Stanford had close ties with the Government of Antigua and Barbuda and, among other things, Mr. Stanford is alleged to have loaned at least $85,000,000 to the Government of Antigua and Barbuda, which likely came from investor funds;

Whereas the relationship of the Stanford Financial Group with the Government of Antigua and Barbuda was described in a joint statement by the Stanford Financial Group and the Cabinet of Antigua and Barbuda as a "productive and mutually beneficial relationship";

Whereas the United States Securities and Exchange Commission alleged that Leroy King, the chief executive officer of the Financial Services Regulatory Commission of Antigua and Barbuda, was bribed by Mr. Stanford not to investigate the Stanford International Bank, to provide Mr. Stanford with access to the Financial Services Regulatory Commission's confidential files, to allow Mr. Stanford to dictate the Financial Services Regulatory Commission's responses to inquiries by the Securities and Exchange Commission about the Stanford International Bank, and to withhold information from the Securities and Exchange Commission;

Whereas, after the fraud allegedly perpetrated by the Stanford Financial Group was made public, the Government of Antigua and Barbuda seized Stanford property in Antigua and Barbuda worth up to several hundred million dollars;

Whereas, in an October 28, 2009 report, the United States court-appointed receiver, Ralph Janvey, reported that "the total of all cash collected is $128.8 million, of which $71.5 million remains on hand after payment of expenses", which falls far short of investor losses;

Whereas Janvey's report also noted that "the Antiguan liquidators object to every attempt to secure and liquidate assets, worldwide", and "[t]he government of Antigua refuses to recognize US orders even as to entities for which there is no other owner i.e. the Antiguan liquidators were only appointed to liquidate two of the more than 150 Stanford entities, but we are hindered by Antigua's refusal to recognize the Court's orders even as to non-disputed entities"; and

Whereas the Government of Antigua and Barbuda is seeking loans from the International Monetary Fund and the World Bank: Now, therefore, be it

Resolved, That it is the sense of the Senate that the Secretary of the Treasury should direct the United States Executive Directors to the International Monetary Fund and World Bank to use the voice and vote of the United States to ensure that any loan made by the International Monetary Fund or the World Bank to the Government of Antigua and Barbuda is conditioned on providing complete redress to the victims of the Stanford Financial Group fraud, including through—

(1) the full cooperation of the Government of Antigua and Barbuda and the liquidators appointed for the liquidation proceeding relating to the Stanford International Bank in Antigua and Barbuda with the Securities and Exchange Commission, the Department of Justice, and the United States court-appointed receiver in investigating the Stanford Financial Group fraud and marshaling the assets of Mr. Stanford and Stanford-affiliated entities;

(2) an agreement by the Government of Antigua and Barbuda to be subject to the jurisdiction and bound by the judgment of any United States court or international court that is adjudicating the claims of victims of the Stanford Financial Group fraud;

(3) the transfer of the assets seized by the Government of Antigua and Barbuda and the liquidators in Antigua and Barbuda to the United States court-appointed receiver for the benefit of victims of the Stanford Financial Group fraud;

(4) a contribution by the Government of Antigua and Barbuda to the United States receivership estate, for the benefit of victims of the Stanford Financial Group fraud, in an amount equal to the amount of any funds provided to Antigua and Barbuda by Mr. Stanford or any Stanford-affiliated entity; and

(5) a contribution by the Government of Antigua and Barbuda to the United States receivership estate, for the benefit of victims of the Stanford Financial Group fraud, in an amount equal to any payments made by Mr. Stanford or the Stanford Financial Group to officials of the Government of Antigua and Barbuda for the purpose of subverting regulatory oversight of the Stanford International Bank.

SENATE RESOLUTION 363—HONORING THE LIFE AND SERVICE OF BREAST CANCER ADVOCATE, STEFANIE SPIELMAN

Mr. VOINOVICH (for himself and Mr. BROWN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 363

Whereas Stefanie Spielman, a tremendous advocate and a true champion for the cause of breast cancer research, passed away on November 19, 2009, after a decade-long battle with breast cancer;

Whereas despite her constant battle with her own illness, Stefanie showed grace and compassion for others, touching countless lives in Ohio and beyond;

Whereas Stefanie tirelessly advocated for additional research into the prevention and treatment of breast cancer, and along with her husband, Chris, founded the Stefanie Spielman Fund for Breast Cancer Research at the Ohio State University Comprehensive Cancer Center—James Cancer Hospital and Solove Research Institute shortly after her diagnosis;

Whereas Stefanie and Chris later established the Stefanie Spielman Fund for Patient Assistance, which to date has generated more than $6,500,000 to help translate laboratory discoveries into effective treatments for breast cancer patients;

Whereas Stefanie served as an active and vital member of the James Cancer Hospital and Solove Research Institute Foundation Board;

Whereas Stefanie was actively engaged in advocacy issues, including Ohio Mammography Day, which received the strong support of former Ohio First Lady Janet Voinovich and was designated by the Ohio General Assembly as the third Thursday in October;

Whereas in 2000, Stefanie and Chris established "Stefanie's Champions" to honor one of the most important factors in cancer treatment—the loving and healing presence of a devoted caregiver;

Whereas Stefanie gave the first Champion award to her beloved husband after Chris put his professional football career on hold to care for her when she was first treated; and

Whereas Stefanie was a loving mother to her 4 children: Now, therefore, be it

Resolved, That the Senate—

(1) acknowledges the outstanding achievements and profound impact of Stefanie Spielman in the fight against breast cancer;

(2) commends Stefanie for her commitment to caring for others suffering from breast cancer; and

(3) celebrates her life as a wife, mother, and advocate for breast cancer awareness, research, and treatment.

SENATE RESOLUTION 364—SUPPORTING THE OBSERVANCE OF NATIONAL DIABETES MONTH

Mrs. SHAHEEN (for herself and Mr. DURBIN) submitted the following resolution; which was considered and agreed to:

S. RES. 364

Whereas there are nearly 24,000,000 people in the United States with diabetes and 57,000,000 with pre-diabetes;

Whereas diabetes contributed to the deaths of over 300,000 people in the United States in 2007, making diabetes the seventh leading cause of death;

Whereas every minute, 3 people are diagnosed with diabetes;

Whereas each day approximately 4,384 people are diagnosed with diabetes and, in 2007, approximately 1,600,000 new cases of diabetes were diagnosed in people 20 years or older;

Whereas between 1990 and 2001, diabetes prevalence in the United States increased by more than 60 percent;

Whereas over 24 percent of diabetes is undiagnosed, down from 30 percent in 2005, and 50 percent 10 years ago;

Whereas over 10 percent of adults and nearly ¼ (23.1 percent) of people in the United States age 60 and older have diabetes;

Whereas diabetes is a serious chronic condition that affects people of every age, race, income level, and ethnicity;

Whereas Hispanic, African, Asian, and Native Americans are disproportionately affected by diabetes and suffer at rates much higher than the general population;

Whereas annually, 15,000 youth in the United States are diagnosed with type 1 diabetes and approximately 3,700 youth are diagnosed with type 2 diabetes;

Whereas 1 in 3 people in the United States born in the year 2000 will develop diabetes in their lifetime, and this statistic grows to nearly 1 in 2 for minority populations;

Whereas diabetes costs the United States an estimated $174,000,000,000 in 2007, and $1 in every $10 spent on health care is attributed to diabetes and its complications;

Whereas approximately 1 out of every 4 Medicare dollars is spent on the care of people with diabetes;

Whereas every day 230 people with diabetes undergo an amputation, 120 people enter end-stage kidney disease programs, and 55 people go blind from diabetes;

Whereas there is not yet a cure for diabetes;

Whereas there are proven means to reduce the incidence of and delay the onset of type 2 diabetes;

Whereas people with diabetes live healthy, productive lives with the proper management and treatment; and

Whereas National Diabetes Month is celebrated in November: Now, therefore, be it

Resolved, That the Senate—

(1) supports the goals and ideals of National Diabetes Month, including encouraging people in the United States to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease;

(2) recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for diabetes, which include—

(A) being over the age of 45;

(B) coming from certain ethnic backgrounds;

(C) being overweight;

(D) having a low physical activity level;

(E) having high blood pressure; and

(F) a family history of diabetes or a history of diabetes during pregnancy; and

(3) supports decreasing the prevalence of diabetes, developing better treatments, and working toward an eventual cure in the United States through increased research, treatment, and prevention.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2790. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2791. Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

TEXT OF AMENDMENTS

SA 2790. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 436, strike line 18 and all that follows through page 439, line 20, and insert the following:

SEC. 2101. PROTECTING LOW-INCOME CHILDREN FROM HARM AND ENSURING THAT THEY BENEFIT FROM HEALTH REFORM.

(a) INTEGRATING CHIP ELIGIBILITY WITH METHODOLOGIES USED FOR OTHER SUBSIDIES WHILE PRESERVING CHIP FOR CHILDREN WHO CURRENTLY QUALIFY AND ASSURING CHIP COVERAGE FOR LOW-INCOME CHILDREN.—

(1) DEFINITION OF TARGETED LOW-INCOME CHILD.—Effective January 1, 2014, section 2110(b)(1) of the Social Security Act (42 U.S.C. 1397jj(b)(1)) is amended by striking subparagraph (B) and inserting the following:

''(B) whose family's modified gross income, as determined for purposes of allowing a premium credit assistance amount for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986, does not exceed 250 percent of the poverty line for a family of the size involved; and''.

(2) STATE PLAN ELIGIBILITY REQUIREMENT.—Section 2102(b)(1)(B) of such Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the period at the end and inserting ''; and'' and

(C) by adding at the end the following:

''(v) with respect to fiscal years beginning with fiscal year 2014, may not deny eligibility or enrollment, because of excess family income, to any child whose family income is at or below the percentage of poverty level specified in section 2110(b)(1)(B), determined using the methodology described in such section.''.

(b) MAINTENANCE OF EFFORT.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

''(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN.—

''(A) FISCAL YEARS BEFORE FISCAL YEAR 2014.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2013, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on October 1, 2009.

''(B) FISCAL YEAR 2014 AND THEREAFTER.—

''(i) IN GENERAL.—Subject to clause (ii), with respect to fiscal years beginning with fiscal year 2014 a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children that are more restrictive than the eligibility methodologies or procedures, respectively, under such plan (or waiver) as in effect on October 1, 2009.

''(ii) EXCEPTION.—A State that, prior to fiscal year 2014, has an income eligibility standard, methodology, or procedure under its State child health plan (including any waiver under such plan) for children that results in children whose family's modified gross income (as determined for purposes of allowing a premium credit assistance amount for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986) exceeds 250 percent of the poverty line may modify such standard, methodology, or procedure so that it will not result in eligibility for children under the State plan in whose family modified gross income exceeds that percentage of the poverty line.

''(C) RULE OF CONSTRUCTION.—Subparagraphs (A) and (B) shall not be construed as preventing a State from applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that were in effect on October 1, 2009.''.

(c) PROTECTING CHIP CHILDREN AGAINST UNAFFORDABLE COSTS FOR ESSENTIAL HEALTH CARE.—

(1) CONTINUATION OF COST-SHARING PROTECTIONS FOR CHILDREN.—Section 2103(e) of such

Act (42 U.S.C. 1397cc(e)) is amended by adding at the end the following:

''(5) CONTINUATION OF COST-SHARING PROTECTIONS FOR CHILDREN.—

''(A) IN GENERAL.—Except as described in subparagraph (B), during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act, a State shall not have in effect cost-sharing policies under its State child health plan (including any waiver under such plan) that increase premiums or out-of-pocket costs above the amounts for children of the same income level (stated as a percentage of the Federal poverty level) under such plan (or waiver) as in effect on October 1, 2009.

''(B) EXCEPTION.—With respect to fiscal years beginning with fiscal year 2014, a State may increase cost-sharing amounts above those described in subparagraph (A) by an amount that does not exceed the median percentage increase in national household income since fiscal year 2013, as determined by the Secretary, for households with incomes at or below the percentage of poverty level specified in section 2110(b)(1)(B).

''(C) RULE OF CONSTRUCTION.—This paragraph shall not be construed to prevent a State from reducing premiums or out-of-pocket costs below the amounts described in subparagraph (A).''.

(2) EQUITABLE COVERAGE OF ESSENTIAL BENEFITS.—Section 2103(f) of such Act (42 U.S.C. 1397cc(f)) is amended by adding at the end the following:

''(4) EQUITABLE COVERAGE OF ESSENTIAL BENEFITS.—With respect to fiscal years beginning with fiscal year 2014, the State plan for child health assistance (including any waiver under such plan) may not deny (whether through a restriction on amount, duration, or scope, through excluding a category of health care services or items, or otherwise) a service or item to a child whose family income is at or below the percentage of poverty level specified in section 2110(b)(1)(B), determined using the methodology described in such section, if the State would cover or be required to cover such service or item had the child qualified for medical assistance under sub-clause (IV), (VI) or (VII) of section 1902(a)(10)(i).''.

(d) BASING FEDERAL PAYMENTS ON STATE CONDITIONS, RATHER THAN INFLEXIBLE DOLLAR AMOUNTS.—Section 2104(a) of such Act (42 U.S.C. 1397dd(a)) is amended by striking paragraph (16) and inserting the following:

''(16) notwithstanding any other provision of this title, for each of fiscal years 2013 through 2019, such amounts as are necessary to carry out this title.''.

(e) DEFRAYING STATE EXPANSION COSTS WITH ADDITIONAL FEDERAL DOLLARS.—Section 2105(b) of such Act (42 U.S.C. 1397dd(b)) is amended—

(1) by striking ''For purposes'' and inserting the following:

''(1) IN GENERAL.—For purposes''; and

(2) by adding at the end the following:

''(2) OPTION FOR INCREASED FEDERAL FINANCIAL PARTICIPATION BEGINNING IN FISCAL YEAR 2014.—Notwithstanding paragraph (1), beginning with fiscal year 2014, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 94 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D) of that subsection, paragraphs (8), (9), or (11) of subsection (c), or clause (4) of the first sentence of section 1905(b). A State may not qualify for an enhanced FMAP pursuant to this paragraph unless it implements—

''(A) each enrollment and retention provision described in subparagraphs (A), (B)(i), and (C) through (G), respectively, of section 2105(a)(4); and

''(B) any other practice for eligibility determination, enrollment or retention that the Secretary finds—

''(i) has a substantial impact increasing the number of eligible children who receive health coverage through State plans for child health assistance under this title or State plans for medical assistance under title XIX;

''(ii) reduces erroneous eligibility determinations under the state plans described in clause (i); and

''(iii) lowers operational administrative costs under the state plans described in clause (i).''.

(f) CONTINUING PERFORMANCE BONUSES FOR STATES THAT ENROLL LARGE NUMBERS OF ELIGIBLE CHILDREN.—Section 2105(a)(3) of such Act (42 U.S.C. 1397dd(a)(3)) is amended—

(1) in subparagraph (A), by striking ''and ending with fiscal year 2013''; and

(2) in subparagraph (E), by adding at the end the following:

''(iv) LATER APPROPRIATIONS.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for each of fiscal years 2013 through 2019, 25 percent of the amount described in clause (i), adjusted to reflect the proportionate change in Consumer Price Index for All Urban Consumers since fiscal year 2009, as determined by the Secretary.''.

(g) GIVING FAMILIES THE OPTION OF USING THEIR FEDERAL INCOME TAX RETURNS TO ESTABLISH ELIGIBILITY.—Section 6055 of the Internal Revenue Code of 1986, as added by section 1502(a) of the Patient Protection and Affordable Care Act, is amended by adding at the end the following:

''(f) USE OF INDIVIDUAL INCOME TAX RETURNS TO HELP DETERMINE ELIGIBILITY FOR SUBSIDIES.—

''(1) IN GENERAL.—For taxable years beginning not later than January 1, 2012, the Secretary shall develop forms that require all individuals filing returns with respect to income taxes under subtitle A—

''(A) to identify the members of the individual's household who lack health insurance at the time the return is filed; and

''(B) to indicate whether there are members of the individual's household who are under 19 years of age and for whom the individual requests disclosure of pertinent tax return information, pursuant to section 6103(c), to agencies determining eligibility for subsidies for purposes of helping such agencies determine whether the applicable household members qualify for subsidies.

In developing the applicable language on tax forms, the Secretary shall consult with the Secretary of Health and Human Services. The goals of such consultation shall include maximizing the form's comprehensibility to low-income taxpayers and the convenience of making such identification and indication.

''(2) TRANSFER OF INFORMATION.—When an individual identifies a household member pursuant to paragraph (1)(B), the Secretary shall promptly transfer pertinent tax return information to all agencies determining eligibility for subsidies in such member's state of residence, except that such transfer shall not take place to an agency unless it is subject to an enforceable agreement or other legal obligation that meets the Secretary's requirements for safeguarding taxpayer privacy and data security. The transfer described in this paragraph may take place through the data matching program described in section 1413(c)(2) of the Patient Protection and Affordable Care Act.

''(3) ELIGIBILITY DETERMINATION.—

''(A) IN GENERAL.—Notwithstanding any other provision of law except subparagraph (B), when an agency determining eligibility for subsidies receives the information described in paragraph (2), it shall determine such eligibility on the basis of such information and other information obtainable by data-matching, to the maximum extent possible.

''(B) EXCEPTIONS.—An agency described in subparagraph (A) shall base eligibility on information other than described in paragraph (2) (including through seeking additional information from the applicable individual or household member, if such information cannot be obtained through other means)—

''(i) to the extent that an eligibility requirement for subsidies cannot be decided based on the information described in subparagraph (A);

''(ii) if the agency has good reason to believe that the information described in subparagraph (A) is inaccurate; or

''(iii) if the information described in subparagraph (A) does not result in a finding of eligibility for medical assistance under title XIX of the Social Security Act, in which case—

''(I) the agency shall provide the individual with notice of—

''(aa) the circumstances under which such individual or applicable household members may qualify for additional assistance; and

''(bb) an opportunity to request a determination of whether such circumstances apply to the individual or applicable household members; and

''(II) if the individual requests such a determination, the agency shall ensure that the individual and applicable household members receive—

''(aa) an opportunity to provide any additional information needed to determine whether the circumstances described in subclause (I)(aa) apply;

''(bb) a determination of whether the circumstances described in subclause (I)(aa) apply (but only if the individual or applicable household members furnish requested information that is necessary to such determination); and

''(cc) receive any subsidies for which the individual or applicable household members qualify.

''(4) DEFINITIONS.—In this subsection:

''(A) HOUSEHOLD.—The term 'household' includes the individual filing the return, the individual's spouse (if any), and all dependents of the individual or the individual's spouse (if any).

''(B) SUBSIDIES.—The term 'subsidies' includes premium credits under section 36B, medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act, and cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act.

''(C) PERTINENT TAX INFORMATION.—The term 'pertinent tax information' refers to all information on the tax return that is potentially relevant to determining the applicable household member's eligibility for subsidies or that may facilitate data-matching with other records that are potentially relevant to determining such eligibility.

''(5) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to forbid

the Secretary, pursuant to section 6013(c) and other applicable legal authority, or the Secretary of Health and Human Services from implementing, with respect to individuals who have attained age 19, policies and procedures similar to those described in paragraphs (1) through (3) with respect to individuals under 19 years of age.''.

(h) CONTINUING CHIP OUTREACH AND ENROLLMENT GRANTS.—Section 2113(a) of the Social Security Act (42 U.S.C. 1397mm(a)) is amended—

(1) in paragraph (2), by striking ''such amounts'' and inserting ''the amounts described in paragraph (1)''; and

(2) by adding at the end the following:

''(3) ADDITIONAL GRANTS FOR FISCAL YEAR 2012 AND THEREAFTER.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2019, for purposes of awarding grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX and, with respect to fiscal years beginning with fiscal year 2014, premium credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act. Such grants and appropriations shall supplement and not supplant grants and appropriations that are made pursuant to other provisions of this section.''.

(i) SECRETARIAL REPORT COMPARING CHIP TO SUBSIDIZED COVERAGE IN THE EXCHANGE.—

(1) IN GENERAL.—Not later than March 1, 2016, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall submit to Congress a report that compares—

(A) the health plan coverage offered to eligible children in fiscal year 2015 by an average or median State plan for child health assistance under title XXI of the Social Security Act; and

(B) the health plan coverage that such children would have received in fiscal year 2015 if they were enrolled in a qualified health benefits plan through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and received all premium credits under section 36B of the Internal Revenue Code of 1986 and all cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act for which such children would have qualified if they were not eligible for child health assistance under title XXI of the Social Security Act.

(2) POLICY ANALYSIS.—If, as to an aspect of health plan coverage described in paragraph (3) (except as provided in the next sentence of this paragraph), the Secretary finds that the coverage described in paragraph (1)(A) is more favorable to families and children than is the coverage described in paragraph (1)(B), the report shall describe policy changes that would be needed to improve the latter coverage so that it reaches the level of favorability achieved by the former coverage. The analysis described in the previous sentence need not address the aspect of health plan coverage described in paragraph (3)(C)).

(3) HEALTH PLAN COVERAGE.—In this subsection, the term ''health plan coverage'' includes the following:

(A) The adequacy of covered benefits in meeting the health care needs of children, including those with special health care needs.

(B) Families' out-of-pocket and premium costs.

(C) Public-sector costs.

(D) Adequacy of pediatric provider networks.

(E) Quality of care measures focused specifically on children.

(F) Legal protections for children.

(G) Barriers to enrollment and service utilization.

(H) Interstate variation.

(I) Continuity of coverage and care.

(J) The impact of placing children and parents in different health plans.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prevent the report required under paragraph (1) from—

(A) analyzing State programs of child health assistance under title XXI of the Social Security Act that go beyond the average or median such program; or

(B) including in its comparative analysis factors in addition to those described in paragraph (3).

(j) SAFEGUARDING PROGRAM INTEGRITY AND IMPROVING EFFICIENCY BY PROVIDING HEALTH SUBSIDY PROGRAMS WITH ACCESS TO THE NATIONAL DIRECTORY OF NEW HIRES.—Section 453(j) of the Social Security Act (42 U.S.C. 653(j)) is amended by adding at the end the following:

''(12) INFORMATION COMPARISONS AND DISCLOSURE TO ASSIST IN ADMINISTRATION OF HEALTH SUBSIDY PROGRAMS.—

''(A) IN GENERAL.—If, for purposes of administering a State's medical assistance program under title XIX, a State's children's health assistance program under title XXI, premium assistance under section 36B of the Internal Revenue Code of 1986, or reduced cost-sharing subsidies under section 1402 of the Patient Protection and Affordable Care Act, a State or Federal agency responsible for the administration of the program transmits to the Secretary the names and social security account numbers of individuals, the Secretary shall disclose to such agency information on the individuals and their employers maintained in the National Directory of New Hires, subject to this paragraph.

''(B) CONDITION ON DISCLOSURE BY THE SECRETARY.—The Secretary shall make a disclosure under subparagraph (A) only to the extent that the Secretary determines that the disclosure would not interfere with the effective operation of the program under this part.

''(C) USE AND DISCLOSURE OF INFORMATION BY STATE OR FEDERAL AGENCIES.—

''(i) IN GENERAL.—A State or Federal agency may not use or disclose information provided under this paragraph except for purposes of administering a program referred to in subparagraph (A).

''(ii) INFORMATION SECURITY.—A State or Federal agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of information obtained under this paragraph and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures.

''(iii) PENALTY FOR MISUSE OF INFORMATION.—An officer or employee of a State agency described in this paragraph who fails to comply with this subparagraph shall be subject to the sanctions under subsection (l)(2) to the same extent as if the officer or employee were an officer or employee of the United States.

''(D) PROCEDURAL REQUIREMENTS.—State or Federal agencies requesting information under this paragraph shall adhere to uniform procedures established by the Secretary governing information requests and data matching under this paragraph.

''(E) REIMBURSEMENT OF COSTS.—The State or Federal agency shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this paragraph.''.

(k) DEFICIT REDUCTION CONTINGENCY.—

(1) IN GENERAL.—If a deficit reduction contingency applies to this section and the amendments made by this section, then there is appropriated, for each of fiscal years 2010 through 2019, to the Fund for Vulnerable Children and Families described in paragraph (2), out of any money in the Treasury not otherwise appropriated, an amount equal to 50 percent of the annualized deficit reduction contingency amount.

(2) THE FUND FOR VULNERABLE CHILDREN AND FAMILIES.—

(A) AUTHORITY TO ESTABLISH.—If a deficit reduction contingency applies as described in paragraph (1), the Secretary of Health and Human Services shall establish a Fund for Vulnerable Children and Families. Any dollars appropriated or donated to such Fund shall be used for any of the following purposes:

(i) Combating infant mortality.

(ii) Providing additional supports or services for low-income children with autism spectrum disorders or other disabilities.

(iii) Assisting in the provision of services to improve health care services (including mental health care services) for children in foster care under the responsibility of a State and homeless children.

(B) ANNUAL REPORTS.—The Secretary shall provide annual reports to the Congress that provide a full accounting of the revenue and expenditures of the Fund for Vulnerable Children and Families.

(3) DEFINITIONS.—In this subsection:

(A) DEFICIT REDUCTION CONTINGENCY.—A ''deficit reduction contingency'' applies to this section and the amendments made by this section if the Director of the Congressional Budget Office has found that such provisions, taken together (but without regard to this subsection), will cause a net reduction in the projected Federal budget deficit over the period of fiscal years 2010 through 2019.

(B) ANNUALIZED DEFICIT REDUCTION CONTINGENCY AMOUNT.—The term ''annualized deficit reduction contingency amount'' means the amount of the net deficit reduction described in subparagraph (A) divided by 10.

(l) CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding before the period '', except as required under section 1902(e)(14)''.

SA 2791. Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

On page 17, strike lines 9 through 24, and insert the following: ''ance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

''(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the

current recommendations of the United States Preventive Services Task Force;

''(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

''(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

''(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.''.

''Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.''.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS

Mr. DORGAN. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, December 3, 2009, at 2:15 p.m. in room 628 of the Dirksen Senate Office Building to conduct a business meeting on pending committee issues, to be followed immediately by an oversight hearing on Expanding Dental Health Care in Indian Country, and a second hearing entitled ''Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services.''

Those wishing additional information may contact the Indian Affairs Committee at 202–224–2251.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Stic Harris, a fellow in the office of Senator FRANKEN, be granted floor privileges for the duration of the debate on H.R. 3590.

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

Mr. DODD. Mr. President, I ask unanimous consent that privileges of the floor be granted for the remainder of this Congress to the following members of my staff: Joe Caldwell and Melinda Leidy.

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

Mr. CASEY. Mr. President, I ask unanimous consent that a member of my staff, Avni Shridharani, be granted the privilege of the floor for the remainder of the Senate consideration of H.R. 3590.

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

Mr. DURBIN. Mr. President, I ask unanimous consent that Jeff Peltola and Rob Paolucci, fellows in the office of Senator PRYOR, be granted floor privileges during the consideration of H.R. 3590.

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

SUPPORTING THE OBSERVANCE OF NATIONAL DIABETES MONTH

Mr. DURBIN. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 364, which was submitted earlier today.

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

The clerk will report.

The assistant legislative clerk read as follows:

A resolution (S. Res. 364) supporting the observance of National Diabetes Month.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. Madam President, I ask unanimous consent that my name be added as a cosponsor of the resolution.

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

Mr. DURBIN. Madam President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 364) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 364

Whereas there are nearly 24,000,000 people in the United States with diabetes and 57,000,000 with pre-diabetes;

Whereas diabetes contributed to the deaths of over 300,000 people in the United States in 2007, making diabetes the seventh leading cause of death;

Whereas every minute, 3 people are diagnosed with diabetes;

Whereas each day approximately 4,384 people are diagnosed with diabetes and, in 2007, approximately 1,600,000 new cases of diabetes were diagnosed in people 20 years or older;

Whereas between 1990 and 2001, diabetes prevalence in the United States increased by more than 60 percent;

Whereas over 24 percent of diabetes is undiagnosed, down from 30 percent in 2005, and 50 percent 10 years ago;

Whereas over 10 percent of adults and nearly ¼ (23.1 percent) of people in the United States age 60 and older have diabetes;

Whereas diabetes is a serious chronic condition that affects people of every age, race, income level, and ethnicity;

Whereas Hispanic, African, Asian, and Native Americans are disproportionately affected by diabetes and suffer at rates much higher than the general population;

Whereas annually, 15,000 youth in the United States are diagnosed with type 1 diabetes and approximately 3,700 youth are diagnosed with type 2 diabetes;

Whereas 1 in 3 people in the United States born in the year 2000 will develop diabetes in their lifetime, and this statistic grows to nearly 1 in 2 for minority populations;

Whereas diabetes costs the United States an estimated $174,000,000,000 in 2007, and $1 in every $10 spent on health care is attributed to diabetes and its complications;

Whereas approximately 1 out of every 4 Medicare dollars is spent on the care of people with diabetes;

Whereas every day 230 people with diabetes undergo an amputation, 120 people enter end-stage kidney disease programs, and 55 people go blind from diabetes;

Whereas there is not yet a cure for diabetes;

Whereas there are proven means to reduce the incidence of and delay the onset of type 2 diabetes;

Whereas people with diabetes live healthy, productive lives with the proper management and treatment; and

Whereas National Diabetes Month is celebrated in November: Now, therefore, be it

Resolved, That the Senate—

(1) supports the goals and ideals of National Diabetes Month, including encouraging people in the United States to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease;

(2) recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for diabetes, which include—

(A) being over the age of 45;

(B) coming from certain ethnic backgrounds;

(C) being overweight;

(D) having a low physical activity level;

(E) having high blood pressure; and

(F) a family history of diabetes or a history of diabetes during pregnancy; and

(3) supports decreasing the prevalence of diabetes, developing better treatments, and working toward an eventual cure in the United States through increased research, treatment, and prevention.

ORDERS FOR TUESDAY, DECEMBER 1, 2009

Mr. DURBIN. Madam President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. tomorrow, Tuesday, December 1; that following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed to have expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, for debate only, until 11:30 a.m., with the Republicans controlling the first 30 minutes and the majority controlling the next 30 minutes, and with the remaining time equally divided and controlled between the two leaders or their designees, and with Senators permitted to speak therein for up to 10 minutes each; further, that at 11:30 a.m. the Senate proceed to executive session to consider the nomination of Calendar No. 487, Jacqueline Nguyen, as provided for under the previous order; and finally, I ask that the Senate recess from 12:30 until 2:15 p.m. to allow for the weekly caucus luncheons.

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

PROGRAM

Mr. DURBIN. Madam President, under a previous order, at 12 noon, the Senate will proceed to vote on the confirmation of the Nguyen nomination. That will be the first vote of the day.

Following the recess for the caucus luncheons, the Senate will resume consideration of the health care reform legislation. Additional rollcall votes are expected to occur throughout the day.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. DURBIN. Madam President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 6:55 p.m., adjourned until Tuesday, December 1, 2009, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF STATE

ALLAN J. KATZ, OF FLORIDA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE PORTUGUESE REPUBLIC.

IAN C. KELLY, OF MARYLAND, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE U.S. REPRESENTATIVE TO THE ORGANIZATION FOR SECURITY AND COOPERATION IN EUROPE, WITH THE RANK OF AMBASSADOR.

BISA WILLIAMS, OF NEW JERSEY, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF NIGER.

RAUL YZAGUIRRE, OF MARYLAND, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE DOMINICAN REPUBLIC.

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

PATRICK K. NAKAMURA, OF ALABAMA, TO BE A MEMBER OF THE FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION FOR A TERM OF SIX YEARS EXPIRING AUGUST 30, 2010, VICE ROBERT H. BEATTY, JR., TERM EXPIRED.

PATRICK K. NAKAMURA, OF ALABAMA, TO BE A MEMBER OF THE FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION FOR A TERM OF SIX YEARS EXPIRING AUGUST 30, 2016. (REAPPOINTMENT)

DEPARTMENT OF JUSTICE

BARBARA L. MCQUADE, OF MICHIGAN, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF MICHIGAN FOR THE TERM OF FOUR YEARS, VICE STEPHEN JOSEPH MURPHY III, RESIGNED.

JAMES L. SANTELLE, OF WISCONSIN, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF WISCONSIN FOR THE TERM OF FOUR YEARS, VICE STEVEN M. BISKUPIC, RESIGNED.

THOMAS GRAY WALKER, OF NORTH CAROLINA, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF NORTH CAROLINA FOR THE TERM OF FOUR YEARS, VICE GEORGE E. B. HOLDING.

CHRISTOPHER A. CROFTS, OF WYOMING, TO BE UNITED STATES ATTORNEY FOR THE DISTRICT OF WYOMING FOR THE TERM OF FOUR YEARS, VICE KELLY HARRISON RANKIN.

WILLIE LEE RICHARDSON, JR., OF GEORGIA, TO BE UNITED STATES MARSHAL FOR THE MIDDLE DISTRICT OF GEORGIA FOR THE TERM OF FOUR YEARS, VICE THERESA A. MERROW, RESIGNED.

EXTENSIONS OF REMARKS

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Tuesday, December 1, 2009 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

DECEMBER 2

9 a.m.
Armed Services
To hold hearings to examine Afghanistan.
SD–106

9:30 a.m.
Agriculture, Nutrition, and Forestry
To hold hearings to examine over-the-counter (OTC) derivatives reform and addressing systemic risk.
SH–216

10 a.m.
Commerce, Science, and Transportation
To hold hearings to examine transportation security challenges post-9/11.
SR–253

Energy and Natural Resources
To hold hearings to examine policy options for reducing greenhouse gas emissions.
SD–366

Judiciary
To hold hearings to examine the Supreme Court, focusing on Americans' access to courts.
SD–226

Joint Economic Committee
To hold hearings to examine unregulated markets, focusing on regulatory reform in the financial sector.
210, Cannon Building

2:30 p.m.
Homeland Security and Governmental Affairs
Disaster Recovery Subcommittee
To hold hearings to examine disaster case management, focusing on developing a comprehensive national program focused on outcomes.
SD–342

Environment and Public Works
Superfund, Toxics and Environmental Health Subcommittee
To hold an oversight hearing to examine the Federal Toxic and Substances Control Act.
SD–406

DECEMBER 3

9 a.m.
Foreign Relations
To hold hearings to examine Afghanistan, focusing on assessing the road ahead.
SH–216

10 a.m.
Banking, Housing, and Urban Affairs
To hold hearings to examine the nomination of Ben S. Bernanke, of New Jersey, to be Chairman of the Board of Governors of the Federal Reserve System.
SD–106

Energy and Natural Resources
To hold hearings to examine H.R. 3276, to promote the production of molybdenum-99 in the United States for medical isotope production, and to condition and phase out the export of highly enriched uranium for the production of medical isotopes.
SD–366

Homeland Security and Governmental Affairs
To hold hearings to examine the nomination of Caryn A. Wagner, of Virginia, to be Under Secretary of Homeland Security for Intelligence and Analysis.
SD–342

Judiciary
Business meeting to consider S. 448, to maintain the free flow of information to the public by providing conditions for the federally compelled disclosure of information by certain persons connected with the news media, S. 714, to establish the National Criminal Justice Commission, S. 1624, to amend title 11 of the United States Code, to provide protection for medical debt homeowners, to restore bankruptcy protections for individuals experiencing economic distress as caregivers to ill, injured, or disabled family members, and to exempt from means testing debtors whose financial problems were caused by serious medical problems, S. 1765, to amend the Hate Crime Statistics Act to include crimes against the homeless, S. 1353, to amend title 1 of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits, S. 678, to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, and the nominations of Thomas I. Vanaskie, of Pennsylvania, to be United States Circuit Judge for the Third Circuit, Louis B. Butler, Jr., to be United States District Judge for the Western District of Wisconsin, Denny Chin, of New York, to be United States Circuit Judge for the Second Circuit, Rosanna Malouf Peterson, to be United States District Judge for the Eastern District of Washington, and William M. Conley, to be United States District Judge for the Western District of Wisconsin, and Susan B. Carbon, of New Hampshire, to be Director of the Violence Against Women Office, John H. Laub, of the District of Columbia, to be Director of the National Institute of Justice, Sharon Jeanette Lubinski, to be United States Marshal for the District of Minnesota, Mary Elizabeth Phillips, to be United States Attorney for the Western District of Missouri, Sanford C. Coats, to be United States Attorney for the Western District of Oklahoma, and Stephen James Smith, to be United States Marshal for the Southern District of Georgia, all of the Department of Justice.
SD–226

2 p.m.
Environment and Public Works
Water and Wildlife Subcommittee
To hold hearings to examine S. 373, to amend title 18, United States Code, to include constrictor snakes of the species Python genera as an injurious animal, S. 1519, to provide for the eradication and control of nutria in Maryland, Louisiana, and other coastal States, S. 1421, to amend section 42 of title 18, United States Code, to prohibit the importation and shipment of certain species of carp, S. 1965, to authorize the Secretary of the Interior to provide financial assistance to the State of Louisiana for a pilot program to develop measures to eradicate or control feral swine and to assess and restore wetlands damaged by feral swine, H.R. 2188, to authorize the Secretary of the Interior, through the United States Fish and Wildlife Service, to conduct a Joint Venture Program to protect, restore, enhance, and manage migratory bird populations, their habitats, and the ecosystems they rely on, through voluntary actions on public and private lands, S. 1214, to conserve fish and aquatic communities in the United States through partnerships that foster fish habitat conservation, to improve the quality of life for the people of the United States, H.R. 3537, to amend and reauthorize the Junior Duck Stamp Conservation and Design Program Act of 1994, H.R. 3433, to amend the North American Wetlands Conservation Act to establish requirements regarding payment of the non-Federal share of the costs of wetlands conservation projects in Canada that are funded under that Act, and H.R. 509, to reauthorize the Marine Turtle Conservation Act of 2004.
SD–406

2:15 p.m.
Indian Affairs
Business meeting to consider pending calendar business; to be immediately followed by an oversight hearing to examine expanding dental health care in

Indian Country; to be immediately followed by an oversight hearing to examine Contract Health Services.

SD–628

2:30 p.m.

Energy and Natural Resources

National Parks Subcommittee

To hold hearings to examine S. 760, to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the ''National World War I Memorial'', S. 1838, to establish a commission to commemorate the sesquicentennial of the American Civil War, S. 2097, to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I, S. 2722, to authorize the Secretary of the Interior to conduct a special resource study to determine the suitability and feasibility of adding the Heart Mountain Relocation Center, in the State of Wyoming, as a unit of the National Park System, S. 2726, to modify the boundary of the Minuteman Missile National Historic Site in the State of South Dakota, S. 2738, to authorize National Mall Liberty Fund D.C. to establish a memorial on Federal land in the District of Columbia to honor free persons and slaves who fought for independence, liberty, and justice for all during the American Revolution, H.R. 1849, to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the National World War I Memorial, to establish the World War I centennial commission to ensure a suitable observance of the centennial of World War I, and H.R. 3689, to provide for an extension of the legislative authority of the Vietnam Veterans Memorial Fund, Inc. to establish a Vietnam Veterans Memorial visitor center.

SD–366

Intelligence

To hold closed hearings to consider certain intelligence matters.

S–407, Capitol

DECEMBER 4

9:30 a.m.

Joint Economic Committee

To hold hearings to examine the employment situation for November 2009.

SH–216

DECEMBER 9

9:30 a.m.

Veterans' Affairs

To hold hearings to examine the nominations of Robert A. Petzel, of Minnesota, to be Under Secretary for Health, and Raul Perea-Henze, of New York, to be Assistant Secretary for Policy and Planning, both of the Department of Veterans Affairs.

SR–418

10 a.m.

Judiciary

To hold an oversight hearing to examine the Department of Homeland Security.

SD–216

DECEMBER 10

10 a.m.

Energy and Natural Resources

To hold hearings to examine the role of grid-scale energy storage in meeting our energy and climate goals.

SD–366

Foreign Relations

To hold hearings to examine Treaty Between the Government of the United States of America and the Government of the United Kingdom of Great Britain and Northern Ireland Concerning Defense Trade Cooperation, done at Washington and London on June 21 and 26, 2007 (Treaty Doc. 110–07), and Treaty Between the Government of the United States of America and the Government of Australia Concerning Defense Trade Cooperation, done at Sydney, September 5, 2007 (Treaty Doc. 110–10).

SD–419

DECEMBER 15

10 a.m.

Energy and Natural Resources

To hold hearings to examine S. 2052, to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out a research and development and demonstration program to reduce manufacturing and construction costs relating to nuclear reactors, and S. 2812, to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs.

SD–366

SENATE—*Tuesday, December 1, 2009*

The Senate met at 10 a.m. and was called to order by the Honorable ROLAND W. BURRIS, a Senator from the State of Illinois.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Our Father God, author of liberty, as our governmental leaders face grave questions and perplexing problems so vitally affecting national welfare and world concord, we bow in reverence in Your presence. We acknowledge that it is because of You that we live and move and have our being.

Strengthen the leaders of our executive, judicial, and legislative branches to make their utmost contribution to the healing of the tangled tragedy of our troubled world. Through the lips that speak in this forum of freedom, Lord, speak to our Nation and world so that Your will may be accomplished on Earth. Heal the divisions which shorten the arm of our national might in this decisive season. Help our lawmakers to be patient and considerate one with another, as You give them reverence for truth and a passion for justice.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable ROLAND W. BURRIS led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 1, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable ROLAND W. BURRIS, a Senator from the State of Illinois, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. BURRIS thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Mr. President, following the remarks of the two leaders, the Senate will resume consideration of H.R. 3590, the health care reform legislation. That will be until 11:30 a.m., for debate only. The Republicans will control the first 30 minutes, the majority will control the next 30 minutes. Any remaining time will be equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each.

At 11:30 a.m., the Senate will turn to executive session to debate the nomination of Jacqueline Nguyen to be a U.S. District Judge for the Central District of California. The vote on confirmation of that nomination will occur at 12 noon today. That will be the first vote today.

The Senate will recess from 12:30 to 2:15 p.m., to allow for our weekly caucus luncheons. Following the recess, the Senate will resume consideration of the health care reform legislation. Additional votes are expected this afternoon in relation to the health care legislation.

HEALTH CARE REFORM

Mr. REID. Mr. President, here are two truths about the historic health care reform bill that is now before this body. First, it will save money, it will save lives, and it will save Medicare. Again, the legislation before this body will save lives, money, and Medicare.

While this is a pretty good start toward that, the second fact is, there is always room for improvement for this bill. Of course, that is what the legislative process is all about. Senator BARBARA MIKULSKI of Maryland has offered an amendment that does both. Her proposal would improve this bill by making sure women get, at no cost, the preventive screenings they need to stay healthy. These are important screenings that can catch potential problems as early as possible and that will save lives and save money.

Health care premiums rise higher and higher every year. The insurance industry this year has already raised insurance rates an average of 10 percent—an average. Of course, this is far faster than incomes in this country, and that is an understatement. As this happens, more and more women are simply skipping the important preventive care they need. Why? They are skipping screenings for cervical cancer, they are skipping screenings for breast cancer, they are skipping screenings for pregnancy. They are even skipping annual checkups and doctor visits that could flag serious problems, such as postpartum depression and domestic violence.

Why is this happening? Do women simply care less about their well-being? Of course not. Are diseases on the decline? Quite to the contrary. The only reason women are putting off going to the doctor is because, in our broken health care system, it simply costs too much to stay healthy.

Senator MIKULSKI's amendment also makes clear that the decision of whether and when to get a mammogram should be made by a patient and a doctor. It shouldn't be made by an insurance company, by Members of Congress or by someone you have never met. No matter what independent task forces recommend and no matter what some Republican Senators falsely claim, this legislation—the one before this body—offers free preventive services to millions of women who are being discriminated against by their insurance companies, and this amendment before this body makes that absolutely clear.

Senator MIKULSKI has long been someone who has been a leader and has looked out for women's health. Years ago, she worked with me on a problem women have; 90 percent of the people who have a disease called interstitial cystitis are women. I discovered that when three women came to visit me in Las Vegas. It was a disease that was ignored. People thought it was psychosomatic. Working with Senator MIKULSKI, we had the National Institutes of Health set up a protocol. Now 40 percent of those people, who previously were thought to be psychosomatic and who suffered with symptoms they described as shoving slivers of glass up and down their bladder, are symptom free—not 100 percent but 40 percent. It is easier to diagnose now.

Senator MIKULSKI has also worked hard to have the National Institutes of Health set up a division for women's health problems. So she is a leader in this area, has been for a long time, and with this amendment she does it once again.

I am sorry to see Republicans deliberately confuse the facts about women's health, particularly as they relate to mammograms. It shows how desperate some of them are to distract the

American people from the real debate and from the fact they have no vision for fixing our health care system, which is so broken.

I am even more sorry to say it is part of a larger trend. In recent days, they have been distorting the data from the Congressional Budget Office, an independent agency Republicans in the past have praised. What are they complaining about now, the Republicans? They are complaining about two of this Nation's top priorities: reforming our health care insurance system and helping our economy recover.

First, on health care. The Congressional Budget Office said yesterday the majority of American families who buy insurance in the new marketplace we will create—what we call health insurance exchanges—will see their premiums go down. They will go down by as much as 60 percent. Out of 100 percent of the American people, 93 percent will have a drop in their insurance premiums with this legislation—93 percent.

CBO's experts aren't the first to recognize these benefits. Massachusetts Institute of Technology's Jonathan Gruber, who is one of the most respected economists in the world, said in today's Washington Post:

> Here's a bill that reduces the deficit, covers 30 million people and has the promise of lowering premiums in the long run.

Pretty good statement. That means millions of Americans who today cannot afford coverage or whose medical bills drive them to financial ruin. Remember what I said yesterday as this debate began. Last year, 750,000 people in America filed for bankruptcy. Almost 70 percent of the bankruptcy filings were because of health care costs. But of those people who filed for bankruptcy because of health care costs, 62 percent of them had health insurance. Does that speak about a system that is in trouble? Of course it does.

So I repeat: This bill will mean millions of Americans who today cannot afford coverage or whose medical bills drive them to financial ruin will be able to afford to stay healthy. It means, if we don't reform health care, millions more will find themselves in bankruptcy, bad health or worse.

Second, on economic recovery. The Congressional Budget Office said yesterday the extraordinary steps we took to bring our economy back from the brink have created and saved hundreds of thousands of jobs. I will direct my comments to the American people but also to the brave Republicans who joined with us to make this possible—Senators SNOWE and COLLINS. I want them to know that what they did helped us get that legislation passed and, according to the Congressional Budget Office, saved hundreds of thousands of jobs. The CBO said yesterday the extraordinary steps we took to bring our economy back from the brink have created or saved hundreds of thousands of jobs. Its estimate reaches as high as 1.6 million jobs, each one a direct result of our economic recovery plan. Pretty good. The same report also said our country's gross domestic product has gone up by as much as 3.2 percentage points higher than it would have if we hadn't acted.

Let us not do what our colleagues on the other side of the aisle are doing—betting on failure. This country is coming out of a hole that was dug by this administration for some 8 years. The facts are that what we did on a bipartisan basis in January and February has brought this country out of an economic hole. We still have a ways to go, no question about it. But we created 1.6 million jobs and increased the gross national product by as much as 3.2 percentage points. Pretty good. These facts tell us the same thing: Not acting is not an option.

Some of my Republican colleagues prefer to close their eyes and ears to this reality. They prefer to play politics than to do what is right and what is necessary. They are content to say no, instead of offering constructive alternatives and a way to lead our country and our constituents back to health.

At the beginning of this second day of debate, I say: Come along and work with us to improve this legislation. Try to improve it the way Senator MIKULSKI looked at it and said: This legislation can be improved. We want to work with the minority. We want to have legislation that is bipartisan. We don't want to do this alone. We need the Republicans' help, and I hope they will join with us. It would certainly look better. Let's stop berating this legislation before this body. If they do not like it, try to do something to make it better.

As we know, this legislation saves lives, it saves money, it saves Medicare, and it brings down insurance premiums. That is a pretty good deal. And it brings down the debt. It saves $130 billion over the next 10 years and, after that, $650 billion. Not bad. So the numbers they keep talking about are out of—I don't know where they come from. We, as a body, have used the Congressional Budget Office for 50 years. It is bipartisan. That is the way it should be. We should start talking real numbers, not fake numbers.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. McCONNELL. Mr. President, certainly in a country of 300 million people there are differences of opinion, and you will see them on full display in the Senate on this monumental 2,074-page scheme that would expand the reach of government deeper into our lives, raise taxes, increase health care premiums, and cut Medicare for seniors.

On the other side are the American people. We know, from all the surveys we have seen, the American people are opposed to this bill. They are astonished that we are trying to pass a bill that is clearly opposed by the American people in every survey that has been published.

Americans do support reform, but this isn't the reform they were asking for, and it is not the reform they were told they could expect. In fact, it is pretty clear by now that the American people were sold a bill of goods when the administration and its allies in Congress said their health care bill would lower costs and help the economy because the plan that has been produced, that is before the Senate, will not do either.

The debate is no longer about improving care by reducing costs. We are past that. This plan will raise costs on American families, and it will make an already struggling economy even worse. The only question now is how we got to a point where we are actually considering spending trillions of dollars on a brand new government entitlement at a time when more than 1 in 10 Americans is looking for a job and when our debts and deficits are well past the tipping point.

For many, the answer to that question is quite clear. We know that some here in Washington have wanted government-run health care for many years. It is hard to escape the conclusion that these same people saw the current economic crisis as their moment. Earlier in this year, some in this administration said that "a crisis is a terrible thing to waste." Americans are hoping this bill is not what they meant, but they are concerned that it is.

Americans already know this bill will make our economic problems worse, not better, without even addressing the serious health care problems we already face—and they would be right. That is why they want us to start over and accomplish the real mission of lowering costs.

That is precisely what the McCain amendment would allow us to do. The McCain amendment would send this bill back for a rewrite. It would send it back to the Finance Committee with instructions to give us a new bill that does not include $½ trillion cuts to Medicare. It would send the bill back to committee; send us a new bill without $½ trillion cuts to Medicare, one that does not pay for the bill on the backs of seniors; that is, if you pass the McCain amendment.

Here is a program, the Medicare Program, that is already struggling, a program that needs help. Yet, in order to

finance their vision of reform, our friends on the other side want to use Medicare as a piggy bank to create an all-new government program that is bound to have the same problems as Medicare. As written, their bill would cut nearly $½ trillion from Medicare—not to make the program stronger but to fund more government spending. In the process, millions of seniors would lose benefits. Literally millions of seniors would lose benefits.

The McCain amendment would not let that happen. The McCain amendment tells the committees: Don't cut hospitals. The McCain amendment tells the committees: Don't cut hospice. The McCain amendment tells the committees: Don't cut home health care. The McCain amendment tells the committees: Don't cut Medicare Advantage. It would allow us to focus our efforts, instead, on the prevention of waste, fraud, and abuse, which we know to be rampant in this program. It would ensure we are not cutting one government program just to create a new one. That is what a vote in favor of the McCain amendment would be, it would be a vote to preserve Medicare, not weaken it. That is the message America's seniors want to hear in this health care debate, that improving health care in America doesn't have to come at their expense.

Some may argue that they need to cut Medicare to create a new government program. That is their call. But it is not the call Americans are asking us to make. I haven't gotten a call yet from anybody in Kentucky or around the country saying: Please cut Medicare so you can start a new program for somebody else—not my first call.

The American people want us to start over from the beginning and craft a bill they can actually support, and we know they don't support this bill. All the surveys indicate that. Then we could start over and end junk lawsuits against doctors and hospitals that drive up costs, something the majority didn't find any room for in their 2074-page bill—not a word about controlling junk lawsuits against doctors and hospitals. Then we could encourage healthy choices such as prevention and wellness programs, something the majority somehow couldn't squeeze into their 2074-page bill. Then we could lower costs by letting consumers buy coverage across State lines, something the majority must have overlooked in their 2074-page bill. Then we could address the rampant waste, fraud, and abuse, something our friends didn't think was important enough to seriously address in their 2074-page bill.

The McCain amendment would allow us to vote with seniors. That is what the McCain amendment is about. It would allow the Senate to say we are not going to finance a new government program on the backs of seniors, we are not going to use Medicare as a piggy bank to fund a new government program. It would allow us to vote with the American people. Most important, it would allow us to start over and get this right.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Mikulski amendment No. 2791 (to amendment No. 2786), to clarify provisions relating to first dollar coverage for preventive services for women.

McCain motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 11:30 will be for debate only, with the Republicans controlling the first 30 minutes and the majority controlling the next 30 minutes, with the remaining time equally divided and controlled between the two leaders or their designees and with Senators permitted to speak therein for up to 10 minutes each.

The Senator from Arizona is recognized.

Mr. KYL. Mr. President, I ask unanimous consent that during the 30 minutes controlled by the Republicans, we be allowed to engage in a colloquy.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. KYL. Mr. President, I will begin by making some comments about the amendment Senator MCCAIN, my colleague from Arizona, has filed. This is an amendment that, as the minority leader just said, will protect America's seniors. It will disallow the Medicare cuts this bill includes.

The economist Milton Friedman famously said, ''There is no such thing as a free lunch,'' and that applies to health care as well. There is no such thing as free health care. Someone has to pay. Since this bill is a $2.5 trillion bill, the first question is, Who pays? The first answer to who pays is, it is America's seniors, because about half of the cost of the bill is allegedly paid for by cuts to Medicare.

Let me break down a little bit more specifically than the Republican leader did exactly what that means. This is about $500 billion in Medicare cuts as follows: $137.5 billion from hospitals who treat seniors; $120 billion from Medicare Advantage, which is the insurance program that provides benefits to seniors which will be cut more than in half as a result of this $120 billion reduction; $14.6 billion from nursing homes that treat seniors; $42.1 billion from home health care for seniors; and $7.7 billion from hospice care, one of the most cruel cuts of all.

Obviously, with cut this dramatic there is no way to avoid jeopardizing the care seniors now enjoy, and seniors know this. That is why they have been writing our offices and attending townhall meetings to let us know they disapprove. I quoted from two letters constituents of mine from Arizona sent asking to please not cut their Medicare Advantage Program. This has been called the crown jewel of the Medicare system, and many of them rely on Medicare Advantage for dental care or vision care or hearing assistance they have come to rely on. They are not buying the claims that somehow or other we can make $½ trillion cuts in Medicare without somehow hurting their care. They know better than that, and they are right. The care they have been promised will be compromised to pay for this new government entitlement under the bill.

Finally, many are wondering what happened to the promise that they get to keep the care they have. We all heard the President say that many times: If you like the care you have, you get to keep it. That is simply not true. There are 337,000 Arizonans who are Medicare Advantage patients. They like what they have. Yet we know, according to the Congressional Budget Office, that the benefits they have under Medicare Advantage are going to be cut by more than half. They are saying: What happened to the policy I like? I am not going to be able to keep it if this bill passes.

This is why the McCain amendment must pass. If our Democratic colleagues are not willing to protect Medicare, then I cannot imagine how the bill could otherwise be made acceptable since it starts with the commitments that Congress and the President have made to our senior citizens.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee is recognized.

Mr. ALEXANDER. I congratulate the Senator from Arizona on his analysis of the Medicare cuts. I heard the Democratic leader talk about figures and how we have some figures and the Democrats have other figures. I agree with him. I think someone watching this must think we are on two different planets sometimes, so let me focus in on the figures.

I believe I heard my colleague say to pay for this health care bill over 10

years there would be $465 billion in the Medicare cuts. Where does that figure come from?

Mr. KYL. Mr. President, I say to my friend from Tennessee, first of all it comes from a reading of the bill. It is very clear in the bill as to how much money is taken from Medicare. The number the Senator from Tennessee just articulated is the correct number.

In addition to that, the Congressional Budget Office and the Joint Tax Committee analyzed the specific numbers. Obviously they were given the numbers in the bill, but the numbers they are using are—I just broke it down into four or five general categories. There are other divisions within that. But as I said, for notional purposes here: $137.5 billion from hospitals; $120 billion from Medicare Advantage. That number might be $118 billion; I am not precisely certain of it, but it is very close. There is $14.6 billion from nursing homes, $42.1 billion from home health, and $7.7 billion from hospice care. If any of our colleagues would like to contest these numbers, I would be happy to be corrected, but I believe those are the correct numbers.

Mr. ALEXANDER. I think the Senator from Arizona is right. The President of the United States, in his address to us about health care, and the New York Times, the Wall Street Journal—everyone who has reported on the Congressional Budget Office figures said the same thing. We are going to pay for this bill, which is $2.5 trillion over 10 years when fully implemented, by $465 billion cuts in Medicare.

What Senator MCCAIN in his amendment that we are in support of is saying is, don't cut grandma's Medicare to pay for someone else's insurance. He goes on to say, if you are going to find some savings in waste, fraud, and abuse in grandma's Medicare, spend it on grandma. The reason for that is that the Medicare trustees have said to us that there is $38 trillion in unfunded liabilities for the Medicare Program and that the program will start going bankrupt between 2015 and 2017. According to the Medicare trustees, they say, ''We need timely and effective action to address Medicare's financial challenges,'' and the proposal, if I may say to the Senator from Arizona, who is on the Finance Committee and deeply involved in what we need to do about our Nation's finances, I don't think the Medicare trustees were thinking that the timely and effective action we could take to keep Medicare from going broke was to take $465 billion out of it and spend it on some new program.

Mr. KYL. On a new program. That is exactly correct. What the Medicare trustees were saying is, if we can effect cost savings in Medicare, and surely there are some to be had there, they should go to strengthen the Medicare Program itself and not allow it to go bankrupt, rather than it being used to create a new government program.

Perhaps one of the reasons why there are different numbers from one side of the aisle to the other is that sometimes we are not talking apples to apples. We are talking apples to oranges, and perhaps both numbers are correct in their context. The Senator from Tennessee used the number $2.5 trillion when the program is fully implemented. That is a very important statement. The other side will argue it is only $1½ trillion for the first 10 years of the program. That is a correct statement. But it is $2.5 trillion for the first 10 years of total implementation of the program. What is the reason for the difference? For the first 4 years, money is being collected, but very few benefits are going out. The benefits start after year No. 4. So if we take the first 10 years of the program, we are collecting money to pay for it over the entire 10 years, but almost all of the benefits only occur during the last 6 years. Naturally, we have collected more money than we have paid out. But when we take the first 10 years of full implementation, it is as my colleague from Tennessee noted, a cost of $2.5 trillion. That is how sometimes we get somewhat different numbers.

As long as we are clear about what we are talking about, one thing is crystal clear: Whether it is $1½ trillion or $2.5 trillion, we are talking real money. Somebody has to pay for it. If America's seniors are being asked to pay for half of it, that is not fair to America's seniors, given the commitment we have made to them. That is the point of the McCain amendment. Protect Medicare, protect America's seniors. We can do that with the simple amendment Senator MCCAIN has which is send the bill back to committee—it would only take 1 day—and send it back here without those Medicare cuts in the bill.

Mr. ALEXANDER. I see the Senator from Idaho here. I wish to hear his observations. If there is any issue in this entire health care debate that symbolizes why we on the Republican side want to change the debate to a step-by-step approach to reducing the cost of premiums, it would be the Medicare issue. As the Senator from Arizona said, what we need to do about Medicare is make it solvent as quickly as we can, as effectively as we can. The Senator from Kansas said the other day that the proposal to take $465 billion from grandma's Medicare and spend on it some new program is like writing a check on an overdrawn account in a bank to buy a big, new car. There is a lot of truth to that.

The President said earlier this year something I agree with. He said this health care debate is not just about health care. It is about the role of the Federal Government in the everyday life of Americans. He is exactly right about that. This health care debate, which we are beginning this week, is not just about health care. It is about the stimulus package, about the takeover of General Motors. It is about the trillion dollar debt. It is about the Washington takeovers. It is about too much spending, too much taxes, too much debt. The Medicare provisions in this bill are a perfect symbol of that. That is why Senator MCCAIN is right. What he is saying is, don't cut grandma's Medicare and spend it on some new program. If you can find some savings in the waste, fraud, and abuse of grandma's Medicare, spend on it grandma. Make sure those of us who are older and those of us who are younger and looking forward to Medicare can count on its solvency.

Later this week we will talk more about premiums going up. There was a lot of discussion yesterday because, according to the Wall Street Journal, some health premiums would rise. For people who get their insurance from large employers, this bill won't make much difference. And for small employers, if you get your insurance from a small employer, it won't make much difference. If you are going to the individual market to buy insurance yourself, your premiums will go up, except we are going to get some money from somewhere to help pay part of your premiums, at least for about half of Americans who are in the individual market. Where are we going to get that money? From grandma. We are going to get it from Medicare. So that is what is wrong with this bill. And what is right about the McCain amendment is, it says simply, don't cut Medicare. If we find savings, which we hope we can in Medicare, we should spend it on making Medicare solvent.

I wonder if the Senator from Idaho is hearing from seniors in his State about the proposed $465 billion cuts to Medicare and how they feel about taking that money and spending it to create a new program?

Mr. CRAPO. I thank the Senator from Tennessee. Very definitely we are hearing from seniors in Idaho who see through this. It is very clear to the folks in Idaho that what we are seeing is a proposed massive growth of the Federal Government by over $2.5 trillion, when fully implemented, that is to be funded on the backs of American taxpayers and senior citizens through cuts in Medicare. In fact, in addition to those who have contacted me who are seeing their health benefits lost, I have also been contacted by a number of the providers. We are talking about those who are in home health care or hospice health care, skilled nursing facilities or hospitals and the like.

They make a very interesting point. Their point is that not only will senior citizens—in Medicare Advantage in particular—literally be losing their benefits dramatically, but that other senior citizens who are in traditional

Medicare will also be losing access and quality of care. How is that the case? We know from the details of this bill that we are going to see major cuts in hospice care, home health care, skilled nursing facilities, and hospitals.

The points made to me by those providers are that they have already gone through a series of very deep cuts, cuts to the point that in Idaho for home health care, we have lost something like 30 percent of our facilities already. The way one of them explained to it me was that if you reduce the compensation we are receiving, then we have to reduce something in our budget. He said: We can't just start taking bricks off of our buildings. What we will end up having to do is to reduce personnel. That would be the nurses and the doctors and the other care providers who are there to provide support for these individuals. We will have to reduce the number of rooms we operate or the facilities we provide. In the end, there will be a reduction of services and access available to senior citizens, including a reduction in the quality of the care they are able to be provided.

Mr. ALEXANDER. In discussing the Medicare cuts, another provision of the bill which we will be talking about this month and next month as we go through the health care debate is what about the problem of paying doctors and hospitals who see Medicare patients. They get paid about 83 percent of the rate they would be paid if they were seeing a private care patient. Every year Congress has to make an adjustment in something we did a few years ago which automatically cuts the amount of money that we pay doctors who are seeing Medicare patients.

That is a big problem for Medicare patients. Because if the doctors can't be paid, they won't see the patients, and Medicare patients may find themselves increasingly in the condition that Medicaid patients do, low-income Americans who are covered through the State program—that is our largest government-run program—where they are paid about 60 percent of what doctors who see private patients are paid and about half of Medicaid doctors won't see new patients.

I ask the Senator, does he see anywhere in this bill a provision for the $1¼ trillion that will be needed to pay doctors 10 years from now what they are making today? If it is not in the bill, where is that $1¼ trillion going to come from? Is it going to come from Medicare cuts, or will it come from adding to the deficit?

Mr. CRAPO. Obviously, it will come from cuts in Medicare or increased taxes or simply more debt on the Federal level.

The Senator raises a very interesting point. This question of fixing the compensation rates for physicians in Medicare is a huge question, one which we have been fighting for for a number of years to try to find a solution to, as each year we delay the expected cuts that will happen. I have talked about this factor in the context of being a budget gimmick in this bill. What do I mean by that? Those who say this bill reduces the deficit are able to say so only because it has about $500 billion of new taxes, about $500 billion of Medicare cuts, and a number of budget gimmicks that delay the implementation of the spending side of the bill or, in this case, don't even include at all one of the major expenses that needs to be accommodated, and that is the fix for physician compensation. If any of those things were not in this bill, this bill would drive up the deficit tremendously.

What we are going to see, in addition to these fiscal impacts on the Federal Treasury in terms of huge increases in the debt or huge increases in more taxes, even more than we are talking about with this bill, is we are going to see the very real potential that access to medical care for seniors will be again reduced because of this factor.

Let me give a couple of statistics. In their June 2008 report, the Medicare Payment Advisory Commission, or MedPAC, said that 29 percent of Medicare beneficiaries who were surveyed were looking for a primary care physician and had trouble finding one to treat them. In other words, about 30 percent of Medicare beneficiaries today are having trouble finding a physician who will take a Medicare patient. That is before the $465 billion of cuts and before simply not including physicians at all in this legislation.

A 2008 survey by the Texas Medical Association found that only 58 percent of the State's doctors took new Medicare patients, and only 38 percent of the primary care doctors accepted new patients. Again, it is an example from MedPAC and from one State that indicates what we know is happening around the country; namely, that doctors in increasing numbers are no longer taking new Medicare patients, just as they have been doing with Medicaid patients for years. Yet we see these massive cuts to Medicare being proposed that will have the same impact on hospice care and home health service and skilled nursing facilities and hospitals, and we see that doctors are not even included at all, meaning they are projected now to receive major reductions. I think it is over 20 percent reduction in their compensation for taking Medicare patients.

The solution here to establishing a massive new Federal entitlement program is not to cut Medicare. I want to repeat something both the Senators from Arizona and Tennessee have already said that is critical. Reducing the Medicare budget by $464 billion, by any number, is something that has been encouraged in terms of trimming the growth path for Medicare. That is something this Congress has looked at in the past. But never was it intended by those who made these projections about needing to control the spiraling cost of Medicare that we address the fiscal circumstances in Medicare with the intended purpose of creating another new, massive Federal entitlement program that will grow the Federal Government by over $2 trillion—we talked about the numbers; the full 10-year period is $2.5 trillion—and leave Medicare with these dramatic cuts, this loss of service and loss of benefits to the recipients, while they see this new government growth with a new government program. That was not in the mind of anybody who was asking us to deal with the solvency issues on Medicare, and I don't think it was in the mind of anybody who asked that we have some kind of health care reform to deal with the rising cost of premiums.

Mr. ALEXANDER. Mr. President, how much time remains on the Republican side?

The ACTING PRESIDENT pro tempore. The Senator has 8½ minutes.

Mr. ALEXANDER. Would the Chair let me know when 4 minutes remain.

The Senator from Idaho will conclude our remarks at that time.

The Senator from Idaho has made an important point, anticipating our Democratic friends will have the next 30 minutes and some other things they may be saying the rest of the day. There was a lot of talk yesterday about the CBO report about the effect of this $2.5 trillion proposal on premiums. Rather than take my word for it, let's go to the news section of the Wall Street Journal of today which has the headline: "Some Health Premiums to Rise." That means going up. That means the cost of your insurance is going up for some Americans.

So my question is, why would we spend $2.5 trillion over 10 years, cut Medicare, raise taxes, and run up the debt to raise some health premiums? I thought the whole exercise was to lower the cost of health care premiums.

The article says:

> The analysis released Monday by the nonpartisan Congressional Budget Office and the Joint Committee on Taxation—

We are supposed to pay some attention to these outfits as nonpartisan—

> painted a more complicated and uncertain picture. It said people who pay for their own insurance would see a higher bill, albeit for more generous benefits—

That is the government-approved insurance you are going to be forced to buy.

> unless they are lower earners who qualify for a new government tax credit.

Where is the money going to come from for those subsidies? It is going to come from grandma. It is going to come from Medicare. It is going to come from taxes. And it is going to come from increasing the debt.

Those are facts.

Employees of small firms—

Says the Wall Street Journal—

would effectively see their insurance premiums unchanged—

So for small firms, we are going to spend $2.5 trillion over 10 years, cut Medicare, cut taxes, and run up premiums for millions of Americans, so your insurance will continue to go up at about the rate it already was. Why should we be doing that?

while workers at large firms would see something between unchanged and slightly lower premiums under the bill—

Compared to what would already happen—

according to the analysis.

We need to change the debate. We need to start over. Instead of this comprehensive 2,000-page bill that is full of taxes, mandates and, as a general effect, raises premiums and taxes and cuts Medicare, we should set a clear goal, reducing costs, and begin to go step by step toward that goal—reducing junk lawsuits against doctors, allowing health care to be purchased across State lines to increase competition, allowing small businesses to combine in health plans so they can offer more insurance to employees at a lower cost.

These three bills I mentioned have been offered and rejected so far by the Democratic majority. We should have more flexibility in health savings accounts, efforts at waste, fraud, and abuse, which are, in effect, Medicaid—the largest government program—and Medicare—the second largest—and more aggressive steps to encourage wellness and prevention.

One approach, the comprehensive 2,000-page bill, Washington-takeover approach, Americans are very leery of. In my respectful opinion, this bill is historic in its arrogance for thinking we could take a system that affects almost all 300 million Americans, 16 percent of the economy, and change it all at once.

Instead, why don't we go step by step to re-earn the trust of the American people? Republicans will be making those proposals on the floor this month and next month and as long as it takes to try to see that we get real health care reform. Cutting grandma's Medicare by $½ trillion and spending it on a new program at a time when Medicare is going broke is not real health care reform.

Mr. CRAPO. Mr. President, how much time remains?

The ACTING PRESIDENT pro tempore. There is 4½ minutes remaining.

The Senator from Idaho.

Mr. CRAPO. Thank you, Mr. President. I wish to conclude with our time this morning by focusing on the larger picture a little bit, as my colleague from Tennessee has done in his concluding remarks.

When you ask Americans whether they want health care reform, the vast majority would say yes. When you ask them what they mean by that, the vast majority in the polls and in my personal experience are saying: We want to see the spiraling costs of health care and our health insurance brought under control and reduced, and we want to see increased access to quality health care for those who do not have access today and for those who have limited access today.

This bill fails on those two central points. What this legislation does, instead, is increase the size of government by $2.5 trillion of new Federal spending, establishing massive new Federal controls over the economy, and even creating a Federal Government insurance company. It increases taxes by about $500 billion, and not just on the so-called wealthy. The vast majority of these taxes is going to squarely hit those who President Obama said would not be hit: those who make less than $200,000 a year and, frankly, all the way down the income chain.

It cuts Medicare by $464 billion. It puts a major new unfunded mandate on our States, which are already struggling in their fiscal budgets. As my colleague indicated, it causes the price of insurance premiums to go up for the individual market, to go up in the small group insurance market, and to be basically unchanged in the large insurance market, according to the CBO study.

By the way, one of the things that is not pointed out in that CBO study very much is in that large market, which it says will be the only part of the market that does not see insurance rates go up, one of the reasons is because their health care will go down. In other words, there is a tax on these larger, high-cost insurance premiums that is going to be either passed through and cause their insurance to go up or will be avoided by reducing the cost of their insurance and reducing coverage of the benefits in these policies. So one way or the other, all Americans are going to see their health care premiums go up or, in the large groups, see their health care premiums be held the same by reducing the quality of the insurance they have.

If you go back to those two reasons Americans wanted health care reform, did we see premiums go down? No. Did we see increased quality or increased access to care? Well, there are some who are going to get a subsidy in this program for this new massive Federal program. But at what price? Mr. President, $2.5 trillion, $464 billion of cuts in Medicare, the establishment of a major new government program that would essentially be funded on the backs of massive new tax increases, massive Federal tax increases, and Medicare cuts, and in the end we will still be in a system in which we are seeing spiraling increases in health care costs. To me, that is not the kind of reform we need.

My colleague from Tennessee indicated there are a number of reforms on which we can find common ground that will reduce health care costs. There are a number of reforms on which we can find common ground that will help us to increase access to quality care. That is where our focus should be. That is why I stand here today in support of my colleague JOHN MCCAIN, his motion to commit this legislation to the Finance Committee. As was indicated, it could be done in 1 day, to simply remove the Medicare cuts that are contained within it. Let's fix that part of this bill, and then let's work forward.

I see my time has expired. I encourage this Senate to focus closely on the legislation and to let us work together in a bipartisan fashion rather than speeding ahead and trying to pass legislation that has not had the opportunity for this kind of bipartisan effort to develop a good work product for the American people.

The ACTING PRESIDENT pro tempore. The Senator from Connecticut.

Mr. DODD. Mr. President, our colleague from Maryland, Senator MIKULSKI, I believe is on her way to the floor of the Senate. She and several other Members, in the time we have allocated to us between now and 11:30, will address her amendment she proposed yesterday. But pending her arrival, I want to respond, if I could, very briefly to some of the conversation here this morning.

First, I know some people have short memories, but I am somewhat intrigued to hear our good friends and colleagues talk about preserving Medicare. I have been around here a few years and recall very vividly the debates of 1995 and 1997 on the issue of Medicare, where our friends, who were in the majority in those days, were talking about slowing the growth of Medicare and one of the proposals they had for doing so was to cut into the benefits of Medicare recipients.

We do not do that in this bill at all. Quite to the contrary, despite the language about ''big cuts in Medicare,'' we strengthen the Medicare Program substantially. That is the reason the AARP and other major organizations involved with the elderly have endorsed our proposals. They would hardly be doing so if they thought this was some massive cut into the Medicare Program that has been so critical to so many of our fellow citizens.

Just for a little bit of history here—In 1995 our Republican colleagues proposed cutting benefits to Medicare beneficiaries. Newt Gingrich, our former Speaker and friend from the other body, was quoted as saying ''let's let Medicare wither on the vine.'' That is not ancient history. That is not 1965. That is just a few years ago in all of this debate.

There are some very strong provisions in the bill that reduce premiums and co-pays for seniors, ensure seniors are able to see their own doctors, and keep Medicare from going bankrupt for an additional 5 years. If we adopt the McCain amendment, we are being told today by CBO and others that Medicare becomes insolvent in 8 years. So vote for the McCain amendment and you are going to have an insolvent program in 8 years. That is a fact.

We extend the life here an additional 5 years. We provide new preventive and wellness benefits for seniors, lower prescription drug costs, allow seniors to stay in their homes and not end up in nursing homes.

This is a long bill. It is a big bill. But instead of complaining about its size, I would encourage my colleagues to read it and understand what is being done for Medicare. This is a complicated area, but, nonetheless, critically important.

Mr. President, I see my colleague from California, Senator BOXER, who is here, and others who want to address the issue of the Mikulski amendment, and I will yield the floor so they can be heard. I believe it is going to be each for 5 minutes. There are about seven of our colleagues who want to be heard on the issue before 11:30.

Mrs. BOXER. Mr. President, if I might respond.

The ACTING PRESIDENT pro tempore. The Senator from California is recognized.

Mrs. BOXER. The plan is, women colleagues will be coming to the floor. As they come, I will yield to them, until Senator MIKULSKI gets here, and then she will yield the time, if that is all right.

Mr. DODD. Very good.

Mrs. BOXER. Mr. President, before I start, I want to say to my colleague from Connecticut how much I appreciate his work and the work of Senator BAUCUS and Senator REID. What a remarkable moment we have here.

When I go home—and I was home for the holidays—people are urging us to get this done. They know their biggest chance of going into bankruptcy is a health care crisis—62 percent. They know, as my friend Senator DODD has said almost every day of this debate, every morning 14,000 people lose their health care. They know if we do not intervene with a good bill, their premiums—in my home State, I say to the Senator—will be 41 percent of their income, the average income, by 2016.

Can you imagine? That is unsustainable. For people who say: Why don't we address the economy instead of health care, let me say what happens to my constituents if they have to pay 41 percent of their income for premiums. Even if they have a good job, I say to my friend from Connecticut, they cannot make it. So the status quo is cruel, and it is particularly cruel to women.

AMENDMENT NO. 2791

Mrs. BOXER. Mr. President, I am proud to support the Mikulski-Harkin-Boxer amendment to improve preventive health coverage for women. The Mikulski amendment addresses this critical issue by requiring that all health plans cover comprehensive women's preventive care and screenings—and cover these recommended services at little or no cost to women. These health care services include annual mammograms for women at age 40, pregnancy and postpartum depression screenings, screenings for domestic violence, annual women's health screenings, and family planning services.

The preventive services covered under this amendment would be determined by the Health Resources and Services Administration to meet the unique preventive health needs of women. HRSA is an agency within the Department of Health and Human Services. HHS Secretary Kathleen Sebelius has already said that ''Mammograms have always been an important life-saving tool in the fight against breast cancer and they still are today.'' The Secretary made clear that recommendations by the U.S. Preventive Services Task Force ''do not set federal policy and they don't determine what services are covered by the federal government.''

This is not the first time that experts have disagreed about this issue. I have been in this battle before, with Senator MIKULSKI, who called a hearing with all of the women Senators in 1994 where I insisted that routine mammograms for women over 40 must be covered. And thank goodness we fought back then, and in 1997 and in 2002 when this issue was raised again and again. Since 1991, the death rate from breast cancer has been reduced by over 20 percent.

According to a 2007 Partnership for Prevention report, 3,700 additional lives would be saved each year if we increased to 90 percent the portion of women age 40 and older who have been screened for breast cancer in the past 2 years. The most recent data show us that approximately 17 percent of breast cancer deaths occurred in women who were diagnosed in their forties. That is why the American Cancer Society continues to recommend annual screening using mammography and clinical breast examination for all women beginning at age 40. Mammograms are still the most effective and valuable tool for decreasing suffering and death from breast cancer. The Mikulski amendment will ensure women are able to get access to this and other life-saving preventive services at no cost.

The underlying bill introduced by Senator REID already requires that preventive services recommended by the U.S. Preventive Services Task Force be covered at little to no cost. These recommendations already include some women's preventive services such as osteoporosis screenings.

But they do not include certain recommendations that many women's health advocates and medical professionals believe are critically important, such as screenings for ovarian cancer—a disease that will claim the lives of nearly 15,000 women this year. We know that when ovarian cancer is diagnosed early, more than 93 percent of women survive longer than 5 years.

Women are often the decisionmakers for their families when it comes to health care. But women too often put the health needs of their family members and their children ahead of their own.

By passing this amendment, we are saving the lives of countless mothers, daughters, grandmothers and sisters who would otherwise forgo preventative health care because of high copays and expensive deductibles.

I would like to share with my colleagues a story from a doctor in my home State of California, William Leininger, that drives home the importance of this amendment:

> In my last year of residency, I cared for a mother of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband's insurance, but it was an abusive relationship, and she lost her health insurance when they divorced.
>
> For the next five years, she had no health insurance and never received follow-up care (which would have revealed that her cancer had returned). She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread.
>
> She had two children from her previous marriage—her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn't gain custody of her kids after her death. She succeeded. She was 28 when she died.

That is not a story that should be told in the richest nation in the world.

As I said, I am so proud to support the Mikulski-Harkin-Boxer amendment to improve preventive health care coverage for women. Here is why. It is a fact that women are increasingly delaying or skipping altogether preventive health care, and they are doing it because of costs.

I read a statistic done by a nonpartisan group that said about 39 percent of men are delaying going to a physician to check on a problem. But over 50 percent of women are doing that either because they do not have health coverage or they are fearful of the copay. So we could sit here and do nothing—that is the easy thing to do: Scare people, do nothing—or we could step to the plate, save Medicare, which is very important to save, and that is what this bill does. Because we say we are not going to spend money on waste, fraud, and abuse. We are going to spend money on health care for our people.

And to believe that my friends on the other side are the ones who are going

to save Medicare? You just have to read history. Senator DODD explained it; Newt Gingrich saying: Let Medicare wither on the vine; Bob Dole, our friend, who said, at the time of his Presidential campaign: I fought against Medicare. It was a failure.

Well, if you ask our seniors, I think they are the group most pleased with their coverage. It is not perfect, but it is critical, and we save it here. We extend the life of Medicare.

So here we are in a situation where many women are delaying going to the doctor, getting their preventive services, and the Mikulski amendment addresses this critical issue. It requires that all health plans cover comprehensive women's preventive care and screenings, and cover them at little or no cost.

The reason this is so important is—first of all, in the HELP Committee, under Senator DODD's and Senator Kennedy's leadership, this piece of the package was in the bill because Senator MIKULSKI and others pushed so hard to get it placed into the bill.

Mr. President, I would ask my friend from Maryland, Senator MIKULSKI, if I could complete my remarks and then give the floor over to her?

Mr. President, I thank the Senator.

I am so proud to work with Senator MIKULSKI. I say to the Senator, we worked on this issue over the years. I just asked my staff to go back and look at the first time we teamed up to ensure that women get mammograms at age 40. That was in 1994. Then, again, over the years, every 3 or 4 years, this whole notion would rear its ugly head: Well, women can do without mammography. The question I have is, What is going to replace it? They would keep trying to take away our tools of self-examination and mammography. We know if you look through the years—and Senator MIKULSKI and I are proud of a lot of the work we do, but this goes right at the top of the list—we know mortality for breast cancer is way down since the early 1990s. It is 20 percent down since the early 1990s. We have had to stand our ground to protect women, to make sure they get those services they need, those lifesaving services, at little or no cost.

I would also say the American Cancer Society continues to recommend annual screening using mammography and clinical breast exams for all women beginning at age 40. There are a lot of other very important tests that are included in the Mikulski amendment—very important tests—to deal with cervical cancer and ovarian cancer, finding the markers so we know how to deal with these deadly diseases. To give up the tools we have, to turn it over to some organization that does not report to the Secretary of HHS, makes no sense.

What my friend has done with her amendment is to make sure the group that decides this is under the jurisdiction of the HHS Secretary. We know the HHS Secretary has already said she wants to make sure women, starting at age 40, get those mammograms.

I am going to close by reading from an article in the March 10, 1994, San Francisco Chronicle. It says:

> Joining what became a phalanx of six female Senators staring down at federal health officials Boxer said she will insist that routine mammograms and a host of other women's health needs be part of any new nationwide benefit package.

The article goes on. It is very clear. What I said at the time is:

> After all of these years of women being told it is crucial by age 40 to get a baseline mammogram, now to have this tremendous confusion hit us is very disturbing.

Well, it was disturbing on March 10, 1994, when I first got involved in this issue. It was disturbing when Senator SNOWE, 3 years later, had us pass S. Res. 47 which said this is our only tool. Let's do it. Thank goodness we have now in this body women and men who get the fact that we refuse as women to be stripped of the only tools we have. Making all of these important tests part of this package is going to save lives. It is going to save money. It is going to mean our families can breathe a deep sigh of relief out there.

So I wish to thank Senator MIKULSKI for her leadership on this issue and to always stand right at her side on this issue of mammography. We also worked on standards for mammography. Remember that one? It was the deregulation fever that hit the Republican side. They wanted to take away the regulations for mammography, roll them back. We fought the fight, and we will continue to fight the fight.

So thank you very much. I strongly support this amendment.

I yield the floor for my friend, Senator MIKULSKI.

The ACTING PRESIDENT pro tempore. The Senator from Maryland is recognized.

Ms. MIKULSKI. Mr. President, as we debate health care reform, we need to recognize in the United States of America that health care is a women's issue. Health care reform is a must-do women's issue, and health insurance reform must be a must-change women's issue.

Too often when we look at when health care is even available to us, we face discrimination. We face continually the punitive practices of insurance companies that charge women more and give us less in a benefit. A 25-year-old woman pays more for health insurance than her male counterpart of the same health status. A 40-year-old woman pays almost 35 percent more for her insurance than a male of the same age, same health status. We want to change that in health care reform. We want to end the punitive practices of the private insurance companies in their gender discrimination.

We, the women of the Senate, are concerned that even being a woman is being viewed by the insurance companies as a preexisting condition.

Now we have the opportunity to change the law and change the direction of health care. I have offered an amendment to expand the screening and preventive services available to women in order to save our lives, make sure our lives are not impaired as we get older and, at the same time, be able to save money. We know early detection saves lives, curtails the expansion of disease, and, in the long run, saves money.

There are certain killers of women, the dread ''c'' word, cancer—breast cancer, ovarian cancer, cervical cancer that are unique to we women. Then there is the dread disease of lung cancer that affects men and women but is emerging as a main killer of women. Then there is the other issue of heart disease and vascular disease. We know for years women were often left out of the research on heart disease. For years women's heart disease went undetected and unrecognized because our symptoms are different. We can change this law.

In my amendment we expand the key preventive services for women, and we do it in a way that is based on recommendations from the Centers for Disease Control and from HRSA. It will be based on the benefit package available to Federal employees. It means if our amendment passes, the women of America will have the same access to preventive and screening services as the women of Congress. What is good enough for a United States Senator should be good enough for any woman in the United States of America.

That is why we ask not only the women to join us but the good men of quality who support us. We know people such as Senator DODD, Senator REID, Senator BAUCUS, men of quality, never fear we women who seek equality. They have raced for the cure as long and as hard as we have and have fought for mammogram standards. This is why we are wearing pink today. Pink is the universal color that says while we race for the cure, we want to have access to it when we find it. But to have access to the cure, we are going to need to have access to mammograms to be able to get that diagnosis, and then we are going to have to have health insurance to be able to pay for the treatment we have.

This is the Titanic battle we have today: Are we going to have access to health insurance and are we going to have access to these preventive services?

We do know in the area of heart disease and cancer and silent, undetected killers such as diabetes, it is often undetected. What happens is, for many women they do not get that early detection and screening, No. 1, because

they can't afford it. They can't afford it because they either don't have health insurance and there are other demands on their family or, No. 2, when they go, if they do have insurance, they find their benefit might not be covered. So many of these benefits are based on State mandates, but worse than that it is the copayments and high deductibles.

Many women say: Well, my insurance company provides for it, but this copayment and deductible, I have to choose between my children's shoes or my deductible. We want to either eliminate or shrink those deductibles and eliminate that high barrier, that overwhelming hurdle that prevents women from having access to these early detection and screening programs.

Much is being debated about mammograms. We believe access to mammograms should be universal, universal access. But the decision on whether to get one should be made with your doctor. Well, that is great to say, but you need to have access to your doctor. You need to not have to overcome the high hurdle of deductions or copayments to be able to do it.

We know mammogram screenings decrease breast cancer by over 40 percent. Regular pap smears reduce cervical cancer by 40 percent. This year, 4,000 women will die of cervical cancer. Then let's take the dread, but often overlooked, diabetic screening. Diabetes is the underlying cause of two-thirds of chronic illness in both younger and older women. If we find it early and get everybody in the right program, they are going to be able to get the treatment they need so they don't lose an eye, they don't lose a kidney, they don't lose a leg.

We can't lose any more time. We need to provide universal access to health care to the American people and we need to make sure they have access to the screening and early preventive actions that will save lives.

Mr. President, I urge the adoption of the Mikulski amendment, and I thank you for your leadership on this issue.

I ask unanimous consent that the remaining time be equally divided between Governor SHAHEEN, Senator HAGAN, Senator MURRAY, and Senator GILLIBRAND.

The PRESIDING OFFICER (Mr. DODD). Without objection, it is so ordered.

Who seeks recognition?

The Senator from New Hampshire.

Mrs. SHAHEEN. Mr. President, I rise today in support of Senator MIKULSKI's amendment to ensure that women have access to preventive health care screenings and care at no cost. I wish to thank Senator MIKULSKI for her leadership not just in this effort but over the years to make sure women are treated fairly when it comes to our health care.

As a woman, a mother of three daughters and a grandmother of three granddaughters, this is an issue that is critically important to me personally. But as a former Governor, now a Senator and a policymaker, I understand these preventive services are not just good for women but they are good for families—for the children and husbands and brothers and fathers of the women we are talking about today. This amendment is good for our society as a whole.

Women must have access to vitally important preventive services such as screenings for breast cancer, cervical cancer, pregnancy, and postpartum depression screenings, annual well-woman visits, and preconception counseling that promotes healthier pregnancies and optimal birth outcomes. It is the right thing to do, but it is also fiscally responsible.

Not only does diagnosing disease early significantly increase a woman's chance for survival, but it also significantly decreases the projected costs of treatment. In fact, one recent study estimated that almost 80 percent of all health care spending in the United States can be attributed to potentially preventable chronic illness. This amendment takes a great step forward to early diagnosis of these costly and potentially preventable diseases. We must ensure these important services are provided at no cost.

Too often, women forgo their health care needs because they are not affordable. We know cost plays a greater role in preventing women from accessing health care than it does men. In 2007, more than half of all women reported problems accessing needed health care because of costs.

It is clear we need to support Senator MIKULSKI's amendment that will give women access to important health care screening.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mrs. GILLIBRAND. Mr. President, I rise in support of Senator MIKULSKI's amendment, which improves the health care measures that are already in this act.

Women must shoulder the worst of the health care crisis, including outrageous discriminatory practices in care and coverage. Not only do we pay more for the coverage we seek for the same age and the same coverage as men do, but in general women of childbearing age spend 68 percent more in out-of-pocket health care costs than men.

Some of the most essential services required by women are currently not covered by many insurance plans, such as childbearing, Pap smears, and mammograms. A standard in-hospital delivery can cost between $5,000 and $10,000 and much more if there are complications. You cannot imagine what it is like for a pregnant woman to recognize she may not have coverage for the essential services she needs for herself and her child. The health care bill before us ensures that this will no longer happen.

However, there is much room for improvement. In America today, too many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost.

This fundamental inequity in the current system is dangerous and discriminatory and we must act.

The prevention section of the bill before us must be amended so coverage of preventive services takes into account the unique health care needs of women throughout their lifespan.

With Senator MIKULSKI's amendment, even more preventive screening will be covered, including for postpartum depression, domestic violence, and family planning.

Covering more preventive screening at no cost to women will encourage that more women go to the doctor, improving their health, saving lives and, as Senator MIKULSKI brought out, saving money.

The whole point of this health care bill is to lower costs across the board. When you shift America's health care system to preventive services over the current emergency room services, you are going to do exactly that.

This amendment will ensure that the coverage of women's preventive services is based on a set of guidelines developed by women's health experts.

This amendment will also preserve the doctor-patient relationship, to allow the patient to consult with their doctor on what services are best for them.

This amendment will cost $490 million over 10 years and it is fully paid for.

The health care crisis in America must be addressed, and I am very supportive of Senator MIKULSKI's amendment.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mrs. HAGAN. Mr. President, I rise in support of the amendment offered by the senior Senator from Maryland.

This amendment tackles a serious problem: Women are increasingly skipping critical preventive health care screenings because of costs, even when they have health insurance.

This summer, I received an e-mail from a woman named Julie in Raleigh, NC, about her sister who had no insurance and waited years to get a mammogram because she couldn't afford to pay the $125 fee for a mammogram. Then she found a lump in her breast.

Eventually, the mass grew so large Julie's sister finally got her mammogram and paid for it with cash. The mammogram confirmed what she had

suspected, that she had breast cancer. But now that she had a diagnosis, she had no way to pay for the treatment.

She lost her battle with breast cancer in March of this year. Julie's sister, perhaps, could have beaten this cancer if she had had access to affordable, preventive care and, after her diagnosis, access to insurance or medical care to cover her cancer treatment.

In this heartbreaking situation, Julie's sister was sick and stuck. This health care reform bill will provide people such as Julie's sister with access to affordable, quality health insurance.

The President of Randolph Hospital in Asheboro, NC, wrote to me recently that a few years ago, he was in a meeting with 20 to 30 of his nursing assistants who were covered by the hospital's insurance plan. Of those who were old enough to require a mammogram, only 20 percent had actually gotten one. The reason, they said, was the high out-of-pocket costs they would have to pay.

When these women had to choose between feeding their children, paying the rent, and meeting other financial obligations, they skipped important preventive screenings and took a chance with their personal health.

The hospital then decided to remove the financial barrier to preventive care and pay for 100 percent of preventive screenings.

With the passage of Senator MIKULSKI's amendment, we will do the same for all women. A comprehensive list of women's preventive services will be covered with no added out-of-pocket expenses.

With this amendment, we will ensure that, as the old saying goes, ''An ounce of prevention is worth a pound of cure,'' for women across America.

The PRESIDING OFFICER (Mrs. GILLIBRAND). The Senator from Washington is recognized.

Mrs. MURRAY. Madam President, I add my thanks to the Senator from Maryland, Ms. MIKULSKI, for bringing forth this important issue as we address health care reform in this country to ensure that all our families have access to health care.

One of the most important things we can do is make sure the caregivers in our families—the women—get access to preventive care so they can take care of their families.

This amendment will require all the health plans to cover comprehensive women's preventive care and screenings at no cost to women. That is extremely important. We all understand that—but especially in these tough economic times, when families across the country are struggling. One of the results has been that a lot of women are skipping or delaying their health care. We all know this personally. As moms, you take care of your kids first. When you do that, you often leave your families at risk because you haven't gotten the necessary preventive care.

We know that, in 2007, a quarter of women reported delaying or skipping health care because of the costs. In May of 2009, a report by the Commonwealth Foundation found that more than half of women delayed or avoided preventive care because of its cost.

This amendment will ensure that those women don't delay their preventive care because they cannot afford it. It is extremely important for this bill, it is important for women in this country, and it is important for men and children in this country as well.

I add my thanks to the senior Senator from Maryland and all our Senate colleagues who have been down here to make sure that one of the first things we do as we move the bill to the floor is make sure women's preventive care is covered.

I yield the floor.

Ms. MIKULSKI. Madam President, that concludes our discussion and our responses to this portion of the health care reform bill.

I must say: Alert, alert, alert. We have just been informed that a shrill advocacy group is spreading lies about this amendment. They are saying that because it is prevention, it includes abortion services. There are no abortion services included in the Mikulski amendment. It is screening for diseases that are the biggest killers for women—the silent killers of women. It also provides family planning—but family planning as recognized by other acts. Please, no more lies. Let's get off of it and save lives.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Montana is recognized.

Mr. BAUCUS. Madam President, I yield myself 1 minute. Very much straight to the point here, there has been some discussion about CBO's assessment on the health care premiums. The letter was out yesterday. That letter shows that for all Americans—all Americans—premiums will be lower. They will be modestly lower to those larger employers. We have a range between those small businesses of between a 1-percent reduction and a 2-percent increase, and for the individual market there is more variation because there is much more variation today currently in the individual market.

Those who purchase in the individual market will be getting a lot better quality of insurance than they are getting today—much better. About 60 percent of those in the individual market will find that their premiums are actually lower after the tax credit/subsidies are taken into consideration.

So netted all out together, all Americans are going to see their premiums are lower for what they get today. About 7 percent will see an increase, but they are getting better coverage than today—quite a bit better coverage. On a net basis, basically, bottom line, everyone were will see his or her premiums lower. For the 7 percent that are not lowered, they will get a lot better quality of insurance. That will more than offset the increase in premium. That is what that CBO letter says. I urge all folks who are interested to read that letter.

I have one other minor point on the so-called Cadillac plans. CBO said that those who receive Cadillac plans will find their premiums reduced, not increased—I think it is by about 6 or 7 percent. That, too, is very important. There has been a lot of discussion about the effect of premiums on Cadillac plans. CBO says those premiums will be reduced.

My minute is probably up. I wish to use the last seconds to just say that the net, all the way across the board, CBO says premiums will be reduced when you take subsidies into consideration and compare the plans people get today with what they would otherwise get in the future, the quality of coverage.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. COBURN. Madam President, how much time remains on the Republican side?

The PRESIDING OFFICER. Three minutes.

Mr. COBURN. Madam President, I ask unanimous consent to consume that 3 minutes and the other 15 minutes allotted to our side on the executive nomination, and when that 18 minutes is up, the remainder be followed by the time on the Democratic side and the nomination be reported.

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

Mr. COBURN. Madam President, I wished to spend a few minutes on this.

As a physician who cared for Medicare patients for 25 years, I cannot tell you how worried I am about what this bill is going to do to my senior patients. When Medicare was first written, two things were put into the law—very straightforward, very direct. Let me read them to you, for a minute. I hope Americans listen to this. Here is what the law is. CMS is breaking the law today and, with the new Medicare Commission, they are going to break it even further under this bill.

Section 1801 says this:

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

That says that the Federal Government cannot practice medicine. That is what it says.

Section 1802 says this—and this is where it is important for my Medicare patients and everyone out there:

> Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

Well, what we have in this bill is the gutting of those two foundational principles of Medicare. The first is the Medicare Advisory Commission is going to tell you what you can and cannot have. Here is what we are going to see: You will choose what I tell you to choose if you are a Medicare patient.

Not only do we have almost $500 billion in cuts to Medicare, under the auspices that we have to control entitlement spending; not only are we taking away plans from people who are very satisfied with what they have today, but we have enhanced, and will enhance, the ability of the Federal Government to practice medicine.

My colleagues on the other side of the aisle, who have never practiced medicine, who know the legalese but don't know the consequences of right now the rationing of Medicare on drugs such as Epigen and Neupogen—you see, Medicare has decided when oncologists can use those drugs. They have taken a blanket position, although they have released it somewhat. But what it says is this—I will give you a patient who has breast cancer. She is 67 years old. She is being treated for breast cancer. She becomes anemic and neutropenic. That means her white blood cell count, her ability to fight infection goes down.

We have wonderful drugs that raise the white blood cell count and raise the red blood cell count. But Medicare, in its obvious wisdom of practicing medicine, has told the oncologists when they can and cannot use it. That is fine for 75 percent of the patients, but it totally ignores the other 25 percent of the patients who happen to have complicating factors, such as congestive heart failure or if they become anemic under breast cancer chemotherapy and have congestive heart failure as well. The government says you cannot have erythropoietin at this level of hemoglobin regardless of whether you have congestive heart failure.

What happens is the practice of medicine out of Washington or Maryland, more specifically, determines who can and cannot have a drug; in this case, erythropoietin.

What is the consequence of that? The consequence is that the patient did not die of breast cancer; she died of congestive heart failure that could have easily been treated had we not had medicine practiced by CMS denying the ability of the physician to give the patient exactly what she needed when she needed it.

We are starting down that road with this bill—aggressively starting down that road—because the Medicare Payment Advisory Commission, combined with the Comparative Effectiveness Panel will not look at complications and will not look at secondary diseases. They will look at the average.

I want to tell my colleagues, when you are sitting in an office with your doctor, you are not average. You are you, and you are a specific individual with a set of factors that nobody else has. The judgment in the practice of medicine cannot be done by an insurance company or CMS at a distance without them having a hand on the patient. They never have their hand on a patient.

The whole art of medicine, which is 40 percent of getting people well, is the knowledge and training and experience and gray hair that comes with looking at the total patient, being one on one, not having the government between the doctor and their treatment of a patient.

What this bill does—this bill is a lie one of two ways. One, it says we are going to take this money out of Medicare and you are not going to notice any difference. That cannot be true. If we take $500 billion or $400 billion-plus out of Medicare, millions of seniors are going to notice a difference in their health care and what they get under Medicare. If we say that is not true, then the only way that is not true is the game that is being played on the financing of this program; that is to say, we are going to cut this money out of Medicare and then with a wink and a nod know we are never going to do it.

The majority leader said yesterday there is nothing more important in this Nation right now than passing health care reform. I differ with that statement. I think 10.2 percent unemployment is a whole lot more important, and finding those people jobs, than passing health care reform. I think a $12 trillion debt is more important to address than fixing health care right now. I think the fact that we have $350 billion worth of waste, fraud, and duplication in the Federal Government every year, and we are not addressing it, is more important than fixing health care right now. I think the fact that our economy is still on its back and people are continuing to lose jobs is more important than fixing health care right now.

I understand the political dynamics, but I also understand very well with my quarter of a century of practicing medicine that what this bill is going to do is destroy the best health care system in the world, and it is going to undermine the security of every senior in this country because what starts as a small couple of things, such as Neupogen and Epogen or like when you can have bone densitometry and whether your osteoporosis can truly be evaluated, CMS has already said how much you can do that, whether your bones are falling apart or not. It is the start of the government practicing medicine.

It is the beginning of our seniors having the government step in between them and their physician in terms of the physician wanting to do what is best for that senior and the government saying: No, I will tell you what you are going to have. I will tell you what you will have.

Thomas Jefferson taught us a lot. He predicted we would have "future happiness for us if we can prevent the government from wasting the labors of the people under the pretense of taking care of them."

I want to see a lot of things changed in health care. I want to see true competition in the insurance industry. I want to make sure nobody loses their insurance because they get sick. I want to make sure everybody can get insurance if they are sick. I do not disagree with the basic premise. What I disagree with is moving $2.5 trillion more under government control, which will raise costs ultimately in the health care sector. If it does not raise costs and we are truly going to take this money from Medicare, what it is going to do to our seniors, I have a message for you: You are going to die soon, and they are going to say that is not true, that it is not true.

When you restrict the ability of the primary caregivers in this country to do what is best for their senior patients, what you are doing is limiting their life expectancy. We are saying CMS, the Medicare Payment Advisory Commission, and the Comparative Effectiveness Panel will tell the doctors what they can and cannot do, ignoring the 20 percent of the people for whom that is exactly the wrong prescription. So for 20 percent of our seniors, this bill is going to be a disaster, but it is going to save money because you are not going to be around for us to spend any money on you because the government will have already told us what the treatment plan will be for you. We will decide in Washington through the Center for Medicare and Medicaid Services what you will receive.

They will dispute that, but the people who are going to be disputing that are lawyers; they are not doctors. They have never laid a hand on a patient. They have never put their hand forward on a Medicare patient knowing the consequences of the total patient, the background, the medical history, the sociologic factors that fit, the family dynamics, the past medical history, the family history, and the present state of mind of that patient.

Even more important, what this bill is going to do is divide the loyalty of your doctor away from you. When you go to the doctor today, most of the time that doctor's No. 1 interest is in you and your well-being. When you have this Medicare Payment Advisory

Commission and you have this Comparative Effectiveness Panel, what that does is that causes the physician—he or she—to take their eyes off of you. Now they are going to put their eyes on what the government says because the consequences of not doing what the government says will ultimately result in some type of sanction.

Do we want physicians to be patient-centered and focused on their patients or do we want physicians to have their eye on the government and half of an eye on the patient? Which do you think is going to give us the best care? Which do you think is going to give us the greatest quality of life? What is going to give us the greatest longevity with the greatest quality of life? Is it the government practicing medicine, or is it the trust that has been developed through years between a patient and a doctor to do what is in the best, long-term interest of that patient?

I cannot tell you the number of people who die from the CMS regulations on Epogen for oncologists. But there were hundreds—hundreds—because Medicare never looked at the patient; they looked at dollars.

As we go forward in this debate, what I want seniors in America to know—and I am fast approaching Medicare age; I am 3 years from it—I want them to know the key thing they are going to lose in this bill is the loyalty and primacy of their physician thinking about them. We are going to divide that loyalty to where the physician is going to be looking at the government. If you think that is not true, just look at what has happened so far when CMS has decided to start practicing medicine.

In the HELP Committee, I offered an amendment to change the language so there would be absolutely a prohibition on rationing care and directing the care from Washington. It was rejected out of hand—rejected out of hand. Not one of my colleagues on the other side of the aisle voted to prohibit rationing of health care.

Why would they do that? Because the ultimate intention through the Comparative Effectiveness Panel is to ration care. It is to ration the care. It is to limit the amount of dollars we spend and never look at the individual patient.

If we think about the Medicare cuts in this bill, we are going to take $135 billion out of the hospitals. Do you think seniors will ever notice that? I do. I think when you ring your button and you are hurting and you need pain medicines or you need to go to the bathroom, the time it takes for somebody to get there will not be sufficient. What will happen is you will wait. You will have a complication. If you have acute shortness of breath and press the button, the available nurses will not be there. There will be a consequence to cutting $135 billion from payments to hospitals in this country.

We are going to take $120 billion out of the seniors—the one in five seniors who now have Medicare Advantage. I agree, it is more expensive than Medicare. It needs to have some cost containment through competitive bidding, but we should not be decreasing the services, which is exactly what is going to happen. If you are a senior on Medicare Advantage, you are going to lose benefits you now have. You are going to lose them.

One of the ideas of Medicare Advantage was preventive services. One of the things that improved the care in rural America was Medicare Advantage. Yet we are going to take that away. The vast majority of the benefits we are going to cut in half.

We are going to take $15 billion from nursing homes. That may or may not be appropriate, but the way to do that is through a competitive experience based on quality and outcome rather than some green-eyeshade staffer saying we can take $15 billion out of Medicare from payments to nursing homes.

One little secret that is not in this bill, that has not been addressed in this bill, is the estimate by a Harvard researcher that there is $120 billion to $150 billion a year in fraud in Medicare alone. HHS admits to $90 billion. We know it is well over $100 billion a year. Cleaning up the fraud in Medicare would pay for a lot of health care for a lot of folks in this country. There is $2 billion in this whole bill to clean up the fraud.

Why would we not fix that first? Why would we take money from Medicare to create a new program when in fact we are wasting 10 to 15 percent?

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. COBURN. I will close with this remark. If you are a senior and you are on Medicare, you better be afraid of this bill. I don't come to the floor and say that very often, but your health care is totally dependent, in terms of being decreased by this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Madam President, I ask unanimous consent I be allowed to speak for 1 minute 7 seconds and the time be taken from that of my good friend and colleague from Vermont, the chairman of the Judiciary Committee.

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

Mr. DODD. Madam President, Senator TOM COBURN and I have become great friends. We have spent a lot of time together this summer in my HELP Committee. He talked with great eloquence about that distance that can occur between a doctor and patient, and obviously as someone who practiced medicine for a long time, he speaks from strong personal experience, and I admire and respect that immensely. But let me say to my colleagues, without this bill we are talking about here, this comes to a simple choice. Under existing law, the way things are today, one institution stands between a doctor and patient and that is your insurance company. They ration care all the time. In fact, I am a living example of rationed care, having been through surgery, getting preapproval twice before surgery and then being rejected by the very insurance company I paid premiums to for a long time as a Member of this body. We are working it out, I believe, because they thought—I am 65—that Medicare ought to pay for my surgery rather than the company I paid premiums to for a long time.

They were rationing my care. That insurance company, it wasn't some government entity or someone else, they are the ones. Without our bill, the only one getting to decide what health services anyone receives is the insurance industry.

I hope we would have a chance to debate this further, as I am confident we will.

Let me also say how much I support the effort by Senator MIKULSKI on her efforts to see to it that women are treated equally, and particularly in preventive care, and I strongly urge the adoption of her amendment and ask to be added as a cosponsor to that amendment.

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

Mr. DODD. I thank the Chair.

Mr. LEAHY. Madam President, our Nation is in the midst of a historic debate about how to reform our health insurance system. Three House committees and two Senate committees have spent countless hours trying to answer the question of how best to introduce competition and make health insurance affordable for all Americans. I applaud their efforts, and I applaud the efforts of the many Senators who have fought to bring this important debate to the Senate floor.

I have pushed and will continue to push for provisions that accomplish the ''three C's'' of health insurance reform: choice, competition, and cost control. I recently reaffirmed my support for a public option.

A public option would give consumers more choices to purchase an affordable and quality health insurance plan and will help drive down overall health care costs. I will continue to push for inclusion of a public option in the final Senate bill.

Amid this discussion of how best to introduce competition into the health insurance industry, it is important to remember that today the health insurance industry does not have to play by the same rule of competition as other industries. Due to a six decade-old special interest exemption, the business of insurance is not subject to the Nation's antitrust laws. If there was ever a good

reason for such an exemption, it no longer exists.

While there are divergent views on the best way to introduce choice and competition into health insurance market, we can surely agree that health and medical malpractice insurers should not be allowed to collude to set prices and allocate markets.

Today, I am filing the Health Insurance Industry Antitrust Enforcement Act of 2009 as an amendment to the Patient Protection and Affordable Care Act. This legislation, which I introduced in September and which is cosponsored by 18 Senators, will repeal the antitrust exemption for health insurance and medical malpractice insurance providers, and ensure that the basic rules of fair competition apply to the industry as part of the reforms that the larger health care bill will enact. Our Nation's antitrust laws exist to protect consumers, and it is vital that the health insurance and medical malpractice insurance companies are subject to these laws.

These laws promote competition, which ensures that consumers will pay lower prices and receive more choices.

The Majority Leader, an original cosponsor of this legislation, testified before the Senate Judiciary Committee that ''[i]t is of the upmost importance that we make sure the insurance industry is playing by the same rules as everyone else, and that they are subject to competition.'' I could not agree more, and I encourage the leader to schedule a vote on this amendment early in this debate. The President also recently supported Congress's efforts to determine whether any justification remains for permitting price fixing.

The vast majority of the companies doing business in the United States are subject to the Federal antitrust laws.

However, a few industries have used their influence to maintain a special, statutory exemption from the antitrust laws. The insurance industry is one of those few remaining industries. In the markets for health insurance and medical malpractice insurance, patients and doctors are paying the price, as costs continue to increase at an alarming rate, while patients and small businesses suffer. This is wrong, and this amendment fixes this problem.

The Health Insurance Industry Antitrust Enforcement Act is supported by a cross-section of groups interested in promoting competition, including the Consumer Federation of America, Health Care for American Now, and the American Hospital Association. I also received a letter from a coalition of 10 State attorneys general who voiced their specific need for this legislation.

The top law enforcement officers in those States argue that ''Repeal of the McCarran-Ferguson exemption would enhance competition in health and medical malpractice insurance by giving state enforcers, as well as federal enforcers, additional tools to combat harmful anti-competitive conduct.'' The letter goes on to state that ''The McCarran-Ferguson exemption serves no plausible public interest.''

This amendment will prohibit the most egregious anticompetitive conduct—price fixing, bid rigging and market allocations—conduct that harms consumers, raises health care costs, and for which there is no justification. Subjecting health and medical malpractice insurance providers to the antitrust laws will enable customers to feel confident that the price they are being quoted is the product of a fair marketplace.

The lack of affordable health insurance plagues families throughout our country, and this amendment is a first step towards ensuring that health insurers and medical malpractice insurers are subject to fair competition. I hope all Senators will join me in support of this important amendment.

Madam President, I note my amendment removes the outdated, antiquated, unnecessary antitrust protection given to our insurance companies, a protection which, instead of allowing them to thrive and give us lower premiums, has perversely acted in such a way that our premiums continue to rise 15 percent in the last year alone. This will help change that.

EXECUTIVE SESSION

NOMINATION OF JACQUELINE H. NGUYEN TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to executive session to report the following nomination.

The bill clerk read the nomination of Jacqueline H. Nguyen, of California, to be United States District Judge for the Central District of California.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. LEAHY. Madam President, I understand the Senator from California desires some time. I yield her 5 minutes, beginning now.

Mrs. FEINSTEIN. Madam President, I rise to speak in support of the nomination of California Superior Court Judge Jacqueline Nguyen to be a Federal District Court Judge from the Central District of California. I urge her confirmation.

Judge Nguyen is a tested judge with a track record of success as both a judge and a Federal prosecutor. She will be the first Vietnamese American on the Federal bench. Her nomination comes about this way.

I have had, for a long time, a bipartisan judicial selection committee in California to advise me in recommending judicial nominees to the President. The committee gave Judge Nguyen its unanimous recommendation. Then I recommended her to the President for his nomination to the Federal district court. I believe she is going to be an excellent Federal district court judge in the Central District.

Judge Nguyen was born in South Vietnam. She immigrated to this country with her family at the age of 10 during the final days of the Vietnam war. The Nguyens spent several months living in a refugee camp in Camp Pendleton, San Diego, before moving to the La Crescenta neighborhood of Los Angeles. She was naturalized in 1984.

Judge Nguyen's parents worked two and three jobs at a time in Los Angeles, and Judge Nguyen and her siblings worked side by side with them, cleaning a dental office, peeling and cutting apples for a pie company, and finally managing the doughnut shop that their parents bought and owned.

In her application to my selection committee, she explained that looking back on these experiences she realizes now that they were difficult. She wrote:

> But I nevertheless feel incredibly fortunate because those early years gave me invaluable life lessons that have shaped who I am today.

She went on to graduate from Occidental College in 1987 and from UCLA Law School in 1991. She was in the Moot Court Honors Program.

For the first 4 years of her career, she practiced commercial law as a litigation associate at the private law firm of Musick, Peeler and Garrett, where her caseload included complex contract disputes and intellectual property cases. In 1995 she left the firm to become an assistant U.S. attorney in the U.S. Attorney's Office in Los Angeles, and a very good one.

As an assistant U.S. attorney in the criminal division, she prosecuted a wide variety of crimes, including violent crimes, narcotics trafficking, organized crime, gun cases, and all kinds of fraud. She spent 6 months in the organized crime strike force section, handling a title III wiretap investigation of a Russian organized crime group responsible for smuggling sex slaves into the United States from the Ukraine. In 2000, she received a special commendation from FBI Director Louis Freeh for obtaining the first conviction ever in the United States against a defendant for providing material support to a designated terrorist organization.

The Justice Department recognized her with three additional rewards for superior performance as an assistant U.S. attorney, and in 2000 she was promoted to deputy chief of the general crimes section.

In 2002, Judge Nguyen left the U.S. attorney's office when Governor Gray Davis appointed her to the Superior

Court in Los Angeles, and she has been on that bench for more than 7 years and has presided over more than 65 jury trials.

As she has said in her own words:

I am deeply passionate about the privileges that we enjoy as Americans and am committed to spending my life in public service. If I am given the honor to serve as a United States District Judge, I believe my experiences, work ethic, maturity and judgment will serve me well.

I could not agree more. I think Judge Nguyen will be a truly outstanding judge of the Federal district court and I urge my colleagues to support her nomination.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. LEAHY. Madam President, I absolutely concur with the comments of the distinguished senior Senator from California in support of the nomination of Judge Jacqueline Nguyen to serve on the Federal Court in the Central District of California. I supported Judge Nguyen in the committee and I am glad we are able to act on her nomination today.

Judge Nguyen participated in a confirmation hearing before the Judiciary Committee on September 23. Hers was a historic hearing at which, for the first time, three Asian Pacific American judicial nominees appeared together—Judge Nguyen, Dolly Gee and Judge Edward Chen. Indeed, three Asian Pacific American judicial nominees have never been confirmed in the same year. Of the 876 active judges serving on our Federal courts, only 8 are Asian Pacific American.

We also held a November hearing for Judge Denny Chin, a well-respected judge on the Southern District of New York, whom President Obama has nominated for elevation to the Second Circuit Court of Appeals. Judge Chin was the first Asian Pacific American appointed as a Federal district court judge outside the Ninth Circuit. If confirmed to the Second Circuit, he will be the only active Asian Pacific American judge to serve on a Federal appellate court anywhere in the country. It is unbelievable that with 179 Federal appellate court judgeships in our country, none are currently held by an Asian Pacific American. More than 14 years have passed since an Asian Pacific American was nominated to a Federal appellate court. This progress is long overdue.

I commend President Obama for following his commitment to nominate men and women to the Federal bench who reflect the diversity of America. Diversity on the bench helps ensure that the words ''equal justice under law,'' inscribed in Vermont marble over the entrance to the Supreme Court are a reality, and that justice is rendered fairly and impartially.

Judge Jacqueline Nguyen will be the first Vietnamese American to serve as a Federal district court judge in the United States, and the first Asian Pacific American woman to serve as a Federal district court judge in the State of California. Today is an important milestone not only for Judge Nguyen, the Vietnamese American community and the Asian Pacific American community, but for all Americans.

Judge Nguyen, Ms. Gee, and Judge Chen were reported favorably to the Senate on October 15, more than 6 weeks ago. I am glad we are proceeding with Judge Nguyen but urge Senate Republicans to allow the other nominations to proceed to Senate debate and votes, as well. When she is confirmed, Ms. Gee will be the first female Chinese American Federal district court judge in the Nation. When he is confirmed, Judge Chen will be the first Asian Pacific American Federal district court judge in the history of the Northern District of California. Judge Chen is already the first Asian Pacific American to serve in that district as a magistrate judge. The American Bar Association's Standing Committee on the Federal Judiciary has rated the three of them unanimously as ''well qualified,'' their highest rating.

I thank the committee's ranking member, Senator SESSIONS, for his cooperation in securing the recent confirmations of Judge Christina Reiss of Vermont and Judge Abdul Kallon of Alabama before the Thanksgiving recess. They were confirmed 17 days after their hearing. That prompt action by the Senate demonstrates what we can do when we work in good faith. It should not take weeks for the Judiciary Committee to report nominations and additional weeks and months before Senate Republicans allow nominations to be considered by the Senate. We have shown what we can do.

Following the model we have established for Judges Reiss and Kallon, the Senate should be able to consider and confirm all eight of the judicial nominations currently on the Executive Calendar awaiting final action by the Senate, the additional five judicial nominees included at confirmation hearings in November, and Justice Thompson of Rhode Island, who had her hearing this morning. Acting on these nominations, we can reach a total of 23 Federal circuit and district court confirmations this year. That is well short of the total of 28 a Democratic Senate majority worked to confirm in President Bush's first year in office, 2001, but better than the 9 confirmations achieved in the first 11 months of this year.

This year we have witnessed unprecedented delays in the consideration of qualified and noncontroversial nominations. We have had to waste weeks seeking time agreements in order to consider nominations that were then confirmed unanimously. We have seen nominees strongly supported by their home state Senators, both Republican and Democratic, delayed for months and unsuccessfully filibustered. I have been concerned that these actions by the Republican leadership signal their return to their practices in the 1990s, which resulted in more than doubling circuit court vacancies and led to the pocket filibuster of more than 60 of President Clinton's nominees. The crisis they created eventually led to public criticism of their actions by Chief Justice Rehnquist during those years.

I hope that instead of withholding consent and threatening filibusters of President Obama's judicial nominees, Senate Republicans will treat the nominees of President Obama fairly. I made sure that we treated President Bush's nominees more fairly than President Clinton's nominees had been treated. In the 17 months that I served as chairman of this Committee during President Bush's first term, the Senate confirmed 100 of his judicial nominations. We should continue that progress, but need Republican cooperation to do so. I urge them to turn away from their partisanship and begin to work with the President and the Senate majority leader.

During the month of December in 2001, a Democratic-led Senate confirmed 10 of President Bush's judicial nominees, bringing the total number of nominations confirmed that year to 28. We will have to exceed that number this month in order to get to 20 confirmations, and a possible total of 23 this year. I fear that Senate Republican delaying tactics will, instead, yield the lowest total in modern history. If Senate Republicans continue their delaying tactics, the total could be as low as that during the 1996 session when a Republican Senate majority would only allow 17 judicial confirmations all session, including none for circuit courts.

Today, with the confirmation of Judge Nguyen, we will finally move into double digits in the confirmations of Federal circuit and district court judges—hers is our 10th this year. Although there have been nearly 110 judicial vacancies this year on our Federal circuit and district courts around the country, only 10 vacancies have been filled. That is wrong. The American people deserve better.

It has not been for lack of qualified nominees. As I have noted, there are seven more nominations awaiting Senate action on the Senate Executive Calendar and another six who have had their confirmation hearings and can be considered once approved by the Judiciary Committee. The Senate should do better and could if Senate Republicans would remove their holds and stop the delaying tactics.

During President Bush's last year in office, we reduced judicial vacancies to

as low as 34, even though it was a presidential election year. Judicial vacancies have now spiked. There are currently 98 vacancies on our Federal circuit and district courts, and 23 more have already been announced. This is approaching record levels. I know we can do better. Justice should not be delayed or denied to any American because of overburdened courts and the lack of Federal judges.

Mr. LEAHY. Madam President, have the yeas and nays been requested on this nomination?

The PRESIDING OFFICER. They have not.

Mr. LEAHY. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is, Will the Senate advise and consent to the nomination of Jacqueline H. Nguyen, of California, to be U.S. district judge for the Central District of California?

The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. DURBIN. I announce that the Senator from Alaska (Mr. BEGICH) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Alabama (Mr. SESSIONS).

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 97, nays 0, as follows:

[Rollcall Vote No. 354 Ex.]

YEAS—97

Akaka	Feingold	Menendez
Alexander	Feinstein	Merkley
Barrasso	Franken	Mikulski
Baucus	Gillibrand	Murkowski
Bayh	Graham	Murray
Bennet	Grassley	Nelson (NE)
Bennett	Gregg	Nelson (FL)
Bingaman	Hagan	Pryor
Bond	Harkin	Reed
Boxer	Hatch	Reid
Brown	Hutchison	Risch
Brownback	Inhofe	Roberts
Bunning	Inouye	Rockefeller
Burr	Isakson	Sanders
Burris	Johanns	Schumer
Cantwell	Johnson	Shaheen
Cardin	Kaufman	Shelby
Carper	Kerry	Snowe
Casey	Kirk	Specter
Chambliss	Klobuchar	Stabenow
Coburn	Kohl	Tester
Cochran	Kyl	Thune
Collins	Landrieu	Udall (CO)
Conrad	Lautenberg	Udall (NM)
Corker	Leahy	Vitter
Cornyn	LeMieux	Voinovich
Crapo	Levin	Warner
DeMint	Lieberman	Webb
Dodd	Lincoln	Whitehouse
Dorgan	Lugar	Wicker
Durbin	McCain	Wyden
Ensign	McCaskill	
Enzi	McConnell	

NOT VOTING—3

Begich	Byrd	Sessions

The nomination was confirmed.

The PRESIDING OFFICER. Under the previous order, the motion to reconsider is considered made and laid upon the table.

The President will be immediately notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate will stand in recess until 2:15 p.m.

Thereupon, the Senate, at 12:33 p.m., recessed and reassembled at 2:15 p.m. when called to order by the Presiding Officer (Mr. CARPER).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—Resumed

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, as I said yesterday when I spoke on this very same bill, the excesses of the Reid bill appear willfully ignorant of what is going on in the rest of the economy outside of health care.

I believe the reason people have objected to the health care bill so quickly after the summer was that there was a rude awakening on a lot of other things the Congress has done to put this country further into debt, and then they heard us talking about $1.3 trillion and $1.6 trillion for health care, and they thought Congress had gone bananas. So everything seemed to focus on health care reform at that particular time. People were concerned about the economy as a whole. I think the health care issue in and of itself was what people came out for, but health care was kind of the straw that broke the camel's back and brought attention to everything else—the debt and things that weren't working. At the same time, they saw the auto industry going into bankruptcy and, of course, being bailed out or nationalized, as it is. They have seen banks go under. Then they wondered about health care being nationalized as well.

We have seen our Federal debt skyrocket by $1.4 trillion since this President took office. I say ''since this President took office'' because I acknowledge there was a trillion-dollar debt in last year's budget. Just with the addition, it comes out to $11,500 per household. So our Federal debt exceeds $12 trillion for the first time in history. Already, foreign holdings of U.S. Treasuries stand at nearly $3.5 trillion or 46 percent of the Federal debt held by the public. There doesn't appear to be light at the end of the tunnel. Don't just take my word for it. We have the nonpartisan CBO and the White House Office of Management and Budget which have intellectually honest people working there who aren't politically motivated who tell us really what is what. This is what they have to say. Both have stated that within 5 years, the Obama administration's policies will more than double the amount of debt held by the public. Both have stated that by 2019 these policies will more than triple the national debt.

In this context, you would expect Congress to be considering a bill that would create jobs and prevent the country from being burdened with a bigger and more unsustainable Federal budget. Instead of working to bring the Federal budget under control, we have in this Congress—the majority of it, by 60 being Democratic—putting forward a bill, this 2,074-page bill before us that will cost $2.5 trillion when fully implemented. Instead of addressing the budget crisis, this bill will bend the Federal spending curve the wrong way by over $160 billion over the next 10 years.

I remember during the summer that the Gang of 6, under the leadership of Senator BAUCUS—I was part of that bipartisan group—said there are two things we need to accomplish: We need to make sure that what we have comes out balanced, and we also need to make sure we do not have inflation of health care continuing to go up, that we would eventually bring it down. These bills don't do either. I know people say we do have the 10-year window balance. Yes, that is technically right. But when you have 10 years of income and 6 years of policy expenditure, it is easy to do almost anything you want to in that 10-year window. But you have to look beyond that 10-year window, and then you have questions about that.

So instead of addressing this budget crisis, this bill adds to the Federal burden with enormous costs from the biggest Medicaid expansion in history and unfunded liabilities from the new program. Instead of addressing this budget crisis, we are now considering this 2,074-page bill that cuts Medicare by $½ trillion and threatens seniors' access to care.

After the bailouts of Wall Street and Detroit, a stimulus bill that has led to the highest unemployment in 26 years, and the Federal Reserve System shoveling money out the door without any accountability—they even object to having the GAO check on them—the health care reform agenda the Democratic leadership put forward is, once again, kind of the straw that broke the camel's back.

We have the Senator from Arizona offering a motion to send this bill back to the Finance Committee with instructions to report a bill without the drastic, arbitrary Medicare cuts that are in this bill. I support the Senator's motion because it is an opportunity to fix the bill and then come back to the full Senate with a better bill. Anything that comes back to the Senate floor

should not have the drastic and arbitrary Medicare cuts.

I am hearing this from seniors: I have paid into this Medicare for all these years. I am in retirement, and now Congress wants to take that money and establish a new entitlement program for somebody else other than seniors. So to a lot of seniors it just doesn't add up.

This bill, as written, now permanently cuts all annual Medicare provider payment updates in order to account for the supposed increases in productivity by health care providers. The productivity measure used to cut provider payments in this bill does not represent productivity for a specific type of provider, such as nursing homes.

You would think that if Medicare is going to reduce your payments to account for increases in productivity, it would at least measure your productivity, not an entire group of productivity or not somebody else's productivity but yours, and you would be rewarded according to that productivity or, if it wasn't productive, be harmed because of it because you are not doing the best job you can. But that is not the case. Instead, these reform bills would make the payment cuts based on measures of productivity for the entire economy. So if the productivity of the economy grows because computer chips and other products are made more efficiently, then health care providers see their payments go down. What is the relationship? These permanent cuts threaten beneficiary access to care.

The Chief Actuary at the U.S. Department of Health and Human Services recently identified this threat to beneficiary access to care. He confirmed this in an October 21 memorandum analyzing the House of Representatives' bill and again in a November 13 memorandum. Both the House bill and the Senate bill propose the same type of permanent Medicare productivity cuts.

We have a chart here. Here is what Medicare's own Chief Actuary had to say about these productivity cuts. Referring to these cuts, he wrote:

> The estimated savings . . . may be unrealistic.

In their analysis of these provisions, Medicare's own Chief Actuary said:

> It is doubtful that many could improve their own productivity to the degree achieved by the economy at large.

The Actuary goes on to say:

> We are not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy.

So you have a $14 trillion economy today. You have $2.3 trillion of that, or one-sixth, related to health care, and you are going to try to do something to the health care aspect, productivity measure, harm or benefit, based upon what happens to the entire $14 trillion economy? That doesn't make sense.

The Chief Actuary's conclusion is that it would be difficult for providers to even remain profitable over time as Medicare payments fail to keep up with the cost of caring for the beneficiaries.

Going back to my chart again, ultimately here is the Chief Actuary's conclusion—that providers who rely on Medicare might end their participation in Medicare, ''possibly jeopardizing access to care for beneficiaries.''

This bill also cuts $120 billion from the Medicare Advantage Program, which provides health coverage to 11 million seniors, including the 64,000 seniors in my State of Iowa. These drastic Medicare cuts would reduce Medicare payments for those 11 million beneficiaries by close to 50 percent.

Just like a lot of people, seniors are struggling financially right now, and these Medicare Advantage cuts will only make it harder for them to afford vision care, chronic-care management, dental care, and other benefits they have come to rely on, of their own choosing, because they decided to go to Medicare Advantage instead of staying in traditional Medicare. And what they are going to lose if they don't want to stay in Medicare Advantage and they are not going to get the benefits they got out of it, they go over to traditional Medicare, are these sorts of benefits which will not be included in traditional Medicare.

During the campaign, the President said that if you like what you have, you can keep it. Well, that won't be true for Medicare Advantage people. They will either pay more, which is contrary to what the President said in his September speech to the joint session of Congress, they are going to pay more or lose benefits.

Another problem is that this bill creates a new body of unelected officials with broad authority to make even further cuts in Medicare. Ironically, this body has been renamed the ''Independent Medicare Advisory Board,'' but it is not really advisory. I would hardly describe this group that way when its so-called recommendations can automatically go into effect, even absent congressional action—absent Congress going after it.

I want to go to the chart again. The Wall Street Journal has a more appropriate name for this group. They call it the ''rationing commission.'' They described it as ''the unelected body that will dictate future medical decisions.''

These additional cuts in Medicare will be driven by arbitrary spending targets and automatic Medicare cuts written into law by this bill.

This bill, unwisely, makes this board permanent. This bill requires this board to continue making even more cuts to Medicare and to do that forever. If you want to stop it, it will take another act of Congress to do it. Of course, this kind of sounds like the sustainable growth rate, or SGR, that impacts doctors every year. We always have to correct the mistakes that were made by passing the sustainable growth rate, SGR, first set in place probably 20 years ago, because this SGR formula set arbitrary spending targets. These targets turned out to be unrealistic. Now that flawed formula will cause an automatic 21-percent cut in Medicare physician payments on January 1 if Congress doesn't intervene by the end of the year.

We all know the challenges Congress faces every year in trying to prevent these Medicare physician cuts that are supposed to take place because spending targets have been exceeded, so automatic payment cuts are then to automatically kick in.

We have all heard from physicians in our States about the challenges in providing care to Medicare beneficiaries while these payment cuts loom above. This permanent board would cause the same problem for the entire Medicare Program, not just as SGR does for physician payments. This is a far bigger threat to the Medicare Program. It will jeopardize access to health care for our Nation's seniors on a much bigger scale.

If this bill is enacted with this permanent board, we will be hearing from other providers, in addition to doctors, about how they cannot afford to treat Medicare patients.

What is more alarming is that special back-room deals were cut to exempt some providers. This forces then, because of these special exemptions that were made, even greater cuts to fall directly on the remaining providers.

Also, the Congressional Budget Office has confirmed that the board structure requires it to take focus on its Budget Act on premiums that seniors pay for Part D prescription drug coverage and for Medicare Advantage.

I have already spoken about Medicare Advantage but just think: One of the things we hear about this time of the year all the time from seniors is prescription drug costs are going up, premiums on Part D are going up. Then you want to give this advisory commission—that is not advisory—authority to increase premiums that seniors pay for Part D prescription drug coverage? That means higher premiums for some of our most vulnerable populations.

Another issue that cannot be ignored is the pending insolvency of the Medicare Program. The Medicare hospital insurance fund started going broke last year. That means more money is going out than is coming in from the payroll tax. The Medicare trustees—you remember, they report yearly and they look ahead 75 years—the Medicare trustees have been warning all of us for years that this trust fund is in terrible trouble and, by a certain date, 2017, we

bust it. But rather than work to bridge Medicare's $37 trillion in unfunded liabilities—and that $37 trillion is that 75-year figure the trustees give us once a year, each spring, as they update it—so instead of working to bridge that $37 trillion of unfunded liabilities, this bill does what? It cuts $½ trillion from the Medicare Program to fund yet another unsustainable health care entitlement program.

Medicare has a major problem with physician payments that could cost more than $250 billion to fix, but this bill ignores the problem. Instead, the proposed legislation assumes the government would implement the 23-percent Medicare cut scheduled to go against doctors in January 2011, as well as additional cuts that are scheduled for future years under that SGR.

By pretending the physician payment issue does not exist, this bill would leave future Congresses virtually no way to restructure Medicare that would fix this problem. Instead, this bill diverts Medicare resources elsewhere and ignores major problems such as that one.

Besides ignoring major problems, such as the physician payment issue, this bill also ignores the predictions of experts that Medicare cuts, such as are in this bill, will jeopardize access to care of Medicare beneficiaries.

There are no fail-safes in this bill that would automatically kick in if these drastic cuts caused limited provider access or worsened quality of care. Instead, Congress would have to step in. Congress can always step in, but will it step in. We know how impossible it is to undo this kind of damage. By making this board a permanent program and requiring permanent productivity cuts, they become part of the baseline in the next decade. They go on cutting, cutting, cutting forever. If Congress ever wants to shut off those cuts, then this is the problem Congress faces: We have to come up with offsets to do it. The administration can cut and cut and cut or add and add and add. They do not have to do that. But the budget laws require us to have these offsets or to do the famously impossible thing to do—get a 60-vote margin to overcome it.

The Congressional Budget Office has projected that these Medicare cuts keep increasing by 10 to 15 percent each year over the next decade. You heard me right. Medicare cuts keep growing 10 to 15 percent each year beyond the year 2019. Those are some pretty substantial cuts in a program that 43 million seniors and people with disabilities rely on for their health coverage.

Provisions, such as the productivity adjustments and the Medicare independent advisory board, would drive the increased cuts to the program. This gives us an idea of the damage these bills will do to health care. This is an example of the challenge Congress will face in the next decade if this bill—this 2,074-page bill—becomes law.

The few years of extended life this bill would give to the Medicare hospital insurance trust fund is a pyrrhic victory because the drastic and permanent Medicare cuts in this bill will worsen health care quality and access.

This bill is the wrong way to address a big and unsustainable budget. You simply cannot slash Medicare payments, spend those funds to start up another new unsustainable government entitlement program, and then turn a blind eye toward the effect on access and quality. That is why I will support the motion of the Senator from Arizona to commit this bill and develop a bill without these Medicare cuts. I urge my colleagues to do the same.

The reason I urge my colleagues to do the same is because we have an opportunity to step back just a little ways, go back to the drawing board on bipartisanship and maybe come up with something that fits in with the health care issues affecting the lives of 306 million Americans and, secondly, restructuring one-sixth of our economy. That is something I have heard people on both sides of the aisle say ought to be done on more of a consensus basis than the partisan road this is going down. It was a road that, for the first 6 months of this year, looked very doable, but it never turned out that way.

I get back to this bottom line: If you are having a coffee club meeting in some restaurant Saturday morning in Delaware, Illinois or Iowa, and they are talking about health care reform and I go in to explain that what we are discussing right now on the floor of the Senate is going to raise taxes, it is going to raise premiums, it is going to not do anything about the inflation of health care costs, and we are going to take almost $½ trillion out of the Medicare fund to fund a new entitlement program, I would say that unanimously people would say: This is not health care reform. There has to be something else. But we throw away the word ''reform'' when we are not accomplishing the kind of goals we set out to accomplish the first 6 months of this year.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, there is a saying in Iowa; that is, that any old mule can kick down a barn door, but it takes a carpenter to build one. I would modify that slightly and say any old elephant can kick down a barn door, but it takes a carpenter to build one.

We are debating health care reform. The American people are following us closely because it affects every single one of us in this room, everyone in the galleries, and everyone watching. This is one of the few issues we will debate which you can bet is going to affect you and your family personally. It is rare that an issue comes before us of this gravity and an issue that reaches every single person in America. It may be the biggest single issue we have ever tackled on the floor of the Senate in terms of its scope and its impact on the future of every single one of us.

For more than a year, a lot of people have been working hard to come up with a piece of legislation that will have a positive impact on health care in America. It has involved lengthy committee hearings. The Presiding Officer is a member of the Senate Finance Committee. They sat in meetings hour after weary hour, day after weary day, considering amendments before they produced a bill that is part of what we have before us today.

The Senator from Iowa is part of that same committee. I understand he met personally over 60 times with Democratic Senators and a few from his own side trying to see if we could come up with some kind of bipartisan approach. I commend him for his good-faith effort in doing that.

There is another committee, the Health, Education, Labor, and Pensions Committee, that spent even more days in deliberation on a bill, considered over 100 different amendments, adopted over 100 Republican amendments to the bill, and not one single Republican Senator would then vote for the bill—not one. One Senator, Senator SNOWE of Maine, voted for the Senate Finance Committee bill. One Republican Senator voted for that version of the bill.

What we have today—and I wish to slightly modify the remarks of my friend from Iowa—is a 2,074-page bill with a 1-page add. This is Senator REID's amendment to use it as a substitute. So it is 2,075 pages, created by these two committees in the Senate and a similar endeavor taking place in the House.

For at least 10 days, this bill, in its entirety, has been available for public review. I ask anyone interested who wants to read this bill, as every Member should, to go to the Senate Democratic Web site. If you Google ''Senate Democrats,'' you will find it and you will find this bill in its entirety, every single word of it, sitting out there to be read and reviewed, as it should be.

Then I invite you, for comparison's sake, to go to the Senate Republican Web site to look at the bill produced by the Senate Republican side. Take a look at the Senate Republican health care reform bill. Take a look at what they propose to change—the health care system in America. Look at the Senate Republican proposals for making health insurance more affordable.

Look at the Senate Republican proposals for dealing with health insurance companies which deny you coverage because of preexisting conditions. Take a look at the Senate Republican approach to pass health care reform and not add to the deficit. I am afraid you will be disappointed because, as the Senator from Iowa knows, when you go to the Senate Republican Web site, there is no Senate Republican bill. In fact, what you will find on the Senate Republican Web site is the Democratic bill.

For more than a year, while we have labored to produce this monumental, historic legislation, our Republican colleagues on the other side of the aisle have not broken a sweat to produce their own answer to this challenge facing America. All they can do is come before us and criticize this bill. Any old mule can kick down a barn door, but it takes a carpenter to build one.

We have been working for over a year—almost a year—to build this health care reform package. Here is what we know. We just received a report from the Congressional Budget Office, which is akin to the referee up here. This is an agency that takes a look at what we do and tells us whether it is going to reduce the deficit, add to the deficit, reach its stated goal or fail to reach it. It is maddening sometimes to have this separate agency kind of looking over your shoulder, but they do. They reported just yesterday that this bill will make health insurance more affordable for many Americans and will not add to the costs for many others.

I wish it would do more. I wish it would bring down costs dramatically, even more. But for weeks and months we have heard from the Republican side that our health care reform proposal would run premiums sky high. It turns out they were wrong. This bill we have produced moves us toward more affordable health insurance. Every American who pays any attention to the cost of health insurance knows that is absolutely essential. In the last 10 years, health insurance premiums have gone up 131 percent in America. Ten years ago, a family could have bought health insurance for about $6,000 a year. Now they buy it on average for about $12,000 a year. In 7 or 8 years it will go up to $24,000 a year in premiums, projecting it will eat up 40 percent of your income for health insurance in just 8 or 10 years.

That is an impossible situation. We know it is. It is unsustainable. Businesses can't offer health insurance that expensive. Individuals can't buy health insurance that expensive. So if we do nothing we will reach a situation where the current health care system in America will start to collapse. I do not want to stand idly by and let that happen; neither does President Obama. He has challenged us to address it and address it honestly.

On the other side of the aisle, the Senate Republicans have not produced a bill, a proposal, an alternative which will make health insurance more affordable—nothing. They come before us in criticism of what we have done, and yet they cannot produce a bill.

I might also tell you the same Congressional Budget Office tells us the bill we put together will actually reduce the Federal deficit over the next 10 years by at least $130 billion. This bill, this 2,075-page bill, will cut more deficit than any piece of legislation we have ever enacted in Congress.

The Senator from Iowa is concerned about our national debt. So am I. Where is the Senate Republican proposal for health care reform that is going to reduce America's deficit? Incidentally, the same Congressional Budget Office says in the second 10 years—think that far in advance—this approach will reduce the Federal deficit by another $650 billion.

I ask the Senator from Iowa, with all his concern about the Federal deficit, where is the Senate Republican bill that will reduce the Federal deficit by $750 billion over 20 years?

The answer, I am sorry to tell you, is it does not exist. They either have not or cannot write a bill. They are legislators, but frankly they have come here to be critical of what we have done and will not offer a substitute or an alternative.

There is something else this bill does. It is a travesty in America today that almost 50 million people do not have health insurance. A lot of these folks are children. A lot of them are people in low-wage jobs with no benefits. A lot of them are the newly unemployed. These are 50 million of our neighbors in America who go to sleep at night without the peace of mind of having health insurance protection.

In my life it happened once: newly married, college student, baby on the way, no health insurance, and our baby had a problem. I ended up carrying, for 8 years, medical bills that I slowly paid off year after year. That goes back many years ago, as you might imagine, but it was troubling and heartbreaking to be the father of a child and not have health insurance; to sit at Children's Memorial Hospital in Washington, in the room that was set aside for people without health insurance, and wait until my number was called to bring my wife and my baby in for a checkup. I didn't have health insurance. I never felt more helpless in my life.

Fifty million Americans go to bed each night with that feeling. They don't have health insurance. What does this bill, this 2,075-page bill, do about it? It extends the coverage of health insurance, the peace of mind and protection of health insurance to 94 percent of Americans. It is the largest extension of health insurance in our history.

Where is the Republican alternative that offers coverage for 94 percent of Americans? It doesn't exist. They have not written that bill. They don't know how to write that bill. They do know how to come and criticize this bill, but they cannot produce a bill which covers 94 percent of Americans and provides tax credits and tax assistance to help those Americans pay their premiums.

If you are making under poverty wages, let's say you are making less than $14,000 a year—and I have friends of mine in my State who are—you are covered by Medicaid. You don't pay premiums. The Federal Government compensates the States and pays the premiums. All the way up to about $80,000 for a family of four, we provide credits and help to pay the premiums, as we should, because premiums can break the bank not only for businesses but for families.

There is also something we do in this bill I never hear from the other side of the aisle—and I will tell you why in just a second. We give consumers across America a fighting chance when the health insurance company goes to war with you. Do you know what I am talking about? If somebody in your family gets sick, you know it is going to require a hospitalization or surgery and you know the cost is going to go sky high, and you say: Thank goodness, I have health insurance. You make the claim and the health insurance company comes back and says: We dispute the claim. We are not paying. People say: Wait a minute, I have been paying health insurance premiums for years just for this day, and you are telling me I don't have coverage?

It happens thousands and thousands of times each day. Do you know why? Health insurance companies are profitable when they say no. What are the reasons for saying no? ''You failed to disclose a preexisting condition when you applied for the insurance.'' It turns out they go to ridiculous extremes to find an excuse not to provide coverage.

We also know what happens when you lose a job. You can't take your insurance with you, by and large. We know when your child reaches the age of 24 they are no longer carried on your family health insurance. Those are the realities of health insurance companies saying no. I have yet to hear the first Republican Senator come to the floor and say that is outrageous and it has to change. We have to tackle the health insurance industry because the health insurance industry opposes this bill.

The health insurance industry believes their profitability and their future depend on saying no. This bill starts saying to these companies: You can't say no based on a preexisting condition, based on lifetime limit, based on losing a job. And we cover kids through the age of 26. We extend the family coverage to children of that age, and you know that is only sensible

because a lot of kids are going to college and getting out without jobs. You want them covered by your family health insurance plan. This bill does it.

Republicans have yet to produce one bill, just one, on health care reform to take on the health insurance industry. Instead, what they have come to do, and the pending amendment by the Senator from Arizona leads with this, is to protect the health insurance companies. The first thing the motion to commit does, from the Senator from Arizona, is to instruct the committee, the Senate Finance Committee, to protect a program called Medicare Advantage.

This is a great idea for health insurance companies and not a great idea for most seniors or taxpayers in America. Allow me to explain. The health insurance companies came to us several years ago and said Medicare is a bureaucratic mess. The government cannot run these programs. We are in the private sector. We understand competition. Let us compete with Medicare.

They were given the right to do that. Private health insurance companies were given the right to write health insurance that provides Medicare benefits. They said they could do it more cheaply and, in fact, some of them did. But at the end of the day, after years of watching them, it turned out these Medicare Advantage policies cost 14 percent more—not less, 14 percent more—than government-administered Medicare Programs. In other words, we were subsidizing health insurance companies, paying them more for the same Medicare coverage people already had received.

They loved it. Thousands and thousands of Americans are now covered by Medicare Advantage with these great subsidies coming from the Federal Government. Talk about an earmark, Senator, 14 percent—what an earmark that is, a subsidy given to the private health insurance companies.

Mr. MCCAIN. Will the Senator yield for a question? Since the Senator mentioned my name, will he yield for a question?

Mr. DURBIN. What the basic problem with the amendment of the Senator form Arizona is—and I will yield in just a moment—what the basic problem with his amendment is, he is protecting these health insurance companies with Medicare Advantage. First thing he does. He is protecting this subsidy, this big fat earmark we put in legislation, 14 percent bump in premiums is protected by this motion to commit.

It is understandable the health insurance companies want to keep this. It is a sweet deal. They are getting paid for something they promised us would never happen. Also, there is a provision in the motion to commit of the Senator that says we should take out the conflict-of-interest sections in Medicare. Do you know what that is? That is when your doctor also owns the laboratory which does your blood test and the imaging center which does the x rays and says: I am not sure what is wrong with you, but I know there are two things you need: You need a blood test and you need an x ray.

Maybe you do; maybe you don't. We say in this bill you have to disclose to your patient that you have a personal financial interest in this laboratory and this processing operation, and you have to give them an alternative to shop for another place if they want. Is that unreasonable? It is one of the provisions the Senator from Arizona wants to take out. It is a savings in Medicare.

That is unfortunate. We have to do our best to eliminate the waste and fraud and abuse, as terrible as that old cliche is, in Medicare. Why is it that the same medical procedure offered in Rochester, MN, to a Medicare recipient costs twice as much or more in Miami, FL? Do you think maybe we ought to take a look at that? I think we should. I think maybe there is some price gouging. I want to know.

Does that mean we are going to reduce the benefits for someone living in Miami? Not necessarily. But it means the taxpayers will not be ripped off. Medicare would not go broke. We are doing what we need to do to be responsible. So taking money out of Medicare means shutting off the subsidy to the private health insurance companies for Medicare Advantage. It means stopping the self-dealing of some doctors who are sending Medicare patients to their own labs and their own processing companies. It means finding out where the waste is taking place.

The Senator from Arizona says we instruct the Finance Committee to take out those provisions in the bill. Keep Medicare Advantage there, with the 14 percent subsidy for private health insurance companies, don't engage these doctors when it comes to these conflicts of interest. I don't think that is right.

It was not long ago that my friend from Arizona was a candidate for another office. During the course of his campaign for President, he suggested we have a pretty substantial cut in Medicare and Medicaid. In fact, during the campaign the Senator from Arizona called for $1.3 trillion in reforms in Medicare and Medicaid, more than twice as much as we are calling for in Medicare, 2½ times as much.

Douglas Holtz-Eakin, who worked for the Senator from Arizona, said the campaign planned to fund tax credits in their health care proposals with savings from Medicare and Medicaid. So the idea of saving money in Medicare is certainly not something with which the Senator is unfamiliar. We all understand there are possibilities for savings that don't jeopardize basic services for seniors. We also understand that left untouched, Medicare is going broke. Ignoring the problem will make it worse. If we want to put Medicare on sound footing we have to tackle this issue foursquare. We cannot afford these subsidies for private health care companies for Medicare Advantage, and we cannot afford the waste that is going on in the system today.

I might also tell you the increase in payroll taxes for those individuals making over $200,000 a year and families over $250,000 a year—that is the increase in the Medicare tax—is going to be buying 5 years of solvency for Medicare. So when they talk about our raising taxes—true, at the highest income levels—what they don't tell you is the other side of the coin. The money brought in goes straight to the Medicare trust fund to keep it solid.

What else does this bill do? It starts filling the doughnut hole. You may not know what that means until you happen to be a senior or have one in your family, but Medicare prescription drug coverage stops paying at a certain point. This bill starts coverage in the doughnut hole, in the gap in coverage that currently exists in Medicare prescription Part D.

Where is the Republican bill to fill the doughnut hole? It doesn't exist—at least I have not seen it. It is not on their Web site. Here is ours. That is why AARP has endorsed this bill. The American Association of Retired Persons knows this bill is a good bill for seniors.

I urge my colleagues to oppose the McCain motion to commit.

If we take this bill off the floor, which many Republicans want us to do, it will take us days, maybe a week, to bring it back to the floor. They want to delay this as long as possible. They want us to fail. They want us to stop. They want us to adopt the Senate Republican approach to health care reform which is do nothing, leave the system the way it is. We cannot continue the system the way it is. This is a responsible bill. It makes health insurance affordable. It reduces the deficit, according to the CBO, and covers 94 percent of Americans. It finally tackles the health insurance companies for the first time in a long time, and it buys at least 5 years more for the Medicare Program. I wish I could compare it to the Senate Republican approach, but that doesn't exist. Any mule can kick down a barn door. It takes a carpenter to build one.

I yield the floor.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The Senator from Arizona.

Mr. MCCAIN. I regret that the Senator from Illinois did not observe the courtesies of the Senate, particularly when a person's name is mentioned, as he continued to mention my name

throughout and totally falsifying my position both in the Presidential campaign and the position that we have on this side and this amendment. I have always extended that courtesy to the Senator from Illinois. I deeply regret that even this comity of the Senate is no longer observed.

I say to the Senator from Illinois, I regret you would not respond to a question I had posed, when you had said: I will respond in a minute. Again, even comity is not observed here.

Mr. DURBIN. Will the Senator yield for a second?

Mr. MCCAIN. I will go ahead with the—the Senator did not provide me with the courtesy of allowing me to respond to a question. Now you want me to respond to a question from you? I will display more courtesy than you displayed to me. Go ahead.

Mr. DURBIN. I apologize. I planned on yielding to you. I would be happy to yield to you. I always do, and I failed to. I apologize.

Mr. MCCAIN. Well, I guess my questions were, one, did the Senator, who claimed that no Republican has done anything to curb the health care insurance industry, was the Senator in the Senate when Senator Kennedy and I fought for weeks and months for the Patients' Bill of Rights? Was the Senator here then? Was he engaged in that debate? Senator Kennedy and I fought for the Patients' Bill of Rights, and the majority on that side of the aisle opposed it. The fact is, there have been efforts on my part to curb the abuses of the health insurance industry by sponsorship of the Patients' Bill of Rights.

Second, during the campaign, yes, I said that we could reduce and eliminate waste, fraud, and abuse in spending, and I said it because of Senator COBURN's Patients' Choice Act which would save $1 trillion in the States in Medicaid savings, $400 billion over the next 10 years in Medicare savings. I wish the Senator from Illinois would examine the Patients' Choice Act, as proposed by the Senator from Oklahoma. Maybe he would learn something. The Coburn bill wants to preserve the best quality health care in America and not eliminate $12 billion in the Medicare Advantage Program, which 330,000 of my citizens who are enrollees like and want to keep, not eliminate $150 billion to providers, including hospitals, hospice, and nursing homes, $23 billion in unspecified decreases to be determined by an independent Medicare advisory board, as well as billions of additional cuts to the Medicare Program.

There is no relation between what I tried to do in my campaign and what is being done in this legislation, I tell my friend from Illinois. I would be glad to hear the Senator's response. I would be glad to extend him that courtesy.

Mr. DURBIN. I thank the Senator from Arizona. I commend him for his work on the Patients' Bill of Rights which I joined him in with Senator Kennedy and would do it again. The point I was making——

Mr. MCCAIN. Your statement was that no Republican had done anything. You just said no Republican had done anything to curb the health insurance industry. The Patients' Bill of Rights certainly would have done it.

Mr. DURBIN. My point was that there are provisions in this bill dealing with the rights of consumers against health insurance companies which I have not heard the Senator or others——

Mr. MCCAIN. That is not what you said.

Mr. DURBIN. I ask you, do you support the health insurance reforms in this bill that give patients rights against health insurance companies; preexisting conditions, for example?

Mr. MCCAIN. My record is very clear of advocating for patients and against the abuses of insurance companies across the board.

Mr. DURBIN. Thank you.

Mr. MCCAIN. I ask unanimous consent to yield to the Senator from Oklahoma to describe the Patients' Choice Act and the way we could truly save money and reduce fraud, abuse, and waste in the system and at the same time preserve quality health care.

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

The Senator from Oklahoma.

Mr. COBURN. There needs to be some clarification. Medicare doesn't cover everything. Eighty-four percent of all Medicare patients have to buy a supplemental policy now. Do you know what Medicare Advantage is about? Who set the prices on Medicare Advantage? The government set the prices on Medicare Advantage. The very same people you want to run it now created a 14-percent premium. The insurance industry didn't set the prices. The Center for Medicare and Medicaid Services set the prices. The government is responsible for that differential.

Why is Medicare Advantage important? Because the vast majority of the people in my State and every State who have Medicare Advantage can't afford to buy a supplemental policy to make them whole on Medicare, because Medicare won't cover it. So Medicare Advantage for 89,000 Oklahomans is the only way they get equality with the rest of their peer group who can afford to buy a supplemental policy.

Now we are going to take that ability away from poor seniors in Oklahoma, Arizona, Iowa, and Illinois, and we are going to say: You don't get what everybody else has because you are economically disadvantaged. So we are going to give you substandard care, and we are going to take more of your income. Medicare Advantage offers the things you get with a supplemental policy when you can't afford to buy a supplemental policy. The very idea of saying we are going to take that away, when you are taking that away from the cheapest program we have in terms of performance, because what Medicare Advantage does, which their bill and this bill purports to do, is recommends and encourages and incentivizes prevention as the Senator from Iowa wants to do for everybody. It incentivizes it. It doesn't cost to have a prevention exam under Medicare Advantage. There is no out-of-pocket cost for our seniors who are poor who happen to have the benefit of Medicare Advantage. You are going to take that away. You are going to destroy it for 11 million seniors, the ability to get a preclearance, a screening exam, without them having to spend money on it.

Is there a way to get money out of Medicare? Yes, there is $100 billion worth of fraud a year in it. According to Harvard, there is $150 billion worth of fraud a year in Medicare. There is $2 billion worth of fraud.

I want to address something else the Senator——

Mr. MCCAIN. Before the Senator continues, I ask unanimous consent to regain the floor and then yield to the Senator from Oklahoma.

The PRESIDING OFFICER. Is there objection?

Mr. MCCAIN. I ask unanimous consent to engage in a colloquy with the Senator from Oklahoma.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. MCCAIN. Mr. President, I have to address the situation since I have been accused by the majority leader of changing my position. The Senate considered the Deficit Reduction Act of 2005 which called for approximately $10 billion in reduction in Medicare costs, approximately $10 billion. Senator HARRY REID, Democrat of Nevada, said:

> Unfortunately, the Republican budget is an immoral document. Let's look at what is in the bill before us. The budget increases burdens on America's seniors by increasing Medicare premiums, and we have not seen what the House is going to give us. It cuts health care, both Medicare and Medicaid, by a total of $27 billion.

The majority leader was outraged in 2005 that there should be reductions in Medicare and Medicaid spending of $27 billion. Now the distinguished majority leader, with the white smoke coming out of his office, says he is for $483 billion in cuts in Medicare. That is a remarkable flip-flop.

By the way, I might add, Senator DODD, who is here on the floor, said, concerning the Deficit Reduction Act of 2005:

> For example, this bill cuts funding for Medicare and Medicaid which provide health care to poor children, working men and women, the disabled, and the elderly.

What a plea. What a plea.

Senator BARBARA BOXER said:

> Mr. President, I strongly oppose the reconciliation bill before the Senate. The bill

would cut vital programs for the middle class, elderly, and poor. That is why I cannot believe only 2 months after Katrina we have a bill that would cut Medicare and Medicaid by $27 billion.

The list goes on and on.

Now before us we have cuts of $483 billion, including hospice, hospitals, other vital programs for our seniors. If we are going to go around and talk about flip-flops, let's look at the rhetoric that accompanied my colleagues on the other side in their opposition to $27 billion in savings which, by the way, actually only saved $2 to $3 billion over 5 years.

I ask my friend from Oklahoma, does he believe it is possible to make these cuts, including from the Medicare Advantage Program, and establish a Medicare commission that would not, over time, cut benefits that exist today for Medicare and Medicaid patients?

Mr. COBURN. Mr. President, I would answer my colleague by saying this bill is a government-centered approach, not a patient-centered approach. It is the very reason we are in the trouble we are in today. We have had the government making decisions rather than the patients and the physicians. It will, in fact, lessen the care for seniors.

I gave a speech earlier this morning on the floor that if you are a senior, you should be worried. Because the Medicare Advisory Commission and the cost comparative effectiveness commission will now decide ultimately what you get. We have an amendment on the floor, which in many ways I support but I would like to modify, about reinstituting what should be the standard for mammography for women. How did we get there? We have a commission that looks at cost and not patients. From a cost standpoint, the task force on screening is absolutely right. But from the patient's standpoint, it is absolutely wrong. How do we decide the difference? Do we make the difference based on what something costs or do we make it on what my wife, who will soon be a Medicare patient, receives? The question is, will the cuts that are manifested by this bill impact seniors' care? As somebody who has practiced medicine for 25 years and cared for seniors for longer than that, I will tell you undoubtedly they will have delay, denied care, and 80 percent of them will be fine. But 20 percent of the seniors in this country will be markedly hurt by this bill because a bureaucracy looking at numbers, not patients, never putting their hand on the patient, will make a decision about what is good for them and what is not.

Everything we know about medicine is that is exactly the wrong way to practice it. Every patient is different. Every patient's family history is different. When we talk about taking $120 billion out of the Medicare Advantage Program, what we are talking about is decreasing access to some of the most important screening capabilities that many of these people have and making them unaffordable because they cannot afford a supplemental Medicare policy. They cannot accomplish it.

I want to address one other question. The majority whip said the Republicans have not had a bill. During the markup in the HELP Committee, I went through point by point the Patients' Choice Act. The Patients' Choice Act puts patients and doctors in charge, not the government in charge. The Patients' Choice Act neutralizes the tax effect to make everybody treated the same in this country, as far as the IRS is concerned.

Right now, if you get insurance through your insurance company, you get $2,700 worth of tax benefits. If you do not, you get $100. That is really fair. That is one of the reasons why people who do not get insurance through their employer cannot afford health insurance. It is because we do not give them the same tax benefit. It would give a tax cut to 95 percent of Americans, plus help them buy their care.

The Patients' Choice Act solves the liability problem by incentivizing States to have reforms in terms of the tort problem we have, where we know the cost is at least 6 to 7 percent more that we have spent on health care than we would if we had a realistic tort system.

Finally, we go after insurance companies because we do what is called risk readjustment. If you are dumping patients or cherry-picking—guess what—you have to pay extra; you have to pay to the very insurance companies that are covering those sick people. So we change the incentive to where an insurance company is incentivized to care for somebody rather than to dump them.

I was an advocate, when I was in the House, for the Patients' Bill of Rights. I was defeated at every turn, trying to make this. To say we did not come with a bill, on a party-line vote in the HELP Committee 13 voted against a commonsense bill that did not increase taxes, did not increase premiums, covered more people than this bill will cover by 4 million, putting everybody in Medicaid on a private insurance policy so no longer are they discriminated against by the doctors who will not take Medicaid, taking the Medicaid stamp off their forehead and giving them the same access to health care we have.

Mr. MCCAIN. So does my colleague find it entertaining that my friends and colleagues on the other side of the aisle, in 2005—as part of the Deficit Reduction Act, we had to bring in the Vice President, who I think was overseas, in order to break the tie because they were worried about what Senator REID called an ''immoral document,'' referring to the Republican budget?

By the way, is the Senator aware that Citizens Against Government Waste has come out in favor of this amendment?

Mr. President, I ask unanimous consent that the letter from Citizens Against Government Waste be printed in the RECORD.

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

COUNCIL FOR CITIZENS AGAINST GOVERNMENT WASTE,
Washington, DC, December 1, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: You will soon vote on Senator John McCain's (R–Ariz.) motion to commit H.R. 3590 to the Senate Committee on Finance with instructions to remove the drastic cuts made to Medicare. On behalf of the more than one million members and supporters of the Council for Citizens Against Government Waste (CCAGW), I urge you to support this motion.

H.R. 3590, the Patient Protection and Affordable Care Act, would slash Medicare by $500 billion. Depriving seniors of their much-needed benefits is not a responsible way to achieve healthcare reform.

As it currently stands, the legislation calls for significant reductions including $120 billion to the highly successful Medicare Advantage program; $150 billion to providers including hospitals, hospice programs, and nursing homes; and $23 billion in unspecified decreases to be determined by an ''Independent Medicare Advisory Board.''

While CCAGW has been a long-time critic of improper payments and Medicare waste and fraud, the $500 billion in cuts in H.R. 3590 would not solve these inherent problems or help make Medicare solvent. The major reductions proposed to Medicare merely help lawmakers offset the costs of a massive new entitlement program to the detriment of the nation's senior citizens.

I urge you to support Senator McCain's motion to commit. All votes on this motion and other amendments pertaining to Medicare cuts will be among those considered in CCAGW's 2009 Congressional Ratings.

Sincerely,

THOMAS SCHATZ,
President.

Mr. MCCAIN. Also, I say to the Senator, as you know, many of the seniors in my State—I would ask my colleague—have been very puzzled at the AARP's endorsement of a proposal that would cut their Medicare, where it has already been made clear that Medicare Advantage—and there are 330,000 seniors citizens in my State who are under Medicare Advantage—that it has been announced it will be slashed, and that somehow AARP is now supporting it.

All I can say is, is my friend aware there is an organization called 60 Plus that is working very hard on behalf of seniors to make sure they do not lose these benefits?

Mr. COBURN. I am. I would tell the Senator, again—how are we where we are? How are we where we are, when we are going to take a program that is working—granted, I think Medicare Advantage could be decreased through true competitive bidding. But CMS did not do that. We could bring the costs down and still have the same benefits. But this bill cuts the benefits in half,

the extra benefits that Medicare patients have by being signed up on Medicare Advantage that everybody has who can afford a supplemental policy.

I want to address one other thing, if the Senator would allow me. The majority whip said: Don't we want to get rid of conflicts of interest? Yes. But his argument was specious because the price is set for an X-ray or a mammogram or a CT or a blood test. They are set by Medicare now. There is no differential in the price other than what Medicare says the differential will be. There is no arbitrariness. The government sets the price for every Medicare test out there by region. So there is no way to game it, as the Senator from Illinois said it was gamed. The best reason to have a lab in a doctor's office is so you do not have to wait and come back for another visit to the doctor who charges Medicare another $60 because you get the answer right then. We want to eliminate that. So what will we do? There is no cost savings in that. There is a cost increase because now, instead of giving an answer to the patient, the patient is going to wait as they send it off to the lab, and have them come back in.

Mr. McCAIN. Can I ask the Senator another question? How does the Senator envision that we can eliminate fraud and abuse and waste and institute significant savings? One of the ways is to retain the provisions in this amendment, this motion to commit, that uses the savings from fraud, abuse, and waste elimination to make the trust fund stronger, but at the same time preserves the benefits that our senior citizens have earned. How many times have you heard from senior citizens in your State saying: I paid into this trust fund. I paid for my Medicare all my life. Now it is going to be cut. How is that fair? How is that fair to my generation, the greatest generation?

Mr. COBURN. Well, if you take $100 billion a year—and that is not an exaggeration; even HHS, this last week, said their improper payments were $92 billion; the Inspector General and the GAO both say it is higher than that; that is on Medicare alone—if we just captured $70 billion of that.

How do you do that? Do you know how Medicare pays down? They pay and then chase. So you submit an invoice. They do not know if it is accurate. They pay it, and then they go try to get the money back afterwards.

How about precertification of a payment, as everybody else does that has anything to do with the volume that Medicare has? The other way you do it is with undercover patients, where you put people actively defrauding Medicare in jail. Less than $2 billion in this whole bill goes after fraud. That is 2 percent of the fraud per year. We could cover everybody in the country or extend the life of Medicare 20 years by eliminating the fraud that is in Medicare today. What are we going to do? We are not. We are going to create more government programs and more agencies that are going to be designed to be defrauded. So, therefore, the fraud is going to go up, not down. The fraud is going to go up, not down.

We are also going to limit the availability of prevention to seniors. I have read the prevention text in the bill. There are parts of it I absolutely agree with. We know if we manage prevention and we manage chronic diseases, we are going to save a lot of money. But we are not going to save any of it by building jungle gyms and sidewalks. What we have to do is incentivize people, both physicians and patients, to get in the preventive mode. We need accountable care organizations.

There are lots of things we can do. There are lots of things we can agree on. I know the Senator from Iowa and I agree on a lot on the prevention, but we ought to be saving that money, and we ought to eliminate the fraud. If we did nothing in this body except eliminate the fraud in Medicare, think what we would have done, think what we would have done for the kids who follow us.

Mr. President, $447 billion spent on Medicare; $100 billion in fraud. Wheelchairs that have been billed out so many times they have collected $5 million on them, doctors who submit false invoices, suppliers who submit invoices for people who are deceased. And we try to go get that after the fact? There are lots of things we could do. This bill is short on that. You all recognize it is short on it. It is the biggest savings out there. The reason there is not more in it is because CBO will not score it because we have never demonstrated that capability.

One final point. This bill only scores the way CBO scores because it says you intend to do what no Congress has ever done. It says you intend to cut Medicare $460 billion to $480 billion. If you intend to cut Medicare, the American people ought to know where you are going to do it, how it is going to affect them. But if you are just doing it for a scoring point, the young people in this country ought to know that too. Because where you say you are claiming $460 billion, you are adding to the deficit if, in fact, we do not cut Medicare that much. And is it fair to the Medicare Advantage patients, who are poor—who do not qualify for dual coverage with Medicaid, who cannot afford a supplemental policy—is it fair to take away the benefits they have today that we have given them—and it was not priced by the insurance industry; it was priced by CMS—and say because CMS, the government agency, did not price it, we are going to take away half of your benefits? It is not fair. It is not right. If there is anything immoral, that is immoral.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, the Senator from Iowa is to be recognized next.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Well, Mr. President, sitting here listening to the Senator from Arizona and the Senator from Oklahoma go on, I hardly know where to start. There have been so many accusations and so much misinformation it is hard to know where to begin.

I would begin by, first of all, saying the people who keep saying we are slashing Medicare and we are going to harm seniors are totally wrong. The fact is, the bill we have before us protects Medicare's guaranteed benefits, reduces premiums and copays for seniors, ensures that seniors can keep their own doctors, and ensures Medicare will not go broke in 8 years by stopping the waste, fraud, and abuse.

I might also say, as an aside, every time I hear the Senator from Oklahoma talking about waste and abuse and fraud in Medicare, it sounds like it is all in Medicare. The waste, fraud, and abuse we are talking about are the ripoffs of Medicare by pharmaceutical companies, many of which have been fined big fines and have settled. One of the most recent ones, I think, was almost for a billion-some dollars. It was one of the largest settlements in our history with a pharmaceutical company that was caught ripping off Medicare. And insurance companies have ripped off Medicare, and others. It is not within Medicare; it is those who are coming at Medicare and trying to plunder it.

But that is what we do in this bill: We are stopping that kind of waste and abuse against Medicare; not in Medicare but against Medicare. We provide new preventive and wellness benefits for seniors. We lower prescription drug costs, keep seniors in their own homes, and not nursing homes, with the CLASS Act and the Community Choice Act that is also in this bill.

When they talk about going after Medicare, boy, talk about crocodile tears. Was it not Newt Gingrich, the former Speaker of the House, the leader of the Republican revolution, who said he wanted Medicare to ''wither on the vine''? Was it not Senator Bob Dole, their standard bearer for President in the 1990s, who said he had fought against Medicare and was proud he voted against it? Now, all of sudden, it seems as though Republicans are the guardians of Medicare.

People know the truth. The American people know the truth. They know it is the Democrats who fought for Medicare. Lyndon Johnson, as President, and the Democrats in the House and Senate, if it were not for them, Medicare would have never been

passed. It is the Democrats who have fought to keep Medicare alive and well and healthy, and expanding it to people all over this country every step of the way—being opposed by our friends on the other side of the aisle. And now to hear them talk about how much we are going after Medicare, boy, talk about crocodile tears.

The other thing I want to say is that I want to correct something the Senator from Oklahoma said. He talked about the recommendations that recently came out—I will have more to say about this in a minute—on mammograms. He said the U.S. Preventive Services Task Force—all they did was look at costs. That is what the Senator said. They looked at costs but they did not look at the people.

Recommendations that come from the U.S. Preventive Services Task Force cannot take into account cost. Cost cannot be a factor. They can only look at scientific evidence, safety, and efficacy. Cost cannot be taken in as any factor in their deliberations. So I wanted to set the record correct on that.

As I said, there were so many things I heard from the other side it is hard to know where to start. I see my leader here, Senator DODD, who did such a great job in getting our bill to the committee and getting it in the form that it is now and on the floor.

I wish to ask the Senator—I know the Senator was here listening to our friend, the Senator from Arizona, speak. Did it strike you that what he said was kind of missing the mark here a little bit and maybe not quite what we are doing in this bill?

Mr. DODD. I thank my colleague. Just to set the record straight, because it is amazing to me, in a very short amount of time, how people can misconstrue events. First of all, the Senator from Oklahoma was talking about the Medicare Advantage bill, and he said: Do you know who sets the rates? The government sets the rates.

That is true. That is because when that bill was passed, with very few people on this side supporting that bill—almost overwhelmingly on the other side—the requirement under the law, the requirement to pass, mandated under the law that the private plans of Medicare be overpaid, and on average those overpayments averaged 14 percent and in some States over 50 percent. The law that was passed here by the majority—and running the place at the time—insisted upon the mandates being included. So if you wonder why that occurs today, it is because they required it in the law.

Secondly, when you talk about the Deficit Reduction Act of 2005—again, memories fade for some people. In fact, under that bill, children, working families lost the insurance they had. Cuts occurred. Women lost access to mammographies. Cervical cancer screenings were cut. Families lost benefits. There were direct cuts in them. The difference is, today, with what we are talking about, you don't cut these benefits at all—at all. In fact, we are increasing the opportunity for Medicare to be strengthened under this bill. There is a vast difference between what happened in 2005 and what is being supported today. So, again, I just want the record to be clear. You can't make these things up as you go along. That is what happened in 2005. It was an abomination and did great damage to people in this country. People lost their insurance.

Under our bill, 31 million Americans will have coverage. We now know the premiums are going to drop for 93 percent of all Americans. Premiums will actually come down for individuals, small businesses, and large employers. For five out of six people who have their jobs, those premiums come down. Thirty-one million Americans will be covered with health insurance. Compare that, if you will, with 2005 when we actually cut mammography screening, cervical cancer research, and assistance in health care for infants and children and women. That all got damaged in that year. Not in this bill. This is the difference.

I thank my colleague for yielding.

Mr. HARKIN. Mr. President, the only thing I would say to my friend from Connecticut—he said that in 2005 we had made all of these cuts in the Deficit Reduction Act. I just want to say for the record that I didn't vote for it and neither did the Senator from Connecticut.

Mr. DODD. Absolutely not.

Mr. HARKIN. Is this not when the Republicans were in charge and they had a Republican President and a Republican House and Senate? That is when they cut all the mammogram screenings and things such as that?

Mr. DODD. That is true. The record is very clear on this. People had the right to do so; that was their choice at the time. But to try to rewrite history somehow and say those cuts didn't occur—in fact, they did occur in these areas. That is why there were those of us here who objected strongly at the time. My colleague from Arizona is absolutely correct when he said that I said this was going to cut benefits for children and working families and cut screenings and tests for people. It did do that. Those of us who made those warnings on that day were proven to be 100 percent accurate. Compare that, if you will, with what we are talking about here today, particularly regarding reducing costs, premiums, and providing increased access for millions of Americans. That is the difference.

If you vote for the McCain amendment, we are right back where we were before—right back—which, of course, we all know means premium increases go up by literally 100 percent in the next 7 years. Tell that to a family of four in my State who is paying $12,000 right now and will go to $24,000 in 7 years, as opposed to having those premiums being reduced, depending on if you are an individual, small business, or large employer, by as much as 20 percent, 11 percent, or 3 percent, not to mention, of course, that you will also increase the number of people who will be covered under this.

The present situation runs the risk of bringing our economy to its knees if we don't act. Recommitting this bill—going back, in a sense—would roll the clock back and do great damage to both individuals and to our country economically. That vote in 2005 set us back terribly in this country. This proposal allows us to move forward and provide the coverage a lot of people need.

I thank my colleague.

Mr. HARKIN. I thank my friend for pointing out those facts.

Mr. President, I have a letter dated December 1, 2009, from the National Committee to Preserve Social Security and Medicare. It says:

Dear Senator:

On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing to express our opposition to the amendment offered by Senator McCain which would recommit the bill to the Senate Finance Committee.

Much of the rhetoric from opponents of health care reform is intended to frighten our Nation's seniors by persuading them that Medicare will be cut and their benefits reduced so that they too will oppose this legislation. The fact is that H.R. 3590, the Patient Protection and Affordable Care Act—

The bill we have before us—

does not cut Medicare benefits; rather, it includes provisions to ensure that seniors receive high quality care and the best value for our Medicare dollars. This legislation makes important improvements to Medicare which are intended to manage costs by improving the delivery of care and to eliminate wasteful spending.

I won't read all of it, but it concludes:

The committee urges you to oppose the motion to recommit the bill to the Finance Committee.

Sincerely, Barbara B. Kennelly, President and CEO.

Mr. President, I ask unanimous consent to have this letter printed in the RECORD.

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

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,
Washington, DC, December 1, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing to express our opposition to the amendment offered by Senator McCain which would recommit H.R. 3590, the Patient Protection and Affordable Care Act,

to the Senate Finance Committee with instructions to remove important Medicare provisions.

Much of the rhetoric from opponents of health care reform is intended to frighten our nation's seniors by persuading them that Medicare will be cut and their benefits reduced so that they too will oppose this legislation. The fact is that H.R. 3590, the Patient Protection and Affordable Care Act, does not cut Medicare benefits; rather it includes provisions to ensure that seniors receive high-quality care and the best value for our Medicare dollars. This legislation makes important improvements to Medicare which are intended to manage costs by improving the delivery of care and to eliminate wasteful spending.

The National Committee opposes any cuts to Medicare benefits. Protecting the Medicare program, along with Social Security, has been our key mission since our founding 25 years ago and remains our top priority today. In fact, these programs are critical lifelines to today's retirees, and we believe they will be even more important to future generations. But we also know that the cost of paying for seniors' health care keeps rising, even with Medicare paying a large portion of the bill. That is why we at the National Committee support savings in the Medicare program that will help lower costs. Wringing out fraud, waste and inefficiency in Medicare is critical for both the federal government and for every Medicare beneficiary.

The Senate bill attempts to slow the rate of growth in Medicare spending by two to three percent, or not quite $500 billion, over the next 10 years. However, it is important to remember that the program will continue growing during this time. Medicare will be spending increasing amounts of money—and providers will be receiving increased reimbursements—on a per capita basis every one of those years, for a total of almost $9 trillion over the entire decade. Even with the savings in the Senate bill, we will still be spending more money per beneficiary on Medicare in the coming decades, though not quite as much as we would be spending if the bill fails to pass.

America's seniors have a major stake in the health care reform debate as the sky-rocketing costs of health care are especially challenging for those on fixed incomes. Not a single penny of the savings in the Senate bill will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings included in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits; and it will extend the solvency of the Medicare Trust Fund by five years. To us, this is a win-win for seniors and the Medicare program.

The National Committee with urges you to oppose the motion to recommit the bill to the Finance Committee with instructions to strike important Medicare provisions from health care reform legislation.

Cordially,

BARBARA B. KENNELLY,
President & CEO.

AMENDMENT NO. 2791

Mr. HARKIN. Mr. President, I wish to talk about the amendment before us which has been offered by the Senator from Maryland, my colleague, Senator MIKULSKI. I am going to have more to say about the bill and engage with, perhaps, the Senators from Arizona and Oklahoma in the days and weeks ahead on the structure of the bill itself, but I wish to focus on the amendment that is now before us.

First of all, I am proud that this bill, the Patient Protection and Affordable Care Act, makes significant investments in prevention and wellness because I have long believed that such investments are essential for transforming our sick care system—that is what we have now, a sick care system—into a true health care system, one that keeps Americans healthy in the first place. It keeps them out of the hospital. It will keep a check on rising costs in both the public and private health care markets.

It does this in a number of ways. I won't go into all of them, but among the most important is that this bill requires insurance companies to cover highly effective preventive services with no copayments or deductibles—no copayments or deductibles. This is critical because we know that all too often people forgo their yearly checkups or screenings either because their insurance company doesn't cover them or, secondly, because they have high copays or deductibles that make them simply unaffordable. For example, I had a recent conversation with a small business owner in western Iowa, and he and his few employees have a $5,000 deductible. He recently turned 50. His doctor said: Time for you to get your first colonoscopy. Well, he found out that the colonoscopy was $3,000. He has a $5,000 deductible. This is all out-of-pocket. So not being a man of wealth and not having a lot of means, trying to struggle to keep his small business afloat, he is putting it off. He is putting it off. So that is what is happening now. But what we say in our bill is that these have to be covered without copays or deductibles.

There has been a lot of discussion recently on the coverage of preventive services for women in light of the recent recommendations issued by the U.S. Preventive Services Task Force on mammogram screenings. It has been alleged that the Reid bill, like the HELP and Finance bills that preceded it, only requires coverage of those services strongly recommended by the Preventive Services Task Force. This simply is not true. Under the language of this bill, health plans are required at a minimum—at a minimum—to provide coverage without cost for preventive services recommended by the Preventive Services Task Force. Understand that. It only says that health plans are required at a minimum to provide coverage at no cost for certain preventive services recommended by the Preventive Services Task Force. But these are simply the minimum level, not the maximum. The task force will establish the floor of covered preventive services, not the ceiling. No health plan will be prohibited from providing free coverage of a broader range of preventive services, and in many cases the Secretary of Health and Human Services may well require that. That is because our bill gives the Secretary of Health and Human Services the authority to identify additional preventive services that will be part of the essential health benefits offered by health insurers in the exchange.

The simple fact is, the Preventive Services Task Force cannot set Federal policy and they cannot deny coverage, period, although there has been a lot of misinformation that has gone out about this. They simply give doctors and patients the best medical information, as I said earlier, not based on cost—cost cannot be a factor—but based on science and based upon efficacy and based upon outcomes and nothing else.

Still, I share the concerns of some that the task force has not spent enough time studying preventive services that are unique to women. This is a concern that was raised when the HELP Committee debated the bill in committee. At that time, I worked with the Senator from Maryland, Ms. MIKULSKI, to include language requiring that all health plans cover comprehensive women's preventive care and screenings based upon guidelines supported by what we call HRSA, the Health Resources and Services Administration, again, with no copays, no deductions. That language is in our bill. It was not included in the merged bill. Senator MIKULSKI's amendment which is now before us and which I have cosponsored would add that language—would add that language—like we had in our committee bill, and I strongly urge its adoption.

By voting for this amendment, which I understand we will do in a couple of hours, we can ensure all women will have access to the same baseline set of comprehensive preventive benefits that Members of Congress and those in the Federal Employees Health Benefits Program currently enjoy. Let me repeat that. If you vote for the Mikulski amendment, you will ensure that all women will have access to the same baseline set of preventive services that are enjoyed by Members of Congress, women Members of Congress, and all women Federal employees in the Federal Employees Health Benefits Plan. That is what voting for the Mikulski amendment will do.

Expanding preventive health care is just one of the ways this bill benefits women. Again, our health care system is broken. It is expensive. Today, less than half of women have access to employer-sponsored insurance coverage. Think about that. Less than half of the women in this country have access to employer-based insurance coverage. Again, many of these women work for very small businesses, and they can't afford to provide that kind of insurance coverage.

In most States, it is legal for insurance companies to charge women more than men for the same policy. Women can pay more than double what men pay at the same age for the same coverage. Each year, thousands of women are denied coverage from health insurance companies for preexisting conditions. In many States, a history of hospitalizations from domestic violence is considered a preexisting condition. Think about that. A battered woman lives through domestic violence and now can't get health insurance coverage because of a preexisting condition—being battered. That happens in many States. With these options, it is not surprising that more than 16 million women are uninsured in this country.

Women are often the health care decisionmakers for their families. They face difficult choices daily. One-third of women are forced to make tradeoffs between basic necessities and health care. In 2009, more than one-half of women reported delaying care because of its high cost.

Today, we have the opportunity to fix these problems. This historic legislation now before us increases access to affordable health insurance and ensures that women's coverage meets their health care needs.

We will end premium discrimination against women. We will end discrimination against those with preexisting conditions. We will prohibit the rescission of health insurance coverage because of an illness. We will provide more affordable insurance choices through the health insurance exchange, including a strong public option to increase competition and choice. We will ensure that the policies families buy are good enough. We will require that all insurance policies sold in all markets provide adequate coverage for primary and preventive care, for screenings, maternity services, and many other services that women and their families need to stay healthy.

As has been said many times before, this bill will extend coverage to an additional 31 million Americans who are currently uninsured. As I said, 16 million women in America are uninsured. So that is why Senator MIKULSKI's amendment is so important, vitally important. That is why this bill is so vitally important.

We are going to talk a lot about Medicare. I see the Republicans are focusing on that, although a recent letter I read and had inserted in the RECORD from the National Committee to Preserve Social Security and Medicare says we ought to oppose the McCain amendment. We will hear a lot about that.

What about the women of this country and what is happening to them? The Mikulski amendment addresses that in a very profound way. But then this bill takes it even a step further by making sure that women, many of whom work for small businesses, who are sort of in an uncovered pool, so to speak, out there by themselves, now they can go on the exchange. Now they can get the kind of coverage they need. They will have choices available to them—not just maybe one option and in some States no option. They will have different options available. They will be able to join with other like women around so they will have a bigger pool and better coverage for themselves and their families.

Yes, I can honestly say the health care reform bill before us, the Patient Protection and Affordable Care Act, is a pro-woman bill. It is not talked about a lot, but many of the things in this bill will go to ease the dilemma so many women find themselves in, in this country—providing basic necessities for their children or trying to get health care coverage for themselves. I can tell you so many women whom I have met and talked to have given up on buying health insurance for themselves so they will have enough money to feed and clothe their kids and send them to school. Women should not be forced to make that kind of a choice.

This bill before us will enable women to not have to make that choice. They will be able to get the insurance coverage they need at an affordable price, with the tax credits that are included for low-income women, and they will be able to have the piece of mind of knowing that they and their kids are truly covered with the health insurance they need.

I will keep coming back to these two things, time after time, as we go through the bill: prevention and wellness. Keeping people healthy in the first place is a big part of this bill. If there is one thing that will bend the cost curve, it is putting more focus upfront on prevention and more focus on keeping people healthy in the first place. That will save us money in the future.

The second theme is what this is going to do for the women of America; how is it going to help them and their families to have peace of mind and to have the health insurance coverage they need.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the next four Republican speakers to be recognized be Senators JOHANNS, ROBERTS, HUTCHISON, and CORNYN and for the Democrats to speak in an alternating fashion, with the next Democrats being Senators MURRAY and CANTWELL to speak on the tragic shootings in Washington, and that following Senator ROBERTS, I be recognized.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I yield to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. JOHANNS. Mr. President, I rise to speak in support of the McCain amendment. I have been down here for a while, and I have listened to the debate on the Medicare cuts.

What strikes me about this debate is that reality sets in. It simply does. There will be a point at which hospitals, hospice programs, and skilled nursing facilities are going to see less money. That is simply the reality of what we are debating.

It is kind of remarkable to me that you could go from a period just a few years ago, where $10 billion over 5 years was described as immoral, and today we are talking about nearly $½ trillion in cuts. That is going to have a real impact on real programs that involve real people in our States.

From our standpoint, we try to look at this in a way that says: OK, if this were to happen, if, in fact, this gets the necessary votes, what impact will it have on real programs in Nebraska?

Let me walk down through that, if I might. For example, more than $40 billion in cuts from home health on the national level would translate back to the State I represent to the tune of $120 million in cuts. By 2016, according to our analysis back home, 68 percent of Nebraska home health agencies will be operating in the red.

In rural areas, as high as 80 percent will have negative margins. If you lose those services in rural areas, they are lost. In fact, they may be lost forever.

Skilled nursing facilities are already struggling to keep their doors open. I visit these facilities when I get back home. Many of us do that. They are already doing everything they can to make ends meet. We are already seeing them go under in community after community. I visit these facilities and they tell me: MIKE, we are just holding on.

Hospice programs in Nebraska have been very well received. Years ago, I might have predicted otherwise. The reality is, hospice has worked well in my State, and I am guessing it is also in other States in the country. A survey reported that 100 percent think access to hospice services is important. This bill cuts $80 billion nationally from hospice programs.

How can we legitimately expect little or no impact, or simply attempt to argue it away, when 38 Nebraska hospice programs are already operating right at the margin? If there is any reduction, they will go out of business.

Hospitals will also see negative impacts. Let me quote, if I might, from a Nebraska Hospital Association letter:

Our 85 community hospitals have a unique stake in this debate. Not only are we providers of care to more than 10,000 patients

per day, we are also one of the largest consumers of health care because we employ 42,000 people. . . . Hospitals are an economic mainstay of the community they serve and we (the NHA) are opposed to all measures that weaken our financial stability and viability.

The Nebraska Hospital Association indicates that disproportionate share hospital cuts will be $128 million. If other hospital cuts are factored in, Nebraska hospitals say they will see a total loss of $910 million.

I visit these little 25-bed hospitals. They have no room for error. There is no margin there. When they lose something such as this, they simply cease to exist. That community, then, is on its way to ceasing to exist.

Finally, it is very clear that Medicare Advantage is on the chopping block. That is 35,000 Nebraskans. No matter how hard you want to argue that, there are 35,000 Medicare Advantage beneficiaries in my State who will experience cuts in the very program that is such an important safety net to them.

CBO, the Congressional Budget Office, estimates reduced benefits from $135 to $42 a month. The so-called extra payments that would be cut are helping Medicare Advantage beneficiaries get very valuable benefits. Many who utilize Medicare Advantage are truly our most vulnerable citizens.

We cannot ignore that important fact. Seniors with a Medicare Advantage plan might receive vision or dental benefits or have their Medicare copayments reduced. In our State—I am guessing this is true of States all across the country—what you see is some of the poorest actually have Medicare Advantage.

If you don't believe me, just yesterday I received a letter from some Hispanic groups which said this:

With the growing number of Hispanic seniors, one in four of whom have Medicare Advantage, the defunding of the Medicare Advantage program and other Medicare cuts proposed would result in fewer benefits and a significant disruption in the care and coverage senior Hispanic Americans receive.

I ask unanimous consent that this letter be printed in the RECORD.

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

NOVEMBER 16, 2009.

DEAR SENATOR: As organizations that represent Hispanic Americans, we are deeply concerned with the health care reforms currently being discussed. We do not support reforms that will lead to increases in taxes for all Americans but especially for small business owners, cuts in Medicare, and mandates on families and businesses.

Hispanic small businesses are among the fastest-growing sectors in the U.S.—growing at a rate of over three times faster than the national average. We have been hit hard by this slow economy and cannot afford a greater tax burden and mandates on our families and small businesses. The result will be more Hispanics out of work and reduced wages that directly impact low-income and minority communities.

With the growing number of Hispanic seniors, one in four of whom have Medicare Advantage, the de-funding of the Medicare Advantage program and other Medicare cuts proposed would result in fewer benefits and a significant disruption in the care and coverage senior Hispanic Americans receive.

Many of our families came to the United States to escape hardship, pursue business opportunities and enjoy its economic freedoms. We deserve the right to make our own health care choices and not be subjected to costly and inefficient government mandates.

More than 30 percent of Hispanics are currently uninsured, and we want real reform that would help them. These reforms must promote real competition and choice. We want to ensure that Hispanic families have affordable health care, more choices and that their direct relationships with their doctors remain intact and uninhibited by bureaucrats.

Competition-increasing solutions include allowing businesses and individuals to purchase health insurance across state lines, which would make it easier and less costly for small businesses to provide employees with coverage. Allowing groups to join together to purchase insurance—whether they be small business or church or community groups—would also have a significant impact on the affordability of insurance for Hispanics and increase choices.

Government-focused proposals where bureaucrats and not individual business owners will decide what coverage an employer should provide will not help our families or businesses. Also, individuals will be penalized with fines and higher taxes if they do not follow the rules in Washington.

We hope that you will consider these concerns and what is in the best interest of Hispanic Americans, and all Americans, as you vote on health care reform.

Sincerely,

Hialeah Chamber of Commerce & Industries, Hispanic Alliance for Prosperity Institute, Hispanic Leadership Fund, Hispanic Professional Women Association, CAMACOL—Latin Chamber of Commerce of U.S.A.

Patients' First (Pacientes Primero), The Latino Coalition, U.S. Mexico Chamber of Commerce, Virginia Hispanic Chamber of Commerce, Voces Action.

Mr. JOHANNS. How could any Member go back to their State and defend these cuts to services that provide very important health care needs? Americans simply deserve better than that. If we want serious Medicare reform, we should start with true waste and fraud and concentrate on Medicare insolvency—especially when we all agree insolvency arrives in 2017.

What we are doing in these days of debate is truly robbing from Peter to pay Paul—and Peter is soon to be broke. Unfortunately, that is exactly what we are doing. Americans deserve better than the bill we are debating. I can't stand silently and accept a bill that has such dramatic cuts in the services provided to Nebraska seniors.

I will conclude by saying I support the McCain motion to commit to remedy these problems and get us back on track with commonsense reform.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington is recognized.

LAKEWOOD, WA, POLICE SHOOTINGS

Mrs. MURRAY. Mr. President, we are obviously in the middle of a very important debate on health care. I thank the managers of this bill for allowing my colleague from Washington, Senator CANTWELL, and me to interrupt this important debate to talk for a few minutes about a very tragic event that occurred in Washington over this past weekend.

Just 2 days ago, our State was shocked and saddened and appalled by news of the deadliest attack on law enforcement in Washington State's history. On Sunday morning, just after 8 a.m., a gunman walked into a coffee shop in Pierce County, WA, and opened fire, killing four members of the city of Lakewood Police Department who were going over the details of their upcoming shift.

It was a senseless and brutal killing. It specifically targeted the people who sacrifice each and every day to keep all of us safe—our police officers.

This terrible crime has not only left the families of these victims shattered, but it has shattered our sense of safety and left an entire community and State in disbelief.

It is also part of a shockingly violent month for my State's law enforcement community that has also included a senseless attack on October 31, which killed Seattle police officer Timothy Brenton and left another officer, Britt Sweeney, injured.

These attacks remind all of us of the incredible risks our law enforcement officers take each day and that even when doing the most routine tasks and aspects of their jobs, our law enforcement officers put themselves on the line for our safety.

Today my thoughts and prayers, like those all across Washington State and our Nation, remain with the families of the brave police officers who were killed on Sunday.

Officer Tina Griswold was a 14-year veteran who served in the police departments in Shelton and Lacey before she joined the Lakewood Police Force in 2004. She leaves behind a husband and two children.

Officer Ronald Owens followed his father into law enforcement. He was a 12-year veteran of law enforcement and served on the Washington State Patrol before moving to the Lakewood Police Department. He leaves behind a daughter.

SGT Mark Renninger was a veteran who wore the uniform of the United States before putting on the uniform of the Tukwila Police Department in 1996. He joined the Lakewood Police Department in 2004. He leaves behind a wife and three children.

Officer Greg Richards was an 8-year veteran who served in the Kent Police Department before he joined the Lakewood Police Department. He leaves behind a wife and three children.

Because of this senseless attack, nine children have lost their parents. These were officers—mother and fathers, husbands and wife—who woke up every day, put on their uniforms, and went out to protect our children, our communities, and our safety. On Sunday, they did not come home.

Already in news reports, Internet postings, and candlelight vigils thousands of tributes to these officers' dedication to their families and jobs have been shared. They paint a picture of brave officers who not only kept our communities safe but were also respected and revered members of our communities; a mother and fathers who in the wake of this tragedy will leave young families behind; neighbors and friends who coached softball and helped repair local homes and reached out to help those in need. They are police veterans who helped build the foundation of a new police force. They are public servants who put the safety of all of us behind their own every single day.

Already this year 111 police officers across our country have given their lives while serving to protect us. Each of those tragedies sheds light on just how big a sacrifice our police officers make in the line of duty. But these most recent attacks in my home State also offer an important reminder: that our officers are always in the line of duty, even when they are training other officers or out on routine patrols or simply having coffee.

There is no doubt these senseless attacks have left many law enforcement officers across my State and our country feeling targeted. But there is also no doubt that their willingness to put themselves on the line to protect us will continue unshaken. In fact, over the last 3 days, law enforcement officers from all across my State have risked their own lives in the successful search to find the man accused of this killing and to keep him from hurting more innocent people. That is a testament to the unwavering commitment they make to serve and protect each of us every day. It should remind all of us that these brave men and women deserve all the support we can provide to keep them safe.

No words are adequate to express the shock, the anger, and the disbelief that comes with such a brutal crime. No words will be enough to lessen the loss. Our law enforcement professionals put themselves between us and danger every day.

Right now, in light of such horrible events, we hold them even closer in our thoughts and our prayers.

Mr. President, I yield to my colleague from Washington State, Senator CANTWELL.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, I rise today to join my colleague, Senator MURRAY, in expressing my sorrow over the tragedy that struck Washington State and the law enforcement community. I extend the prayers and condolences of the Senate and the entire Nation to the families, loved ones, and colleagues of the four police officers who lost their lives in the line of duty Sunday in Lakewood, WA.

Those four officers, part of Washington's best, are SGT Mark Renninger, Officer Ronald Owens, Officer Tina Griswold, and Officer Greg Richards.

Collectively, they served for 47 years in the line of duty. As Lakewood Police Chief Bret Farrar describes them, they were "outstanding individuals" who brought a range of talents to a 5-year-old department.

These heroes, who put their lives at risk for our safety every day, will be deeply missed and never forgotten. The men and women in blue who keep our communities safe make tremendous sacrifices daily, and so do their families.

The senseless tragedy that claimed the lives of these four officers, as my colleague said, the deadliest attack in Washington State history, reminds us of the risk that police officers take every day when they put on their badges.

The risks that police take every day was driven home again today when a Seattle police officer on routine patrol confronted, shot, and killed the person believed responsible for this crime. And at a time when we are all in shock over the loss of these officers, the police remain vigilant. They did not stop doing their job, even when tragedy struck close to home.

I thank all those who participated in the law enforcement's response since this tragedy happened. I thank the Pierce County Sheriff's Office and Sheriff Paul Pastor for the investigation they have led. My heart goes out to the Lakewood Police Department and Chief Bret Farrar.

I also thank the efforts of the Seattle Police Department and the interim Chief John Diaz for his efforts and his agency's work.

In a matter of days, police and public safety officers from all around the country will converge on Puget Sound. They will form a long blue line in a show of respect for those who have fallen—Mark Renninger, Ronald Owens, Tina Griswold, and Greg Richards.

This moving ritual, which happens all too often in our country, speaks eloquently of the solidarity all of us feel with those who risk their lives to keep us safe. This tragedy also struck our State earlier in October when Officer Timothy Brenton was struck down randomly while sitting in his police car.

I hope everyone in this country will take time today and tomorrow and next week, if they see a police officer, to thank them. Thank them for their service. Express your appreciation for the job they do putting themselves at risk for all of us. We did not have enough time to thank Mark, Ronald, Tina, and Greg, but we are thanking them in our thoughts and prayers, and we are sending strength to their families with much love and appreciation for what those officers and their families have done to serve us and their communities.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I am sorry. I think Mr. ROBERTS is to be recognized.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. ROBERTS. Mr. President, I thank the distinguished Senator from Montana and my chairman of the Finance Committee.

Let me say first to the Senators from Washington State that I think all Senators appreciate both Senators bringing to the attention of the Senate the heartfelt feelings in regard to the tragedy that happened in their State. I share their dismay with regard to what has happened. I know the thoughts and prayers of all Senators are with them. I appreciate the remarks they have brought to the body at this time.

I would now like to discuss briefly the motion to commit in regard to Medicare and the tremendous cuts that are proposed in the bill—a bill I define not as the Finance Committee bill, not as the HELP Committee bill, but the bill that was done behind closed doors, which I think was most unfortunate.

This bill slashes—and I think that is the appropriate word—nearly $1/2 trillion from Medicare. Then it is used to establish a huge new government entitlement program.

Earlier this year during the Finance Committee markup of the health care reform legislation, I offered a nearly identical amendment to the McCain motion to commit we are now considering, which is a motion simply to send the legislation back to the Finance Committee with instructions to strike the cuts to Medicare in this bill. Unfortunately, my amendment during that time failed in committee on a party-line vote.

Let me see if I understand this correctly. Medicare is going broke. It has around $38 trillion in projected future unfunded liabilities. It is a huge, crushing entitlement program that threatens to bankrupt this country. But instead of owning up to this enormous threat and doing something about it for our financial future, instead of considering a Medicare reform bill to address this menace to future generations of Americans, instead of guaranteeing that the government-run plan we currently have remains solvent, instead we are actually cutting some $465 billion from Medicare in order to start a brandnew, huge, crushing entitlement program that makes no sense.

If Medicare needs to be reformed—and I certainly believe it does—then we should be considering a Medicare reform bill right now. We certainly should not be cutting Medicare for the purpose of financing a huge new entitlement program.

My friends on the other side of the aisle have the temerity—that is a pretty strong word, but I think it applies—to assert these huge cuts will actually make Medicare more solvent. Nothing could be further from the truth. I have news for them. Cutting reimbursements to doctors, cutting reimbursements to hospitals and other providers—all providers—and it has been mentioned by my distinguished colleague from Nebraska—home health care providers, hospices is not reform. These cuts will hurt Medicare beneficiaries, our seniors who have worked their entire lives with the promise that this program would support them through their older age.

Medicare already pays doctors and hospitals well below cost—70 percent approximately for hospitals, 80 percent for doctors approximately. The only saving grace is that these providers have the ability to shift their losses on to private payers to keep their doors open or their practices going. But there is a limit to their ability to cost shift. There is only so much the private sector is willing to absorb.

American families already pay—now get this—an extra $90 billion in a hidden tax to make up the Medicare and Medicaid underpayments that we in past years have provided each year. More cuts to reimbursements coupled with the massive increase to Medicaid this bill assumes will push these limits, meaning that fewer doctors will open their doors to new Medicare patients. They are doing that right now. We are rationing right now as to access to doctors who accept Medicare patients, and health care access and quality for our seniors will be compromised.

Take the $105.5 billion cut to hospitals as an example. I know the National Hospital Organization has signed off on these cuts. I don't know why, but they have signed off on these cuts. I also know for a fact they will harm Kansas hospitals. I asked my Kansas Hospital Association—I did, at my request—to run the numbers on how this bill will affect their bottom lines. Their findings are frightening.

According to the Kansas Hospital Association's outside experts, this bill will result in nearly $1.5 billion in losses to Kansas hospitals over the next 10 years. It may be true that some urban hospitals that currently have large percentages of uninsured patients may have some of their cuts offset by the potential reduction this bill will make to the uninsured population. But that is no consolation to a hospital in McPherson, KS, for example, that may be too large to qualify for the higher reimbursements allotted for what we call critical access hospitals, and has, unfortunately, the misfortune of serving a smaller than average uninsured base. Those hospitals will see huge cuts without seeing any of the gains. This bill's $100 billion cut will only hurt these hospitals and their ability to serve Medicare and even non-Medicare patients. Remember the cost sharing.

Medicare's own actuaries at CMS, the Center for Medical Services—sort of an oxymoron—have agreed that the Democrats' cuts to hospitals and other providers could be dangerous and could cause them to end their participation in Medicare. So why are we doing this?

Another huge cut to Medicare in this bill is that $120 billion cut to the Medicare Advantage Program. My distinguished colleague from Nebraska has already talked about that, the effects of Medicare Advantage to Nebraska. Let me talk about Kansas. Close to 11 million, or one-quarter, of Medicare beneficiaries are enrolled in Medicare Advantage; 40,000 of those beneficiaries are in Kansas. I want to read an excerpt from one letter I received from a very satisfied Medicare Advantage customer in Shawnee, KS. Ms. Lila J. Collette is enrolled in Humana Gold Plus, a Medicare Advantage plan. She writes:

> Please use everything in your power to let me and the many, many other people in Kansas who have chosen Humana Gold Plus to keep this wonderful plan.

Ms. Collette is not alone. Satisfaction rates among seniors enrolled in Medicare Advantage plans are very high. I know they are very unpopular to the other side and there are a lot of allegations made, but these people made that decision on their own, so why are we essentially gutting this program that provides quality and choice to our seniors?

I could go on about the cuts to hospice, home health care providers, nursing homes, but I think you get the point. I disagree with the failure to prioritize the solvency of Medicare over the establishment, again, of new government programs. And I certainly will never agree to financing these government expansions by bleeding the Medicare Program dry.

That is why, as I have said, I offered amendments in the Finance Committee markup that would have struck these Medicare cuts. Again, unfortunately, they were defeated on a party-line vote.

As the President is fond of saying, ''Let me be clear.'' This bill is funded on the backs of our seniors and those who provide Medicare to our seniors. This bill slashes Medicare by $½ trillion. This bill threatens access to care for seniors and health care for all Americans. I hope my colleagues will join me in opposing these cuts by voting for the McCain motion to commit.

This is the key vote. Don't kid yourselves, this is the key vote. You are either for protecting Medicare or not.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I wish to once and for all lay to rest this false claim that the pending bill is going to ''hurt seniors'' and is going to hurt providers; it is going to be this long parade of horribles that the other side likes to mention. It is totally, patently untrue, the claims they are making.

No. 1, all the crying allegations on the other side that the underlying legislation cuts Medicare, it cuts Medicare, it cuts Medicare—that is what they say. What they do not say is it does not cut Medicare guaranteed benefits. It doesn't cut benefits. It does reduce the rate of growth that hospitals would otherwise receive. It does reduce the rate of growth that medical device manufacturers might receive. All that is true. So it is true it is cutting the rate of growth of Medicare providers. It is not true that this legislation cuts Medicare benefits. That is not true. The other side would like you to believe that is true by using the words they choose. By saying ''cutting Medicare,'' they want you to think that is cutting Medicare benefits.

But it is not cutting Medicare benefits. Rather, the underlying bill reduces the rate of growth of government spending on providers, on hospitals, home health, hospice—lots of other providers. That is what is going on here. Don't let anybody fool you. This bill does not cut Medicare benefits. It does not. But it does reduce the rate of growth of providers.

Why are we doing that? First of all, most of these providers, virtually all the providers say—gee, we don't like our rate of growth, the Federal dollars coming to us, cut, but they will go along with it. They are OK with it. Why are they OK with it? Why is the American Hospital Association OK with reducing the rate of growth of hospital payments by $155 billion? Why are they OK with that? They are OK with that because they are going to make it up on volume. This legislation provides coverage for many more Americans. They are going to have health insurance. Americans who do not have health insurance now often have to go to the emergency room of the hospital, the hospital has to provide the care, it is uncompensated care—nobody is paying for those hospital benefits—and that cost is transferred on to private health insurance premium holders. They have to pick it up. On average, that is about $1,000 per family per year.

No. 1, let me repeat, there are no cuts to Medicare benefits. There are reductions in the rate of growth to Medicare providers—which the providers agree with, by and large. I won't say totally,

I wouldn't stand here and say they are jumping up and down and they are enthusiastic about it, but I am saying they realize they are not getting hurt. They are going to do OK. They are going to do OK because they are going to make up in volume what they might otherwise lose. That is a very important point for people to understand.

Second, if you listen to the other side, what they would have us do is virtually do nothing. What does doing nothing mean? Doing nothing means the solvency of the Medicare trust fund is just over the horizon. This legislation extends the solvency of the Medicare trust fund another 4 to 5 years. Man, if I am a senior—I am about to be a senior—I would sure like the Medicare trust fund to be solvent. I would like that very much. This legislation extends the solvency of the Medicare trust fund by another 4 to 5 years, to about the year 2017. So without this legislation, the actuaries say the Medicare trust fund is going to become insolvent 5 years earlier, 2012, somewhere there. That is not many years from now; not many years at all. So it is very important we extend the solvency of the Medicare trust fund.

You might ask why is the Medicare trust fund in a little bit of jeopardy? Why is that? The very basic reason is because health care costs are going up at such a rapid rate in America. Our health care costs are going up by 50 or 60 percent more quickly than the next most expensive country. We already are paying per capita 50 percent or 60 percent more than the next most expensive country. So there is a whole host of things we are doing in this legislation to make sure we have some limit over our health care costs.

I realize I misspoke earlier. Currently the Medicare trust fund is due to be insolvent about the year 2017. This legislation extends the solvency of the Medicare trust fund to the year 2022. The principle is the same, just the 5 years is tacked on a little later period of time rather than upfront.

But we are doing a whole host of things in this legislation to reduce the rate of growth of health care costs to people in this country. It is health care costs which are driving up the Medicare trust fund costs so we are doing all we can to extend the solvency of the Medicare trust fund.

People are saying the Medicare trust fund is getting insolvent because baby boomers are retiring, and that will increase the pressure on it. But the Congressional Budget Office did a study 6 or 8 months ago that said about 70 percent of the additional cost of the Medicare trust fund is due to cost increases, it is not due to more baby boomers retiring when they reach the age of 65.

What do some of the groups say about this legislation? Let me say what AARP says. We have a chart here which indicates what the American Association of Retired People says about the underlying bill. If it was cutting Medicare as the other side says, you would think they would not like this bill. You would think they would have problems with it.

AARP has not totally endorsed this bill, but they don't have problems with it because they know we are doing the right thing. What do they say? AARP says:

> Opponents of health care reform won't rest. [They are] using myths and misinformation to distort the truth and wrongly suggesting that Medicare will be harmed. After a lifetime of hard work, don't seniors deserve better?

That is what the AARP says, referring to the distortions, misrepresentations, and untruths, trying to scare seniors, mentioned by opponents of this legislation.

Here is another AARP quote. This is this month:

> The new Senate bill makes improvements to the Medicare program by creating a new annual wellness benefit, providing free preventive benefits, and—most notably for AARP members—reducing the drug costs for seniors who fall into the dreaded Medicare donut hole, a costly gap in prescription drug coverage.

That is a very important point. This bill not only does not cut benefits, it increases benefits for seniors. A big one is referred to right there and that is the so-called doughnut hole, the gap in coverage under the prescription drug program. This legislation in effect says that seniors now who have $500 of their drug benefit, prescription drug benefits paid for when they are in that doughnut hole period, and add to that this bill also says it is all paid for, at least for 1 year, in this doughnut hole. We have to worry about that in subsequent years, but this bill improves the benefits that seniors will get, not take away benefits as the other side would imply.

It is true that private programs, such as Medicare Advantage, are reduced from what they otherwise would be, just as hospitals are reduced in payments from what they otherwise would get. I have a chart here. Let me point out the next chart here, if I could, which shows that the provider groups, hospitals, et cetera, are actually going to do OK under this legislation. What does this chart show? This chart shows that Medicare spending will continue to grow under this legislation. It will grow, and grow by a lot. Here, in 2010, it is $446 billion and you see a steady growth through the 10 years of this bill.

I might say parenthetically, one of the previous speakers said rural health care is going to be hurt, rural hospitals are going to be hurt in this legislation. I do not think that is entirely true. I have a lot of hospitals in my home State of Montana, rural hospitals. They are not upset with this legislation. They say it is OK. They approve it.

In addition, there are no cuts to critical access hospitals. In rural America most of those hospitals are critical access hospitals. So they are going to be OK.

Basically, if we did not pass this legislation, these provider groups—hospitals, nursing homes, home health, hospice, Medicare Advantage, even Part B Medicare improvement—would all increase by about 6.5 percent over the decade. Under this legislation they all increase by about 5 percent over this decade, with a 1.5 percent cut which they basically agree to.

I want to make that point clearly. We are not cutting Medicare. We are not cutting Medicare benefits, but we are reducing the rate of growth of Medicare spending.

Another point I want to make, if I may, is there is nothing new here. Many of the Senators who are advocating killing this bill made the opposite statement not too many years ago. What did they say? They said: You have to reduce the rate of growth in Medicare spending in order to save Medicare benefits. That is what they said a few years ago, exactly what they said. Let me read:

> We propose slower growth in Medicare. Medicare would otherwise be bankrupt.

They are standing on this floor making the opposite statement today, the exact opposite statement today, trying to scare people to kill the bill.

Here is another Senator. I will not embarrass them by giving their names, but they are Senators who currently serve in this body.

> We do heed the warning of the Medicare Board of Trustees and limit growth to more sustainable levels to prevent Medicare from going bankrupt in 2002. That is what is necessary to ensure that seniors do not lose their benefits altogether as a result of bankruptcy in 7 years.

One Senator said that. When? About 14 years ago. Exact same thing that is going on today.

We know, experts know that if we are going to save Medicare benefits, we have to stop overpaying some of the providers, hospitals and so forth. We are overpaying them.

Let me tell you one small example of how we are overpaying them. Did you know that the updates—the fancy term for paying more for hospitals and so forth—did you know they don't take productivity into account when they make these update recommendations? The recommendations are basically made by an organization called MedPAC. MedPAC is a nonpartisan organization composed of doctors and experts that advise Congress on what the payment updates—what the payment increases should be for different groups over the years. We in Congress basically look at them. We try to decide what makes sense, what doesn't, and so forth. But MedPAC has said that this is what we have to do. We have to slow

the rate of growth in some of these providers because they are getting paid too much. They are getting paid more than they need to be paid.

I repeat: We are still going to allow 5 percent growth for all the providers over the next 10 years. None of them are really crying wolf, I might say. That is the main point I wanted to make.

I mentioned what AARP is saying. Let me mention the American Medical Association:

[We are] working to put the scare tactics to bed once and for all and inform patients about the benefits of health reform.

That is the American Medical Association. They are referring to the scare tactics of the other side. The AARP and the American Medical Association and others know that no senior will see a single reduction in their guaranteed Medicare benefits under this bill, not a single one.

I might also say that this bill would reduce premiums seniors would have otherwise paid. Much of those savings to seniors comes from eliminating massive overpayments to private insurers; that is, private companies such as Medicare Advantage.

A small point here. When seniors hear the words ''Medicare Advantage,'' they tend to think that is Medicare. It is not. It is a private company. Those are private companies. They were basically enhanced. Under the 2003 Medicare Part D legislation, they were given a lot more money to encourage them to have competition in rural areas. It turns out we gave them way too much additional money. They know it. This legislation is trying to cut back on the excess they were provided back in the year 2003. The cut is about $118 billion over 10 years. I don't have with me how much is remaining. But that 5 percent figure I gave you of growth, that includes Medicare Advantage.

I mentioned already that this legislation would reduce prescription drug costs. That doesn't sound like a benefit cut to me; that sounds like an additional benefit for seniors. We also provide for new prevention and wellness benefits in Medicare. That is an addition. That is not a cut. That is an addition. We are also helping seniors stay in their own homes, not nursing homes. That is a benefit.

It is important to point out here that the opponents of health care reform do not have a plan to protect seniors and strengthen the Medicare Program. They say don't do what they said a few years ago. They say: Commit the bill, do nothing. They say: Go back and start from scratch again. That is basically what they say. If you listen to the music as well as the words, if you read between the lines, basically they are saying: Kill it. Don't do it. That doesn't make sense.

That is what they are saying. I hate to say this because I tend to be a pretty nonpartisan kind of a guy. But these are scare tactics. They are not truths. Sometimes you have to call a spade a spade, and that is exactly what is happening here.

I might say that MedPAC, the outfit that advises us, is nonpartisan. They can't help us decide what to do here. They think Medicare Advantage plans are overpaid by 14 percent. In addition, a typical couple will pay $90 more per year in Part B premiums to pay for Medicare Advantage overpayments even if they are not enrolled in these plans. That is not right.

Medicare home health providers—I gave that list earlier. One small part of that is Medicare home health providers. They have an average margin of 17 percent. That is a little high.

If we are trying to protect Medicare benefits, we have to make sure we are not overpaying the Medicare providers. That is just common sense. It is the right thing to do. So many seniors just need help with their Medicare benefits.

Nursing homes are making profits of 15 percent off of Medicare. In my judgment, that, too, is unacceptable. We have to bring those down within reason.

We have an obligation. This is a government program. We have an obligation to taxpayers to make sure we are not overpaying hospitals and providers. We have to do right by them, make sure they are doing OK, but just not overpay. That is a tough line to draw sometimes. It is a judgment call. But that is what we are doing here.

In addition, the Office of Inspector General has found rampant fraud and waste and abuse in the Medicare Program. There is a lot of fraud and waste in the Medicare Program. The last figure I saw was about $60 billion in fraud in Medicare—providers, frankly, just ripping off taxpayers and seniors. We have added additional provisions in here to outlaw that fraud—additional screening, additional certification, additional ways to make sure that Medicare does a better job, that CMS does a better job in knowing which payments to providers are right and which are not right.

What is the real impact of the Medicare policies here? Let's be clear: The real impact of these policies, even with the Medicare changes in the bill, overall provider payments will still go up. I don't want to beat that horse too much, but I want to make it clear. We are not cutting benefits. We are reducing the rate of growth of spending for health care providers, hospitals, and nursing homes, but we are reducing it in a moderate way. We are not reducing it by too much. As this chart shows, those providers still get at least a 5-percent net increase in payments over the years, and the groups themselves have not really complained about them. Take the pharmaceutical companies, hospitals, nursing homes, home health, hospice—they are not crying crocodile tears because they know they are going to do better under health care reform.

Remember that famous meeting down at the White House not too long ago. The industry came in and talked to the President. Remember what they pledged, all these providers, how much they can cut reimbursements to them? This is including the insurance companies, hospitals, and everybody. They said they would cut $2 trillion over 10 years—$2 trillion. This legislation doesn't come close to cutting $2 trillion. I think the figure is about $400 billion. That is not $2 trillion, that is $400 billion. So we are not hurting them that much. We are not hurting them, frankly. They are doing OK.

I have quotes from hospital associations. This is from Sister Carol Keehan, president of the Catholic Health Association:

Clearly, the Catholic Health Association thinks the possibility that hospitals might pull out of Medicare . . . to be very, very unfounded.

I have heard the claim over here that this legislation is going to cause providers to pull out of Medicare. That is totally untrue. I have so many quotes here from people in the hospital industry who believe this is OK. They are not going to pull out.

Chip Khan, president of the Federation of American Hospitals:

Hospitals will always stand by senior citizens.

I also know some providers are going to do very well under this reform legislation. Wall Street analysts have suggested that many providers, including hospitals, will be ''net winners,'' according to the basic feeling among Wall Street analysts. Under our bill, they estimate hospital profitability will increase with reform because more and more hospital patients will have private health insurance.

Nobody is going to pull out. They are not going to cut Medicare benefits. It is true that there is a reduction in some of the private plan nonguaranteed benefits companies would give to seniors at the expense of private patients. That is true.

MedPAC has said it should be cut. MedPAC has said it should be cut more. We are giving these plans a break by not cutting them by what MedPAC says they should be cut.

Again, the reductions in this bill—for the providers, not beneficiaries—are far less than the health care industry itself said it could save over the next decade. A reminder: They pledged to save $2 trillion over 10 years. Under this legislation, they are going to be hit for $400 billion.

I mentioned before that the other side has often said this is exactly what we to have do, although today they say: No, no, no. I am not quite sure what the difference is between a few

years ago when they said this is what we should do. Perhaps they can explain that.

I might mention, too—and this is very important, although we tend to lose sight of it—under this legislation, we provide delivery system reform.

There is a lot of waste in our health care system—estimates are 15, 20, 30 percent waste in the American system. Why is there so much waste, which means seniors are not given the benefits they should receive, which means private patients generally aren't getting the benefits they should receive because of all the waste? The waste is basically because of the way we pay for health care. We pay on the basis of quantity. We pay on the basis of volume. We do not pay on the basis of quality. To state it differently, a hospital tries to do the right thing, doctors try to do the right thing. They are paid on the basis of how many procedures they provide, basically, not outcomes, not quality. That is the basic root that has caused a lot of the waste in the current American system.

Health care is provided for differently in different parts of the country. The fancy term is ''geographic disparity.'' Health care in one community is practiced one way. Health care in another community is practiced another way. They are very different.

Many of us have read the June 1 New Yorker article written by Dr. Gawande comparing El Paso, TX, with McAllen, TX. I see the two Senators from Texas on the floor. Perhaps they can help us elucidate what is going on in El Paso and what is going on in McAllen. In El Paso, the cost of health care is about half per person what it is McAllen, another border town. Spending per person in El Paso is about half what it is in McAllen. Yet the outcome; that is, how well the patients do, is a little bit better in El Paso than it is in McAllen. Why? According to the author of the article, it is because of how medicine is practiced, what is the ethic, what is the sense in El Paso regarding health care and what is it in McAllen regarding health care. It may be dangerous for me to say so, but according to the author, his conclusion is that in El Paso, it is because the care is more patient centered, it is coordinated care, it is less on making a buck; whereas in McAllen, it is less coordinated care, more specialties in hospitals, a little bit more providers wanting to go make a buck.

The main point is that medicine is practiced so differently all over the country. There are geographic disparities. In Northern High Plains States, it is less spending per person and the outcomes are terrific. In some of the Sunbelt States—and I don't want to step on the toes of any Senators from Sunbelt States—there is more spending and the outcomes are worse. It is just because it is based on volume and quantity, not based on quality.

This legislation starts to put in place ways to move toward reimbursing based on quality, not volume. That, paradoxically, is going to result in lower costs and higher quality—lower costs but higher quality. Virtually all the folks in the health care community—the doctors, hospitals, and administrators I talk to—virtually all agree—I will be very conservative—80 percent agree, 85 percent agree, this is the direction in which we have to go.

This legislation goes in that direction. Failure to pass this legislation, which the other side wants, means we do not do any of that. It means we do not start putting in place ways to more properly reimburse doctors and hospitals and other health care providers.

This bill includes those patient-centered reforms I just mentioned. What are they? They include accountable care organizations, bundling is another concept, reducing unnecessary hospital readmissions, creating innovation centers. This bill starts to do that.

There is something else this bill does but which some on the other side get all exercised over and which I think they get exercised over improperly; that is, ways to start to compare one drug versus another, compare one procedure versus another, one medical device versus another. We have to start doing more of that with a nongovernment agency, with a private-public agency that works together so it gives good, solid information so we have more evidence-based medicine in America.

Right now, a lot of docs want to do the right thing, but what they do depends on the drug rep who comes in their office and starts peddling a certain drug. Docs feel uneasy about that, they do not like it, but they are so busy they see so many patients, it is hard to keep up to date. So we are trying to help them keep up to date with evidence-based medicine, and with a lot more health IT, health information technology, so they can get access to the best evidence through these various organizations.

There are just so many reasons this legislation is so important. I personally believe we have to move a bit toward what is called integrated systems. We hear about Geisinger, the Mayo Clinic, the Cleveland Clinic, Intermountain Healthcare. There is some home health out in Seattle where doctors and hospitals and nursing homes and pharmacists are more integrated, and that, therefore, cuts down on cost, increases quality. It is more patient centered. It is more care coordinated. This legislation helps us move in that direction.

We are just trying to get started with this legislation, get started in doing some of the right things we know we should do. We do not have all the answers. Nobody has all the answers. But if we get this legislation passed, in the next couple, 3 or 4 or 5 years, working with the basic underpinnings of this legislation, we are going to help correct some mistakes. We are going to see some new opportunities. We are going to be working on getting health care costs down, which we have to begin doing to help our people, help our companies.

We are going to work to get more coverage so more people have health insurance. It is an embarrassment today. It is an absolute embarrassment that the United States of America, an industrialized country, does not provide health insurance for its people. It is more than an embarrassment. It is a travesty. It is a tragedy. It is just wrong, it is morally wrong.

So this legislation gets us moving on the right track. It helps Medicare beneficiaries not hurt them, as the other side would like you to believe. It does not unnecessarily harm doctors and hospitals. They kind of go along with this. They kind of know it is the right thing to do. They are still getting big increases in payments, and there are other reforms here which I have not the time to mention tonight. But I strongly urge us to say: Hey, this is the right thing to do. Let's get started. Let's pass this legislation and certainly trounce this committal motion to stop what we are doing. It is not right to stop this. We are getting started. Let's keep going.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I want to talk about health care legislation. That is what we have been talking about now on the Senate floor for the last week. I expect we will be talking about it for quite a long time.

We have just begun considering this bill, and the American people are growing in their opposition. According to a new Gallup Poll released yesterday, American independent voters now oppose this bill by an 18-point margin: 53 percent against it, 37 percent for it. This Gallup Poll states:

> Despite the considerable efforts of Congress and the President to pass health insurance reform, the public remains reluctant to endorse that goal.

But this poll is just confirming what we have really known for months; that is, the bill before us—and the one that passed the House before that—is the wrong approach.

We are not against reform of health care; we need reform of health care. People are concerned about the rise of premiums in health care. So we ought to be looking at ways to address that issue. By doing what? By cutting the costs in the system and by allowing people to have more affordable health care options, none of which is in this bill.

Americans do not support $½ trillion in Medicare cuts. They do not support

$½ trillion in new taxes. They do not support mandates. They do not support our growing national debt, which has hit its ceiling at $12 trillion. They certainly do not support a government takeover of our health care system.

Let's talk about the Medicare cuts. The Americans who are most impacted are those we are usually trying to protect: our seniors. I hear others on the Senate floor saying there are no cuts to Medicare. I am looking at the language in the bill. I am looking at the description of the bill, and the fact is there is $135 billion in cuts to hospitals, $120 billion in cuts to Medicare Advantage, $15 billion in cuts to nursing homes, $8 billion in cuts to hospice care. That is nearly $½ trillion in Medicare cuts. That is $500 billion.

In Texas, over half a million seniors are enrolled in Medicare Advantage. We know this bill will reduce their choices and the benefits they have today—benefits such as eyeglasses, hearing aids, dental benefits, preventive screenings, flu shots, home care, medical equipment, and more. So more and more seniors are not going to take the Medicare Advantage option which they now take and enjoy. This is not a solid approach.

I have heard others on the Senate floor on the other side of the aisle say it was Republicans who attempted to cut Medicare in previous years. The Republican effort to cut Medicare growth was $10 billion over 5 years. Not one Democrat voted for a $10 billion cut over 5 years. Yet today they are touting a $500 billion cut over 10 years.

Mr. President, $10 billion was out of the question, and $500 billion is now something that can be accepted? There is no reason to cut Medicare by $½ trillion. We should save Medicare. We should make it last longer and be more stable. But $500 billion in cuts is just going to make it worse. It is going to make it insupportable. Health care for our seniors will surely suffer on its face. That is a fact.

It is a fair question to ask: Well, what are Republicans for? Are you for health care reform? Well, of course we are for health care reform. Every one of us pays health insurance premiums, and we know people who are complaining about the rise in premium costs, especially small businesspeople. I sympathize with that. We all do.

So what is our approach? Step-by-step reform. What the American people are looking for is reform that does not cripple the health care industry in our country, that does not bankrupt our country, and that does not include a government takeover of the health care system.

There are commonsense, fiscally responsible reforms that Republicans have been promoting for years and would support today if we could have a bill that had any Republican input whatsoever, which this one does not—allowing small businesses to pull together and purchase insurance.

Sitting on the floor with us today is Senator MIKE ENZI. Senator ENZI was the chairman, previously, of the HELP Committee. He produced a bill. He produced a bill that would have given more people coverage than the bill before us today—allowing small businesses to come together and pool their risk pool, make it larger, and give much more affordable premiums to more small businesses so they could afford to do what every small business wants to do; and that is, offer health care coverage to their employees.

But the Democrats killed Senator ENZI's bill. That would have been the first step to health care reform. We could have passed that years ago and been on the right track increasing the number of people who have affordable options for health care.

No. 2, reducing frivolous lawsuits. Where States have taken the measure to reduce frivolous lawsuits, such as Texas and a few other States, it has been a phenomenal success. It has brought down the cost of medical malpractice premiums for doctors. It has increased the number of doctors who are willing to practice medicine again. It has increased the number of doctors who will go into rural areas that are underserved. It works.

The estimates are that if we had a part of this bill that would reduce frivolous lawsuits, it would save about $50 billion a year. If we could reduce $50 billion out of the cost in the system that is not going for anything productive, we could then put that into either helping shore up Medicare or give the Medicare reimbursements to doctors and health care providers, to hospitals. We could help the system by cutting those costs. That is something Republicans would support in a heartbeat.

How about tax incentives to people who are buying their own health care insurance? If we provided families with a tax credit worth $5,000, it would give them the ability to put that on a health care policy for their families. It would cut the cost and allow them to have an affordable option. Another is a tax deduction above the line or a tax credit, which would be a huge incentive to employers, as well as to individuals, who would be able to have that kind of help in covering the cost of health care. We are willing to support that.

Another is allowing individuals to purchase insurance across State lines; tear down that bureaucracy that keeps people from going across State lines and getting the very best deal for themselves and their families.

Even an exchange could work. That is something that is embedded in the bill, but it is an exchange that has so many mandates that it is going to raise the cost for everyone. Just a simple exchange that has competition and transparency could actually make a difference in cutting the costs of health care.

So I think there are many things we could do to reform health care, if we could have Republican input and a bipartisan bill that would offer more affordable health care coverage to more people in our country. These are ideas that would improve competition in the marketplace, reduce costs, increase access. We do not need a government-run plan to achieve that objective.

I will be offering an amendment that will allow States to opt out, without penalties, of this plan, if it passes, not just the government part of the plan, but all of the harmful measures. We should be providing choices, not forcing people into government plans. States should not be forced to participate in the government plan. They should not be forced to subsidize it. They should not pay for a plan through increased taxes, nor mandates on businesses.

We want businesses to grow. We want businesses to hire people. We want to have jobs created. This bill is a job killer. Has anyone noticed we have one of the worst recessions since the Great Depression in this country, that over 3 million people in this country have lost their jobs this year? Mr. President, 300,000 of them live in my home State of Texas. Yet we are talking about a bill that is going to increase mandates on businesses and surely will reduce the number of people who can be hired. There is a disconnect we need to put back together. We need to talk about options that can work, that can give more people health insurance coverage at a reasonable price and most certainly not be job killers, with mandates and taxes on small businesses that already are having a hard time staying afloat, creating jobs, and providing health care for their employees.

The first amendment we will vote on tonight is the Mikulski amendment that has to do with breast cancer screening and other preventive services for women. Senator MIKULSKI and I have worked together on women's health issues for a long time in this body. Two years ago, we championed the reauthorization of the National Breast and Cervical Cancer Early Detection Program, which provides screening and diagnostic services. So we know how important it is to address women's health care issues.

I was in complete disagreement with this new task force recommendation on mammograms and the need for mammograms for women under the age of 50. But I am very concerned that with the recent recommendations of the task force and how this health care bill that is before us relies on the task force, that the amendment is not going to do anything to solve that problem. The health care reform bill relies on the task force 14 times, and it even allocates money to pay for advertising

the task force recommendations. This amendment does not address the problem. Rather than severing the ties with that task force so it will not become the norm, the amendment now allows yet another government agency, the Health Resources and Services Administration, to interfere with the relationship between a woman and her doctor. So now coverage decisions will be dictated by both the task force and the Health Resources and Services Administration. Instead of letting doctors and their patients make the decision about when a woman needs a mammogram, we have now not one government task force but two that we will have to intervene in that decision. Oh, my gosh, that does not make any kind of common sense. While I agree with Senator MIKULSKI about the great importance of preventive care for women, I disagree with this approach because it still injects a government agency or task force into the decision that is going to determine whether women have access, easy access, full access to the health care of their choice.

The item we will be considering after the Mikulski amendment and the Murkowski amendment is the McCain motion. The McCain motion is going to strike the Medicare cuts from this bill. His motion, which I certainly endorse and support, would send the bill back for a rewrite. It would send it back to the Finance Committee with instructions to give us a new bill that does not include $½ trillion in Medicare cuts, a bill that would not be paid for on the backs of our seniors whom we should be protecting. As I mentioned previously, the bill that is before us would cut nearly $½ trillion—$500 billion—from Medicare. It will not make it stronger; it will fund more government spending, more government takeover in our health care system. Health care reform should not mean slashing Medicare by cutting $½ trillion from seniors' care. This is not reform.

If we can support the McCain motion to go back to the drawing board and look for a way we can have a bipartisan bill that would have Republican as well as Democratic input and agree to step-by-step reforms that would increase access, reduce costs and not take away choices of seniors and certainly not have a government takeover of health care, then I think we could produce something the President would sign and the American people would embrace. Right now, everyone I talk to in Texas is scared to death. They are scared to death of this big government takeover of our health care system because they know that when government gets involved, we are not going to have the quality we have known in the past, that the jobs are not going to be in the private sector, that we are not going to have the choice. When this bill—which relies on this task force 14 times to make the recommendations that would determine what the coverage is of the government plan—was put before us, all of a sudden people started to say women don't need mammograms before the age of 50, when we have always said it was after the age of 40; and after the age of 50, with a doctor's input, and that it would generally be on an annual basis.

The former head of the Red Cross, Bernadine Healy, and many of our health care agencies and task forces said that is going to kill women. That is going to kill women if they don't have early detection. Early detection is all we have for breast cancer right now. We don't have a cure. We only have early detection as a way to fight breast cancer. But all of a sudden, the task force that is relied on by this bill says we don't need mammograms before the age of 50; and after the age of 50, every 2 years, not every year; and after the age of 72, not at all. That is not health care reform. That is not what the President promised, and it is certainly not what Congress ought to assent to.

We can produce health care reform. We can lower the cost. We can give people access. We can give people choices. We don't have to mandate taxes and hurt businesses in this economic climate to do it. We have the capability to do something right. If we pass the McCain motion, we can go back to the drawing boards and do this right. That is the most important thing I hope we will do this week in the Senate for the American people, and they deserve it.

Thank you. I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, I ask unanimous consent, if I may, that I be allowed to speak for 15 minutes and that that time include a colloquy with my colleague, the Senator from Minnesota.

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

Mr. DODD. Thank you, Mr. President. I wish to address a couple issues, if I may; one is this debate about Medicare cuts and savings. Let me put up one chart. I will not spend a long time on this, but I wish to make a point to my colleagues.

About a year ago, the Bush administration sent us a budget. According to the Congressional Budget Office and the Senate Budget Committee, the proposals in the Bush administration's budget in the last year alone called for $481 billion in Medicare savings and cuts. It was not in the context of a health care bill; that was part of a budget proposal. That was $481 billion, according to the CBO just last year. Literally, 12 months ago that was the proposal. In the context of the overall reform of the health care system, in which we are trying to achieve savings to make sure the dollars are going to go further and go for the things that are needed, our proposal calls for $380 billion in savings over the coming 10 years.

I think, again, people need to understand what we are talking about and that is the difference. So a year ago, $481 billion and no health care proposal—just to get to budget proposals. Here we are in the context of over 10 years of trying to put things in this bill to ensure a more solid footing.

The National Committee to Preserve Social Security and Medicare, representing millions of our fellow citizens, wrote a letter to the Senate, every Member, dated December 1, 2009. Senator HARKIN earlier put the entire letter in the RECORD. I am going to read just one sentence from the letter, signed by Barbara Kennelly, the President and CEO of this organization:

> Not a single penny of the savings in the Senate bill

This bill we are debating—

> will come out of the pockets of beneficiaries in the traditional Medicare program.

This is an organization that does not bear a political label. It doesn't represent Democrats, Republicans, Independents. It merely spends every hour of every working day assessing what happens to Social Security and Medicare. That is all they do—all they do. Believe me when I tell my colleagues this organization would not make a statement such as this if it were untrue. I know the organization. I know the people involved. They are highly critical of Democrats and have been when they think we have gone too far in various areas. They state, categorically, what this bill does to Medicare.

I ask unanimous consent that the entire letter be printed in the RECORD.

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

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE,
Washington, DC, December 1, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing to express our opposition to the amendment offered by Senator McCain which would recommit H.R. 3590, the Patient Protection and Affordable Care Act, to the Senate Finance Committee with instructions to remove important Medicare provisions.

Much of the rhetoric from opponents of health care reform is intended to frighten our nation's seniors by persuading them that Medicare will be cut and their benefits reduced so that they too will oppose this legislation. The fact is that H.R. 3590, the Patient Protection and Affordable Care Act, does not cut Medicare benefits; rather it includes provisions to ensure that seniors receive high-quality care and the best value for our Medicare dollars. This legislation makes important improvements to Medicare which are intended to manage costs by improving the delivery of care and to eliminate wasteful spending.

The National Committee opposes any cuts to Medicare benefits. Protecting the Medicare program, along with Social Security, has been our key mission since our founding

25 years ago and remains our top priority today. In fact, these programs are critical lifelines to today's retirees, and we believe they will be even more important to future generations. But we also know that the cost of paying for seniors' health care keeps rising, even with Medicare paying a large portion of the bill. That is why we at the National Committee support savings in the Medicare program that will help lower costs. Wringing out fraud, waste and inefficiency in Medicare is critical for both the federal government and for every Medicare beneficiary.

The Senate bill attempts to slow the rate of growth in Medicare spending by two to three percent, or not quite $500 billion, over the next 10 years. However, it is important to remember that the program will continue growing during this time. Medicare will be spending increasing amounts of money—and providers will be receiving increased reimbursements—on a per capita basis every one of those years, for a total of almost $9 trillion over the entire decade. Even with the savings in the Senate bill, we will still be spending more money per beneficiary on Medicare in the coming decades, though not quite as much as we would be spending if the bill fails to pass.

America's seniors have a major stake in the health care reform debate as the skyrocketing costs of health care are especially challenging for those on fixed incomes. Not a single penny of the savings in the Senate bill will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings inclued in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits; and it will extend the solvency of the Medicare Trust Fund by five years. To us, this is a win-win for seniors and the Medicare program.

The National Committee urges you to oppose the motion to recommit the bill to the Finance Committee with instructions to strike important Medicare provisions from health care reform legislation.

Cordially,

BARBARA B. KENNELLY,
President & CEO.

Mr. DODD. Thirdly, I wish to commend our colleague from Maryland, Senator MIKULSKI. Again, a lot has been said about her proposal dealing with women's health. Consider these two statistics as we try to get this right: Less than half the women in the United States have the option of obtaining health insurance through a job—less than half. They are forced either to purchase expensive insurance in the individual market or are dependent upon a spouse to provide health care.

Right now, today, whether you are a Democrat, Republican, conservative, liberal, whether you live in Connecticut, Texas or Minnesota, consider this: A healthy 22-year-old woman can be charged insurance rates 150 percent higher than a 22-year-old man in a similar condition. Our bill before us ends that—ends that. If you defeat the Mikulski amendment or recommit this bill, remember tonight or tomorrow, when the vote occurs, that 22-year-old woman and that 22-year-old man have a differential as much as 150 percent in health care premiums. That is what happens at this very hour. The Mikulski amendment changes that as well in our bill, among other things.

Lastly—and then I wish to turn to my colleague from Minnesota—just to remind my colleagues, again, what Senator BAUCUS has done with his committee in the Finance Committee and what we did in the HELP Committee to provide some meaningful advantages and help to people across this country immediately. One, our bill will provide $5 billion in immediate Federal support for a new program to provide affordable coverage to uninsured Americans with preexisting conditions. Coverage under this program will continue until the new exchanges are operating over the next few years.

Secondly, the bill creates immediate access to reinsurance for employer health care plans providing coverage for early retirees. Again, this will help protect coverage, while reducing premiums for employers and their retirees.

The bill also reduces the size of the doughnut hole immediately by raising the ceiling in initial coverage by $500 in 2010, the coming year—immediately. This will guarantee a 50-percent price discount on brand-name drugs and biologics purchased by low- and middle-income beneficiaries in the coverage gap. That is immediate.

Fourth, our bill will offer tax credits immediately to small businesses to make employee coverage more affordable. That is not a year or two or three from now, this is immediate. Tax credits of up to 50 percent of premiums will be available to firms that choose to offer the coverage as a result of the tax break.

Fifth, our bill will require insurers to permit children to stay on family policies until age 26. Right now, that ends at 23. Our bill extends it to 26 immediately, to have this benefit for people across the country who have families and children today who are staying home longer because of the absence of jobs out there for them.

Our bill will provide coverage for prevention and wellness benefits immediately and exempt these benefits from deductibles and other cost-sharing requirements in public and private insurance coverage. Not in a year, not 2 years, not 3 years but immediately when this bill becomes law.

Sixth, the bill would prohibit insurers from imposing lifetime limits on benefits and will restrict annual limits as well.

The bill also would prohibit group health plans from establishing eligibility rules of health care coverage that have the effect of discriminating in favor of higher wage employees.

In this bill, we also establish standards for insurance overhead to ensure that premiums are spent on health benefits. We also require public disclosure of overhead and benefit spending and require premium rebates from insurers that exceed established standards for overhead expenses.

Lastly, it would create new Web sites to provide information on a facilitated form of consumer choice of insurance options. And there are other immediate benefits to this legislation.

I think it is important, as we discuss the bill, that you understand there are substantial and meaningful improvements. We have debated this bill and debated these issues for months and months on end. The time has come to act. That is what we are proposing with this legislation.

With that, I appreciate the indulgence of my colleague from Minnesota. I yield to him for any additional comments he may wish to make.

Mr. FRANKEN. Mr. President, I thank Senator DODD for his leadership on this bill. I want to talk about Senator MIKULSKI's amendment.

First, a little bit about some of the claims that have been made on the floor today about Medicare. Senator DODD pointed out that in the Bush budget—the last Bush budget—there was a bigger cut to Medicare, but not in the context of any kind of health care reform. Senator BAUCUS said it so well about what the cuts are. They are to hospitals, and the hospitals are fine with it. They are not jumping-up-and-down excited about it, but they are fine with it because it comes in the context of health care reform.

We are covering 30 million more people. What does that mean to hospitals? When people come into the emergency room, they have coverage. The hospitals get paid. That is the context in which we are doing this; whereas, when President Bush was proposing those kinds of cuts, they were not in the context of insuring 31 million more people. When the uninsured were going into emergency rooms for the most inefficient care possible—and won't be now—it was costing every American family $1,100 in additional insurance costs. So they are comparing apples and oranges. We are doing so many things, and Senator DODD talked about some of the things this bill does. I want to talk about Senator MIKULSKI's amendment, because women are among the most severely disadvantaged in our current health care system. Right now, health insurance companies can and do discriminate against women solely on the basis of their gender.

Right now, it is legal in many States—again, not in all States, and this is why, when you are talking about getting health insurance from another State, you have to be careful. In Minnesota, we have stronger regulations. In other States, you don't. In many States, it is legal to charge women higher premiums, or deny them coverage at all, if they have had a C-section. It is a preexisting condition. If they have been the victim of domestic

violence—in many States in this country an insurance company can deny a woman coverage because she has been the victim of domestic violence, because it is considered a preexisting condition. That is wrong.

I am immensely pleased that under this bill, for the first time, women will have access to comprehensive health benefits, including maternity care, without having to pay more than their male counterparts. But we can do even more for women's health in this country.

Senator MIKULSKI's amendment improves the bill to make sure women can get the preventive screenings they need to stay healthy. Most important, the amendment will make sure that women have access to these lifesaving screenings at no cost. So it doesn't interfere with a woman and her doctor, as my distinguished colleague from Texas said a few minutes ago. It makes these screenings available at no cost. Why is this important? Because right now, women are delaying or skipping preventive health care because they cannot afford it. That is not just bad for women's health, it is bad for our system because it drives up costs unnecessarily. Even in Minnesota, where we generally do a good job at health care, there are women right now who are not getting the care they need. They are skipping their annual exam because they are uninsured. Women who are uninsured are twice as likely not to get the care they need.

Other women in Minnesota simply cannot afford the coverage they have now. Since 2007, the number of women who have delayed or avoided preventive care because of cost has doubled. The economic crisis has only made things worse. But the economic situation is no excuse. The reality is that women are forgoing preventive services that could save their lives because of the way insurance works now.

Make no mistake what that is about. From 2000 to 2007, the health insurance companies saw their profits increase 428 percent. Women are forgoing preventive measures that could save their lives. Is this the kind of country we want to live in?

There was some good news yesterday. The CBO confirmed what many of us already knew—that with the insurance market reforms and subsidies in our bill, women will be able to purchase better coverage at a lower cost than they would be paying without the bill. That is huge. With Senator MIKULSKI's amendment, we will go even further, guaranteeing that women receive preventive care when they need it, without barriers. These screenings catch potential problems such as cancer as early as possible. This saves lives and, by the way, it saves money.

For example, cervical cancer screenings every 3 to 5 years could prevent four out of every five cases of invasive cancer. Regular screenings could prevent more than half of the cases of infertility. Senator MIKULSKI's amendment will give women the care they need when they need it. This is a huge step forward for justice and equality in our country.

It is also a top priority for me that health reform includes another crucial women's health service, which is access to affordable family planning services. These services enable women and families to make informed decisions about when and how they become parents. Access to contraception is fundamental, a fundamental right of every adult American, and when we fulfill this right, we are able to accomplish a goal we all share—all of us on both sides of the aisle to reduce the number of unintended pregnancies. And so I believe that affordable family planning services must be accessible to all women in our reformed health care system.

We can't wait any longer, and I urge all of my colleagues to stand up with us and support this amendment.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. FRANKEN. My apologies to Senator DODD. I guess I, as a freshman, am not necessarily familiar with all the rules. I think that means I must yield the floor, is that right?

The PRESIDING OFFICER. That is correct.

Mr. FRANKEN. I yield to my good friend from Texas.

Mr. BAUCUS. Mr. President, I didn't think there was a time agreement here.

Mr. DODD. Yes, I had asked consent for a time agreement. I suspect we are going to have a lot of time to talk about the bill.

I appreciate the comments of my colleague from Minnesota.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, I want to talk principally about the Medicare cuts in this bill and make sure that people understand the context in which this takes place and what it means in terms of benefits for seniors.

There has been a lot of parsing of language here in a way that I think can perhaps obscure the real impact of these proposals.

First, let me say there is broad agreement that our health care system needs reform. But I thought the purpose of that reform was to lower costs and make it more affordable—not raise premiums, raise taxes, and cut Medicare benefits.

Again, I say to our friends across the aisle, no one wants the status quo. But it is clear that our friends across the aisle are not interested in any proposals from this side of the aisle, as demonstrated by the party-line votes in the HELP Committee and the Finance Committee, and the product coming from the House of Representatives.

This is simply too important to do on a purely partisan basis. Yet that seems to be the intention of the majority. The American people want us to get this right because they understand this impacts 17 percent of our economy, and it affects all 300 million of us. This is important to them. As they have watched these debates and proposals, as they have learned more about them, it is no mystery why public opinion for these proposals has dropped like a rock. Again, it has dropped like a rock.

First of all, on cost, they realize that the proposals as made have masked the true cost of this bill, and there was celebration when the bill came in under $900 billion. Forget the fact it doesn't actually go into effect until 4 years into the 10-year budget window, so it was only 6 years of implementation; and never mind that it didn't include reversing the 23-percent cut in physician payments that go into effect at the first part of next year, unless Congress acts. That was left out intentionally to make this look cheaper than it is.

The Senate Budget Committee has pointed out that this bill, when fully implemented, would cost the American people $2.5 trillion. I have constituents who asked me: Do you know what a trillion dollars is? They say: I don't know. We used to talk about a million dollars being a lot of money, and then a billion dollars. Now we are into the trillions—hence, the bumper sticker ''don't tell Congress what comes after a trillion,'' for fear we will spend it.

This bill, written by the majority leader behind closed doors, increases taxes by nearly $½ trillion on American families and small businesses during the worst recession we have had since the Great Depression. Unemployment is 10.2 percent, and it is perhaps headed higher. This bill proposes to make it harder on businesses to retain employees, or perhaps maybe someday hire employees and bring down that unemployment rate.

This is a job-killing bill. That is why the American people, the more they learn about it, like it less and less. I predict that the longer this debate goes on, the more they learn about it, the less they will find to like about the bill for that and many other reasons.

This bill also, according to the CBO, increases health insurance premiums by $2,100 for American families purchasing insurance on their own. If you are fortunate and you have large group coverage, it is a little better. But for the millions who are not, it increases the cost of their insurance by $2,100 a year.

I want to focus primarily on the cuts in Medicare. When our colleagues celebrate the fact that this comes back budget neutral, let me explain that mystery. That means you have raised taxes so much and cut Medicare benefits so much, you can claim it is budget

neutral. I daresay that is not cause for celebration. In order to create a $2.5 trillion new entitlement program—and that is what this is, at a time when the unfunded liabilities of our current entitlement programs go somewhere into the $40 trillion to $60 trillion range—this bill actually cuts $465 billion in payments from Medicare. These cuts include $135 billion to hospitals; $120 billion from 11 million seniors on Medicare Advantage, including a half million—or to be more precise, 523,000 Texans who depend on Medicare Advantage will see a cut in benefits because of this proposal if it passes.

Mr. President, $15 billion will be cut from nursing homes, $40 billion will be cut from home health agencies and $8 billion from hospice care.

You can try to parse those words and say we really are not cutting Medicare, but we are cutting Medicare Advantage. Indeed, the Obama administration's own Actuary at the Center for Medicare and Medicaid Services said Medicare cuts of this size would hurt seniors' access to care for several reasons.

First, let me start with Medicare Advantage. Medicare Advantage provides benefits over and above Medicare fee for service. But I think we need to understand that with regard to Medicare fee for service in my State, the last time I checked, 42 percent of physicians will not see a new Medicare patient because the payment rate is too low for the doctors to be able to break even or maybe perhaps earn a small profit. Again, 42 percent of Medicare patients are denied access to a doctor in my State because Medicare payments are so low.

What we did a few years ago was pass the Medicare Advantage Program, which was created to give seniors choice. In other words, there has been so much celebration of the public option or the government-run plan. We have a government-run plan now—Medicare fee for service, which has, depending on where you read, somewhere between an 8- to 12-percent faulty payment rate. In other words, it pays somewhere around 7.8 to 12.4 percent of bills it does not owe to people who do not deserve it, diverting that money away from payment for beneficiaries.

We decided a few years ago to give Medicare beneficiaries a choice—something I thought we all were for—a choice that provided better care coordination and better benefits. Today, 11 million seniors, including the 532,000 I mentioned in Texas, have chosen Medicare Advantage. But this bill, if passed in its current form, will take away health care benefits from those 11 million seniors on Medicare Advantage by cutting $118 billion from the program.

During the Finance Committee markup, the Congressional Budget Office acknowledged that Medicare Advantage cuts would mean fewer services, such as dental or vision.

Senator MIKE CRAPO asked this question:

So approximately half of the additional benefit would be lost to those current Medicare Advantage policyholders?

Congressional Budget Office Director Doug Elmendorf said:

For those who would be enrolled otherwise under current law, yes.

So approximately half the additional benefit would be lost to those current Medicare Advantage policyholders.

What happened to the President's promise that if you like what you have now, you can keep it? This is another example of a promise that breaks under this bill, in addition to the $2,100-per-family premium increase for those who buy their insurance on the individual market.

Despite the fact that this bill cuts $465 billion from the Medicare Program, it also fails to deal with draconian cuts that will go into effect in January, unless Congress acts, which will further ensure that seniors will be less likely to see a doctor in 2012. We all know this is sometimes called the doc fix, but this is basically a misguided decision Congress made back in the late nineties to cut provider benefits, thinking that they could do so and it would not have any impact on access to care. But what it has done is while on one hand Congress can stand here and say: Yes, we kept our promise to seniors by providing Medicare coverage, seniors are finding it harder and harder to find a physician who will actually see them because of those low reimbursement rates. This bill does nothing to cut the 23-percent cut in those benefits in 2012 which will have an extremely negative impact on seniors' ability to see a doctor.

We know the majority leader tried, on a standalone bill, to address this issue earlier. But it was not paid for. On a bipartisan basis, Senators in this body rejected sending a bill for $200 billion more to our children. We said we need to be responsible and pay for the bill.

Then the President said health care reform would be paid for by dealing with waste, fraud, and abuse in Medicare. But that is not what this bill does. The Congressional Budget Office said the Reid bill only saves $5.9 billion from reducing waste, fraud, and abuse—$5.9 billion in a bill which over a full 10 years of implementation will cost the American taxpayers $2.5 trillion.

Instead of cutting Medicare, we should be addressing this problem. We know it is a serious problem. The Obama administration found that there was at least $47 billion in Medicare fraud, and that is a conservative estimate. According to Harvard professor Malcolm Sparrow, Medicare fraud may consume as much as 15 to 20 percent of the $454 billion Medicare budget. That means the amount lost to fraud each year in Medicare alone is $70 billion to $90 billion. As I mentioned, improper payment rates, depending on where you look, range anywhere from 7.8 percent of all Medicare payments paid improperly to as much as 12.4 percent, depending on where you look.

Defrauding Medicare has become so lucrative that even the Mafia and other organized criminals are getting into the act. According to the Associated Press last month, members of a Russian-Armenian crime ring in Los Angeles were indicted for bilking Medicare of more than $20 million, and a week after the FBI issued search warrants for a Medicare fraud investigation in Miami, the body of a potential witness was found in the backseat of a car, riddled with bullets.

Earlier this year, I introduced a bill which I hope our colleagues on the other side of the aisle will look at as a way to change the paradigm in terms of the way we address this problem of Medicare fraud. Rather than the pay-and-pursue model, we would have a model which would actually detect potential fraud on the front end by certifying payees and otherwise making sure that money is spent properly. We need to implement commonsense solutions such as this to fix fraud in Medicare before we simply cut in half or cut $½ trillion out of benefits in provider benefits to create a new entitlement.

We all understand Medicare is in miserable shape financially—miserable shape. If nothing is done, Medicare will go broke in 2017, according to the Medicare trustees. The Medicare part of entitlement problems has unfunded liabilities—promises Washington made but cannot keep and does not know how to pay for, nearly $38 trillion. Mr. President, $38 trillion is more than three times the current national debt of $12 trillion, and $38 trillion translated into the burden on every American family means that each American family owes $322,000—more than most American families' homes are worth.

The bottom line is, it is simply irresponsible, without fixing Medicare, without fixing the fraud and the waste—which I know the Presiding Officer is as concerned about as I am—and without dealing with the fact that Medicare promises coverage but denies access because of low payments, to pillage nearly $½ trillion from the bankrupt Medicare program to create a new budget-busting entitlement program.

There had been some talk on the floor about earlier attempts to reduce the rate of growth of Medicare. Interestingly, back in 2005, when there were some proposals to do just that—but, frankly, the numbers paled in comparison: about $10 billion in cuts compared to $500 billion in cuts—the majority leader called those cuts immoral. I have a long list of comments made by

our friends across the aisle which stand in stark contrast to the comments they are making today.

Frankly, we need to do something about the insolvency of Medicare. Even if we did not do anything else, that would be a great benefit to the seniors to whom we promised health coverage but who are currently denied coverage because of the problems I talked about.

I know the distinguished chairman of the Finance Committee talked about the sterling endorsements that come from a variety of Washington-based advocacy groups. One of them is the AARP, the American Association of Retired Persons.

Mr. President, I ask unanimous consent to have printed in the RECORD an article about AARP dated October 27 at the conclusion of my comments.

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

(See exhibit 1.)

Mr. CORNYN. Mr. President, what this article demonstrates is that one reason AARP might be opposed to maintaining Medicare Advantage and be for the cuts in benefits to current Medicare Advantage beneficiaries is because that group and its subsidiaries collected more than $650 million in royalties and other fees last year from the sale of insurance policies, some of which are designed to fill that gap between Medicare fee for service and what it actually costs to get to see a doctor. It is a conflict of interest for this association. Frankly, I don't think its endorsement is worth the paper it is written on, just like other associations that, contrary to the best interests of their members, have made a deal that is bad for the American consumer. The American consumers know it. They know a bad deal when they see it—a deal that includes increased premiums, higher taxes, and cuts in Medicare. Frankly, I think those people with such glaring conflicts of interest should not be in the position of trying to endorse something that is basically going to enrich them to the detriment of the American people.

I plan to offer amendments about this bill's provisions as currently proposed to cut $½ trillion from the Medicare Program. My first amendment would make Medicare play by the same financial solvency rules as private insurers.

We hear our friends on the other side of the aisle talk about insurance companies. I have no doubt that their desire is, frankly, to do away with private sector involvement in the health coverage field, which leaves, of course, only the Federal Government—ultimately a single-payer system making decisions out of Washington, DC, that affect the health care delivery of 300 million people—a bad idea.

My first amendment would make Medicare play by the same financial solvency rules as private insurers. Because private insurers are owned by their shareholders and have fiduciary responsibilities, they could not do business the way Medicare does. They could not tolerate high fraud, waste, and abuse rates. They could not function based on the same risk-based capitalization that private insurance companies do. My amendment would ensure that before we pillage $½ trillion from the Medicare Program to pay for yet another unsustainable entitlement program, the Medicare Program should be able to meet the same solvency and risk-based capitalization requirements private insurance plans meet.

My second amendment will be to strike the unelected, unaccountable board of bureaucrats known as the Medicare advisory board.

We have heard this Medicare advisory board extolled, but this is the same kind of unelected, unaccountable board that we saw just a couple of weeks ago issued a new order or recommendation on mammograms based on cost-benefit, which would have condemned some women between the age of 40 and 49, denied them access to a mammogram and, frankly, condemned them to an early, premature death because of breast cancer. When you put all the power to determine the coverage and also payment in an unelected, unaccountable board, such as the Medicare advisory board, then, frankly, you are going to get more of that rationing and that same sort of cost-benefit analysis which is going to consign too many Americans to a premature death because, frankly, the Federal Government doesn't care and is not going to see them get access to care.

After the Reid bill pillages $465 billion from the Medicare Program to create a new entitlement, it sets up this new Medicare advisory board, an unaccountable board of bureaucrats, to find more ways to cut billions of dollars from Medicare. Unsurprisingly, patients, providers, and even Congress don't always agree with experts, including the ones we have in place today. According to the Wall Street Journal, the Medicare Payment Advisory Commission, created by Congress in 1997, has recommended more than $200 billion in cuts in the last year alone, which lawmakers—that means Congress—has ignored.

Artificial and arbitrary budget targets leave little room for innovation as well. What if we were to find a cure for Alzheimer's in 2020 but because it would be too expensive, the Medicare advisory board would say the Federal Government is not going to pay for it?

Some have said this independent board would be a way to insulate Medicare payment decisions from politics. But the very creation of the Board was the result of a political deal with the White House that insulated hospitals from future cuts.

I wish to close by saying I hope my colleagues will reconsider and vote for the McCain amendment, which will reverse the pillaging of $½ trillion from the Medicare Program to create a new entitlement program. We should fix Medicare's unfunded liabilities of nearly $38 trillion and not steal from Medicare to create another unsustainable entitlement program that will, of course, have to be paid for by our children and grandchildren on top of all the other debt we are piling on them. At a time of insolvent entitlement programs, record budget deficits, and unsustainable national debt, this country simply cannot afford to spend $2.5 trillion on an ill-conceived Washington health care takeover.

I yield the floor.

EXHIBIT 1

[From the Washington Post, Oct. 27, 2009]

AARP: REFORM ADVOCATE AND INSURANCE SALESMAN

(By Dan Eggen)

The nation's preeminent seniors group, AARP, has put the weight of its 40 million members behind healthcare reform, saying many of the proposals will lower costs and increase the quality of care for older Americans.

But not advertised in this lobbying campaign have been the group's substantial earnings from insurance royalties and the potential benefits that could come its way from many of the reform proposals.

The group and its subsidiaries collected more than $650 million in royalties and other fees last year from the sale of insurance policies, credit cards and other products that carry the AARP name, accounting for the majority of its $1.14 billion in revenue, according to federal tax records. It does not directly sell insurance policies but lends its name to plans in exchange for a tax-exempt cut of the premiums.

The organization, formerly known as the American Association of Retired Persons, also heavily markets the policies on its Web site, in mailings to its members and through ubiquitous advertising targeted at seniors.

The group's dual role as an insurance reformer and a broker has come under increasing scrutiny in recent weeks from congressional Republicans, who accuse it of having a conflict of interest in taking sides in the fierce debate over health insurance. Three House Republicans sent a letter to AARP on Monday complaining that the group was putting its ''political self-interests'' ahead of seniors.

GOP lawmakers point to AARP's thriving business in marketing branded Medigap policies, which provide supplemental coverage for standard Medicare plans available to the elderly. Democratic proposals to slash reimbursements for another program, called Medicare Advantage, are widely expected to drive up demand for private Medigap policies like the ones offered by AARP, according to health-care experts, legislative aides and documents.

Republicans also question the high salaries and other perks given to some top AARP executives, who would not be subject to limits on insurance executives' pay included in the Senate Finance Committee's health reform package. Former AARP chief executive William Novelli received more than $1 million in compensation last year.

''We are witnessing a disturbing trend of handouts to special interests like AARP,''

said House Republican spokesman Matt Lloyd, referring to Democratic negotiations over health reform. ''In return, AARP is lobbying for a government-run health-care bill that will pad their own executives' pockets at the expense of its own members and other vulnerable seniors.''

AARP officials strongly dispute such allegations, arguing that the group's heavy reliance on brand royalties allows it to offer members a wide range of benefits—from lobbying for seniors in Washington to discount travel packages and financial advice. The organization notes that even though it offers a Medicare Advantage plan, it has long advocated curbing waste in that federal program.

''We're a consumer advocacy organization; we're not an insurance firm,'' said David Certner, AARP's director of legislative policy. ''That drives everything we do. It's got to be good for our members, or we don't endorse it.''

Added AARP spokesman Jim Dau: ''We spend far more time at odds with private insurers than not.''

AARP's ties to the insurance business date to its founding by former educator Ethel Percy Andrus, who started a group to help retired schoolteachers find health insurance in the years before Medicare; the effort led to the creation of AARP in 1958.

Now, the group relies more than ever on payments from auto, health and life insurers, according to financial statements. From 2007 to 2008, AARP royalties from insurance plans, credit cards and other branded products shot up 31 percent—from less than $500 million to $652 million—making such fees the primary source of revenue for the group last year, the records show. AARP's annual financial report shows that 63 percent of that, or about $400 million, came from the nation's largest health insurance carrier, UnitedHealth Group, which underwrites four major AARP Medigap policies. Other carriers with AARP-branded plans include Aetna Life Insurance, Genworth Life Insurance and Delta Dental.

AARP is also a major powerhouse in Washington, spending more than $37 million on lobbying since January 2008. The organization's close ties with insurers have long attracted criticism from politicians of both parties.

During the health-care debate of the early 1990s, then-Sen. Alan Simpson (R–Wyo.) held hearings lambasting the group's business operations. Some Democrats criticized the group for supporting the Bush administration's expensive Medicare prescription-drug legislation in 2003.

Earlier this year, AARP and UnitedHealth said they were halting the sale of ''limited benefit'' health insurance policies after complaints from Sen. Charles E. Grassley (R–Iowa) that the plans were marketed in a misleading way.

Dean A. Zerbe, a former Grassley senior counsel who is now national managing director at the corporate tax firm Alliant Group, argues that AARP's involvement in the sale of insurance plans ''really hurts their credibility.''

''Either you're a voice for the elderly or you're an insurance company; choose one,'' Zerbe said. ''They put themselves forward in the public arena as nonbiased observers, but they're very swayed by business interests.''

Republicans renewed their attacks on AARP this year after the group emerged as a vigorous defender of many of the reforms under consideration by the Democrat-controlled Congress. Nancy LeaMond, an AARP executive vice president, appeared at a press conference Friday alongside House Speaker Nancy Pelosi (D–Calif.) to announce a new proposal for plugging gaps in coverage of Medicare prescription benefits.

Rep. Dave Reichert (R–Wash.), who has asked AARP to provide him with more details about its insurance-related businesses, said he believes the group is ''misleading'' its members about the alleged benefits of Democratic reforms. ''Right now there's a feeling among seniors that AARP may not be entirely forthcoming,'' he said.

AARP launched a ''fact check'' section on its Web site this year to counter GOP criticisms of reform, including the discredited ''death panels'' claim, and argues that wringing savings out of Medicare and closing gaps in prescription coverage will help older Americans.

Several top AARP officials also said they have no idea whether the group might gain insurance business as a result of the proposed reforms. ''We wouldn't know it, and we wouldn't really care,'' Certner said. ''The advocacy is what drives what we do here, and not the other way around.''

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I understand we have several Senators who wish to speak. First, the Senator from Michigan, Ms. STABENOW, then Senator HATCH; Senator CARDIN would be third. I don't want to tread on any toes. I say to Senator CARDIN, there is a little bit of time constraint.

We are alternating. We are respecting the alternating back and forth.

The Senator from Michigan is next, Ms. STABENOW.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, I, first, thank our distinguished leader on the Finance Committee. It is my pleasure to serve on the Senate Finance Committee. We have been working on this issue for well over a year—2 years now. I very much thank the Senator from Montana and appreciate his leadership in getting us to this point because I don't think we would have been here without his leadership. I very much appreciate that, as well as our leader, Senator REID, who has worked tirelessly, and, of course, the Senator from Connecticut, Mr. DODD, and Senator HARKIN from Iowa as well. We certainly appreciate their leadership.

The bottom line of the legislation in front of us is very simple. On behalf of the American people, we have put forward a health care reform bill that will save lives, it will save money, and it will save Medicare. It does that in multiple ways.

I wish to spend just a few moments this evening talking about Medicare because there is a very significant amendment in front of us that would undercut what we are trying to do to save Medicare. As we go through this next debate, as I have done many times, I am going to continue to talk about the ways in which we are saving lives and saving money.

The reality is, Medicare is a sacred trust with America's seniors, with people with disabilities. Our health care reform efforts, both in the House and the Senate, will help ensure that trust is never broken. That is what this is all about. In fact, I don't think I could look my 83-year-old mother in the eye, knowing how much she has benefited from Medicare, and be doing anything that would weaken Medicare—now or on into the future.

We are going to extend Medicare solvency while providing better, more affordable care for America's seniors and people with disabilities. In fact, we are going to add 5 years to the Medicare trust fund solvency, which is extremely important. In the long run, I expect, as we go forward, as we bring down costs, as we save money, we will, in fact, be adding years to the trust fund by what we are doing.

We are going to crack down on waste, fraud, and abuse in the Medicare Program and wasteful overpayments to insurance companies through a Medicare Advantage effort that essentially was set up to privatize Medicare—turn it over to primarily for-profit insurance companies.

Reform is going to make sure we have more affordable services for seniors. We are going to begin to close that doughnut hole, a gap in prescription drug coverage, right now. It was passed a number of years ago—and I might indicate not paid for—and our effort is entirely paid for. It does not add a dime to the national debt. In fact, it brings down the deficit. But we are closing a gap in coverage on prescription drugs by 50 percent. We are going to phase that in. We are going to keep going until we get that completely closed.

We are going to make sure preventive services do not have a cost connected with them—no deductible, no copay. We want people to be getting the cancer screenings, the mammograms, the wonderful colonoscopies, the other preventive services people need, as well as being able to have a yearly physical with their physician, without deductibles and copays. We are going to aggressively attack fraud and abuse that raises Medicare costs for seniors and for taxpayers.

Reform is also about improving quality of care. It will move Medicare toward a system of rewarding high-quality care, investing in innovations, more efforts in primary care, family doctors, better coordination of care, cutting down on duplication of tests and bureaucracy and all those things we so frequently complain about in the Senate—as we should.

It is going to make long-term care services more affordable. There is such a growing demand and need for long-term services.

It is going to eliminate the imminent physician payment cut that threatens to stop seniors from having full choice of seeing their own doctor. As my colleagues know, I am deeply committed

to permanently fixing a flawed physician payment system, but in this bill we make sure the 21-percent cut that is scheduled to take place next year does not take effect, and we will continue. We are committed to working until we completely solve this problem.

It is not a surprise our Republican colleagues are opposing a plan that actually protects Medicare, it actually protects Medicare benefits for seniors, people with disabilities, and keeps Medicare finances in the black for 5 additional years. Just months, 7 months ago, nearly 80 percent of the Republican House Members voted to end Medicare as we know it by turning it into a voucher program that provides a fixed sum of money to pay to private insurance companies, which, by the way, has led—we are now trying to fix overpayments to private for-profit insurance companies at the expense of Medicare and services for seniors.

A top AARP policy official called this scheme that was supported by 80 percent of the House Republicans, just 7 months ago—called this scheme ''a very dangerous idea,'' saying it would raise costs for all beneficiaries and lower the quality of care for less-affluent seniors, lower income seniors.

Now faced with a plan that actually strengthens Medicare, actually saves Medicare for the future and makes sure money goes to Medicare beneficiaries rather than to insurance companies in high payments, some colleagues are pulling out all the stops to defend the health care status quo that sends hundreds of billions of dollars in overpayments to private insurance companies. That is, unfortunately, the result of the McCain amendment, which I strongly oppose.

Many Republicans are resorting to traditional scare tactics and falsehoods, myths. We have heard this over and over. You can go to the AARP Web site and see the fact that, time after time, they have put up falsehoods to try to scare seniors, which I think is outrageous. For proof of how politically motivated these attacks are on the President's proposal and our proposals to eliminate waste and insurance company overpayments in Medicare Advantage, you have to look no further than the fact that a group of Republican Senators actually introduced a similar proposal as recently as this past May.

These kinds of distortions, the fear tactics that have been used, would be offensive under any circumstance, but they are especially disingenuous coming from a group of people who have a long history—a party that has a long history of opposing Medicare and that very recently tried to kill the program as we know it. Their most recent assault was just the latest in a war that Republicans have been waging on the program since the beginning when a majority of them voted no on even establishing Medicare. The overwhelming majority of Republican colleagues voted no.

Last time we had a Democratic President, leading Republicans across the country launched a vicious attack on Medicare. They bragged about opposing the creation of the program in the first place. They called for huge cuts to Medicare and even the ''elimination'' of entitlement programs such as Medicare, as we know them. One even blamed seniors' greed for Medicare's budget problems.

As we now debate this issue, I find it so interesting that colleagues on the other side of the aisle are indicating that, after years of history of trying to cut, eliminate, change Medicare, Republicans having voted against even establishing Medicare, that somehow they are now the protectors of Medicare. As AARP has said, there is nothing in this proposal that is going to cut benefits or increase out-of-pocket costs for seniors. They would not be supporting the efforts we have been involved with if, in fact, it did. I think we all know that.

President Obama and the Democratic majority in this Congress are committed to protecting and strengthening Medicare, a program we created—I should say my predecessors. I was not here. I was not fortunate enough to be here, but it was Democrats who created that program. I am very proud of it because it is one of the great American success stories, Medicare and Social Security. It is a sacred trust with our seniors, and our health insurers reform plan will ensure that trust is never broken.

Health care reform is about saving lives, saving money, and saving Medicare.

I yield the floor.

The PRESIDING OFFICER (Mr. TESTER). The Senator form Utah is recognized.

Mr. HATCH. Mr. President, I am honored to be able to speak on the floor on this very important set of issues. I rise in support of Senator MCCAIN's motion to recommit in order to eliminate the Medicare cuts contained in the legislation.

I do have to say, having listened to my friend from Michigan—and she is a good person and good friend of mine—I have to say I do not see how in the world taking $500 billion from Medicare is good for the Medicare Program. When you start talking about: We are going to find it in fraud, waste, and abuse, that is the biggest dodge that has been used for years and years. Frankly, it is not good for the Medicare Program, it is not good for Medicare beneficiaries, and it is simply not true. How can cuts of that magnitude, $500 billion, $1/2 trillion, be good for the program?

I support Senator MCCAIN's motion to recommit the Reid health care bill in order to eliminate the Medicare cuts contained in this legislation. Throughout the health care debate, we have heard the President pledge not to ''mess'' with Medicare. Unfortunately, that is not the case with the bill before the Senate, H.R. 3590, the Patient Protection and Affordable Care act. Interesting name. To be clear, the Reid bill cuts Medicare by $465 billion to fund a new government program. Unfortunately, our seniors and the disabled are the ones who suffer the consequences as a result of these reductions. Medicare is very important to the 43 million seniors and disabled Americans covered by the program. Throughout my Senate service, I have fought to preserve and protect Medicare for both beneficiaries and providers. Medicare is already in trouble today. The program faces tremendous challenges in the very near future. The Medicare trust fund will be insolvent by 2017, and the program has more than $37 trillion, almost $38 trillion in unfunded liabilities. So we are going to take $500 billion more out of Medicare? That doesn't make sense. Every senior in this country ought to be up in arms about it.

The Reid bill is going to make a bad situation much worse. Why is that the case? Again, the Reid bill cuts Medicare to create a new government entitlement program. More specifically, the Reid bill will cut nearly $135 billion from hospitals, $120 billion from Medicare Advantage, and almost $15 billion from nursing homes, more than $40 billion from home health care agencies, and close to $8 billion from hospice providers. How can that be good for our seniors? These cuts will threaten beneficiary access to care, as Medicare providers find it more and more challenging to provide health services to Medicare patients. How can cutting $465 billion, almost $500 billion, out of Medicare strengthen the program? It defies logic. I do not know how people can stand on this floor and make that statement. The people out there have caught on to it. Senior citizens have caught on to it. All across the country they are up in arms, and they should be.

In addition, the proposed legislation permanently cuts all annual Medicare provider payment updates. Hospitals, home health agencies, and hospice facilities would face even more annual reductions over the next 10 years. Advocates of these reductions, known as ''productivity adjustments,'' will argue that today Medicare is overpaying certain providers because current payment updates do not take into account increases in productivity which actually reduce the cost of providing beneficiaries health care services. Come on. To me these permanent productivity adjustments will make it harder for Medicare providers to remain profitable, as Medicare payments fail to keep

up with the cost of providing these health care services.

As a result of these payment reductions, I believe many doctors and other Medicare providers will stop seeing Medicare patients. In my home State of Utah, low Medicare reimbursement rates are already a serious problem for beneficiaries and their health care providers. These additional reductions will only make it more difficult. I want to stress to my colleagues that cutting Medicare to pay for a new government program is irresponsible. Any reductions to Medicare should be used to preserve the program, not create a new government bureaucracy or a new entitlement program. I believe it makes more sense to target the Medicare savings towards paying off Medicare's unfunded liabilities or preventing the program's future insolvency.

I wish to take a few minutes to talk about the Medicare Advantage Program and how it is affected by the Reid bill. As I stated previously, the Reid bill reduces Medicare by close to $500 billion. Almost $120 billion comes out of the Medicare Advantage Program. During the Finance Committee's consideration of the Baucus health bill, I offered an amendment to protect extra benefits currently enjoyed by Medicare Advantage beneficiaries. Unfortunately, my amendment was defeated. In other words, the President's pledge assuring Americans that they would not lose benefits was not met by either the Finance Committee bill or the Reid bill currently under consideration in the Senate. Here is how supporters of the Finance Committee bill justified the Medicare Advantage reductions. They argued the extra benefits that would be cut, such as vision care, dental care, reduced hospital deductibles, lower copayments, and premiums, were not statutory benefits offered in the Medicare fee-for-service program. Therefore, these benefits did not count. Well, they counted for the seniors receiving those benefits.

A few weeks back our President once again assured the American people that they could keep their current health plan. Here is what he said:

> The first thing I want to make clear is that if you are happy with the insurance plan that you have right now, if the costs you're paying and the benefits you're getting are what you want them to be, then you can keep offering that same plan. Nobody will make you change it.

I believe that promise should apply to all Americans, including those participating in the Medicare Advantage Program. Congress is either going to protect existing benefits or not. It is that simple. Unfortunately, under the Reid bill, if you are a beneficiary participating in Medicare Advantage, that promise does not apply to you.

I have some history with the Medicare Advantage Program. I served as a member of the House-Senate conference, as did the distinguished chairman of the Finance Committee. We both served as members of the Senate conference committee which wrote the Medicare Modernization Act of 2003. Among other things, this law created the Medicare Advantage Program. We did it because we wanted to provide health care choices to beneficiaries living in rural America. And it did. Medicare+Choice didn't do it. We knew it wouldn't do it. When conference committee members were negotiating the conference report, several of us insisted that the Medicare Advantage Program was necessary in order to provide health care coverage choices to Medicare beneficiaries. At that time there were many parts of the country where Medicare beneficiaries did not have choice in coverage. In fact, the only choice offered to them was traditional fee-for-service Medicare, a one-size-fits-all government-run health program.

By creating the Medicare Advantage Program, we provided beneficiaries with a choice in coverage and then empowered them to make their own health care decisions as opposed to the Federal Government making those decisions for them. Today every Medicare beneficiary may choose from several health plans for his or her coverage. Medicare Advantage works. It has worked. It will work in the future, if we don't louse it up with this bill.

On the other hand, Medicare+Choice and its predecessors did not, because many plans across the country, especially in rural areas, were reimbursed at very low rates by the Medicare Program. I fear history could repeat itself if we are not careful. Let me take a minute to talk about Medicare+Choice. I represent a State where Medicare managed care plans could not exist due to low reimbursement rates. To address that concern, Congress included language which was signed into law establishing a payment floor for rural areas, but it was not enough. In fact, in Utah all of the Medicare+Choice plans eventually left because they were all operating in the red. This happened after promises were made that Medicare+Choice plans would be reimbursed fairly and that all Medicare beneficiaries would have access to these plans.

So during the Medicare Modernization Act conference, we fixed the problem. First, we renamed the program Medicare Advantage. Second, we increased reimbursement rates so that all Medicare beneficiaries, regardless of where they lived, be it in Fillmore, UT or New York City, had choice in coverage. Again, we did not want beneficiaries stuck with a one-size-fits-all government plan. Today Medicare Advantage works. Every Medicare beneficiary has access to a Medicare Advantage plan. Close to 90 percent of Medicare beneficiaries participating in the program are satisfied with their health coverage. But that could all change should the health care reform legislation currently being considered become law. Choice in coverage has made a difference in the lives of more than 10 million individuals nationwide. The extra benefits I have mentioned are being portrayed as gym memberships as opposed to lower premiums, copayments, and deductibles. To be clear, the Silver Sneakers program is one that has made a difference in the lives of many seniors, because it encourages them to get out of their home and remain active. It has been helpful to those with serious weight issues, and it has been invaluable to women suffering from osteoporosis and joint problems. In fact, I have received several hundred letters telling me how much Medicare Advantage beneficiaries appreciate this program.

Additionally, these beneficiaries receive other services such as coordinated chronic care management, dental coverage, vision care, and hearing aids.

In conclusion, I cannot support any bill that would jeopardize health care coverage for Medicare beneficiaries. I truly believe that if the bill before the Senate becomes law, Medicare beneficiaries' health care coverage could be in serious trouble. We owe it to the 43 million Americans, seniors and disabled who depend on Medicare, to reject the nonsensical Medicare cuts included in the Reid bill. We must have better solutions that will not hinder their ability to see the doctor of their choice.

I have been in the Senate now for 33 years. I pride myself for being bipartisan. I have coauthored many bipartisan health care bills since I first joined the Senate in 1977.

Let me be clear: I want a health reform bill to pass this Chamber, but I want it to be a bipartisan bill that passes the Senate by 70 to 80 votes. If a bill involving one-sixth of the American economy cannot get 70 to 80 votes, that bill has to be a lousy bill, especially if it is a partisan bill, like this one.

If we could do it in 2003, when we considered the Medicare prescription drug legislation, we can do it today. There has never been a bill of this magnitude affecting so many American lives that has passed this Chamber on a straight party-line vote. In the past, the Senate has approved many bipartisan health care bills that have eventually been signed into law. The Balanced Budget Act in 1997, which included the Children's Health Insurance Program; the Ryan White Act; the Orphan Drug Act; the Americans with Disabilities Act; and the Hatch-Waxman Act are a few of these success stories, and I was a prime sponsor of every one of those bills. If the Senate passes this bill in its current form with a razor thin margin of 60 votes—or even 61, to be honest

with you—it would be so partisan it wouldn't even be funny. This would be yet one more example of the arrogance of power since the Democrats have secured a 60-vote majority in the Senate.

There is a better way to handle health care reform. First and foremost, it must be bipartisan. We stand ready and willing to work on a bipartisan bill, without the restrictions that were placed on the distinguished Senator who chairs the Finance Committee. It should be bipartisan. Second, we cannot erode the existing system that has provided quality and affordable health care to most Americans for decades. While we all agree that the current system should be improved, this bill is certainly not the answer. If the Senate passes the McCain motion to recommit, we can begin to work on a bipartisan health bill that will eliminate the overwhelming Medicare payment reductions and at the same time address the serious issues facing the Medicare Program in the near future.

Look, we know that insurance should cover preexisting conditions. We know if we use 50 State laboratories by giving the States the money to address health care in accordance with their own demographics, not only will states resolve their own health care issues but we also will be able to learn from the successes of these States.

We all know if we address medical liability reform and eliminate approximately 90 percent of the frivolous cases that are filed—costing anywhere from $54 billion to $300 billion a year in unnecessary costs—we know those savings would help us pay for this bill.

We know there are so many things we could do on wellness and prevention that will work. I think all of us agree on most of these issues. Democrats could never agree on medical liability reform because the personal injury lawyers—and there is a limited group in what used to be the American Trial Lawyers Association—are high funders of Democratic races. So they are not willing to do anything about it. In fact, in the House bill, if you do not cooperate with the personal injury lawyers, you lose your money. It is unbelievable.

We know there are a number of other things we could do that both sides could agree on that would cut costs. We are currently spending in this country, without this bill, $2.4 trillion on health care, all told. This bill will add, over a true 10-year period, another $2.5 trillion to the cost. So it will result in almost $5 trillion in health care spending. Why don't they admit it is going to be at least $2.5 trillion? They do not admit it because for the first 3 or 4 years they count the taxes that are charged, but they do not implement the program until 2014 in the Reid bill. It is 2013 in the House bill, and even 2014 in some aspects of the House bill. That is the only reason they can say it is about $1 trillion. It is actually $2.5 trillion according to figures from the Senate Budget Committee, using the figures of the Congressional Budget Office.

I hate to see $500 billion come out of Medicare, at a time when Medicare is going to go insolvent by 2017 or 2018. I think it is absurd. I think it is ridiculous. I do not blame the seniors for being upset, and they are very upset throughout this country. They have reason to be upset. I urge my colleagues to support the McCain motion to commit this bill, and let's get working on a truly bipartisan bill.

There are some of us who have the reputation of working with the other side in a bipartisan way. We want to do it. We want to get it done. We want the vast majority of the people in this country happy with the final bill. We want to have between 75 and 80 votes, as a minimum, to pass this bill. That way, there would be at least some assurance that it was a bipartisan bill and it might have a real chance to work. But if we pass this bill 60 to 40, let's be honest about it, you know it is a lousy bill.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. CARDIN. Mr. President, first, let me thank the Senator from Montana, Mr. BAUCUS, for bringing forward a bill that has been long overdue on the Senate floor.

This is a historic moment as we debate health care reform. Many of us have been looking forward to this moment for many years. As to this bill, the Congressional Budget Office has now confirmed, for the overwhelming majority of Americans, it will bring down their health care insurance premiums.

This bill will bring down the growth rate of health care costs. It will provide affordable options for millions of Americans who today have been denied the opportunity to buy health insurance.

The Congressional Budget Office tells us that it will insure 31 million Americans who otherwise would not have insurance, bringing down the uninsured rate. And, most importantly, the Congressional Budget Office—that objective scorekeeper; that is not Democrats, not Republicans; this is the objective scorekeeper—tells us this bill will bring down the Federal deficit.

So it is a responsible bill, a bill that will provide affordable insurance options for millions of Americans who are denied insurance today. It will reduce our deficit, and will start to get a handle on the escalating cost of health care. It saves money. It saves lives through prevention and early detection of diseases, and by expanded coverage. And it saves Medicare.

Why does it save Medicare? Because many of us who have been here for a long time understand that the only way you can bring down the cost of Medicare is to bring down the cost of health care. That is exactly what this bill does, providing for the long-term safety of Medicare for our seniors.

It also expands benefits for our seniors in prevention and helps to start to fill the doughnut hole in prescription drug coverage. The underlying bill moves us toward what we need to do in health care reform. It brings down health care costs. How? By managing diseases and understanding the way we pay for diseases today is where most of the cost in health care is. This helps us manage diseases. It expands insurance coverage, which will bring down costs. It provides for investments in health information technology so we can bring down the administrative costs, and it invests in wellness and prevention.

AMENDMENT NO. 2791

Mr. President, I rise today to encourage my colleagues to support the Mikulski amendment, which will ensure women have access to essential preventive services. The leading causes of death for women are heart disease, cancer, and stroke. Early screening for risk factors could prevent many of these deaths and lead to improved health and quality of life for women. But despite the benefits of early screening, many insurers do not cover them, and too often women skip them because the costs are prohibitive. We know early detection of disease saves lives, and so we must ensure that needed preventive services are available to all Americans, regardless of gender.

I have long worked to improve access to preventive services. Knowing what we do now about the importance of prevention, it seems hard to believe that before 1998 Medicare did not cover cancer screenings or other preventive services. I am proud of a bill I authored in 1997 as a Member of the House of Representatives. It established the first package of preventive benefits in traditional Medicare. It was part of the 1997 Balanced Budget Act, and it would not have passed but for strong bipartisan support.

Medicare now covers screenings for breast, colon, and prostate cancer, bone mass measurement for osteoporosis, diabetes testing supplies, glaucoma, and more. Last year's bill, the Medicare Improvements for Patients and Providers Act, gave HHS the authority to expand the list of covered services so that as new, highly effective procedures are discovered, they can be made available to beneficiaries without having to wait the length of time for Congress to act. This bill wisely builds on the benefit package for seniors and expands it to cover all Americans as part of their insurance coverage. We are expanding prevention and making sure it is available so all Americans will have a better insurance

product that will cover preventive services.

Basic screenings can have an enormous impact on health and save money in the long run. Chronic disease incurs a huge cost for our health care system. Today, more than half of Americans live with at least one chronic condition, accounting for 75 percent of all health care spending each year. To bend the cost curve, we need to reduce the onset of chronic diseases before they become much more expensive to treat.

The American Cancer Society reports that the incidence of cervical cancer and mortality rates have decreased by 67 percent over the past three decades. This is mainly attributable to the introduction of the Pap test. The average cost for normal cervical screening in 2004 was $31. In contrast, the treatment for early-stage cervical cancer averaged $20,255, and the treatment for late-stage cervical cancer was almost $37,000. Screening saves lives, saves money. The bill before us invests in prevention. It will save money. It will save lives.

Breast cancer screening has also been shown to reduce mortality. Early-stage diagnosis gives a 5-year survival rate of 98 percent, and statistics compiled by the American Cancer Society indicate that 61 percent of breast cancers are diagnosed at this stage, largely due to mammographies and other early screening methods.

The bill before us guarantees coverage for a number of services to promote public health and wellness and to prevent devastating chronic disease. Some of these measures include providing coverage for everyone for services that have an ‘‘A’’ or ‘‘B’’ rating by the U.S. Preventive Services Task Force. These tests and screenings are either recommended or strongly recommended and include screenings for osteoporosis, colon cancer, and would be covered with no cost sharing—a strong incentive for people taking advantage of these screenings.

Covering immunizations recommended for adults by the Advisory Committee on Immunization Practices of the CDC is also covered. Preventive care services and screenings for infants, children, and adolescents that are supported in comprehensive guidelines from the Health Resources and Services Administration—all that is in the underlying bill that will save us money and will save us lives.

In addition to these vital services, the women's preventive health services must also be covered, the Mikulski amendment. The Mikulski amendment extends the preventive services covered by the bill to those evidence-based services for women that are recommended by the Health Resources and Services Administration. HRSA, a division of the Department of Health and Human Services, has as its goal to improve access to primary and preventive care services to uninsured and underinsured individuals.

It focuses on maternal and child health, HIV/AIDS care, recruiting doctors in underserved areas, health care in rural areas, and organ donation. HRSA strives to develop ‘‘best practices’’ and create uniform standards of care, including eliminating health disparities among minority populations.

Some of the additional services for women that will be covered under the Mikulski amendment include mammograms for women under 50. In 2000, breast cancer was the most common cancer affecting Maryland women, and nearly 800 women died from the disease, according to the Maryland Department of Health and Mental Hygiene. According to the Kaiser Family Foundation, 76.6 percent of women aged 40 and over had a mammography within the past 2 years. This amendment would ensure that all of these women would have access to mammography with no out-of-pocket cost.

Also covered under the Mikulski amendment are cervical cancer screenings for all women, regardless of whether they are sexually active, and ovarian cancer screenings—all those will be made available under the Mikulski amendment. Ovarian cancer is the fifth leading cause of cancer deaths among women in Maryland. General yearly well-women visits would be covered; pelvic examinations, family planning services, pregnancy, and post partum depression screenings, chlamydia screenings for all women over 25. Chlamydia is the most prevalent sexually transmitted disease diagnosed in the United States. Approximately 4 million new cases of this disease occur each year, and up to 40 percent of the women infected with this disease may be unaware of its existence. It is the leading cause of preventable infertility and ectopic pregnancy.

Also included are HIV screenings for all women regardless of exposure to risk. According to the Kaiser Foundation, among those women who are HIV positive, 33 percent of the women were tested for HIV late in their illness and were diagnosed with AIDS within 1 year of testing positive.

We need to do a better job here. This is International Aids Awareness Day. I think it is very appropriate we have the Mikulski amendment on the floor today.

Studies reported by the Kaiser Foundation indicate that women with HIV experience limited access to care and experience disparities in access, relative to men. Women are the fastest growing group of AIDS patients, accounting for 34 percent of all new AIDS cases in 2001, compared with 10 percent in 1985. So this amendment will help in regard to that issue for our women.

Also included is sexually transmitted infection counseling for all women. Women disproportionately bear the long-term consequences of STDs. Screenings for domestic violence are covered. The Maryland Network Against Domestic Violence reports that one out of every four American women—one out of every four American women—reports she has been physically abused by a husband or a boyfriend at some time in her life. Well, the Mikulski amendment provides screenings for domestic violence.

Also included are overweight screenings for teens, gestational diabetes screenings, thyroid screenings.

Much of the debate on health care reform has focused on quality—how do we make our health care system work better and produce better outcomes for the money we spend. Ensuring that women have access to preventive services that are recommended by experts on women's health is absolutely essential to providing quality care.

This amendment protects the rights of a woman to consult with a doctor to determine which services are best for her and guarantees access to these services at no additional cost. Preventive health care initiatives is one area I hoped we could all agree upon. The Senate has a long history of bipartisan support for women's preventive services. I hope the string remains unbroken with this amendment.

I strongly support the efforts spearheaded by Senator MIKULSKI to extend the services that are covered for women. I strongly urge my colleagues to support this very important amendment that makes a good bill better. This bill is desperately needed. Let's vote for those amendments that improve it, such as the Mikulski amendment, and let's move forward with this debate.

With that, I yield the floor.

Mrs. FEINSTEIN. Mr. President, I rise in support of the Mikulski amendment and to discuss the importance of preventive health care for women.

All women should have access to the same affordable preventive health care services as women who serve in Congress.

The Mikulski amendment will ensure that is the case.

It will require plans to cover, at no cost, basic preventive services and screenings for women.

This may include mammograms, pap smears, family planning, and screenings to detect heart disease, diabetes, or postpartum depression—in other words, basic services that are a part of every woman's health care needs at some point in life.

We often like to think of the United States as a world leader in health care, with the best and most efficient system. The facts do not bear this out.

The United States spends more per capita on health care than other industrialized nations but has worse results.

According to the Commonwealth Fund, the United States ranks 15th in

''avoidable mortality.'' This measures how many people in each country survive a potentially fatal, yet treatable medical condition. And the United States lags behind France, Japan, Spain, Sweden, Italy, Australia, Canada, and several other nations.

According to the World Health Organization, the United States ranks 24th in the world in healthy life expectancy. This measures how many years a person can expect to live at full health. The United States again trails Japan, Australia, France, Sweden and many other countries.

These statistics show we are not spending our resources wisely. We are not finding and treating people with conditions that can be controlled.

Part of the answer, without question, is expanding coverage. Too many Americans cannot afford basic health care because they lack basic health insurance.

The Mikulski amendment, and providing affordable access to preventive care, is another part of the answer.

Women need preventive care, screenings, and tests so that potentially serious or fatal illnesses can be found early and treated effectively.

We all know individuals who have benefited from this type of care.

A mammogram identifies breast cancer, before it has spread.

A pap smear finds precancerous cells that can be removed before they progress to cancer and cause serious health problems.

Cholesterol testing or a blood pressure reading suggest that a person might have cardiovascular disease, which can be controlled with medication or lifestyle changes.

This is how health care should work: a problem found early and addressed early. The Mikulski amendment will give more women access to this type of care.

Statistics about life expectancy and avoidable mortality can make it easy to forget that we are talking about real patients and real people who die too young because they lack access to health care.

Physicians for Reproductive Choice and Health shared the following story, which comes from Dr. William Leininger in California.

He states:

In my last year of residency, I cared for a mother of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband's insurance, but it was an abusive relationship, and she lost her health insurance when they divorced.

For the next five years, she had no health insurance and never received follow-up care (which would have revealed that her cancer had returned). She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread.

She had two children from her previous marriage—her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn't gain custody of her kids after her death. She succeeded. She was 28 when she died.

Cases like these explain why the United States trails behind much of the industrialized world life expectancy. For this woman, divorce meant the loss of her health care coverage, which meant she could not afford follow up care to address her cancer, a type of cancer that is often curable if found early.

This story shows the need to improve our system, so women can still afford health insurance after they divorce or lose their jobs, and it shows why health reform must adequately cover all the preventive services that women need to stay healthy.

I urge my colleagues to join me in supporting the Mikulski amendment.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. BUNNING. Mr. President, is the pending business still the health care reform bill?

The PRESIDING OFFICER. It is, and the motion to commit.

Mr. BUNNING. Mr. President, Republicans and Democrats alike agree that Congress needs to look at ways to reform our health care system. Too many Americans are uninsured, underinsured, or cannot afford the health insurance they have.

Reforming health care, which amounts to over 17 percent of our gross domestic product, is no easy task, and it is a process that should not be rushed. I believe Congress should move in an incremental approach to reforming health care. We are restructuring one-sixth of our national economy with this bill, and we should be darn sure we know what we are doing. I believe Congress should work in a bipartisan way to draft reform legislation instead of working in secret behind closed doors.

I support measures such as passing medical malpractice reform, allowing small businesses to band together to buy insurance, and allowing individuals to buy insurance across State lines. These strategies will help lower costs, make insurance more affordable, and increase coverage. That should be the goal of health care reform, and we can do this without putting Washington bureaucrats and Members of Congress in control of our health care. This seems like a win-win situation to me.

I also support the bill introduced earlier this year by Senators COBURN and BURR called the Patients' Choice Act which reforms the health care system. This bill helps States establish State-based exchanges, helps low-income families with health care costs, and improves health care savings accounts. I have heard members of the majority party claim that Republicans don't have a health care plan. They couldn't be more wrong. We just don't have a 2,000-plus page bill as they do that will drive up premiums, cut Medicare by $½ trillion, and raise taxes on all Americans. We just don't have a bill as they do that costs $2.5 trillion and will threaten the future of our children and grandchildren as they struggle to pay the debts we are leaving them.

I wish to take a few minutes to explain my concerns with the bill that Senator REID has laid out before us. Unfortunately, it is hard to even know where to start. As I said, this bill is over 2,000 pages long. Its table of contents—the table of contents—is 13 pages long. It was written behind closed doors by a small group of handpicked people by the majority leader, so most of us in the Senate, and the American people, had no idea what was in it before it was released. For a majority party that billed itself as being transparent, they certainly failed in writing this bill.

The bill we have before us changes the way health care is delivered in this country. It will affect every American regardless of whether they have insurance, regardless of whether they are satisfied with their insurance, or even if they are on Medicare. We need to make sure we know what we are doing and know what the long-term consequences are of any changes we make. At this point, I am not confident that we do.

This bill will cost $2.5 trillion over 10 years when fully implemented. It raises taxes by almost $½ trillion. It cuts almost $½ trillion from the Medicare Program. Yet it still leaves 24 million people uninsured. The bill jeopardizes the ability of Americans to keep their own doctor and will lead to the rationing of care.

The recent recommendations of the U.S. Preventive Services Task Force on breast cancer screening should be a wakeup call to all Americans about Washington bureaucrats meddling in their health care. Under this bill, health care premiums will rise, 5 million Americans will lose their employer coverage, and 15 million more will be added to Medicaid and the CHIP program. I think this is a move in the wrong direction.

Medicaid often underpays medical providers for treating patients which makes it hard for doctors who want to treat these patients and hard for patients to find doctors to treat them. We should be finding ways to help people better afford private insurance, not simply adding them to the public dole. This bill puts Washington bureaucrats and Members of Congress in control over many aspects of our health care which should scare everyone within the sound of my voice.

For example, starting in 2014, Washington will require most Americans to prove they have health insurance or pay a penalty tax. The penalty will be phased in over a couple of years, but in

2016, the penalty will be $750 per person with a maximum of $2,250 for a family. These amounts are indexed in future years, however, so the penalty will continue to increase.

If you aren't in one of the bill's special exemption categories, you will have to prove that you and your family have insurance when you sit down to fill out your taxes. If you don't, then you will get to send Uncle Sam an additional $750 or $2,250 on April 15.

I know the authors of this bill will try to argue that since their bill leads to nearly universal coverage, most Americans would not be affected by this tax. That couldn't be further from the truth. According to the Congressional Budget Office, the official scorekeeper, this bill leaves 24 million Americans uninsured. Twenty-four million Americans without insurance is not ''universal coverage'' or anything close to it. Also, Members of Congress are going to be telling people what type of insurance they have to buy, and we will not even be giving every American access to the cheapest plan on the market.

The bill requires that only four types of health care insurance can be offered in the exchange: bronze, silver, gold, and platinum. All the plans would have to offer certain benefits and meet certain criteria. However, the bill creates a special catastrophic plan for only special groups of people: those under the age of 30 and those who don't have affordable coverage. It doesn't matter that many more people want this level of coverage. If they aren't under 30 or meet some type of income eligibility test, they are just out of luck.

Catastrophic coverage is the right type of coverage for many different types of Americans, including singles, younger people, and the healthy. It is very likely to be the cheapest plan affordable on the exchange. Think about this: a young woman in her thirties, she eats right, she exercises, doesn't smoke, takes good care of herself. She wants a catastrophic plan, and it is all she needs. Under this bill, she couldn't buy into the catastrophic plan because of her age. Members of Congress tell her she isn't entitled to the cheapest plan on the market because she is too old. She is in her thirties. Or think of the 29-year-old male who has been enrolled in this catastrophic plan in his early twenties. On his next birthday, the Federal Government has a big birthday surprise for him. He will get kicked out of the insurance plan he has enjoyed for years and will be forced to join a more expensive health care plan. That is a wonderful birthday gift.

I don't think Congress's role is to require all Americans to buy insurance. I don't think Washington bureaucrats and elected Members of Congress should be dictating what health care options are available for the entire country.

I understand the importance of insurance. I think everyone should have insurance, but I don't think it is the Federal Government's responsibility to force people to buy it or micromanage what insurance looks like.

This bill also makes huge cuts in Medicare which will affect every senior. The bill cuts—and we have heard it many times today—$465 billion from the Medicare Program. These cuts would not be used to shore up the Medicare Program which will be insolvent in just about 8 years. Instead, these cuts will be used to fund new government spending. This move further jeopardizes the viability of the Medicare Program.

I know AARP and the American Medical Association are trying to tell seniors these cuts will actually be good for the Medicare Program and the program would not be harmed, but let's be honest. When you think about it, does it really make any sense? Congress is going to cut $465 billion from a program that is already facing bankruptcy, and it will somehow make it stronger? If you believe that, I have some oceanfront property to sell you in Arizona.

Under this bill, hospitals will be cut, nursing homes will be cut, health home agencies will be cut, hospices will be cut, and Medicare Advantage programs will be cut. By cutting the reimbursement rate for providers, they are making it harder for seniors to find medical providers to treat them. Plain and simple: Seniors will have the same benefit, but if they cannot find anyone to treat them, then their benefits don't do them any good, do they?

I have to tell my colleagues there isn't one medical provider who walks in my office each year who is happy with their reimbursement rate under Medicare. I cannot think of one. Hospitals are not happy. The doctors are not happy. Hospice care providers who provide such valuable services to dying Americans and their families are not happy. No one is happy.

What do you think is going to happen to these reimbursements when the cuts go into effect? How happy will the providers be then?

Another problem with this bill is the creation of a government plan. I can say I do not support a government-run plan in any form. I have already described the significant problems with Medicare and Medicaid. Creating a new government-run health program will lead to the same sort of problems that plague these plans.

I fear it will eventually undermine private insurance enough so we are left with a single-payer, government-run system. I have been in Congress long enough to know it will be a disaster for this country.

Finally, this bill imposes an unprecedented tax increase on Americans. The tax hikes in this bill would start hitting Americans next year, while the spending and benefits will not start, in many cases, until 2014. That is how the majority is hiding the true cost of the bill—using 10 years of tax hikes to offset 6 years of spending.

Everybody knows tax increases are deadly in a fragile economy. But that is not preventing the majority from pushing through $½ trillion in tax hikes in this bill. In further defiance of logic, these tax increases will actually drive up the cost of health care. I was under the impression the goal of health care reform was to reduce costs, not increase them.

As I mentioned earlier, if you have the misfortune of being uninsured, you will be further punished under this bill by paying a penalty tax. If you are an employer that hires a low-income worker and cannot afford to provide health insurance, you probably will be punished with a penalty tax. If you are an employer that offers retirees prescription drug coverage, your taxes will go up. If you have extremely high medical costs and use itemized deductions for medical expenses to defray your costs, your taxes will go up. If you use a flexible spending account, health reimbursement account or health savings account for over-the-counter medicines, your taxes will go up. If you have a flexible spending account, it will be capped and then probably disappear in a few years because of the high-cost plan tax, so your taxes will go up.

This bill also creates a new marriage penalty in the Medicare payroll tax and uses the money to pay for a brandnew entitlement program. It also imposes a new tax on cosmetic surgery. If a family is forced to liquidate a health savings account because of tough economic times, the government will confiscate even more money.

The bill also imposes new taxes on brand-name drugs, medical devices, and health insurance, all of which will increase health care costs and drive up premiums. Now that the government has succeeded in driving up premiums, the government will hit you again by taxing high-cost insurance policies. It makes perfect sense—drive up the cost of insurance premiums with new taxes and then tax them again for being too costly.

We could have health care reform that reduces health care costs for families and businesses. We could have health care reform that didn't raid $½ trillion from Medicare. We could have health care reform that allows people who like the coverage they have to truly keep it. We could have health care reform that doesn't drastically expand government spending on health care or push people into government programs. We could have health care reform that does not increase taxes on the American people at the worst possible time, during a recession. We could

have health care reform that is done in the light of day rather than behind closed doors.

The American people deserve better, and we ought to defeat this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, as I understand it, there are a couple Senators left, besides myself, Senator SESSIONS and Senator BURR. There may be others, but I see them at the moment.

America's health care system is in a crisis. It is a crisis not just for the 46 million Americans who lack health insurance; it is also a crisis for those who have health insurance but are worried they cannot afford to keep it. It is also a crisis for those who are underinsured and those who have poor health insurance.

Rising health care costs affect families and American businesses. That we know. Health insurance premiums continue to outpace wages and inflation by a large margin. Between 1999 and 2008, premiums for employer-sponsored health benefits more than doubled. In that 9-year period, they increased 117 percent for families and individuals, and they increased 119 percent for employers. In each case, both for families and for employers, health insurance premiums doubled. Clearly, that is outpacing wages. I think the margin is 5 or 6 to 1, with premiums going up compared with wages for Americans.

Health care coverage for the average family now costs more than $13,000 a year. If the current trend continues, by 2019, the average family plan will cost more than $30,000. That is over a 10-year period—from $13,000 for the average family today to $30,000 that family will pay then.

Annual health spending growth is expected to continue to outpace average annual growth in the overall economy by 2 percent over the next 10 years. Health care spending is going up faster than the economy is growing. Add to that the insult, frankly, that this year alone not only would health spending increase 5 percent but GDP is expected to decrease two-tenths of a percent. So the gap is widening even further.

Americans spend $4.5 million in health care every minute of every day. Think of that. We, in America, spend about $4.5 million in health care every minute. That is $2.5 trillion a year. It is pretty hard for anybody to get his or hands around 1 trillion, but we are talking about $2.5 trillion that Americans spend on health care every year. Without reform, health care expenditures will increase to $4.4 trillion in just the next 9 years. That would be more than one-fifth of our economy. So health care is taking a bigger and bigger bite out of our economy. These are not just numbers.

Every 30 seconds, another American files for bankruptcy after a serious health problem. Think of that. Every year, about 1.5 million families lose their homes to foreclosure. Why? Because of unaffordable medical costs. In America, nobody should go bankrupt because they are sick. That is immoral.

These numbers tell us what we have to do. We have to do two things at once. First, our health care reform bill must provide health care for millions of Americans who today don't have health insurance. At the same time, we must reduce the rate of growth in health care spending. We must do both. To be successful, health care reform must rein in the cost of health care spending, and we must succeed. Millions of Americans depend on it.

Our plan is to reduce the Federal budget deficit by $130 billion over the next 10 years. Think of that. Many have said an economic recovery is through health care reform. We have to get control of our deficits. One way to do that is to get control of our health care spending. The bill before us now reduces the deficit by $130 billion over the next 10 years.

We need to go much further, clearly, but that reduction is sure a lot better than no reduction. At the same time, our plan would reduce the number of uninsured by 31 million. It would reduce the number of Americans who are uninsured and, at the same time, we will cut the Federal budget deficit. So we are doing both.

This bill reins in costs through changes in spending, reforms how providers deliver health care, and it changes the tax treatment of health care. Savings from this bill are estimated to total $106 billion in 2019. The CBO, Congressional Budget Office, which we all rely upon, expects that, in combination, it would increase 10 to 15 percent in the next decade; that is, savings growth, creative savings would grow by that much. That is what CBO says. That is a strong rate of savings. Those are all provisions to control the excessive growth in health care spending.

Our plan also reevaluates the tax treatment of health care. The current Tax Code includes numerous health care subsidies and incentives. The current tax treatment of certain health care expenses encourages people to spend more on health care than they need to. Why? Because there is no limit under the law, none; that is, all employer-provided health care benefits in America today are totally tax free. The more the benefits are, if a company wanted to provide not only a Cadillac policy but diamond and gold benefits—great benefits—it is not needed tax free. That tends to encourage excessive health care spending. These indirect health care costs totalled nearly $200 billion in 2008. That makes health care the largest Federal tax expenditure. Health care today is the largest Federal tax expenditure. Our laws changed about 60 years ago and moved in that direction, limiting subsidies for expensive insurance plans. Our bill limits incentives to overspend on health care. Our bill will help to slow the growth of health care spending.

Also, the CBO, in a letter they sent to the Congress yesterday, concluded there is about—this provision, the tax on so-called Cadillac plans, would result in a reduction in premiums those persons would otherwise pay—a reduction of, I think, about 5 to 7 percent. There has been a lot of concern in this body and beyond this body that that provision—the Cadillac plan provision—would raise costs for those folks who have those plans. The CBO concluded that the premiums for those kinds of plans would be reduced, I think, by 5 to 7 percent, rather than compared with current law. Several parts of our plan have the effect of reducing costs. I mentioned excess tax on high-cost insurance premiums, and that is a powerful one.

Our plan also caps flexible health savings accounts. It puts a cap on them so it is not unlimited. There is no cap, so the Tax Code tends to encourage excessive use of that provision.

Our plan would also conform with the definition of qualified medical expenses, the definition used by the itemized deduction for medical expenses. That, too, will help.

Reducing existing tax expenditures for health care costs is one of the best ways to slow the growth of health care spending. We could use our code, all the tools available. Our goal is not only to reduce costs but also improve quality. There are many provisions in the bill that accomplish that result, which would improve the quality of health care. A lot of people hear us talk about how costly health care in America is today. It is costly—too costly. There is a lot of waste. We are enacting provisions to cut out the waste.

I sense some Americans are thinking: Gee, maybe they are going to cut my Medicare benefits and reduce the quality back there in Washington, where they are worried about excessive health care costs. The exact opposite is the case. All the provisions in here enhance the quality of health care. The list is very long. One that immediately comes to mind is additional spending for primary care doctors. We all know they are underpaid in America. They are not taking Medicare patients, and they are going out of practice, especially in rural areas. This legislation adds 10 percent additional payment to primary care doctors in each of the next 5 years. That will help primary care doctors continue to practice.

I might mention that health information technology will also help improve quality. There are lots of demonstration projects and pilot projects to improve quality through bundling, care

organizations, reining in excessive readmission rates some hospitals have. We also have an outfit that compares how drugs work compared with other procedures. All that is going to help address quality.

I want folks to know that while we are reducing costs—that is true because costs have to be reduced—we are also increasing the quality of health care in America. There are many other incentives in this bill that I don't have time to mention tonight that accomplish that result.

In response to the excise tax on high-cost insurance, insurance companies will offer lower cost plans that fall under the thresholds. I think that is one of the reasons why premiums for those folks will fall. This will give consumers a lower cost alternative. These plans will still have the minimum level of benefits that will be required by law under the health care system.

Other changes to the tax treatment of health expenses will also help individuals make more cost-effective health care decisions. For example, our plan would require employers to tell their employees the value of their health insurance.

That reminds me two of the other provisions for increasing transparency so hospitals tell people what they charge for various procedures. I think the same should also apply to physicians so people have a better idea what they will pay or their insurance company will pay for these procedures.

As I said, our plan will require employers to tell their employees the value of their health insurance. This will help people to know how much they are actually spending.

I mentioned changes to flexible savings accounts, health savings accounts, and the definition of ''medical expenses.'' That will all help. It will also help to reduce costs by increasing competition. That has not been mentioned enough on the floor. This bill increases competition. We all know that in too many of our States, there are too few health insurance companies. In my State of Montana, Blue Cross/Blue Shield provides at least half the market. There is another company that is basically the rest. In some States, Blue Cross has the entire market. It is wrong. There is not enough competition. The exchange we are putting in place will encourage competition.

Do you know what else will encourage competition? That is all the insurance market reforms—all of them—telling companies they cannot deny coverage based on a preexisting condition, telling companies they cannot rate according to health status, dealing with rules in the States, which means when you go to buy insurances—especially as an individual—there will be competition based on price. Companies will basically offer many of the same products, but they cannot deny coverage for preexisting conditions. The effect of that will be prices should come down because there will be more competition when insurance companies base it on price.

Then there is the public option. That is another addition. That is in this bill. We don't know if it will or not. There are a lot of ways we help provide competition. It will help more competition, and transparency will help more competition. Competition is going to help bring down the costs.

Our bill will reduce costs also by reforming health care delivery system—I mentioned a lot of that already—including how we pay for doctors.

The bill is balanced. It finds savings in health care outlays—savings that are realistic, that make sense. It looks to reduce health tax expenditures. That is a fancy term for deductions. The bill reduces the Federal deficit in the first 10 years. That point needs to be driven home. This bill reduces the Federal deficit in the first 10 years and the subsequent 10 years will have a positive effect bringing down the budget deficit. In fact, CBO says the second 10 years of our plan will cut the deficit by a quarter of a percent of the gross domestic product. That is about $450 billion. That is nearly $½ trillion in deficit reduction.

We need to remember the cost of doing nothing is unacceptable. Basically, we have two choices in life: Try or do nothing. To ask the question is to answer it. Of course, we tried. Our Nation is in crisis. We have a health care crisis. It is a formidable task. It is exceedingly complex and difficult. But we have an obligation to try, at least try, to fix it.

If we try, then that poses a second question. If we try, we ask the question: Do we try our best or not? The answer is obvious: We try our best.

This legislation is a combination of a year or two of work by folks in the medical profession, of health care economists—Americans who are trying to find ways to get control of costs and improve quality. There are not a lot of new ideas here. They are ideas that have been percolating around for the last year or two. Some are in Massachusetts, some in other States. Some of it is going into integrated systems, such as Geisinger and Intermountain. The idea of bundling is already practiced by other institutions. There is not a lot that is terribly new.

We are pulling together, we are helping establish a policy in our country that comes up with a plan, a system in America that allows doctors and patients to have total free choice. They choose. We are helping doctors with the best evidence, the best information so they can focus on the patient care even more than they are now. We are cutting down the budget deficits. That is very important. And we are also helping Medicare by extending the solvency of Medicare another 5 years. These are things we pulled together and have to do.

I very much hope we can move on and get this legislation passed and work with the House and the President signs a bill that we can start finally putting together something of which we will be very proud. Our country does not have a health care system today. It is a free-for-all. It is a free-for-all for all kinds of groups. This is the first effort to get something together that works, giving doctors and hospitals and patients the choice they want to have and they should have. We are also bringing costs down and improving quality of health care.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, I appreciate the statement of the chairman of the Finance Committee. It is one of the most well-reasoned statements we have had. And rightfully so. No one worked harder on this matter than Senator BAUCUS. I appreciate his dedication, hard work, and the way he handles that Finance Committee.

Mr. President, I ask unanimous consent that the time until 2:15 p.m. tomorrow, Wednesday, December 2, be for debate with respect to the pending Mikulski amendment and the McCain motion to commit; that during this period, Senator REID or his designee be recognized to offer an amendment as a side-by-side to the McCain motion, and Senator MURKOWSKI or her designee be recognized to offer an amendment as a side-by-side to the Mikulski amendment; that the debate time be divided equally among the four principals listed above; that no other amendments or motions to commit be in order during the pendency of these amendments and motion; that at 2:15 p.m. tomorrow, the Senate proceed to vote in relation to the above noted in the following order; that prior to each vote there be 2 minutes of debate equally divided and controlled in the usual form, and after the first vote, the remaining votes in the sequence be 10 minutes in duration; further, that all amendments and motion provided under this consent require an affirmative 60-vote threshold for adoption, and that if those included in the agreement do not achieve that threshold, then the amendments and motion be withdrawn:

Mikulski amendment No. 2791; Murkowski amendment regarding preventive care; Reid or designee amendment regarding Medicare; McCain motion to commit regarding Medicare.

Mr. President, before I put this to a final consent request, let me say, we have been trying to get some votes today. It would be very good if we could move this bill along, have some votes tomorrow afternoon. We would have four votes. We have two amendments pending. This, in fact, would dispose of those amendments.

The PRESIDING OFFICER. Is there objection?

Mr. McCONNELL. Mr. President, reserving the right to object, and I will have to object, I wish to say to my good friend, the majority leader, I thought over the last couple of hours we would be able to get consent to have votes on the Mikulski and Murkowski amendments. But I had indicated to him, and I want to say publicly, that we have a number of speakers interested in speaking on the Medicare issue and the McCain motion. So I will not be able to lock in the McCain motion or the side-by-side that I gather under this consent request my good friend, the majority leader, may offer.

I would still like to be able to get the two votes earlier referred to—the Mikulski and Murkowski amendments—but regretfully I cannot even lock those in right now. But I want to do that as soon as possible so at least we can get those two votes at some point reasonably early in the day and turn back to debate on the McCain motion.

I might say, we want to vote on the McCain motion. We certainly have no desire to delay that vote. But we do have a number of people who want to speak to it. With that understanding and with the point I want to make to my good friend that I want to get the two amendments by MIKULSKI and MURKOWSKI locked in as soon as possible, I must object.

The PRESIDING OFFICER (Mr. UDALL of Colorado). Objection is heard.

The Senator from Alabama.

Mr. SESSIONS. Mr. President, I wish to share a few thoughts as we go forward on the health care debate and remind our colleagues what we have been hearing at the town meetings that most of us have been having around the country and what people are concerned about.

Part of it is they think we don't have a very good perspective on what is going on in America. They are not happy with us. They think we are losing our fiscal minds, that we are ignoring the fact that we are facing a soaring debt. We passed on top of the debt we already had an $800 billion stimulus package—$800 billion—the largest spending bill in the history of America on top of all our other baseline bills.

Our baseline appropriations bills, not even including the additions by the stimulus, are showing double-digit increases. These increases are far more than President Bush ever had, and he was criticized for reckless spending. He never had the kind of baseline spending increases that were passed a few months ago, a few weeks ago in some cases.

This year, as of September 30, we acknowledged and accounted for a $1.4 trillion budget deficit in 1 year—1 year, $1.4 trillion, September 30. The Republicans never had a deficit so large in 1 year. And in the next year, it is projected to be over $1 trillion, and continue to average $1 trillion each year over the next 10 years. In the 8th, 9th, and 10th years of the President's 10-year budget, the deficit goes up. It does not ever go down, it continues to go up. Therefore, we end up with a huge debt. That is according to our own Congressional Budget Office hired by the Congress—approved by the majority of our colleagues who are, of course, Democrats. They approve the Budget Director, and he tries to do a pretty good job of giving us honest numbers.

This is what the numbers show. In 2008, we had $5.8 trillion in debt in America since the founding of the Republic. By 2013, 5 years down the road, that will double to $11.8 trillion. And in 10 years, the 10-year budget the President submitted to us—I did not submit this budget, President Obama submitted it and it was passed by the Congress—increases that debt to $17.3 trillion, tripling the debt of America in 10 years. That is what the people are very concerned about, among other things.

What does all this pending mean also? It means government power, government reach, government domination, government takeover. People are concerned about it. They are asking: Are you not getting the message? What is the matter with you? That is what I am hearing. I think people have a right to be concerned.

One of the issues I have raised is the fact that the interest on the debt in 2009 was $170 billion for 1 year—that is for interest alone. By 2019, interest on the debt, according to CBO, in 1 year, will be $799 billion. That number is higher than the budget for defense. It is larger than any other program. We spend about $100 billion a year on education, and $40 or so billion on highways. But in 10 years, we will be spending $800 billion on interest alone. And how much of that is owned by foreign governments, many of whom are not our friends and not our allies?

So even the President has said this debt is unsustainable. The economists say it is unsustainable. Every politician I know of says that it is unsustainable. Yet we continue outrageous spending, and in the midst of this financial tempest, what do we now have before us? The promise of a $2.5 trillion new health care program—$2.5 trillion as it will cost when fully implemented.

The question I have heard asked of the President, and I have heard asked of the Democratic leadership and the Congress: But, Congressman, Senator, we don't have the money. What do you say about that?

They say: Oh, don't worry. We have this great new program that is going to help you in so many ways. We are going to spend a lot of money, true, but it is going to be deficit neutral. My goodness, it is not even going to be budget neutral, it is going to save us $130 billion in 10 years. Will you guys just relax? Don't worry about it. We are going to save $130 billion. Thank us. We are going to give you this program, save $130 billion, and you will get a lot more health care out here—still with 24 million uninsured, but we will have a lot of money spent to help you with your health insurance, they will say.

The President said he would not sign a bill into law that would add one single dime to the national debt. Well, people say: How are you going to do that? That sounds pretty good, if we can make that happen. How are we going to do it? Well, the answer is we are going to raid Medicare, we are going to raise taxes, and we are not going to pay the doctors who do our work. There will be $494 billion in tax increases, $465 billion in Medicare cuts—and Medicare is already on a glide path to insolvency by 2017—and a $250 billion shortfall for our physicians. Those are payments they have been promised and they thought they were going to get as part of this fix.

So I would just make the point that we can give everyone in America a new car if we just raised taxes and raided Medicare. That would be pretty easy, wouldn't it? Anything can count as deficit-neutral if you raise taxes high enough. So this is not a deficit-neutral program. Just because we raise taxes, does it have to be that we should prioritize first to use that money to start a new program? What about addressing the shortfall in highway funding that we are hearing so much about? What about the cost of our effort in Afghanistan? What about other expenses we have? What about saving Medicare, a program our seniors depend on? If we are going to raise taxes, why don't we use the money for that? Who says we have to raise taxes to start a new program?

Well, I suggest to you that based on the omission of doctors fix alone we don't have a $130 billion surplus in this bill. The fact that it is unpaid for, we have a $130 billion net deficit because the bill fails to pay $250 billion in doctor fees that I predict we will eventually pay, one way or another. The way we have done it in the past is we have just socked it to the debt. We have just paid the doctors, raised no revenue, and changed the law. We have just paid them and increased our debt that much each year.

So I say these are not sound numbers. I am telling you, the American people's instincts are right about this. We are not being responsible about how we manage the people's business, promising that this bill is going to be better for everybody. But let me ask for the average American who is doing the right thing, who is struggling and scraping together money to make insurance premiums each month, will that person pay less for their health

care? CBO basically says no. If that individual is not in an employer-provided group plan already, if he's among those who are already paying the highest costs for health care in the country, then he is one of the people who are going to pay as much as 10 to 13 percent more under this bill than he currently pays.

Will health care, as a percentage of our total economy, our total GDP, will it be reduced by this bill, therefore getting more health care at a better cost? Not according to the scoring we have seen. In fact, just the opposite is the case. If this bill passes, a larger percentage of our GDP will go to health care than before.

So I just raise concerns. This is a plan to create an entirely new government-dominated health care plan. This is a new program. How are we going to do it? By raiding Medicare, raising taxes, and not paying doctors, among a bunch of other flimflammery that is in the bill. We talk about this public option. Well, Senator BAUCUS says we may not have a public option. It is in the House bill, and it is in this bill that is on the Senate floor.

So we don't have the money for a monumental new health care program. We could do a lot of things to improve health care in America that could help contain the rising cost of health care, that could be done in a way that would not diminish the circumstances we are in today. What about Medicare? Do you remember when President Bush proposed fixing Social Security and many Senators—Democrats as well as Republicans—said: Well, President Bush, if you want to do something, why don't you fix Medicare? That is the one in the biggest trouble?

In truth, Medicare is sinking faster than Social Security. Medicare will decline by 2017 and go into deficit. We have a shortfall in Medicare now. What we should do is focus on Medicare every way that we can to create efficiencies and more productivity, contain growth and cost and extend that period of time before it goes in default. The last thing we should be doing is taking $465 billion from Medicare. It is only going to accelerate its decline. That is common sense.

Mr. President, I would just like to read a letter I received from one of my constituents—Mr. Bill Eberle in Huntsville, AL. He said:

> I strongly urge you to vote against the health care bill passed by the House. The worst part of this bill is that much of the cost will be paid by cuts to Medicare. I am 68 years old, and I have paid into Medicare for 40 years believing that it would cover much of my health care costs when I became 65. Now I am being told that the government has found people who need coverage more than I do, and they will cut the care for which I have paid for 40 years in order to cover people who have paid nothing. It is not the government's money. The money belongs to those of us who have paid into it for so many years and we are watching as it is being taken from us.

Well, I think that is a pretty fair statement of it. Medicare is heading to insolvency in 2017. We have had a number of proposals to try to help on that front. We haven't had much support from our colleagues on the other side of the aisle even for modest fixes.

I remember one bill that was going to reduce Medicare spending by $10 billion over 5 years, and you would have thought we were going to savage the whole program, although we were trying to make it more sustainable in the long run. It was a big mess. But now we are talking about $465 billion being taken from Medicare.

So, Mr. President, Medicare is a big problem. We need to work hard to bring it under control and honor our seniors who have been paying into this program and not drawing a dime from it on the promise that when they turned 65 they would start being able to draw on Medicare and it would take care of their health care needs in their senior years. That was a solemn commitment. Before we start some monumental new program, we need to make sure we are prepared to honor that commitment because they paid their money. They have paid their money. So if we raise taxes, why shouldn't we pay the Medicare bill first? If we raise taxes, why shouldn't we pay our doctors the money we owe them or some of the other priorities that we have in our country?

Mr. President, I feel strongly that the American people are sending us the right message. They are acting like good public-minded citizens would. They are seeing a reckless new spending program that they rightly anticipate will grow and grow and grow and expand far beyond all the projections we have today; that it will result in a government takeover of a whole large portion of our economy, and they have not been impressed that the government can run these kinds of things very effectively and they are not in favor of it. So they are rightly concerned, and that is why polling numbers show the American people don't favor this legislation.

I think their instincts are right. I think we should listen to them.

I appreciate the effort to improve health care in America. I support a number of reform provisions, some of which are in this bill, but others could be a part of this bill to make health care more affordable, more effective, and help people who are having a hard time financing their insurance premiums. But the truth is, the bill doesn't really reduce the premium cost for most people. Many people who are paying their bills today are not going to get any reduction. In fact, they may see an increase. So for these reasons, I oppose the legislation, I thank the Presiding Officer, and I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I believe Senator DURBIN may be coming to the floor. In the meantime, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. DURBIN. Mr. President, today, all day, we have been debating the health care reform bill, which has been a matter worked on in the Senate and the House for a solid year. I wish to salute the Senator from Wyoming, Mr. ENZI, who joined with several other Senators in, I understand, 61 separate meetings talking about this bill, in an effort which did not bear fruit as they hoped but was a bipartisan effort to come up with some solution to our health care situation in America. I hope we can still reach some bipartisan accommodation before this bill passes.

At this point in time, only one Republican Senator has voted for any form of Senate health care reform and that was Senator SNOWE in the Senate Finance Committee. We hope others will join us before this bill comes to final passage in the Senate, but that is the reality of the political situation.

The bill before us is over 2,000 pages long. Some have criticized its length. I defy anyone to write down, in 2,000 pages or less, a description of the current medical system in America. I think it would take many more pages to explain the complexity of the situation. But people across America understand a few basics.

Health insurance is reaching the point where it is not affordable. Families cannot afford to pay for it anymore, businesses cannot. Fewer people have coverage at their workplace, and many who go out into the open market cannot afford to pay the premiums. Today we have reached a point where our COBRA plan, which is health insurance for those who have lost their job—we provided a helping hand to many unemployed people across America—it expired today. It picked up two-thirds of the premiums. I ran into people who said, even with the two-thirds picked up by the Federal Government, I still cannot afford it. So it is understandable that health insurance is no longer affordable, and it is not getting any better.

In the last 10 years, health insurance premiums have gone up 131 percent. We estimate that, in the next 8 years, the cost of health insurance will double. In 8 years, it is anticipated that families will spend up to 45 percent of their income on health insurance. That is not sustainable.

So the starting point is to find ways to bring down cost. The Congressional Budget Office gave us a report yesterday and said we are on the right track. I can come up with other ideas which I think might be more helpful, but this is the art of the possible. I think we are moving toward a model which will start to bring down costs.

The second thing we do that is critically important is, we expand coverage so it reaches 94 percent of Americans. Currently, there are about 50 million Americans without health insurance. These are people who are unemployed, folks who work at businesses that cannot afford health insurance or folks out on their own who cannot afford to pay for their own health insurance. We now reach a point with this bill where 94 percent of Americans have coverage. That is a good thing.

We also do it in a fiscally responsible way because this bill, according to the Congressional Budget Office, which is the neutral referee in this battle, according to that office, we will save, in the first 10 years of this bill, $130 billion or more from our deficit. It will be the biggest deficit reduction of any bill considered by Congress. In the second 10 years, they estimate $650 billion in savings. To think we have $¾ trillion dollars in deficit reduction in this health care reform says to me, in the eyes of the Congressional Budget Office and most observers, it is a fiscally responsible bill.

There is a section of the bill which I think is critically important too. Many people with health insurance find out that when they need it the most it is not there. The health insurance companies will deny coverage, saying they are dealing with preexisting conditions that were not covered, there is a cap on the amount they will pay, your child is now age 24 and is not covered by your family plan. All these things are excuses for health insurance companies to say no. When they say no, they make more money. We start eliminating, one by one, these perverse incentives for health insurance companies to say no.

We give consumers and families across America a fighting chance, when they actually need health insurance, that it will be there. Two out of three people filing for bankruptcy today in America file because of medical bills. That reflects the reality, that we are each one accident or one diagnosis away from a medical bill that could wipe out our life savings. The sad reality is 74 percent of people filing for bankruptcy because of health care bills have health insurance, and it turns out it is not worth anything. When they needed it, it failed them.

We need to move to a point where the health insurance companies are held accountable, where when you pay premiums for a lifetime, the policy is there to cover you when you need it. That is what this is about.

We eliminate some of the most egregious discrimination in insurance premiums. The insurance industry is one of two businesses in America exempt from antitrust laws. So they literally get together, they collude and conspire when it comes to setting premium costs and allocating markets, and they can do it legally under the McCarran-Ferguson Act. Because of that, what they have done is to create discrimination against some people—women, certain age groups, people living in certain places—when it comes to premiums. We eliminate, by and large—not completely but by and large—this type of discrimination.

The other point that has been raised repeatedly is about Medicare. There is a pending amendment by Senator McCain. As a Democrat, we take great pride in Medicare. It was a Democratic President, Lyndon Baines Johnson, who led a Democratic Congress in passing it. Very few, if any, Republicans supported it. Over the years, it has been a program we have stood behind as a party because we believe it has provided so much well-being for 45 million American, now today, seniors.

This bill starts to move us toward a place where you can basically say there is a sound economic footing for Medicare in the future. If we don't do something today, in 7, 8, or 9 years, the Medicare Program could go bankrupt. If we wait 5 years to do it, imagine what we will have to do then.

This bill moves in the direction of making Medicare more sound by eliminating some of the waste that is currently in the program.

There was a time when our friends on the other side joined us in saying this program could be more efficient. But now the McCain amendment says basically there should be no cuts in Medicare, even if the cut is in wasteful spending. Senator McCain has a strong record on the Patients' Bill of Rights, but I think his amendment goes too far when it comes to Medicare. I hope that we can defeat it or that he will reconsider it.

The last point I want to make is that this debate will continue. We hope to move to amendments. If we get to a point where we are dealing with filibusters and slowdowns in an effort to run out the clock and make us all leave on Christmas Eve with the job not finished, many of us are going to get tired of that approach. If there are honest amendments offered in good faith, debated, and brought for a vote, that is what the Senate is about. But if we continue to delay indefinitely the consideration of these amendments, our patience will grow thin, and we will have to move this toward a point where the bill is honestly considered.

FURTHER CHANGES TO S. CON. RES. 13

Mr. CONRAD. Mr. President, section 301 of S. Con. Res. 13, the 2010 budget resolution, permits the chairman of the Senate Budget Committee to adjust the allocations of a committee or committees, aggregates, and other appropriate levels and limits in the resolution, and make adjustments to the pay-as-you-go scorecard, for legislation that is deficit-neutral over 11 years, reduces excess cost growth in health care spending, is fiscally responsible over the long term, and fulfills at least one of eight other conditions listed in the reserve fund.

I have already made one adjustment pursuant to section 301(a) on November 21, for S.A. 2786, the Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590. I now file further changes to S. Con. Res. 13 pursuant to section 301(a) for S.A. 2791, an amendment to clarify provisions relating to first dollar coverage for preventive services for women. I find that that in conjunction with S.A. 2786, this amendment also satisfies the conditions of the deficit-neutral reserve fund to transform and modernize American's health care system. Therefore, pursuant to section 301(a), I am further revising the aggregates in the 2010 budget resolution, as well as the allocation to the Senate Finance Committee.

I ask unanimous consent to have the following revisions to S. Con. Res. 13 printed in the Record.

There being no objection, the material was ordered to be printed in the Record, as follows:

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

[In billions of dollars]

Section 101	
(1)(A) Federal Revenues:	
FY 2009–	1,532.579
FY 2010–	1,623.888
FY 2011 –	1,944.811
FY 2012 –	2,145.815
FY 2013–	2,322.897
FY 2014	2,560.448
(1)(B) Change in Federal Revenues:	
FY 2009–	0.008
FY 2010–	−42.098
FY 2011 –	−143.820
FY 2012 –	−214.578
FY 2013–	−192.440
FY 2014	−73.210
(2) New Budget Authority:	
FY 2009	3,675.736
FY 2010–	2,910.707
FY 2011 –	2,842.766
FY 2012 –	2,829.808
FY 2013 –	2,983.128
FY 2014–	3,193.887
(3) Budget Outlays:	
FY 2009	3,358.952
FY 2010–	3,021.741
FY 2011 –	2,966.921
FY 2012 –	2,863.655
FY 2013 –	2,989.852
FY 2014 –	3,179.437

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

[In millions of dollars]

Current Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays	1,166,970
FY 2010 Budget Authority	1,249,836
FY 2010 Outlays	1,249,342
FY 2010–2014 Budget Authority	6,824,797
FY 2010–2014 Outlays	6,818,905
Adjustments:	
FY 2009 Budget Authority	0
FY 2009 Outlays	0
FY 2010 Budget Authority	0
FY 2010 Outlays	0
FY 2010–2014 Budget Authority	20
FY 2010–2014 Outlays	20
Revised Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays	1,166,970
FY 2010 Budget Authority	1,249,836
FY 2010 Outlays	1,249,342
FY 2010–2014 Budget Authority	6,824,817
FY 2010–2014 Outlays	6,818,925

MORNING BUSINESS

Mr. DURBIN. I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

CARTAGENA LANDMINE BAN TREATY REVIEW CONFERENCE

Mr. LEAHY. Mr. President, I want to speak briefly on a subject that many Members of Congress—Democrats and Republicans—have had an abiding interest in over the years.

Throughout this week, delegates from countries around the world will gather in Cartagena, Colombia, to participate in the Second Review Conference of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction.

The Cartagena review conference would have been the perfect opportunity for the Obama administration to announce its intention to join the 156 other nations that are parties to the treaty, including our coalition allies in Iraq and Afghanistan.

In fact, every member of NATO and every country in our hemisphere, except Cuba, is a party to the treaty. The United States is one of only 37 countries that have not joined, along with Russia and China.

By announcing our intention to join the treaty in Cartagena, this administration would have signaled to the rest of the world that the United States is finally showing the leadership that has been wanting on these indiscriminate weapons that maim and kill thousands of innocent people every year.

The U.S. military is the most powerful in the world. Yet we have seen how civilian casualties in Afghanistan have become one of the most urgent and pressing concerns of our military commanders, where bombs that missed their targets and other mistakes have turned the populace against us.

Despite this, one of the arguments the Pentagon makes for resisting calls to join the Mine Ban Treaty is to preserve its option to use landmines in Afghanistan, even though we have not used these indiscriminate weapons since 1991.

Since the Pentagon has never voluntarily given up any weapon, including poison gas, which President Woodrow Wilson renounced in 1925, perhaps this is to be expected.

But can anyone imagine the United States using landmines in Afghanistan, a country where more civilians have been killed or horribly injured from mines than any other in history?

A country which, like our coalition partners, is itself a party to the treaty?

A country where if we used mines and civilians were killed or injured the public outcry in Afghanistan and around the world would be deafening?

Can anyone imagine this President, who has been awarded the Nobel Peace Prize which only a few years ago was awarded to the International Campaign to Ban Landmines, having to publicly defend such a decision?

I wonder if anyone at the Pentagon has thought of the military and political implications of that.

Last Tuesday, the State Department spokesman announced that the administration had completed a review on its landmine policy and had decided to continue supporting the Bush administration's policy, which was, in key aspects, a retreat from the policy of President Clinton.

This was a surprise to me and others, as I had encouraged the administration to conduct such a review and then heard nothing for months. In fact, I had spoken personally with President Obama about it just a few weeks before.

I did not hesitate to express my disappointment, as did many others. Thereafter the State Department corrected itself, and announced that a "comprehensive review" is continuing and reaffirmed its earlier decision to send a team of observers to the Cartagena review conference this week.

It is unfortunate that the State Department spokesman misspoke. However, the administration's approach to this issue until this past weekend had been cursory, half-hearted, and deeply disappointing to those of us who expected a serious, thorough reexamination of this issue.

One hopes that an administration that portrays itself as a global leader on issues of humanitarian law and arms control recognizes this is an opportunity.

A serious review should begin by examining the extensive history of the negotiations that led to the treaty, and the technical issues that were debated and addressed.

It should involve consulting our allies, like Great Britain and Canada, whose militaries have operated in accordance with the treaty's obligations for a decade, including with our forces in Iraq and Afghanistan, to determine what their experience has been.

It should involve consulting with the Pentagon, of course, but also with retired senior U.S. military officers and diplomats, many of whom have expressed support for the treaty.

It should involve consulting with Members of Congress, and with the humanitarian and arms control communities who have extensive expertise on all aspects of the treaty and its implementation.

Unfortunately, none of these obvious steps was taken. Instead, an opaque process involving limited consultations with the Pentagon simply resulted in a regurgitation of the Bush administration's talking points.

That is not what we expected of this administration, and I welcome the announcement that a comprehensive review will be carried out.

The United States has not exported anti-personnel mines since 1992.

We have not produced anti-personnel mines since 1997.

And the United States has not used anti-personnel mines since 1991—when many of them malfunctioned.

In effect, we have been in de facto compliance with the treaty for 18 years, with the exception of not yet destroying our stockpile of mines.

And in the interim we have invested millions of dollars to develop alternatives to indiscriminate landmines, to replace them with munitions that include man-in-the-loop technology, so they are not victim-activated.

Indiscriminate landmines, whether persistent mines or those that are designed to self-destruct or deactivate, are nothing more than booby traps. They cannot distinguish between an enemy combatant, a U.S. soldier, a young child, or a woman out collecting firewood. They do not belong in the arsenal of any modern military.

I have supported President Obama and I look forward to supporting him on many issues in the future. I believe this can be one of those issues.

I am confident that after a proper review is conducted, and the President considers the equities, he will conclude, as our allies have, that the humanitarian benefits of banning anti-personnel landmines far exceed their limited military utility. Ultimately, this is a decision President Obama will need to make himself, as President Wilson did almost a century ago.

I want to commend the Government of Colombia, a country where landmines have taken and continue to take a terrible toll on civilians, for hosting

the review conference. Colombia joined the treaty years ago.

I also appreciate that the State Department has sent a team of observers to Cartagena. I hope they use this opportunity not only to highlight the hundreds of millions of dollars the U.S. has provided for humanitarian demining and assistance for mine victims over the years, but also to learn from the delegations of countries that are parties to the treaty.

I want to pay tribute to the leadership of Canada, and my friend Lloyd Axworthy, who as Foreign Minister showed the extraordinary vision and leadership that culminated in the Mine Ban Treaty, and to the other nations that have joined since then.

The treaty has already exceeded the expectations of even its strongest advocates. The number of mine casualties has decreased significantly. The number of countries producing and exporting mines has plummeted.

And at the same time, none of the arguments of the treaty's naysayers have come to pass.

The United States is the most powerful nation on Earth. We don't need these indiscriminate weapons any more than our allies who have abandoned them.

We have not used landmines for many years. We should be leading this effort, not sitting on the sidelines.

It is time for the United States to join the right side of history.

ANTI-KLEPTOCRACY

Mr. LEAHY. Mr. President, on November 16, 2009, the New York Times published an article entitled ''A U.S. Visa, Shouts of Corruption, Barrels of Oil,'' that describes corruption in Equatorial Guinea, which is a major oil producing country. Specifically, the article highlights the comings and goings of Teodoro Obiang, son of Equatorial Guinea's President, who is also the country's agriculture minister.

Mr. Obiang has been a regular traveler to southern California, where he owns an estate reportedly worth some $35 million. He also, according to the article, owns a private jet and various luxury automobiles.

How, one might ask, did he acquire such extraordinary wealth, in a country where many children die before the age of 5? Perhaps he is an exceptionally talented businessman, as Equatorial Guinea's Washington lobbyists have suggested, who, when he isn't running the agriculture ministry on a modest government salary, is earning huge profits that can be legitimately explained. It is fair to say that at least, and probably more, likely is that he has used his family connections to steer a portion of the country's oil revenues into his own pockets.

Mr. Obiang's case is not unique. To the contrary, it is a common practice in countries where the extraction of natural resources—whether oil, gas, timber, or minerals—is the primary source of income. From Angola to Kazakhstan, government officials and their families have abused their power and influence to enrich themselves by siphoning off a portion of the proceeds of the revenues from concessions and leases for the extraction of natural resources, and from the sale of the crude oil or raw timber or minerals.

Billions of dollars that could otherwise have been used to meet the basic needs of the people in these countries—health and education—have instead gone into foreign bank accounts, including in the United States. The beneficiaries have enjoyed lives of comfort and privilege, while their people live in squalor.

The land where oil is drilled, or where gold, cobalt, columbite-tantalite, and other valuable minerals are mined, or where the forest is cut down, is often left in ruins. Soil and water poisoned by oil spills and other toxic chemicals, and drought from deforestation, is left for those who have nowhere else to live, and for future generations.

It is often also the revenues from the exploitation of natural resources that fund the purchase of weapons that fuel civil wars over control of those same resources in these counties. The protracted conflict in the eastern region of the Democratic Republic of the Congo, where thousands of civilians, and particularly women and girls, have been brutalized, is a prime example.

Those who have protested this type of corruption, environmental destruction and waste, and exposed the theft by government officials of income from natural resources that is rightfully owed to the people of these countries, have often been harassed, arrested, tortured, and even killed. I remember Ken Saro-Wiwa, who courageously led peaceful protests against the environmental devastation caused by oil spills and gas flaring in Nigeria's delta region. He was ultimately hanged, despite last minute appeals from people around the world, by the corrupt and cruel dictator Sani Abacha. That was in 1995, but the corruption, waste, and abuses continue today in countries where too often the rule of law does not apply to those in power.

In 2004, President Bush issued Presidential Proclamation 7750, which suspended entry to the U.S. of current and former public officials whose corrupt acts have or had serious adverse effects on the national interests of the United States.

In 2007, I included a similar but more targeted provision in the State and Foreign Operations Appropriations Act, currently section 7086 of Public Law 111–8, which requires the Secretary of State to deny admission to the United States to any foreign government official and their immediate family members who the Secretary has credible evidence have been involved in corruption related to the extraction of natural resources.

The purpose of the law is clear: If you, as a government official or a member of your immediate family, are involved in the corrupt exploitation of natural resources, you are not welcome in the United States.

Unfortunately, despite, I believe, well-intentioned people at the State Department who support the goals of the law, it has not been applied as vigorously as it could and should be.

They do not have the resources to conduct their own investigations, so they rely on other agencies like the Departments of Justice and Homeland Security, which do not always share information and have their own standards of proof. The fact that someone like Mr. Obiang is traveling freely to and from the United States, I believe makes a mockery of the law.

This is not a partisan issue. Senators of both parties have spoken out about the corrosive effects of corruption. We saw the effects of it in our own assistance program in Iraq, where no-bid contracts and lax oversight resulted in enormous fraud and waste of taxpayer funds, and we are witnessing the effects of rampant corruption in the Afghan Government.

It is overdue for the State Department to apply section 7086 with the vigor that Congress intended. It is about promoting good governance, the rule of law, the sustainable use of natural resources, and stopping the squandering of revenues from the extraction of those resources that are urgently needed to help reduce poverty. It is time to apply the law in a manner that resonates far and wide in support of each of those goals.

ELIMINATING THE TERROR GAP

Mr. LEVIN. Mr. President, in the aftermath of the shootings at Fort Hood, TX, law enforcement officials and policymakers continue to piece together the string of events that preceded this tragedy. Although investigations of the shootings are in the early stages, a number of troubling details have already come to light. In December 2008, Major Hasan became the subject of a Joint Terrorism Task Force, JTTF, investigation after intelligence agencies intercepted his e-mail communication with a known radical cleric, Anwar al-Awlaki. After reviewing the e-mails and concluding that Major Hasan was not engaged in terrorist activities, the JTTF investigator and supervisor did not share the information regarding Major Hasan, and he was not placed on a terrorist watch list. While the lack of information sharing between the JTTF and other agencies is problematic, it is just as alarming to

see that the Federal Government would have been unable to prohibit Major Hasan's firearm purchase even if he had been flagged on a terrorist watch list. Again, even if a gun background check had revealed that Major Hasan was on a terrorist watch list, nothing in current law could have prohibited the firearm transfer unless he fell into another disqualifying category. In other words, being on a terrorist watch list does not prevent someone from purchasing a gun.

This ''terror gap'' in Federal law that prevents the Federal Government from stopping the sale of firearms or explosives to a known or suspected terrorist must be eliminated. To close this loophole, I support S.1317, the Denying Firearms and Explosives to Dangerous Terrorists Act, which was introduced by Senator FRANK LAUTENBERG, D-NJ. I am a cosponsor of this common-sense legislation because it would authorize the Attorney General to deny the transfer of a firearm when an FBI background check reveals that the prospective purchaser is a known or suspected terrorist and the Attorney General has a reasonable belief that the purchaser may use the firearm in connection with terrorism. To protect the rights of American citizens, this bill would direct the Attorney General to issue guidelines describing when the authority to deny gun purchases could be used, and it would protect the private information contained in the terrorist watch lists. This legislation also includes due-process safeguards that would allow any individual whose firearms or explosives license application has been denied to bring legal action to challenge the denial.

I have long supported sensible gun safety laws and strict enforcement of those laws to help stem the tide of crimes committed with firearms. I believe Congress can and should pursue legislative solutions to prevent gun violence, and that includes passing legislation that eliminates the ''terror gap.''

BUILD AMERICA BONDS

Mr. WYDEN. Mr. President, I rise to talk about a great success story that not a lot of people have heard about. It is the story of a program that's helping create jobs and solve a lot of problems at the same time. It is the story of Build America Bonds.

These bonds came about from a piece of legislation I introduced last year as a way to shore up our Nation's crumbling infrastructure, and, at the same time, put people back to work.

In my home State of Oregon, infrastructure projects have proven to be an economic engine. People get back to work building a bridge, for example, and all the businesses near the construction site get more activity from the people who need their services. Then, once the project is finished, private investment follows that public investment. That bridge makes it easier for folks to get to work or take their kids to school, and communities grow.

Now, when I initially proposed Build America Bonds, I thought they would sell $10 billion worth, but the most recent report on the bonds has shown they are selling like hotcakes. Build America Bonds dollars are flowing into local communities, creating jobs and helping to strengthen America's infrastructure.

To date more than $50 billion worth of these innovative bonds have funded hundreds of projects in 38 States: fixing our roads and bridges, rebuilding our schools, and upgrading our utilities.

For example, in Oregon's Dayton School District they have already used Build America Bonds to employ up to 150 people building and remodeling classrooms. By using Build America Bonds, the school district saved an estimated $1.2 million in interest costs.

The city of De Pere, WI, was able to use Build America Bonds and lower its financing cost by 2.3 percent, allowing it to move forward with plans to upgrade roads, sewers, and buildings. The city's finance director, Joseph G. Zegers, told Business Week magazine that without Build America Bonds, ''some projects might not be done,'' and ''There would be less employment.''

Recently, the CBO highlighted other benefits from Build America Bonds. In an October report, the CBO found that tax-credit bonds, like Build America Bonds, can be more cost-effective than tax-exempt bonds. The report also concluded that because these bonds are more attractive to investors they are more efficient at raising capital.

Not only are these funds being raised efficiently, they are being put to work quickly. Due to Federal spending guidelines, all bond funds must be spent within 2 years of the bond being issued. This means that money is not only flowing into projects, it is being spent in the short term, funding projects and putting people back to work with little delay.

Before these bonds started being issued, the market for normal municipal bonds was frozen. It was very hard to sell municipal bonds, but that didn't mean the need for financing infrastructure wasn't still there.

Build America Bonds have changed that.

These bonds provide the option of a tax credit to investors or Federal subsidy to issuers of 35 percent of the interest earned over the life of the bond. This has proven to be a strong incentive and opened up new markets for State and local governments, giving financiers a new and profitable opportunity to invest in America.

Build America Bonds have also gained support from the private sector, including the Chamber of Commerce and the National Association of Manufacturers.

While this program has given local governments a powerful new tool in fighting the recession, time is running out. These bonds can only be issued until the end of 2010 and I urge communities to take advantage of this landmark program. Although there is no limit on the number or amount of bonds that can be issued, the clock is ticking and the end of 2010 will be here before you know it.

I am not surprised that Build America Bonds are reinventing the municipal bond market. They are a good deal for investors and our communities. They have freed up financing for badly needed infrastructure construction, and ensured long-term economic growth.

I would also like to highlight the Recovery Zone Build America Bonds program. Recovery Zone Bonds are much like Build America Bonds but are designed to help communities most adversely affected by the recent recession.

These highly targeted bonds offer an even more generous subsidy of 45 percent of the interest to investors. Treasury allocates these bonds based on employment declines in 2008. So, the harder an area is hit, the more Recovery Zone Bonds it can issue, creating jobs where they are needed most.

In some cases, these bonds will make the difference between whether these projects come to fruition or not. In other cases, they will lower the cost of projects and allow the community to reinvest those savings in other projects.

As with Build America Bonds, Recovery Zone Bonds will only be issued until the end of 2010. That is why I am encouraging communities facing high unemployment to take advantage of the billions of dollars available in Recovery Zone Bonds.

I also encourage my colleagues in Congress to begin working now to continue the success of Build America Bonds. As Congress struggles to find funding for a new transportation bill, innovative approaches like Build America Bonds should be part of the solution.

The Build America and Recovery Zone Bond programs are working. They are providing much needed jobs to folks in our communities while strengthening essential infrastructure. They have given investors a profitable opportunity to invest in America. They are giving our children better schools, building energy efficient power grids, providing cleaner water and better roads. In short, they work.

Build America Bonds are examples of how Congress can innovate creative solutions to rebuild our country and our economy. I urge my colleagues and our constituents to use them.

ANNE SLAUGHTER ANDREW

Mr. BAYH. Mr. President, I thank you very much for allowing me to express my support for Anne Slaughter Andrew.

The strong relationship between the United States and Costa Rica is one of mutual respect, shared democratic principles, and a commitment to protecting Costa Rica's abundant natural resources. Costa Rica is a worldwide leader in green energy and sustainability—it currently generates more than 90 percent of its electricity from sustainable sources and has committed to being carbon neutral by 2021.

In recommending my fellow Hoosier, Ms. Andrew, I have the benefit of being able to speak from personal experience. When I was Governor of Indiana, I appointed her to the Indiana Natural Resources Council, an organization which engages in the conservation of Indiana's natural resources and park lands. That is one of many positions in Ms. Andrew's professional life that demonstrates her strong commitment to environmental conservation and clean energy initiatives.

Although Costa Rica covers only 0.01 percent of the Earth's landmass, it is home to approximately 5 percent of the Earth's biodiversity. The United States is committed to protecting this biodiversity through conservation efforts that contribute to the stabilization of Costa Rica's economy.

Ms. Andrew's leadership and involvement with The Nature Conservatory, TNC, in multiple capacities, including as a member of the President's Advisory Council, has spanned a decade and is a strong testament to her unwavering commitment to the preservation of Costa Rica's—and our planet's—natural resources.

Her most recent endeavor as principal of New Energy Nexus has placed her at the cutting edge of the clean energy economy. These combined experiences render her uniquely qualified to represent the United States as it looks to strengthen partnerships with Costa Rica in the field of green energy initiatives. Her service also includes founding and directing Anson Group LLC, a biotech consulting company that she co-led towards sustained growth and national recognition.

The post of Ambassador to Costa Rica carries with it the significant responsibility of managing the diplomatic personnel in country and overseeing the safety of the estimated 1 million Americans who visit Costa Rica each year and the thousands of Americans who live there full time. In her career, Ms. Andrew has demonstrated herself to be a skilled manager who is highly capable of undertaking this responsibility.

I have confidence that Ms. Andrew, if confirmed, will uphold our country's strong relations with Costa Rica.

WORLD AIDS AWARENESS DAY

Mr. BURRIS. Mr. President, today is World AIDS Awareness Day. We dedicate this day to educating Americans and citizens all over the world about the HIV/AIDS epidemic, and promoting awareness and prevention of this disease.

Despite advances in medical technology and treatment options, racial and ethnic minorities and young gay men continue to suffer in disproportionate numbers. African Americans account for 12 percent of the U.S. population, but make up almost half of the 1 million Americans living with HIV/AIDS. Black youth and young adults between the ages of 13 to 24 make up 55 percent of all reported HIV infections. Also, Black women account for almost 70 percent of all new female AIDS cases. It is also the main cause of death for both Black men and women between the ages of 25 to 44.

We continue to make considerable progress in caring for citizens with HIV/AIDS and in raising awareness, but today I call upon my colleagues to join me in demanding that we do even more. I was proud to support the expansion of the Ryan White HIV/AIDS Treatment Program in the Senate, a bill which President Obama recently signed into law. This important piece of legislation makes investments in care and treatment services, and also funds prevention and outreach programs—programs that will be improved and augmented by the sweeping health care reforms currently under consideration by the Senate. As we move forward, I will continue to work to promote awareness, education, and prevention of HIV/AIDS, and will be an ardent supporter of programs that care for those afflicted by this disease.

World AIDS Awareness Day is a chance for citizens of the United States and people all over the world to get proactively involved by getting educated, and by promoting treatment and testing of HIV/AIDS. Together, we can beat this disease.

EXECUTIVE REPORT OF COMMITTEE—TREATY

The following executive report of committee was submitted:

By Mr. KERRY, from the Committee on Foreign Relations:

[Treaty Doc. 111–4: Protocol Amending Tax Convention with France with 1 declaration and 1 condition (Ex. Rept. 111–1)]

The text of the committee-recommended resolution of advice and consent to ratification is as follows:

VIII. RESOLUTION OF ADVICE AND CONSENT TO RATIFICATION

Resolved (two-thirds of the Senators present concurring therein),

Section 1. Senate Advice and Consent subject to a declaration and a condition.

The Senate advises and consents to the ratification of the Protocol Amending the Convention between the Government of the United States of America and the Government of the French Republic for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital, signed at Paris on August 31, 1994, as Amended by the Protocol signed on December 8, 2004, signed on January 13, 2009, at Paris, together with a related Memorandum of Understanding, signed January 13, 2009 (the "Protocol") (Treaty Doc. 111–4), subject to the declaration of section 2 and the condition of section 3.

Section 2. Declaration. The advice and consent of the Senate under section 1 is subject to the following declaration:

The Protocol is self-executing.

Section 3. Condition. The advice and consent of the Senate under section 1 is subject to the following condition:

1. Not later than two years from the date on which this Protocol enters into force and prior to the first arbitration conducted pursuant to the binding arbitration mechanism provided for in this Protocol, the Secretary of Treasury shall transmit the text of the rules of procedure applicable to arbitration panels, including conflict of interest rules to be applied to members of the arbitration panel, to the committees on Finance and Foreign Relations of the Senate and the Joint Committee on Taxation.

2. Sixty days after a determination has been reached by an arbitration panel in the tenth arbitration proceeding conducted pursuant to this Protocol, the 2006 Protocol Amending the Convention between the United States of America and the Federal Republic of Germany for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital and to Certain Other Taxes (the "2006 German Protocol") (Treaty Doc. 109–20), the Convention between the Government of the United States of America and the Government of the Kingdom of Belgium for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income, and accompanying protocol (the "Belgium Convention") (Treaty Doc. 110–3), or the Protocol Amending the Convention between the United States of America and Canada with Respect to Taxes on Income and on Capital (the "2007 Canada Protocol") (Treaty Doc. 110–15), the Secretary of Treasury shall prepare and submit a detailed report to the Joint Committee on Taxation and the Committee on Finance of the Senate, subject to law relating to taxpayer confidentiality, regarding the operation and application of the arbitration mechanism contained in the aforementioned treaties. The report shall include the following information:

I. The aggregate number, for each treaty, of cases pending on the respective dates of entry into force of this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, along with the following additional information regarding these cases:

a. The number of such cases by treaty article(s) at issue;

b. The number of such cases that have been resolved by the competent authorities through a mutual agreement as of the date of the report; and

c. The number of such cases for which arbitration proceedings have commenced as of the date of the report.

II. A list of every case presented to the competent authorities after the entry into force of this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007

Canada Protocol, with the following information regarding each case:

a. The commencement date of the case for purposes of determining when arbitration is available;

b. Whether the adjustment triggering the case, if any, was made by the United States or the relevant treaty partner;

c. Which treaty the case relates to;

d. The treaty article(s) at issue in the case;

e. The date the case was resolved by the competent authorities through a mutual agreement, if so resolved;

f. The date on which an arbitration proceeding commenced, if an arbitration proceeding commenced; and

g. The date on which a determination was reached by the arbitration panel, if a determination was reached, and an indication as to whether the panel found in favor of the United States or the relevant treaty partner.

III. With respect to each dispute submitted to arbitration and for which a determination was reached by the arbitration panel pursuant to this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, the following information shall be included:

a. In the case of a dispute submitted under this Protocol, an indication as to whether the presenter of the case to the competent authority of a Contracting State submitted a Position Paper for consideration by the arbitration panel;

b. An indication as to whether the determination of the arbitration panel was accepted by each concerned person;

c. The amount of income, expense, or taxation at issue in the case as determined by reference to the filings that were sufficient to set the commencement date of the case for purposes of determining when arbitration is available; and

d. The proposed resolutions (income, expense, or taxation) submitted by each competent authority to the arbitration panel.

3. The Secretary of Treasury shall, in addition, prepare and submit the detailed report described in paragraph (2) on March 1 of the year following the year in which the first report is submitted to the Joint Committee on Taxation and the Committee on Finance of the Senate, and on an annual basis thereafter for a period of five years. In each such report, disputes that were resolved, either by a mutual agreement between the relevant competent authorities or by a determination of an arbitration panel, and noted as such in prior reports may be omitted.

4. The reporting requirements referred to in paragraphs (2) and (3) supersede the reporting requirements contained in paragraphs (2) and (3) of Section 3 of the resolution of advice and consent to the 2007 Canada Protocol, approved by the Senate on September 23, 2008.

EXECUTIVE REPORT OF COMMITTEE

The following executive report of a nomination was submitted:

By Mr. LIEBERMAN for the Committee on Homeland Security and Governmental Affairs.

*Alan C. Kessler, of Pennsylvania, to be a Governor of the United States Postal Service for a term expiring December 8, 2015.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. LAUTENBERG (for himself, Mr. SCHUMER, Mr. LEVIN, Mr. REED, Mrs. FEINSTEIN, and Mr. WHITEHOUSE):

S. 2820. A bill to prevent the destruction of terrorist and criminal national instant criminal background check system records; to the Committee on the Judiciary.

By Mr. BROWN (for himself, Mr. FEINGOLD, Mr. WHITEHOUSE, Mr. DORGAN, Mr. CASEY, Mr. SANDERS, and Mr. MERKLEY):

S. 2821. A bill to require a review of existing trade agreements and renegotiation of existing trade agreements based on the review, to establish terms for future trade agreements, to express the sense of the Congress that the role of Congress in making trade policy should be strengthened, and for other purposes; to the Committee on Finance.

By Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2822. A bill to amend the Internal Revenue Code of 1986 to provide additional tax relief for small businesses, and for other purposes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mrs. BOXER:

S. Res. 365. A resolution recognizing the 50th anniversary of the signing of the Antarctic Treaty; considered and agreed to.

ADDITIONAL COSPONSORS

S. 229

At the request of Mrs. BOXER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 229, a bill to empower women in Afghanistan, and for other purposes.

S. 584

At the request of Mr. HARKIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 584, a bill to ensure that all users of the transportation system, including pedestrians, bicyclists, transit users, children, older individuals, and individuals with disabilities, are able to travel safely and conveniently on and across federally funded streets and highways.

S. 970

At the request of Ms. LANDRIEU, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 970, a bill to promote and enhance the operation of local building code enforcement administration across the country by establishing a competitive Federal matching grant program.

S. 1067

At the request of Mr. FEINGOLD, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1090

At the request of Mr. WYDEN, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 1090, a bill to amend the Internal Revenue Code of 1986 to provide tax credit parity for electricity produced from renewable resources.

S. 1156

At the request of Mr. HARKIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1156, a bill to amend the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users to reauthorize and improve the safe routes to school program.

S. 1317

At the request of Mr. LAUTENBERG, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1317, a bill to increase public safety by permitting the Attorney General to deny the transfer of firearms or the issuance of firearms and explosives licenses to known or suspected dangerous terrorists.

S. 1583

At the request of Mr. ROCKEFELLER, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1583, a bill to amend the Internal Revenue Code of 1986 to extend the new markets tax credit through 2014, and for other purposes.

S. 1606

At the request of Mr. WHITEHOUSE, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 1606, a bill to require foreign manufacturers of products imported into the United States to establish registered agents in the United States who are authorized to accept service of process against such manufacturers, and for other purposes.

S. 1660

At the request of Ms. KLOBUCHAR, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1660, a bill to amend the Toxic Substances Control Act to reduce the emissions of formaldehyde from composite wood products, and for other purposes.

S. 1672

At the request of Mr. REED, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1672, a bill to reauthorize the National Oilheat Research Alliance Act of 2000.

S. 1743

At the request of Mrs. LINCOLN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 1743, a bill to amend the Internal Revenue Code of 1986 to expand the rehabilitation credit, and for other purposes.

S. 1756

At the request of Mr. HARKIN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 1756, a bill to amend the Age Discrimination in Employment Act of 1967 to clarify the appropriate standard of proof.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1966

At the request of Mr. DODD, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1966, a bill to provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes.

S. 2607

At the request of Mr. REID, the name of the Senator from Idaho (Mr. RISCH) was added as a cosponsor of S. 2607, a bill to amend the Department of the Interior, Environment, and Related Agencies Appropriations Act, 2010 to repeal a provision of that Act relating to geothermal energy receipts.

S. 2730

At the request of Mr. BROWN, the names of the Senator from Rhode Island (Mr. REED), the Senator from Minnesota (Ms. KLOBUCHAR), the Senator from Connecticut (Mr. DODD) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2794

At the request of Mr. SCHUMER, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 2794, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat.

S. 2816

At the request of Mr. BUNNING, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 2816, a bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs and to allow the adoption credit to be claimed in the year expenses are incurred, regardless of when the adoption becomes final.

S. RES. 356

At the request of Mr. CARDIN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. Res. 356, a resolution calling upon the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay.

AMENDMENT NO. 2791

At the request of Ms. MIKULSKI, the names of the Senator from Washington (Mrs. MURRAY), the Senator from Maryland (Mr. CARDIN), the Senator from Maine (Ms. SNOWE), the Senator from Massachusetts (Mr. KERRY), the Senator from Connecticut (Mr. DODD), the Senator from Michigan (Ms. STABENOW), the Senator from New York (Mr. SCHUMER), the Senator from Ohio (Mr. BROWN), the Senator from Vermont (Mr. LEAHY) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of amendment No. 2791 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. SNOWE (for herself and Ms. LANDRIEU):

S. 2822. A bill to amend the Internal Revenue Code of 1986 to provide additional tax relief for small businesses, and for other purposes; to the Committee on Finance.

Ms. SNOWE. Mr. President, I rise today, along with Senator LANDRIEU, to introduce legislation to make permanent a critical tax incentive currently being utilized by our Nation's small businesses, which will enable them to continue to make vital investments in new plant and equipment. The American Recovery and Reinvestment Act, ARRA, included a crucial provision that extended enhanced small business expensing at $250,000 through 2009. My legislation would make the incentive permanent and, in turn, provide valuable assistance to America's 26 million small firms that represent over 99.7 percent of all employers.

I have long championed enhanced section 179 expensing, which allows small businesses to elect to deduct the cost of qualifying property in the year it was purchased, rather than to recover such costs through depreciation deductions over a number of years. In 2007, I introduced legislation to make permanent section 179 expensing, and in 2008, Congress, as part of the Economic Stimulus Act of 2008, allowed small businesses in Maine and across the Nation to expense up to $250,000 of their investments, including the purchase of essential new equipment.

Congress further reinforced the necessity of this legislation by extending the provision through 2009 in the ARRA. Unfortunately, the ARRA extension was written to last just 1 year, as a result, in 2010, absent additional action, small firms will be able to expense just $134,000 of new capital investment. The provision will be further reduced to $25,000 in 2011, and instead of being able to write off more of their equipment purchases immediately, firms will have to recover their costs over 5, 7, or more years.

Small businesses continue to struggle as a result of the current recession, and many are having trouble finding capital to make job-creating new investments. We simply cannot allow this pattern to continue, Accordingly, my bill would allow small businesses to continue expensing up to $250,000 of new investment permanently. By permitting small businesses to write off more of their equipment purchases today, they will retain substantial savings instead of waiting 5, 7, or more years to recover their costs through depreciation. Additionally, this will save them the vital time that is required to comply with complex and confusing depreciation rules. Accordingly, this provision encourages stable investment in new equipment that will contribute to continued productivity and growth in the business community.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2822

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

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE; TABLE OF CONTENTS.

This Act may be cited as the ''Small Business Expensing Permanency Act''.

SEC. 2. PERMANENT INCREASE IN LIMITATIONS ON EXPENSING OF CERTAIN DEPRECIABLE BUSINESS ASSETS.

(a) IN GENERAL.—Subsection (b) of section 179 of the Internal Revenue Code of 1986 (relating to limitations) is amended—

(1) by striking ''$25,000'' and all that follows in paragraph (1) and inserting ''$250,000.'',

(2) by striking''$200,000'' and all that follows in paragraph (2) and inserting ''$800,000'',

(3) by striking ''after 2007 and before 2011, the $120,000 and $500,000'' in paragraph (5)(A) and inserting ''after 2009, the $250,000 and the $800,000'',

(4) by striking ''2006'' in paragraph (5)(A)(ii) and inserting ''2008'', and

(5) by striking paragraph (7).

(b) PERMANENT EXPENSING OF COMPUTER SOFTWARE.—Section 179(d)(1)(A)(ii) of the Internal Revenue Code of 1986 (defining section

179 property) is amended by striking ''and before 2011''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 365—RECOGNIZING THE 50TH ANNIVERSARY OF THE SIGNING OF THE ANTARCTIC TREATY

Mr. DURBIN submitted the following resolution; which was considered and agreed to:

S. RES. 365

Whereas the Antarctic Treaty was signed by 12 nations in Washington, DC, on December 1, 1959, ''with the interests of science and the progress of all mankind'';

Whereas the Antarctic Treaty was established to continue and develop international ''cooperation on the basis of freedom of scientific investigation in Antarctica as applied during the International Geophysical Year'';

Whereas the Antarctic Treaty came into force on June 23, 1961, after its unanimous ratification by the seven countries (Argentina, Australia, Chile, France, New Zealand, Norway, and the United Kingdom) with territorial claims in the region and five other countries (Belgium, Japan, South Africa, the Soviet Union, and the United States), which had collaborated in Antarctic research activities during the International Geophysical Year from July 1, 1957, through December 31, 1958;

Whereas the Antarctic Treaty now has 47 nations as signatories that together represent nearly 90 percent of humanity;

Whereas Article IV of the Antarctic Treaty states that ''no acts or activities taking place while the present Treaty is in force shall constitute a basis for asserting, supporting or denying a claim to territorial sovereignty in Antarctica'';

Whereas the 14 articles of the Antarctic Treaty have provided a lasting foundation for maintaining the region south of 60 degrees south latitude, nearly 10 percent of the Earth's surface, ''for peaceful purposes only'';

Whereas the Antarctic Treaty prohibits ''any measure of a military nature'';

Whereas the Antarctic Treaty has promoted international nuclear cooperation by prohibiting ''any nuclear explosions in Antarctica and the disposal there of radioactive waste material'';

Whereas the Antarctic Treaty provides a framework for the signatories to continue to meet ''for the purpose of exchanging information, consulting together on matters of common interest pertaining to Antarctica, and formulating and considering, and recommending to their Governments, measures in furtherance of the principles and objectives of the Treaty'';

Whereas common interests among the Antarctic Treaty nations facilitated the development and ratification of the Convention on the Conservation of Antarctic Marine Living Resources;

Whereas the international cooperation represented by the Antarctic Treaty offers humankind a precedent for the peaceful governance of international spaces;

Whereas in celebration of the 50th anniversary of the International Geophysical Year, the Antarctic Treaty Parties in their Edinburgh Declaration recognized the current International Polar Year for its contributions to science worldwide and to international cooperation; and

Whereas the International Polar Year program has endorsed the Antarctic Treaty Summit that will convene in Washington, DC, at the Smithsonian Institution on the 50th anniversary of the Antarctic Treaty: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes that the Antarctic Treaty has greatly contributed to science and science cooperation worldwide and successfully ensured the ''use of Antarctica for peaceful purposes only and the continuance of international harmony'' for the past half century; and

(2) encourages international and interdisciplinary collaboration in the Antarctic Treaty Summit to identify lessons from 50 years of international cooperation under the Antarctic Treaty that have legacy value for humankind.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2792. Mr. KAUFMAN (for himself, Mr. LEAHY, Mr. SPECTER, Mr. KOHL, Mr. SCHUMER, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2793. Mr. DORGAN (for himself, Ms. SNOWE, Mr. GRASSLEY, Mr. MCCAIN, Ms. STABENOW, Ms. KLOBUCHAR, Mr. BROWN, Mrs. SHAHEEN, Mr. VITTER, Mr. KOHL, Mr. LEAHY, Mr. FEINGOLD, and Mr. NELSON, of Florida) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2794. Mr. LEAHY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2795. Mr. LEAHY (for himself, Mr. REID, Mr. KERRY, Mr. ROCKEFELLER, Mr. LIEBERMAN, Mrs. FEINSTEIN, Mr. FEINGOLD, Mr. WYDEN, Mr. SCHUMER, Ms. CANTWELL, Mr. LAUTENBERG, Mrs. MCCASKILL, Mr. WHITEHOUSE, Mr. BURRIS, Mr. KAUFMAN, Mr. BENNET, and Mr. FRANKEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2796. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the resolution S. Res. 71, condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights.

SA 2797. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the resolution S. Res. 71, supra.

TEXT OF AMENDMENTS

SA 2792. Mr. KAUFMAN (for himself, Mr. LEAHY, Mr. SPECTER, Mr. KOHL, Mr. SCHUMER, and Ms. KLOBUCHAR) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1738, between lines 3 and 4, insert the following:

(3) OTHER ENHANCEMENTS RELATING TO HEALTH CARE FRAUD.—

(A) FRAUD SENTENCING GUIDELINES.—

(i) DEFINITION.—In this subparagraph, the term ''Federal health care offense'' has the meaning given that term in section 24 of title 18, United States Code, as amended by this Act.

(ii) REVIEW AND AMENDMENTS.—Pursuant to the authority under section 994 of title 28, United States Code, and in accordance with this subparagraph, the United States Sentencing Commission shall—

(I) review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses;

(II) amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant; and

(III) amend the Federal Sentencing Guidelines to provide—

(aa) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $1,000,000 and less than $7,000,000;

(bb) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $20,000,000;

(cc) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $20,000,000; and

(dd) if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.

(iii) REQUIREMENTS.—In carrying this subparagraph, the United States Sentencing Commission shall—

(I) ensure that the Federal Sentencing Guidelines and policy statements—

(aa) reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and

(bb) provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(II) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in clause (ii);

(III) ensure reasonable consistency with other relevant directives and with other guidelines under the Federal Sentencing Guidelines;

(IV) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements;

(V) make any necessary conforming changes to the Federal Sentencing Guidelines; and

(VI) ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.

(B) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(i) by inserting ''(a)'' before ''Whoever knowingly''; and

(ii) by adding at the end the following:

''(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.''.

(C) HEALTH CARE FRAUD OFFENSE.—Section 24(a) of title 18, United States Code, is amended—

(i) in paragraph (1), by striking the semicolon and inserting ''or section 1128B of the Social Security Act (42 U.S.C. 1320a-7b); or''; and

(ii) in paragraph (2)—

(I) by inserting ''1349,'' after ''1343,''; and

(II) by inserting ''section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131),'' after ''title,''.

(D) SUBPOENA AUTHORITY RELATING TO HEALTH CARE.—

(i) SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.—Section 1510(b) of title 18, United States Code, is amended—

(I) in paragraph (1), by striking ''to the grand jury''; and

(II) in paragraph (2)—

(aa) in subparagraph (A), by striking ''grand jury subpoena'' and inserting ''subpoena for records''; and

(bb) in the matter following subparagraph (B), by striking ''to the grand jury''.

(ii) SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 3 the following:

''SEC. 3A. SUBPOENA AUTHORITY.

''(a) AUTHORITY.—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

''(b) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

''(1) ISSUANCE.—Subpoenas issued under this section—

''(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

''(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

''(2) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt that court.

''(c) PROTECTION OF SUBPOENAED RECORDS AND INFORMATION.—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report or other information obtained under a subpoena issued under this section—

''(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution;

''(2) may not be transmitted by or within the Department of Justice for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

''(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.''.

SA 2793. Mr. DORGAN (for himself, Ms. SNOWE, Mr. GRASSLEY, Mr. MCCAIN, Ms. STABENOW, Ms. KLOBUCHAR, Mr. BROWN, Mrs. SHAHEEN, Mr. VITTER, Mr. KOHL, Mr. LEAHY, Mr. FEINGOLD, and Mr. NELSON of Florida) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 10001. SHORT TITLE.

This title may be cited as the ''Pharmaceutical Market Access and Drug Safety Act of 2009''.

SEC. 10002. FINDINGS.

Congress finds that—

(1) Americans unjustly pay up to 5 times more to fill their prescriptions than consumers in other countries;

(2) the United States is the largest market for pharmaceuticals in the world, yet American consumers pay the highest prices for brand pharmaceuticals in the world;

(3) a prescription drug is neither safe nor effective to an individual who cannot afford it;

(4) allowing and structuring the importation of prescription drugs to ensure access to safe and affordable drugs approved by the Food and Drug Administration will provide a level of safety to American consumers that they do not currently enjoy;

(5) American spend more than $200,000,000,000 on prescription drugs every year;

(6) the Congressional Budget Office has found that the cost of prescription drugs are between 35 to 55 percent less in other highly-developed countries than in the United States; and

(7) promoting competitive market pricing would both contribute to health care savings and allow greater access to therapy, improving health and saving lives.

SEC. 10003. REPEAL OF CERTAIN SECTION REGARDING IMPORTATION OF PRESCRIPTION DRUGS.

Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804.

SEC. 10004. IMPORTATION OF PRESCRIPTION DRUGS; WAIVER OF CERTAIN IMPORT RESTRICTIONS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.), as amended by section 10003, is further amended by inserting after section 803 the following:

''SEC. 804. COMMERCIAL AND PERSONAL IMPORTATION OF PRESCRIPTION DRUGS.

''(a) IMPORTATION OF PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—In the case of qualifying drugs imported or offered for import into the United States from registered exporters or by registered importers—

''(A) the limitation on importation that is established in section 801(d)(1) is waived; and

''(B) the standards referred to in section 801(a) regarding admission of the drugs are subject to subsection (g) of this section (including with respect to qualifying drugs to which section 801(d)(1) does not apply).

''(2) IMPORTERS.—A qualifying drug may not be imported under paragraph (1) unless—

''(A) the drug is imported by a pharmacy, group of pharmacies, or a wholesaler that is a registered importer; or

''(B) the drug is imported by an individual for personal use or for the use of a family member of the individual (not for resale) from a registered exporter.

''(3) RULE OF CONSTRUCTION.—This section shall apply only with respect to a drug that is imported or offered for import into the United States—

''(A) by a registered importer; or

''(B) from a registered exporter to an individual.

''(4) DEFINITIONS.—

''(A) REGISTERED EXPORTER; REGISTERED IMPORTER.—For purposes of this section:

''(i) The term 'registered exporter' means an exporter for which a registration under subsection (b) has been approved and is in effect.

''(ii) The term 'registered importer' means a pharmacy, group of pharmacies, or a wholesaler for which a registration under subsection (b) has been approved and is in effect.

''(iii) The term 'registration condition' means a condition that must exist for a registration under subsection (b) to be approved.

''(B) QUALIFYING DRUG.—For purposes of this section, the term 'qualifying drug' means a drug for which there is a corresponding U.S. label drug.

''(C) U.S. LABEL DRUG.—For purposes of this section, the term 'U.S. label drug' means a prescription drug that—

''(i) with respect to a qualifying drug, has the same active ingredient or ingredients, route of administration, dosage form, and strength as the qualifying drug;

''(ii) with respect to the qualifying drug, is manufactured by or for the person that manufactures the qualifying drug;

''(iii) is approved under section 505(c); and
''(iv) is not—
''(I) a controlled substance, as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802);
''(II) a biological product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262), including—
''(aa) a therapeutic DNA plasmid product;
''(bb) a therapeutic synthetic peptide product;
''(cc) a monoclonal antibody product for in vivo use; and
''(dd) a therapeutic recombinant DNA-derived product;
''(III) an infused drug, including a peritoneal dialysis solution;
''(IV) an injected drug;
''(V) a drug that is inhaled during surgery;
''(VI) a drug that is the listed drug referred to in 2 or more abbreviated new drug applications under which the drug is commercially marketed; or
''(VII) a sterile opthlamic drug intended for topical use on or in the eye.
''(D) OTHER DEFINITIONS.—For purposes of this section:
''(i)(I) The term 'exporter' means a person that is in the business of exporting a drug to individuals in the United States from Canada or from a permitted country designated by the Secretary under subclause (II), or that, pursuant to submitting a registration under subsection (b), seeks to be in such business.
''(II) The Secretary shall designate a permitted country under subparagraph (E) (other than Canada) as a country from which an exporter may export a drug to individuals in the United States if the Secretary determines that—
''(aa) the country has statutory or regulatory standards that are equivalent to the standards in the United States and Canada with respect to—
''(AA) the training of pharmacists;
''(BB) the practice of pharmacy; and
''(CC) the protection of the privacy of personal medical information; and
''(bb) the importation of drugs to individuals in the United States from the country will not adversely affect public health.
''(ii) The term 'importer' means a pharmacy, a group of pharmacies, or a wholesaler that is in the business of importing a drug into the United States or that, pursuant to submitting a registration under subsection (b), seeks to be in such business.
''(iii) The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.
''(iv) The term 'pharmacy' means a person that—
''(I) is licensed by a State to engage in the business of selling prescription drugs at retail; and
''(II) employs 1 or more pharmacists.
''(v) The term 'prescription drug' means a drug that is described in section 503(b)(1).
''(vi) The term 'wholesaler'—
''(I) means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A); and
''(II) does not include a person authorized to import drugs under section 801(d)(1).
''(E) PERMITTED COUNTRY.—The term 'permitted country' means—
''(i) Australia;
''(ii) Canada;
''(iii) a member country of the European Union, but does not include a member country with respect to which—
''(I) the country's Annex to the Treaty of Accession to the European Union 2003 includes a transitional measure for the regulation of human pharmaceutical products that has not expired; or
''(II) the Secretary determines that the requirements described in subclauses (I) and (II) of clause (vii) will not be met by the date on which such transitional measure for the regulation of human pharmaceutical products expires;
''(iv) Japan;
''(v) New Zealand;
''(vi) Switzerland; and
''(vii) a country in which the Secretary determines the following requirements are met:
''(I) The country has statutory or regulatory requirements—
''(aa) that require the review of drugs for safety and effectiveness by an entity of the government of the country;
''(bb) that authorize the approval of only those drugs that have been determined to be safe and effective by experts employed by or acting on behalf of such entity and qualified by scientific training and experience to evaluate the safety and effectiveness of drugs on the basis of adequate and well-controlled investigations, including clinical investigations, conducted by experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs;
''(cc) that require the methods used in, and the facilities and controls used for the manufacture, processing, and packing of drugs in the country to be adequate to preserve their identity, quality, purity, and strength;
''(dd) for the reporting of adverse reactions to drugs and procedures to withdraw approval and remove drugs found not to be safe or effective; and
''(ee) that require the labeling and promotion of drugs to be in accordance with the approval of the drug.
''(II) The valid marketing authorization system in the country is equivalent to the systems in the countries described in clauses (i) through (vi).
''(III) The importation of drugs to the United States from the country will not adversely affect public health.
''(b) REGISTRATION OF IMPORTERS AND EXPORTERS.—
''(1) REGISTRATION OF IMPORTERS AND EXPORTERS.—A registration condition is that the importer or exporter involved (referred to in this subsection as a 'registrant') submits to the Secretary a registration containing the following:
''(A)(i) In the case of an exporter, the name of the exporter and an identification of all places of business of the exporter that relate to qualifying drugs, including each warehouse or other facility owned or controlled by, or operated for, the exporter.
''(ii) In the case of an importer, the name of the importer and an identification of the places of business of the importer at which the importer initially receives a qualifying drug after importation (which shall not exceed 3 places of business except by permission of the Secretary).
''(B) Such information as the Secretary determines to be necessary to demonstrate that the registrant is in compliance with registration conditions under—
''(i) in the case of an importer, subsections (c), (d), (e), (g), and (j) (relating to the sources of imported qualifying drugs; the inspection of facilities of the importer; the payment of fees; compliance with the standards referred to in section 801(a); and maintenance of records and samples); or
''(ii) in the case of an exporter, subsections (c), (d), (f), (g), (h), (i), and (j) (relating to the sources of exported qualifying drugs; the inspection of facilities of the exporter and the marking of compliant shipments; the payment of fees; and compliance with the standards referred to in section 801(a); being licensed as a pharmacist; conditions for individual importation; and maintenance of records and samples).
''(C) An agreement by the registrant that the registrant will not under subsection (a) import or export any drug that is not a qualifying drug.
''(D) An agreement by the registrant to—
''(i) notify the Secretary of a recall or withdrawal of a qualifying drug distributed in a permitted country that the registrant has exported or imported, or intends to export or import, to the United States under subsection (a);
''(ii) provide for the return to the registrant of such drug; and
''(iii) cease, or not begin, the exportation or importation of such drug unless the Secretary has notified the registrant that exportation or importation of such drug may proceed.
''(E) An agreement by the registrant to ensure and monitor compliance with each registration condition, to promptly correct any noncompliance with such a condition, and to promptly report to the Secretary any such noncompliance.
''(F) A plan describing the manner in which the registrant will comply with the agreement under subparagraph (E).
''(G) An agreement by the registrant to enforce a contract under subsection (c)(3)(B) against a party in the chain of custody of a qualifying drug with respect to the authority of the Secretary under clauses (ii) and (iii) of that subsection.
''(H) An agreement by the registrant to notify the Secretary not more than 30 days before the registrant intends to make the change, of—
''(i) any change that the registrant intends to make regarding information provided under subparagraph (A) or (B); and
''(ii) any change that the registrant intends to make in the compliance plan under subparagraph (F).
''(I) In the case of an exporter:
''(i) An agreement by the exporter that a qualifying drug will not under subsection (a) be exported to any individual not authorized pursuant to subsection (a)(2)(B) to be an importer of such drug.
''(ii) An agreement to post a bond, payable to the Treasury of the United States that is equal in value to the lesser of—
''(I) the value of drugs exported by the exporter to the United States in a typical 4-week period over the course of a year under this section; or
''(II) $1,000,000.
''(iii) An agreement by the exporter to comply with applicable provisions of Canadian law, or the law of the permitted country designated under subsection (a)(4)(D)(i)(II) in which the exporter is located, that protect the privacy of personal information with respect to each individual importing a prescription drug from the exporter under subsection (a)(2)(B).
''(iv) An agreement by the exporter to report to the Secretary—
''(I) not later than August 1 of each fiscal year, the total price and the total volume of drugs exported to the United States by the exporter during the 6-month period from January 1 through June 30 of that year; and
''(II) not later than January 1 of each fiscal year, the total price and the total volume of drugs exported to the United States by the exporter during the previous fiscal year.

''(J) In the case of an importer, an agreement by the importer to report to the Secretary—

''(i) not later than August 1 of each fiscal year, the total price and the total volume of drugs imported to the United States by the importer during the 6-month period from January 1 through June 30 of that fiscal year; and

''(ii) not later than January 1 of each fiscal year, the total price and the total volume of drugs imported to the United States by the importer during the previous fiscal year.

''(K) Such other provisions as the Secretary may require by regulation to protect the public health while permitting—

''(i) the importation by pharmacies, groups of pharmacies, and wholesalers as registered importers of qualifying drugs under subsection (a); and

''(ii) importation by individuals of qualifying drugs under subsection (a).

''(2) APPROVAL OR DISAPPROVAL OF REGISTRATION.—

''(A) IN GENERAL.—Not later than 90 days after the date on which a registrant submits to the Secretary a registration under paragraph (1), the Secretary shall notify the registrant whether the registration is approved or is disapproved. The Secretary shall disapprove a registration if there is reason to believe that the registrant is not in compliance with one or more registration conditions, and shall notify the registrant of such reason. In the case of a disapproved registration, the Secretary shall subsequently notify the registrant that the registration is approved if the Secretary determines that the registrant is in compliance with such conditions.

''(B) CHANGES IN REGISTRATION INFORMATION.—Not later than 30 days after receiving a notice under paragraph (1)(H) from a registrant, the Secretary shall determine whether the change involved affects the approval of the registration of the registrant under paragraph (1), and shall inform the registrant of the determination.

''(3) PUBLICATION OF CONTACT INFORMATION FOR REGISTERED EXPORTERS.—Through the Internet website of the Food and Drug Administration and a toll-free telephone number, the Secretary shall make readily available to the public a list of registered exporters, including contact information for the exporters. Promptly after the approval of a registration submitted under paragraph (1), the Secretary shall update the Internet website and the information provided through the toll-free telephone number accordingly.

''(4) SUSPENSION AND TERMINATION.—

''(A) SUSPENSION.—With respect to the effectiveness of a registration submitted under paragraph (1):

''(i) Subject to clause (ii), the Secretary may suspend the registration if the Secretary determines, after notice and opportunity for a hearing, that the registrant has failed to maintain substantial compliance with a registration condition.

''(ii) If the Secretary determines that, under color of the registration, the exporter has exported a drug or the importer has imported a drug that is not a qualifying drug, or a drug that does not comply with subsection (g)(2)(A) or (g)(4), or has exported a qualifying drug to an individual in violation of subsection (i), the Secretary shall immediately suspend the registration. A suspension under the preceding sentence is not subject to the provision by the Secretary of prior notice, and the Secretary shall provide to the registrant an opportunity for a hearing not later than 10 days after the date on which the registration is suspended.

''(iii) The Secretary may reinstate the registration, whether suspended under clause (i) or (ii), if the Secretary determines that the registrant has demonstrated that further violations of registration conditions will not occur.

''(B) TERMINATION.—The Secretary, after notice and opportunity for a hearing, may terminate the registration under paragraph (1) of a registrant if the Secretary determines that the registrant has engaged in a pattern or practice of violating 1 or more registration conditions, or if on 1 or more occasions the Secretary has under subparagraph (A)(ii) suspended the registration of the registrant. The Secretary may make the termination permanent, or for a fixed period of not less than 1 year. During the period in which the registration is terminated, any registration submitted under paragraph (1) by the registrant, or a person that is a partner in the export or import enterprise, or a principal officer in such enterprise, and any registration prepared with the assistance of the registrant or such a person, has no legal effect under this section.

''(5) DEFAULT OF BOND.—A bond required to be posted by an exporter under paragraph (1)(I)(ii) shall be defaulted and paid to the Treasury of the United States if, after opportunity for an informal hearing, the Secretary determines that the exporter has—

''(A) exported a drug to the United States that is not a qualifying drug or that is not in compliance with subsection (g)(2)(A), (g)(4), or (i); or

''(B) failed to permit the Secretary to conduct an inspection described under subsection (d).

''(c) SOURCES OF QUALIFYING DRUGS.—A registration condition is that the exporter or importer involved agrees that a qualifying drug will under subsection (a) be exported or imported into the United States only if there is compliance with the following:

''(1) The drug was manufactured in an establishment—

''(A) required to register under subsection (h) or (i) of section 510; and

''(B)(i) inspected by the Secretary; or

''(ii) for which the Secretary has elected to rely on a satisfactory report of a good manufacturing practice inspection of the establishment from a permitted country whose regulatory system the Secretary recognizes as equivalent under a mutual recognition agreement, as provided for under section 510(i)(3), section 803, or part 26 of title 21, Code of Federal Regulations (or any corresponding successor rule or regulation).

''(2) The establishment is located in any country, and the establishment manufactured the drug for distribution in the United States or for distribution in 1 or more of the permitted countries (without regard to whether in addition the drug is manufactured for distribution in a foreign country that is not a permitted country).

''(3) The exporter or importer obtained the drug—

''(A) directly from the establishment; or

''(B) directly from an entity that, by contract with the exporter or importer—

''(i) provides to the exporter or importer a statement (in such form and containing such information as the Secretary may require) that, for the chain of custody from the establishment, identifies each prior sale, purchase, or trade of the drug (including the date of the transaction and the names and addresses of all parties to the transaction);

''(ii) agrees to permit the Secretary to inspect such statements and related records to determine their accuracy;

''(iii) agrees, with respect to the qualifying drugs involved, to permit the Secretary to inspect warehouses and other facilities, including records, of the entity for purposes of determining whether the facilities are in compliance with any standards under this Act that are applicable to facilities of that type in the United States; and

''(iv) has ensured, through such contractual relationships as may be necessary, that the Secretary has the same authority regarding other parties in the chain of custody from the establishment that the Secretary has under clauses (ii) and (iii) regarding such entity.

''(4)(A) The foreign country from which the importer will import the drug is a permitted country; or

''(B) The foreign country from which the exporter will export the drug is the permitted country in which the exporter is located.

''(5) During any period in which the drug was not in the control of the manufacturer of the drug, the drug did not enter any country that is not a permitted country.

''(6) The exporter or importer retains a sample of each lot of the drug for testing by the Secretary.

''(d) INSPECTION OF FACILITIES; MARKING OF SHIPMENTS.—

''(1) INSPECTION OF FACILITIES.—A registration condition is that, for the purpose of assisting the Secretary in determining whether the exporter involved is in compliance with all other registration conditions—

''(A) the exporter agrees to permit the Secretary—

''(i) to conduct onsite inspections, including monitoring on a day-to-day basis, of places of business of the exporter that relate to qualifying drugs, including each warehouse or other facility owned or controlled by, or operated for, the exporter;

''(ii) to have access, including on a day-to-day basis, to—

''(I) records of the exporter that relate to the export of such drugs, including financial records; and

''(II) samples of such drugs;

''(iii) to carry out the duties described in paragraph (3); and

''(iv) to carry out any other functions determined by the Secretary to be necessary regarding the compliance of the exporter; and

''(B) the Secretary has assigned 1 or more employees of the Secretary to carry out the functions described in this subsection for the Secretary randomly, but not less than 12 times annually, on the premises of places of businesses referred to in subparagraph (A)(i), and such an assignment remains in effect on a continuous basis.

''(2) MARKING OF COMPLIANT SHIPMENTS.—A registration condition is that the exporter involved agrees to affix to each shipping container of qualifying drugs exported under subsection (a) such markings as the Secretary determines to be necessary to identify the shipment as being in compliance with all registration conditions. Markings under the preceding sentence shall—

''(A) be designed to prevent affixation of the markings to any shipping container that is not authorized to bear the markings; and

''(B) include anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies.

''(3) CERTAIN DUTIES RELATING TO EXPORTERS.—Duties of the Secretary with respect to an exporter include the following:

''(A) Inspecting, randomly, but not less than 12 times annually, the places of business of the exporter at which qualifying drugs are stored and from which qualifying drugs are shipped.

''(B) During the inspections under subparagraph (A), verifying the chain of custody of a statistically significant sample of qualifying drugs from the establishment in which the drug was manufactured to the exporter, which shall be accomplished or supplemented by the use of anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies, except that a drug that lacks such technologies from the point of manufacture shall not for that reason be excluded from importation by an exporter.

''(C) Randomly reviewing records of exports to individuals for the purpose of determining whether the drugs are being imported by the individuals in accordance with the conditions under subsection (i). Such reviews shall be conducted in a manner that will result in a statistically significant determination of compliance with all such conditions.

''(D) Monitoring the affixing of markings under paragraph (2).

''(E) Inspecting as the Secretary determines is necessary the warehouses and other facilities, including records, of other parties in the chain of custody of qualifying drugs.

''(F) Determining whether the exporter is in compliance with all other registration conditions.

''(4) PRIOR NOTICE OF SHIPMENTS.—A registration condition is that, not less than 8 hours and not more than 5 days in advance of the time of the importation of a shipment of qualifying drugs, the importer involved agrees to submit to the Secretary a notice with respect to the shipment of drugs to be imported or offered for import into the United States under subsection (a). A notice under the preceding sentence shall include—

''(A) the name and complete contact information of the person submitting the notice;

''(B) the name and complete contact information of the importer involved;

''(C) the identity of the drug, including the established name of the drug, the quantity of the drug, and the lot number assigned by the manufacturer;

''(D) the identity of the manufacturer of the drug, including the identity of the establishment at which the drug was manufactured;

''(E) the country from which the drug is shipped;

''(F) the name and complete contact information for the shipper of the drug;

''(G) anticipated arrival information, including the port of arrival and crossing location within that port, and the date and time;

''(H) a summary of the chain of custody of the drug from the establishment in which the drug was manufactured to the importer;

''(I) a declaration as to whether the Secretary has ordered that importation of the drug from the permitted country cease under subsection (g)(2)(C) or (D); and

''(J) such other information as the Secretary may require by regulation.

''(5) MARKING OF COMPLIANT SHIPMENTS.—A registration condition is that the importer involved agrees, before wholesale distribution (as defined in section 503(e)) of a qualifying drug that has been imported under subsection (a), to affix to each container of such drug such markings or other technology as the Secretary determines necessary to identify the shipment as being in compliance with all registration conditions, except that the markings or other technology shall not be required on a drug that bears comparable, compatible markings or technology from the manufacturer of the drug. Markings or other technology under the preceding sentence shall—

''(A) be designed to prevent affixation of the markings or other technology to any container that is not authorized to bear the markings; and

''(B) shall include anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of such technologies.

''(6) CERTAIN DUTIES RELATING TO IMPORTERS.—Duties of the Secretary with respect to an importer include the following:

''(A) Inspecting, randomly, but not less than 12 times annually, the places of business of the importer at which a qualifying drug is initially received after importation.

''(B) During the inspections under subparagraph (A), verifying the chain of custody of a statistically significant sample of qualifying drugs from the establishment in which the drug was manufactured to the importer, which shall be accomplished or supplemented by the use of anticounterfeiting or track-and-trace technologies, taking into account the economic and technical feasibility of those technologies, except that a drug that lacks such technologies from the point of manufacture shall not for that reason be excluded from importation by an importer.

''(C) Reviewing notices under paragraph (4).

''(D) Inspecting as the Secretary determines is necessary the warehouses and other facilities, including records of other parties in the chain of custody of qualifying drugs.

''(E) Determining whether the importer is in compliance with all other registration conditions.

''(e) IMPORTER FEES.—

''(1) REGISTRATION FEE.—A registration condition is that the importer involved pays to the Secretary a fee of $10,000 due on the date on which the importer first submits the registration to the Secretary under subsection (b).

''(2) INSPECTION FEE.—A registration condition is that the importer involved pays a fee to the Secretary in accordance with this subsection. Such fee shall be paid not later than October 1 and April 1 of each fiscal year in the amount provided for under paragraph (3).

''(3) AMOUNT OF INSPECTION FEE.—

''(A) AGGREGATE TOTAL OF FEES.—Not later than 30 days before the start of each fiscal year, the Secretary, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, shall establish an aggregate total of fees to be collected under paragraph (2) for importers for that fiscal year that is sufficient, and not more than necessary, to pay the costs for that fiscal year of administering this section with respect to registered importers, including the costs associated with—

''(i) inspecting the facilities of registered importers, and of other entities in the chain of custody of a qualifying drug as necessary, under subsection (d)(6);

''(ii) developing, implementing, and operating under such subsection an electronic system for submission and review of the notices required under subsection (d)(4) with respect to shipments of qualifying drugs under subsection (a) to assess compliance with all registration conditions when such shipments are offered for import into the United States; and

''(iii) inspecting such shipments as necessary, when offered for import into the United States to determine if such a shipment should be refused admission under subsection (g)(5).

''(B) LIMITATION.—Subject to subparagraph (C), the aggregate total of fees collected under paragraph (2) for a fiscal year shall not exceed 2.5 percent of the total price of qualifying drugs imported during that fiscal year into the United States by registered importers under subsection (a).

''(C) TOTAL PRICE OF DRUGS.—

''(i) ESTIMATE.—For the purposes of complying with the limitation described in subparagraph (B) when establishing under subparagraph (A) the aggregate total of fees to be collected under paragraph (2) for a fiscal year, the Secretary shall estimate the total price of qualifying drugs imported into the United States by registered importers during that fiscal year by adding the total price of qualifying drugs imported by each registered importer during the 6-month period from January 1 through June 30 of the previous fiscal year, as reported to the Secretary by each registered importer under subsection (b)(1)(J).

''(ii) CALCULATION.—Not later than March 1 of the fiscal year that follows the fiscal year for which the estimate under clause (i) is made, the Secretary shall calculate the total price of qualifying drugs imported into the United States by registered importers during that fiscal year by adding the total price of qualifying drugs imported by each registered importer during that fiscal year, as reported to the Secretary by each registered importer under subsection (b)(1)(J).

''(iii) ADJUSTMENT.—If the total price of qualifying drugs imported into the United States by registered importers during a fiscal year as calculated under clause (ii) is less than the aggregate total of fees collected under paragraph (2) for that fiscal year, the Secretary shall provide for a pro-rata reduction in the fee due from each registered importer on April 1 of the subsequent fiscal year so that the limitation described in subparagraph (B) is observed.

''(D) INDIVIDUAL IMPORTER FEE.—Subject to the limitation described in subparagraph (B), the fee under paragraph (2) to be paid on October 1 and April 1 by an importer shall be an amount that is proportional to a reasonable estimate by the Secretary of the semiannual share of the importer of the volume of qualifying drugs imported by importers under subsection (a).

''(4) USE OF FEES.—

''(A) IN GENERAL.—Fees collected by the Secretary under paragraphs (1) and (2) shall be credited to the appropriation account for salaries and expenses of the Food and Drug Administration until expended (without fiscal year limitation), and the Secretary may, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, transfer some proportion of such fees to the appropriation account for salaries and expenses of the Bureau of Customs and Border Protection until expended (without fiscal year limitation).

''(B) AVAILABILITY.—Fees collected by the Secretary under paragraphs (1) and (2) shall be made available to the Food and Drug Administration.

''(C) SOLE PURPOSE.—Fees collected by the Secretary under paragraphs (1) and (2) are only available to the Secretary and, if transferred, to the Secretary of Homeland Security, and are for the sole purpose of paying the costs referred to in paragraph (3)(A).

''(5) COLLECTION OF FEES.—In any case where the Secretary does not receive payment of a fee assessed under paragraph (1) or (2) within 30 days after it is due, such fee shall be treated as a claim of the United States Government subject to subchapter II of chapter 37 of title 31, United States Code.

''(f) EXPORTER FEES.—

''(1) REGISTRATION FEE.—A registration condition is that the exporter involved pays to the Secretary a fee of $10,000 due on the date on which the exporter first submits that registration to the Secretary under subsection (b).

''(2) INSPECTION FEE.—A registration condition is that the exporter involved pays a fee to the Secretary in accordance with this subsection. Such fee shall be paid not later than October 1 and April 1 of each fiscal year in the amount provided for under paragraph (3).

''(3) AMOUNT OF INSPECTION FEE.—

''(A) AGGREGATE TOTAL OF FEES.—Not later than 30 days before the start of each fiscal year, the Secretary, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, shall establish an aggregate total of fees to be collected under paragraph (2) for exporters for that fiscal year that is sufficient, and not more than necessary, to pay the costs for that fiscal year of administering this section with respect to registered exporters, including the costs associated with—

''(i) inspecting the facilities of registered exporters, and of other entities in the chain of custody of a qualifying drug as necessary, under subsection (d)(3);

''(ii) developing, implementing, and operating under such subsection a system to screen marks on shipments of qualifying drugs under subsection (a) that indicate compliance with all registration conditions, when such shipments are offered for import into the United States; and

''(iii) screening such markings, and inspecting such shipments as necessary, when offered for import into the United States to determine if such a shipment should be refused admission under subsection (g)(5).

''(B) LIMITATION.—Subject to subparagraph (C), the aggregate total of fees collected under paragraph (2) for a fiscal year shall not exceed 2.5 percent of the total price of qualifying drugs imported during that fiscal year into the United States by registered exporters under subsection (a).

''(C) TOTAL PRICE OF DRUGS.—

''(i) ESTIMATE.—For the purposes of complying with the limitation described in subparagraph (B) when establishing under subparagraph (A) the aggregate total of fees to be collected under paragraph (2) for a fiscal year, the Secretary shall estimate the total price of qualifying drugs imported into the United States by registered exporters during that fiscal year by adding the total price of qualifying drugs exported by each registered exporter during the 6-month period from January 1 through June 30 of the previous fiscal year, as reported to the Secretary by each registered exporter under subsection (b)(1)(I)(iv).

''(ii) CALCULATION.—Not later than March 1 of the fiscal year that follows the fiscal year for which the estimate under clause (i) is made, the Secretary shall calculate the total price of qualifying drugs imported into the United States by registered exporters during that fiscal year by adding the total price of qualifying drugs exported by each registered exporter during that fiscal year, as reported to the Secretary by each registered exporter under subsection (b)(1)(I)(iv).

''(iii) ADJUSTMENT.—If the total price of qualifying drugs imported into the United States by registered exporters during a fiscal year as calculated under clause (ii) is less than the aggregate total of fees collected under paragraph (2) for that fiscal year, the Secretary shall provide for a pro-rata reduction in the fee due from each registered exporter on April 1 of the subsequent fiscal year so that the limitation described in subparagraph (B) is observed.

''(D) INDIVIDUAL EXPORTER FEE.—Subject to the limitation described in subparagraph (B), the fee under paragraph (2) to be paid on October 1 and April 1 by an exporter shall be an amount that is proportional to a reasonable estimate by the Secretary of the semiannual share of the exporter of the volume of qualifying drugs exported by exporters under subsection (a).

''(4) USE OF FEES.—

''(A) IN GENERAL.—Fees collected by the Secretary under paragraphs (1) and (2) shall be credited to the appropriation account for salaries and expenses of the Food and Drug Administration until expended (without fiscal year limitation), and the Secretary may, in consultation with the Secretary of Homeland Security and the Secretary of the Treasury, transfer some proportion of such fees to the appropriation account for salaries and expenses of the Bureau of Customs and Border Protection until expended (without fiscal year limitation).

''(B) AVAILABILITY.—Fees collected by the Secretary under paragraphs (1) and (2) shall be made available to the Food and Drug Administration.

''(C) SOLE PURPOSE.—Fees collected by the Secretary under paragraphs (1) and (2) are only available to the Secretary and, if transferred, to the Secretary of Homeland Security, and are for the sole purpose of paying the costs referred to in paragraph (3)(A).

''(5) COLLECTION OF FEES.—In any case where the Secretary does not receive payment of a fee assessed under paragraph (1) or (2) within 30 days after it is due, such fee shall be treated as a claim of the United States Government subject to subchapter II of chapter 37 of title 31, United States Code.

''(g) COMPLIANCE WITH SECTION 801(a).—

''(1) IN GENERAL.—A registration condition is that each qualifying drug exported under subsection (a) by the registered exporter involved or imported under subsection (a) by the registered importer involved is in compliance with the standards referred to in section 801(a) regarding admission of the drug into the United States, subject to paragraphs (2), (3), and (4).

''(2) SECTION 505; APPROVAL STATUS.—

''(A) IN GENERAL.—A qualifying drug that is imported or offered for import under subsection (a) shall comply with the conditions established in the approved application under section 505(b) for the U.S. label drug as described under this subsection.

''(B) NOTICE BY MANUFACTURER; GENERAL PROVISIONS.—

''(i) IN GENERAL.—The person that manufactures a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country shall in accordance with this paragraph submit to the Secretary a notice that—

''(I) includes each difference in the qualifying drug from a condition established in the approved application for the U.S. label drug beyond—

''(aa) the variations provided for in the application; and

''(bb) any difference in labeling (except ingredient labeling); or

''(II) states that there is no difference in the qualifying drug from a condition established in the approved application for the U.S. label drug beyond—

''(aa) the variations provided for in the application; and

''(bb) any difference in labeling (except ingredient labeling).

''(ii) INFORMATION IN NOTICE.—A notice under clause (i)(I) shall include the information that the Secretary may require under section 506A, any additional information the Secretary may require (which may include data on bioequivalence if such data are not required under section 506A), and, with respect to the permitted country that approved the qualifying drug for commercial distribution, or with respect to which such approval is sought, include the following:

''(I) The date on which the qualifying drug with such difference was, or will be, introduced for commercial distribution in the permitted country.

''(II) Information demonstrating that the person submitting the notice has also notified the government of the permitted country in writing that the person is submitting to the Secretary a notice under clause (i)(I), which notice describes the difference in the qualifying drug from a condition established in the approved application for the U.S. label drug.

''(III) The information that the person submitted or will submit to the government of the permitted country for purposes of obtaining approval for commercial distribution of the drug in the country which, if in a language other than English, shall be accompanied by an English translation verified to be complete and accurate, with the name, address, and a brief statement of the qualifications of the person that made the translation.

''(iii) CERTIFICATIONS.—The chief executive officer and the chief medical officer of the manufacturer involved shall each certify in the notice under clause (i) that—

''(I) the information provided in the notice is complete and true; and

''(II) a copy of the notice has been provided to the Federal Trade Commission and to the State attorneys general.

''(iv) FEE.—

''(I) IN GENERAL.—If a notice submitted under clause (i) includes a difference that would, under section 506A, require the submission of a supplemental application if made as a change to the U.S. label drug, the person that submits the notice shall pay to the Secretary a fee in the same amount as would apply if the person were paying a fee pursuant to section 736(a)(1)(A)(ii). Fees collected by the Secretary under the preceding sentence are available only to the Secretary and are for the sole purpose of paying the costs of reviewing notices submitted under clause (i).

''(II) FEE AMOUNT FOR CERTAIN YEARS.—If no fee amount is in effect under section 736(a)(1)(A)(ii) for a fiscal year, then the amount paid by a person under subclause (I) shall—

''(aa) for the first fiscal year in which no fee amount under such section in effect, be equal to the fee amount under section 736(a)(1)(A)(ii) for the most recent fiscal year for which such section was in effect, adjusted in accordance with section 736(c); and

''(bb) for each subsequent fiscal year in which no fee amount under such section is effect, be equal to the applicable fee amount for the previous fiscal year, adjusted in accordance with section 736(c).

''(v) TIMING OF SUBMISSION OF NOTICES.—

''(I) PRIOR APPROVAL NOTICES.—A notice under clause (i) to which subparagraph (C)

applies shall be submitted to the Secretary not later than 120 days before the qualifying drug with the difference is introduced for commercial distribution in a permitted country, unless the country requires that distribution of the qualifying drug with the difference begin less than 120 days after the country requires the difference.

''(II) OTHER APPROVAL NOTICES.—A notice under clause (i) to which subparagraph (D) applies shall be submitted to the Secretary not later than the day on which the qualifying drug with the difference is introduced for commercial distribution in a permitted country.

''(III) OTHER NOTICES.—A notice under clause (i) to which subparagraph (E) applies shall be submitted to the Secretary on the date that the qualifying drug is first introduced for commercial distribution in a permitted country and annually thereafter.

''(vi) REVIEW BY SECRETARY.—

''(I) IN GENERAL.—In this paragraph, the difference in a qualifying drug that is submitted in a notice under clause (i) from the U.S. label drug shall be treated by the Secretary as if it were a manufacturing change to the U.S. label drug under section 506A.

''(II) STANDARD OF REVIEW.—Except as provided in subclause (III), the Secretary shall review and approve or disapprove the difference in a notice submitted under clause (i), if required under section 506A, using the safe and effective standard for approving or disapproving a manufacturing change under section 506A.

''(III) BIOEQUIVALENCE.—If the Secretary would approve the difference in a notice submitted under clause (i) using the safe and effective standard under section 506A and if the Secretary determines that the qualifying drug is not bioequivalent to the U.S. label drug, the Secretary shall—

''(aa) include in the labeling provided under paragraph (3) a prominent advisory that the qualifying drug is safe and effective but is not bioequivalent to the U.S. label drug if the Secretary determines that such an advisory is necessary for health care practitioners and patients to use the qualifying drug safely and effectively; or

''(bb) decline to approve the difference if the Secretary determines that the availability of both the qualifying drug and the U.S. label drug would pose a threat to the public health.

''(IV) REVIEW BY THE SECRETARY.—The Secretary shall review and approve or disapprove the difference in a notice submitted under clause (i), if required under section 506A, not later than 120 days after the date on which the notice is submitted.

''(V) ESTABLISHMENT INSPECTION.—If review of such difference would require an inspection of the establishment in which the qualifying drug is manufactured—

''(aa) such inspection by the Secretary shall be authorized; and

''(bb) the Secretary may rely on a satisfactory report of a good manufacturing practice inspection of the establishment from a permitted country whose regulatory system the Secretary recognizes as equivalent under a mutual recognition agreement, as provided under section 510(i)(3), section 803, or part 26 of title 21, Code of Federal Regulations (or any corresponding successor rule or regulation).

''(vii) PUBLICATION OF INFORMATION ON NOTICES.—

''(I) IN GENERAL.—Through the Internet website of the Food and Drug Administration and a toll-free telephone number, the Secretary shall readily make available to the public a list of notices submitted under clause (i).

''(II) CONTENTS.—The list under subclause (I) shall include the date on which a notice is submitted and whether—

''(aa) a notice is under review;

''(bb) the Secretary has ordered that importation of the qualifying drug from a permitted country cease; or

''(cc) the importation of the drug is permitted under subsection (a).

''(III) UPDATE.—The Secretary shall promptly update the Internet website with any changes to the list.

''(C) NOTICE; DRUG DIFFERENCE REQUIRING PRIOR APPROVAL.—In the case of a notice under subparagraph (B)(i) that includes a difference that would, under subsection (c) or (d)(3)(B)(i) of section 506A, require the approval of a supplemental application before the difference could be made to the U.S. label drug the following shall occur:

''(i) Promptly after the notice is submitted, the Secretary shall notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general that the notice has been submitted with respect to the qualifying drug involved.

''(ii) If the Secretary has not made a determination whether such a supplemental application regarding the U.S. label drug would be approved or disapproved by the date on which the qualifying drug involved is to be introduced for commercial distribution in a permitted country, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country not begin until the Secretary completes review of the notice; and

''(II) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the order.

''(iii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would not be approved, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country cease, or provide that an order under clause (ii), if any, remains in effect;

''(II) notify the permitted country that approved the qualifying drug for commercial distribution of the determination; and

''(III) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(iv) If the Secretary determines that such a supplemental application regarding the U.S. label drug would be approved, the Secretary shall—

''(I) vacate the order under clause (ii), if any;

''(II) consider the difference to be a variation provided for in the approved application for the U.S. label drug;

''(III) permit importation of the qualifying drug under subsection (a); and

''(IV) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(D) NOTICE; DRUG DIFFERENCE NOT REQUIRING PRIOR APPROVAL.—In the case of a notice under subparagraph (B)(i) that includes a difference that would, under section 506A(d)(3)(B)(ii), not require the approval of a supplemental application before the difference could be made to the U.S. label drug the following shall occur:

''(i) During the period in which the notice is being reviewed by the Secretary, the authority under this subsection to import the qualifying drug involved continues in effect.

''(ii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would not be approved, the Secretary shall—

''(I) order that the importation of the qualifying drug involved from the permitted country cease;

''(II) notify the permitted country that approved the qualifying drug for commercial distribution of the determination; and

''(III) promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of the determination.

''(iii) If the Secretary determines that such a supplemental application regarding the U.S. label drug would be approved, the difference shall be considered to be a variation provided for in the approved application for the U.S. label drug.

''(E) NOTICE; DRUG DIFFERENCE NOT REQUIRING APPROVAL; NO DIFFERENCE.—In the case of a notice under subparagraph (B)(i) that includes a difference for which, under section 506A(d)(1)(A), a supplemental application would not be required for the difference to be made to the U.S. label drug, or that states that there is no difference, the Secretary—

''(i) shall consider such difference to be a variation provided for in the approved application for the U.S. label drug;

''(ii) may not order that the importation of the qualifying drug involved cease; and

''(iii) shall promptly notify registered exporters and registered importers.

''(F) DIFFERENCES IN ACTIVE INGREDIENT, ROUTE OF ADMINISTRATION, DOSAGE FORM, OR STRENGTH.—

''(i) IN GENERAL.—A person who manufactures a drug approved under section 505(b) shall submit an application under section 505(b) for approval of another drug that is manufactured for distribution in a permitted country by or for the person that manufactures the drug approved under section 505(b) if—

''(I) there is no qualifying drug in commercial distribution in permitted countries whose combined population represents at least 50 percent of the total population of all permitted countries with the same active ingredient or ingredients, route of administration, dosage form, and strength as the drug approved under section 505(b); and

''(II) each active ingredient of the other drug is related to an active ingredient of the drug approved under section 505(b), as defined in clause (v).

''(ii) APPLICATION UNDER SECTION 505(b).—The application under section 505(b) required under clause (i) shall—

''(I) request approval of the other drug for the indication or indications for which the drug approved under section 505(b) is labeled;

''(II) include the information that the person submitted to the government of the permitted country for purposes of obtaining approval for commercial distribution of the other drug in that country, which if in a language other than English, shall be accompanied by an English translation verified to be complete and accurate, with the name, address, and a brief statement of the qualifications of the person that made the translation;

''(III) include a right of reference to the application for the drug approved under section 505(b); and

''(IV) include such additional information as the Secretary may require.

''(iii) TIMING OF SUBMISSION OF APPLICATION.—An application under section 505(b) required under clause (i) shall be submitted to the Secretary not later than the day on

which the information referred to in clause (ii)(II) is submitted to the government of the permitted country.

''(iv) NOTICE OF DECISION ON APPLICATION.—The Secretary shall promptly notify registered exporters, registered importers, the Federal Trade Commission, and the State attorneys general of a determination to approve or to disapprove an application under section 505(b) required under clause (i).

''(v) RELATED ACTIVE INGREDIENTS.—For purposes of clause (i)(II), 2 active ingredients are related if they are—

''(I) the same; or

''(II) different salts, esters, or complexes of the same moiety.

''(3) SECTION 502; LABELING.—

''(A) IMPORTATION BY REGISTERED IMPORTER.—

''(i) IN GENERAL.—In the case of a qualifying drug that is imported or offered for import by a registered importer, such drug shall be considered to be in compliance with section 502 and the labeling requirements under the approved application for the U.S. label drug if the qualifying drug bears—

''(I) a copy of the labeling approved for the U.S. label drug under section 505, without regard to whether the copy bears any trademark involved;

''(II) the name of the manufacturer and location of the manufacturer;

''(III) the lot number assigned by the manufacturer;

''(IV) the name, location, and registration number of the importer; and

''(V) the National Drug Code number assigned to the qualifying drug by the Secretary.

''(ii) REQUEST FOR COPY OF THE LABELING.—The Secretary shall provide such copy to the registered importer involved, upon request of the importer.

''(iii) REQUESTED LABELING.—The labeling provided by the Secretary under clause (ii) shall—

''(I) include the established name, as defined in section 502(e)(3), for each active ingredient in the qualifying drug;

''(II) not include the proprietary name of the U.S. label drug or any active ingredient thereof;

''(III) if required under paragraph (2)(B)(vi)(III), a prominent advisory that the qualifying drug is safe and effective but not bioequivalent to the U.S. label drug; and

''(IV) if the inactive ingredients of the qualifying drug are different from the inactive ingredients for the U.S. label drug, include—

''(aa) a prominent notice that the ingredients of the qualifying drug differ from the ingredients of the U.S. label drug and that the qualifying drug must be dispensed with an advisory to people with allergies about this difference and a list of ingredients; and

''(bb) a list of the ingredients of the qualifying drug as would be required under section 502(e).

''(B) IMPORTATION BY INDIVIDUAL.—

''(i) IN GENERAL.—In the case of a qualifying drug that is imported or offered for import by a registered exporter to an individual, such drug shall be considered to be in compliance with section 502 and the labeling requirements under the approved application for the U.S. label drug if the packaging and labeling of the qualifying drug complies with all applicable regulations promulgated under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.) and the labeling of the qualifying drug includes—

''(I) directions for use by the consumer;

''(II) the lot number assigned by the manufacturer;

''(III) the name and registration number of the exporter;

''(IV) if required under paragraph (2)(B)(vi)(III), a prominent advisory that the drug is safe and effective but not bioequivalent to the U.S. label drug;

''(V) if the inactive ingredients of the drug are different from the inactive ingredients for the U.S. label drug—

''(aa) a prominent advisory that persons with an allergy should check the ingredient list of the drug because the ingredients of the drug differ from the ingredients of the U.S. label drug; and

''(bb) a list of the ingredients of the drug as would be required under section 502(e); and

''(VI) a copy of any special labeling that would be required by the Secretary had the U.S. label drug been dispensed by a pharmacist in the United States, without regard to whether the special labeling bears any trademark involved.

''(ii) PACKAGING.—A qualifying drug offered for import to an individual by an exporter under this section that is packaged in a unit-of-use container (as those items are defined in the United States Pharmacopeia and National Formulary) shall not be repackaged, provided that—

''(I) the packaging complies with all applicable regulations under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.); or

''(II) the consumer consents to waive the requirements of such Act, after being informed that the packaging does not comply with such Act and that the exporter will provide the drug in packaging that is compliant at no additional cost.

''(iii) REQUEST FOR COPY OF SPECIAL LABELING AND INGREDIENT LIST.—The Secretary shall provide to the registered exporter involved a copy of the special labeling, the advisory, and the ingredient list described under clause (i), upon request of the exporter.

''(iv) REQUESTED LABELING AND INGREDIENT LIST.—The labeling and ingredient list provided by the Secretary under clause (iii) shall—

''(I) include the established name, as defined in section 502(e)(3), for each active ingredient in the drug; and

''(II) not include the proprietary name of the U.S. label drug or any active ingredient thereof.

''(4) SECTION 501; ADULTERATION.—A qualifying drug that is imported or offered for import under subsection (a) shall be considered to be in compliance with section 501 if the drug is in compliance with subsection (c).

''(5) STANDARDS FOR REFUSING ADMISSION.—A drug exported under subsection (a) from a registered exporter or imported by a registered importer may be refused admission into the United States if 1 or more of the following applies:

''(A) The drug is not a qualifying drug.

''(B) A notice for the drug required under paragraph (2)(B) has not been submitted to the Secretary.

''(C) The Secretary has ordered that importation of the drug from the permitted country cease under subparagraph (C) or (D) of paragraph (2).

''(D) The drug does not comply with paragraph (3) or (4).

''(E) The shipping container appears damaged in a way that may affect the strength, quality, or purity of the drug.

''(F) The Secretary becomes aware that—

''(i) the drug may be counterfeit;

''(ii) the drug may have been prepared, packed, or held under insanitary conditions; or

''(iii) the methods used in, or the facilities or controls used for, the manufacturing, processing, packing, or holding of the drug do not conform to good manufacturing practice.

''(G) The Secretary has obtained an injunction under section 302 that prohibits the distribution of the drug in interstate commerce.

''(H) The Secretary has under section 505(e) withdrawn approval of the drug.

''(I) The manufacturer of the drug has instituted a recall of the drug.

''(J) If the drug is imported or offered for import by a registered importer without submission of a notice in accordance with subsection (d)(4).

''(K) If the drug is imported or offered for import from a registered exporter to an individual and 1 or more of the following applies:

''(i) The shipping container for such drug does not bear the markings required under subsection (d)(2).

''(ii) The markings on the shipping container appear to be counterfeit.

''(iii) The shipping container or markings appear to have been tampered with.

''(h) EXPORTER LICENSURE IN PERMITTED COUNTRY.—A registration condition is that the exporter involved agrees that a qualifying drug will be exported to an individual only if the Secretary has verified that—

''(1) the exporter is authorized under the law of the permitted country in which the exporter is located to dispense prescription drugs; and

''(2) the exporter employs persons that are licensed under the law of the permitted country in which the exporter is located to dispense prescription drugs in sufficient number to dispense safely the drugs exported by the exporter to individuals, and the exporter assigns to those persons responsibility for dispensing such drugs to individuals.

''(i) INDIVIDUALS; CONDITIONS FOR IMPORTATION.—

''(1) IN GENERAL.—For purposes of subsection (a)(2)(B), the importation of a qualifying drug by an individual is in accordance with this subsection if the following conditions are met:

''(A) The drug is accompanied by a copy of a prescription for the drug, which prescription—

''(i) is valid under applicable Federal and State laws; and

''(ii) was issued by a practitioner who, under the law of a State of which the individual is a resident, or in which the individual receives care from the practitioner who issues the prescription, is authorized to administer prescription drugs.

''(B) The drug is accompanied by a copy of the documentation that was required under the law or regulations of the permitted country in which the exporter is located, as a condition of dispensing the drug to the individual.

''(C) The copies referred to in subparagraphs (A)(i) and (B) are marked in a manner sufficient—

''(i) to indicate that the prescription, and the equivalent document in the permitted country in which the exporter is located, have been filled; and

''(ii) to prevent a duplicative filling by another pharmacist.

''(D) The individual has provided to the registered exporter a complete list of all drugs used by the individual for review by the individuals who dispense the drug.

''(E) The quantity of the drug does not exceed a 90-day supply.

''(F) The drug is not an ineligible subpart H drug. For purposes of this section, a prescription drug is an 'ineligible subpart H drug' if the drug was approved by the Secretary under subpart H of part 314 of title 21, Code of Federal Regulations (relating to accelerated approval), with restrictions under section 520 of such part to assure safe use, and the Secretary has published in the Federal Register a notice that the Secretary has determined that good cause exists to prohibit the drug from being imported pursuant to this subsection.

''(2) NOTICE REGARDING DRUG REFUSED ADMISSION.—If a registered exporter ships a drug to an individual pursuant to subsection (a)(2)(B) and the drug is refused admission to the United States, a written notice shall be sent to the individual and to the exporter that informs the individual and the exporter of such refusal and the reason for the refusal.

''(j) MAINTENANCE OF RECORDS AND SAMPLES.—

''(1) IN GENERAL.—A registration condition is that the importer or exporter involved shall—

''(A) maintain records required under this section for not less than 2 years; and

''(B) maintain samples of each lot of a qualifying drug required under this section for not more than 2 years.

''(2) PLACE OF RECORD MAINTENANCE.—The records described under paragraph (1) shall be maintained—

''(A) in the case of an importer, at the place of business of the importer at which the importer initially receives the qualifying drug after importation; or

''(B) in the case of an exporter, at the facility from which the exporter ships the qualifying drug to the United States.

''(k) DRUG RECALLS.—

''(1) MANUFACTURERS.—A person that manufactures a qualifying drug imported from a permitted country under this section shall promptly inform the Secretary—

''(A) if the drug is recalled or withdrawn from the market in a permitted country;

''(B) how the drug may be identified, including lot number; and

''(C) the reason for the recall or withdrawal.

''(2) SECRETARY.—With respect to each permitted country, the Secretary shall—

''(A) enter into an agreement with the government of the country to receive information about recalls and withdrawals of qualifying drugs in the country; or

''(B) monitor recalls and withdrawals of qualifying drugs in the country using any information that is available to the public in any media.

''(3) NOTICE.—The Secretary may notify, as appropriate, registered exporters, registered importers, wholesalers, pharmacies, or the public of a recall or withdrawal of a qualifying drug in a permitted country.

''(l) DRUG LABELING AND PACKAGING.—

''(1) IN GENERAL.—When a qualifying drug that is imported into the United States by an importer under subsection (a) is dispensed by a pharmacist to an individual, the pharmacist shall provide that the packaging and labeling of the drug complies with all applicable regulations promulgated under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.) and shall include with any other labeling provided to the individual the following:

''(A) The lot number assigned by the manufacturer.

''(B) The name and registration number of the importer.

''(C) If required under paragraph (2)(B)(vi)(III) of subsection (g), a prominent advisory that the drug is safe and effective but not bioequivalent to the U.S. label drug.

''(D) If the inactive ingredients of the drug are different from the inactive ingredients for the U.S. label drug—

''(i) a prominent advisory that persons with allergies should check the ingredient list of the drug because the ingredients of the drug differ from the ingredients of the U.S. label drug; and

''(ii) a list of the ingredients of the drug as would be required under section 502(e).

''(2) PACKAGING.—A qualifying drug that is packaged in a unit-of-use container (as those terms are defined in the United States Pharmacopeia and National Formulary) shall not be repackaged, provided that—

''(A) the packaging complies with all applicable regulations under sections 3 and 4 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471 et seq.); or

''(B) the consumer consents to waive the requirements of such Act, after being informed that the packaging does not comply with such Act and that the pharmacist will provide the drug in packaging that is compliant at no additional cost.

''(m) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, this section does not authorize the importation into the United States of a qualifying drug donated or otherwise supplied for free or at nominal cost by the manufacturer of the drug to a charitable or humanitarian organization, including the United Nations and affiliates, or to a government of a foreign country.

''(n) UNFAIR AND DISCRIMINATORY ACTS AND PRACTICES.—

''(1) IN GENERAL.—It is unlawful for a manufacturer, directly or indirectly (including by being a party to a licensing agreement or other agreement), to—

''(A) discriminate by charging a higher price for a prescription drug sold to a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section than the price that is charged, inclusive of rebates or other incentives to the permitted country or other person, to another person that is in the same country and that does not export a qualifying drug into the United States under this section;

''(B) discriminate by charging a higher price for a prescription drug sold to a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section than the price that is charged to another person in the United States that does not import a qualifying drug under this section, or that does not distribute, sell, or use such a drug;

''(C) discriminate by denying, restricting, or delaying supplies of a prescription drug to a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section or to a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section;

''(D) discriminate by publicly, privately, or otherwise refusing to do business with a registered exporter or other person in a permitted country that exports a qualifying drug to the United States under this section or with a registered importer or other person that distributes, sells, or uses a qualifying drug imported into the United States under this section;

''(E) knowingly fail to submit a notice under subsection (g)(2)(B)(i), knowingly fail to submit such a notice on or before the date specified in subsection (g)(2)(B)(v) or as otherwise required under paragraphs (3), (4), and (5) of section 10004(e) of the Pharmaceutical Market Access and Drug Safety Act of 2009, knowingly submit such a notice that makes a materially false, fictitious, or fraudulent statement, or knowingly fail to provide promptly any information requested by the Secretary to review such a notice;

''(F) knowingly fail to submit an application required under subsection (g)(2)(F), knowingly fail to submit such an application on or before the date specified in subsection (g)(2)(F)(iii), knowingly submit such an application that makes a materially false, fictitious, or fraudulent statement, or knowingly fail to provide promptly any information requested by the Secretary to review such an application;

''(G) cause there to be a difference (including a difference in active ingredient, route of administration, dosage form, strength, formulation, manufacturing establishment, manufacturing process, or person that manufactures the drug) between a prescription drug for distribution in the United States and the drug for distribution in a permitted country;

''(H) refuse to allow an inspection authorized under this section of an establishment that manufactures a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country;

''(I) fail to conform to the methods used in, or the facilities used for, the manufacturing, processing, packing, or holding of a qualifying drug that is, or will be, introduced for commercial distribution in a permitted country to good manufacturing practice under this Act;

''(J) become a party to a licensing agreement or other agreement related to a qualifying drug that fails to provide for compliance with all requirements of this section with respect to such drug;

''(K) enter into a contract that restricts, prohibits, or delays the importation of a qualifying drug under this section;

''(L) engage in any other action to restrict, prohibit, or delay the importation of a qualifying drug under this section; or

''(M) engage in any other action that the Federal Trade Commission determines to discriminate against a person that engages or attempts to engage in the importation of a qualifying drug under this section.

''(2) REFERRAL OF POTENTIAL VIOLATIONS.—The Secretary shall promptly refer to the Federal Trade Commission each potential violation of subparagraph (E), (F), (G), (H), or (I) of paragraph (1) that becomes known to the Secretary.

''(3) AFFIRMATIVE DEFENSE.—

''(A) DISCRIMINATION.—It shall be an affirmative defense to a charge that a manufacturer has discriminated under subparagraph (A), (B), (C), (D), or (M) of paragraph (1) that the higher price charged for a prescription drug sold to a person, the denial, restriction, or delay of supplies of a prescription drug to a person, the refusal to do business with a person, or other discriminatory activity against a person, is not based, in whole or in part, on—

''(i) the person exporting or importing a qualifying drug into the United States under this section; or

''(ii) the person distributing, selling, or using a qualifying drug imported into the United States under this section.

''(B) DRUG DIFFERENCES.—It shall be an affirmative defense to a charge that a manufacturer has caused there to be a difference described in subparagraph (G) of paragraph (1) that—

''(i) the difference was required by the country in which the drug is distributed;

''(ii) the Secretary has determined that the difference was necessary to improve the safety or effectiveness of the drug;

''(iii) the person manufacturing the drug for distribution in the United States has given notice to the Secretary under subsection (g)(2)(B)(i) that the drug for distribution in the United States is not different from a drug for distribution in permitted countries whose combined population represents at least 50 percent of the total population of all permitted countries; or

''(iv) the difference was not caused, in whole or in part, for the purpose of restricting importation of the drug into the United States under this section.

''(4) EFFECT OF SUBSECTION.—

''(A) SALES IN OTHER COUNTRIES.—This subsection applies only to the sale or distribution of a prescription drug in a country if the manufacturer of the drug chooses to sell or distribute the drug in the country. Nothing in this subsection shall be construed to compel the manufacturer of a drug to distribute or sell the drug in a country.

''(B) DISCOUNTS TO INSURERS, HEALTH PLANS, PHARMACY BENEFIT MANAGERS, AND COVERED ENTITIES.—Nothing in this subsection shall be construed to—

''(i) prevent or restrict a manufacturer of a prescription drug from providing discounts to an insurer, health plan, pharmacy benefit manager in the United States, or covered entity in the drug discount program under section 340B of the Public Health Service Act (42 U.S.C. 256b) in return for inclusion of the drug on a formulary;

''(ii) require that such discounts be made available to other purchasers of the prescription drug; or

''(iii) prevent or restrict any other measures taken by an insurer, health plan, or pharmacy benefit manager to encourage consumption of such prescription drug.

''(C) CHARITABLE CONTRIBUTIONS.—Nothing in this subsection shall be construed to—

''(i) prevent a manufacturer from donating a prescription drug, or supplying a prescription drug at nominal cost, to a charitable or humanitarian organization, including the United Nations and affiliates, or to a government of a foreign country; or

''(ii) apply to such donations or supplying of a prescription drug.

''(5) ENFORCEMENT.—

''(A) UNFAIR OR DECEPTIVE ACT OR PRACTICE.—A violation of this subsection shall be treated as a violation of a rule defining an unfair or deceptive act or practice prescribed under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)).

''(B) ACTIONS BY THE COMMISSION.—The Federal Trade Commission—

''(i) shall enforce this subsection in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made a part of this section; and

''(ii) may seek monetary relief threefold the damages sustained, in addition to any other remedy available to the Federal Trade Commission under the Federal Trade Commission Act (15 U.S.C. 41 et seq.).

''(6) ACTIONS BY STATES.—

''(A) IN GENERAL.—

''(i) CIVIL ACTIONS.—In any case in which the attorney general of a State has reason to believe that an interest of the residents of that State have been adversely affected by any manufacturer that violates paragraph (1), the attorney general of a State may bring a civil action on behalf of the residents of the State, and persons doing business in the State, in a district court of the United States of appropriate jurisdiction to—

''(I) enjoin that practice;

''(II) enforce compliance with this subsection;

''(III) obtain damages, restitution, or other compensation on behalf of residents of the State and persons doing business in the State, including threefold the damages; or

''(IV) obtain such other relief as the court may consider to be appropriate.

''(ii) NOTICE.—

''(I) IN GENERAL.—Before filing an action under clause (i), the attorney general of the State involved shall provide to the Federal Trade Commission—

''(aa) written notice of that action; and

''(bb) a copy of the complaint for that action.

''(II) EXEMPTION.—Subclause (I) shall not apply with respect to the filing of an action by an attorney general of a State under this paragraph, if the attorney general determines that it is not feasible to provide the notice described in that subclause before filing of the action. In such case, the attorney general of a State shall provide notice and a copy of the complaint to the Federal Trade Commission at the same time as the attorney general files the action.

''(B) INTERVENTION.—

''(i) IN GENERAL.—On receiving notice under subparagraph (A)(ii), the Federal Trade Commission shall have the right to intervene in the action that is the subject of the notice.

''(ii) EFFECT OF INTERVENTION.—If the Federal Trade Commission intervenes in an action under subparagraph (A), it shall have the right—

''(I) to be heard with respect to any matter that arises in that action; and

''(II) to file a petition for appeal.

''(C) CONSTRUCTION.—For purposes of bringing any civil action under subparagraph (A), nothing in this subsection shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State to—

''(i) conduct investigations;

''(ii) administer oaths or affirmations; or

''(iii) compel the attendance of witnesses or the production of documentary and other evidence.

''(D) ACTIONS BY THE COMMISSION.—In any case in which an action is instituted by or on behalf of the Federal Trade Commission for a violation of paragraph (1), a State may not, during the pendency of that action, institute an action under subparagraph (A) for the same violation against any defendant named in the complaint in that action.

''(E) VENUE.—Any action brought under subparagraph (A) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

''(F) SERVICE OF PROCESS.—In an action brought under subparagraph (A), process may be served in any district in which the defendant—

''(i) is an inhabitant; or

''(ii) may be found.

''(G) MEASUREMENT OF DAMAGES.—In any action under this paragraph to enforce a cause of action under this subsection in which there has been a determination that a defendant has violated a provision of this subsection, damages may be proved and assessed in the aggregate by statistical or sampling methods, by the computation of illegal overcharges or by such other reasonable system of estimating aggregate damages as the court in its discretion may permit without the necessity of separately proving the individual claim of, or amount of damage to, persons on whose behalf the suit was brought.

''(H) EXCLUSION ON DUPLICATIVE RELIEF.—The district court shall exclude from the amount of monetary relief awarded in an action under this paragraph brought by the attorney general of a State any amount of monetary relief which duplicates amounts which have been awarded for the same injury.

''(7) EFFECT ON ANTITRUST LAWS.—Nothing in this subsection shall be construed to modify, impair, or supersede the operation of the antitrust laws. For the purpose of this subsection, the term 'antitrust laws' has the meaning given it in the first section of the Clayton Act, except that it includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

''(8) MANUFACTURER.—In this subsection, the term 'manufacturer' means any entity, including any affiliate or licensee of that entity, that is engaged in—

''(A) the production, preparation, propagation, compounding, conversion, or processing of a prescription drug, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or

''(B) the packaging, repackaging, labeling, relabeling, or distribution of a prescription drug.''.

(b) PROHIBITED ACTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301 (21 U.S.C. 331), by striking paragraph (aa) and inserting the following:

''(aa)(1) The sale or trade by a pharmacist, or by a business organization of which the pharmacist is a part, of a qualifying drug that under section 804(a)(2)(A) was imported by the pharmacist, other than—

''(A) a sale at retail made pursuant to dispensing the drug to a customer of the pharmacist or organization; or

''(B) a sale or trade of the drug to a pharmacy or a wholesaler registered to import drugs under section 804.

''(2) The sale or trade by an individual of a qualifying drug that under section 804(a)(2)(B) was imported by the individual.

''(3) The making of a materially false, fictitious, or fraudulent statement or representation, or a material omission, in a notice under clause (i) of section 804(g)(2)(B) or in an application required under section 804(g)(2)(F), or the failure to submit such a notice or application.

''(4) The importation of a drug in violation of a registration condition or other requirement under section 804, the falsification of any record required to be maintained, or provided to the Secretary, under such section, or the violation of any registration condition or other requirement under such section.''; and

(2) in section 303(a) (21 U.S.C. 333(a)), by striking paragraph (6) and inserting the following:

''(6) Notwithstanding subsection (a), any person that knowingly violates section 301(i)

(2) or (3) or section 301(aa)(4) shall be imprisoned not more than 10 years, or fined in accordance with title 18, United States Code, or both.''.

(c) AMENDMENT OF CERTAIN PROVISIONS.—

(1) IN GENERAL.—Section 801 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381) is amended by striking subsection (g) and inserting the following:

''(g) With respect to a prescription drug that is imported or offered for import into the United States by an individual who is not in the business of such importation, that is not shipped by a registered exporter under section 804, and that is refused admission under subsection (a), the Secretary shall notify the individual that—

''(1) the drug has been refused admission because the drug was not a lawful import under section 804;

''(2) the drug is not otherwise subject to a waiver of the requirements of subsection (a);

''(3) the individual may under section 804 lawfully import certain prescription drugs from exporters registered with the Secretary under section 804; and

''(4) the individual can find information about such importation, including a list of registered exporters, on the Internet website of the Food and Drug Administration or through a toll-free telephone number required under section 804.''.

(2) ESTABLISHMENT REGISTRATION.—Section 510(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(i)) is amended in paragraph (1) by inserting after ''import into the United States'' the following: '', including a drug that is, or may be, imported or offered for import into the United States under section 804,''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date that is 90 days after the date of enactment of this Act.

(d) EXHAUSTION.—

(1) IN GENERAL.—Section 271 of title 35, United States Code, is amended—

(A) by redesignating subsections (h) and (i) as (i) and (j), respectively; and

(B) by inserting after subsection (g) the following:

''(h) It shall not be an act of infringement to use, offer to sell, or sell within the United States or to import into the United States any patented invention under section 804 of the Federal Food, Drug, and Cosmetic Act that was first sold abroad by or under authority of the owner or licensee of such patent.''.

(2) RULE OF CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the ability of a patent owner or licensee to enforce their patent, subject to such amendment.

(e) EFFECT OF SECTION 804.—

(1) IN GENERAL.—Section 804 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall permit the importation of qualifying drugs (as defined in such section 804) into the United States without regard to the status of the issuance of implementing regulations—

(A) from exporters registered under such section 804 on the date that is 90 days after the date of enactment of this Act; and

(B) from permitted countries, as defined in such section 804, by importers registered under such section 804 on the date that is 1 year after the date of enactment of this Act.

(2) REVIEW OF REGISTRATION BY CERTAIN EXPORTERS.—

(A) REVIEW PRIORITY.—In the review of registrations submitted under subsection (b) of such section 804, registrations submitted by entities in Canada that are significant exporters of prescription drugs to individuals in the United States as of the date of enactment of this Act will have priority during the 90 day period that begins on such date of enactment.

(B) PERIOD FOR REVIEW.—During such 90-day period, the reference in subsection (b)(2)(A) of such section 804 to 90 days (relating to approval or disapproval of registrations) is, as applied to such entities, deemed to be 30 days.

(C) LIMITATION.—That an exporter in Canada exports, or has exported, prescription drugs to individuals in the United States on or before the date that is 90 days after the date of enactment of this Act shall not serve as a basis, in whole or in part, for disapproving a registration under such section 804 from the exporter.

(D) FIRST YEAR LIMIT ON NUMBER OF EXPORTERS.—During the 1-year period beginning on the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') may limit the number of registered exporters under such section 804 to not less than 50, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(E) SECOND YEAR LIMIT ON NUMBER OF EXPORTERS.—During the 1-year period beginning on the date that is 1 year after the date of enactment of this Act, the Secretary may limit the number of registered exporters under such section 804 to not less than 100, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(F) FURTHER LIMIT ON NUMBER OF EXPORTERS.—During any 1-year period beginning on a date that is 2 or more years after the date of enactment of this Act, the Secretary may limit the number of registered exporters under such section 804 to not less than 25 more than the number of such exporters during the previous 1-year period, so long as the Secretary gives priority to those exporters with demonstrated ability to process a high volume of shipments of drugs to individuals in the United States.

(3) LIMITS ON NUMBER OF IMPORTERS.—

(A) FIRST YEAR LIMIT ON NUMBER OF IMPORTERS.—During the 1-year period beginning on the date that is 1 year after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 100 (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups), so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs imported into the United States.

(B) SECOND YEAR LIMIT ON NUMBER OF IMPORTERS.—During the 1-year period beginning on the date that is 2 years after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 200 (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups), so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs into the United States.

(C) FURTHER LIMIT ON NUMBER OF IMPORTERS.—During any 1-year period beginning on a date that is 3 or more years after the date of enactment of this Act, the Secretary may limit the number of registered importers under such section 804 to not less than 50 more (of which at least a significant number shall be groups of pharmacies, to the extent feasible given the applications submitted by such groups) than the number of such importers during the previous 1-year period, so long as the Secretary gives priority to those importers with demonstrated ability to process a high volume of shipments of drugs to the United States.

(4) NOTICES FOR DRUGS FOR IMPORT FROM CANADA.—The notice with respect to a qualifying drug introduced for commercial distribution in Canada as of the date of enactment of this Act that is required under subsection (g)(2)(B)(i) of such section 804 shall be submitted to the Secretary not later than 30 days after the date of enactment of this Act if—

(A) the U.S. label drug (as defined in such section 804) for the qualifying drug is 1 of the 100 prescription drugs with the highest dollar volume of sales in the United States based on the 12 calendar month period most recently completed before the date of enactment of this Act; or

(B) the notice is a notice under subsection (g)(2)(B)(i)(II) of such section 804.

(5) NOTICE FOR DRUGS FOR IMPORT FROM OTHER COUNTRIES.—The notice with respect to a qualifying drug introduced for commercial distribution in a permitted country other than Canada as of the date of enactment of this Act that is required under subsection (g)(2)(B)(i) of such section 804 shall be submitted to the Secretary not later than 180 days after the date of enactment of this Act if—

(A) the U.S. label drug for the qualifying drug is 1 of the 100 prescription drugs with the highest dollar volume of sales in the United States based on the 12 calendar month period that is first completed on the date that is 120 days after the date of enactment of this Act; or

(B) the notice is a notice under subsection (g)(2)(B)(i)(II) of such section 804.

(6) NOTICE FOR OTHER DRUGS FOR IMPORT.—

(A) GUIDANCE ON SUBMISSION DATES.—The Secretary shall by guidance establish a series of submission dates for the notices under subsection (g)(2)(B)(i) of such section 804 with respect to qualifying drugs introduced for commercial distribution as of the date of enactment of this Act and that are not required to be submitted under paragraph (4) or (5).

(B) CONSISTENT AND EFFICIENT USE OF RESOURCES.—The Secretary shall establish the dates described under subparagraph (A) so that such notices described under subparagraph (A) are submitted and reviewed at a rate that allows consistent and efficient use of the resources and staff available to the Secretary for such reviews. The Secretary may condition the requirement to submit such a notice, and the review of such a notice, on the submission by a registered exporter or a registered importer to the Secretary of a notice that such exporter or importer intends to import such qualifying drug to the United States under such section 804.

(C) PRIORITY FOR DRUGS WITH HIGHER SALES.—The Secretary shall establish the dates described under subparagraph (A) so that the Secretary reviews the notices described under such subparagraph with respect to qualifying drugs with higher dollar volume of sales in the United States before the notices with respect to drugs with lower sales in the United States.

(7) NOTICES FOR DRUGS APPROVED AFTER EFFECTIVE DATE.—The notice required under subsection (g)(2)(B)(i) of such section 804 for a qualifying drug first introduced for commercial distribution in a permitted country (as defined in such section 804) after the date of enactment of this Act shall be submitted to and reviewed by the Secretary as provided under subsection (g)(2)(B) of such section 804, without regard to paragraph (4), (5), or (6).

(8) REPORT.—Beginning with the first full fiscal year after the date of enactment of this Act, not later than 90 days after the end of each fiscal year during which the Secretary reviews a notice referred to in paragraph (4), (5), or (6), the Secretary shall submit a report to Congress concerning the progress of the Food and Drug Administration in reviewing the notices referred to in paragraphs (4), (5), and (6).

(9) USER FEES.—

(A) EXPORTERS.—When establishing an aggregate total of fees to be collected from exporters under subsection (f)(2) of such section 804, the Secretary shall, under subsection (f)(3)(C)(i) of such section 804, estimate the total price of drugs imported under subsection (a) of such section 804 into the United States by registered exporters during the first fiscal year in which this title takes effect to be an amount equal to the amount which bears the same ratio to $1,000,000,000 as the number of days in such fiscal year during which this title is effective bears to 365.

(B) IMPORTERS.—When establishing an aggregate total of fees to be collected from importers under subsection (e)(2) of such section 804, the Secretary shall, under subsection (e)(3)(C)(i) of such section 804, estimate the total price of drugs imported under subsection (a) of such section 804 into the United States by registered importers during—

(i) the first fiscal year in which this title takes effect to be an amount equal to the amount which bears the same ratio to $1,000,000,000 as the number of days in such fiscal year during which this title is effective bears to 365; and

(ii) the second fiscal year in which this title is in effect to be $3,000,000,000.

(C) SECOND YEAR ADJUSTMENT.—

(i) REPORTS.—Not later than February 20 of the second fiscal year in which this title is in effect, registered importers shall report to the Secretary the total price and the total volume of drugs imported to the United States by the importer during the 4-month period from October 1 through January 31 of such fiscal year.

(ii) REESTIMATE.—Notwithstanding subsection (e)(3)(C)(ii) of such section 804 or subparagraph (B), the Secretary shall reestimate the total price of qualifying drugs imported under subsection (a) of such section 804 into the United States by registered importers during the second fiscal year in which this title is in effect. Such reestimate shall be equal to—

(I) the total price of qualifying drugs imported by each importer as reported under clause (i); multiplied by

(II) 3.

(iii) ADJUSTMENT.—The Secretary shall adjust the fee due on April 1 of the second fiscal year in which this title is in effect, from each importer so that the aggregate total of fees collected under subsection (e)(2) for such fiscal year does not exceed the total price of qualifying drugs imported under subsection (a) of such section 804 into the United States by registered importers during such fiscal year as reestimated under clause (ii).

(D) FAILURE TO PAY FEES.—Notwithstanding any other provision of this section, the Secretary may prohibit a registered importer or exporter that is required to pay user fees under subsection (e) or (f) of such section 804 and that fails to pay such fees within 30 days after the date on which it is due, from importing or offering for importation a qualifying drug under such section 804 until such fee is paid.

(E) ANNUAL REPORT.—

(i) FOOD AND DRUG ADMINISTRATION.—Not later than 180 days after the end of each fiscal year during which fees are collected under subsection (e), (f), or (g)(2)(B)(iv) of such section 804, the Secretary shall prepare and submit to the House of Representatives and the Senate a report on the implementation of the authority for such fees during such fiscal year and the use, by the Food and Drug Administration, of the fees collected for the fiscal year for which the report is made and credited to the Food and Drug Administration.

(ii) CUSTOMS AND BORDER PROTECTION.—Not later than 180 days after the end of each fiscal year during which fees are collected under subsection (e) or (f) of such section 804, the Secretary of Homeland Security, in consultation with the Secretary of the Treasury, shall prepare and submit to the House of Representatives and the Senate a report on the use, by the Bureau of Customs and Border Protection, of the fees, if any, transferred by the Secretary to the Bureau of Customs and Border Protection for the fiscal year for which the report is made.

(10) SPECIAL RULE REGARDING IMPORTATION BY INDIVIDUALS.—

(A) IN GENERAL.—Notwithstanding any provision of this title (or an amendment made by this title), the Secretary shall expedite the designation of any additional permitted countries from which an individual may import a qualifying drug into the United States under such section 804 if any action implemented by the Government of Canada has the effect of limiting or prohibiting the importation of qualifying drugs into the United States from Canada.

(B) TIMING AND CRITERIA.—The Secretary shall designate such additional permitted countries under subparagraph (A)—

(i) not later than 6 months after the date of the action by the Government of Canada described under such subparagraph; and

(ii) using the criteria described under subsection (a)(4)(D)(i)(II) of such section 804.

(f) IMPLEMENTATION OF SECTION 804.—

(1) INTERIM RULE.—The Secretary may promulgate an interim rule for implementing section 804 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a) of this section.

(2) NO NOTICE OF PROPOSED RULEMAKING.—The interim rule described under paragraph (1) may be developed and promulgated by the Secretary without providing general notice of proposed rulemaking.

(3) FINAL RULE.—Not later than 1 year after the date on which the Secretary promulgates an interim rule under paragraph (1), the Secretary shall, in accordance with procedures under section 553 of title 5, United States Code, promulgate a final rule for implementing such section 804, which may incorporate by reference provisions of the interim rule provided for under paragraph (1), to the extent that such provisions are not modified.

(g) CONSUMER EDUCATION.—The Secretary shall carry out activities that educate consumers—

(1) with regard to the availability of qualifying drugs for import for personal use from an exporter registered with and approved by the Food and Drug Administration under section 804 of the Federal Food, Drug, and Cosmetic Act, as added by this section, including information on how to verify whether an exporter is registered and approved by use of the Internet website of the Food and Drug Administration and the toll-free telephone number required by this title;

(2) that drugs that consumers attempt to import from an exporter that is not registered with and approved by the Food and Drug Administration can be seized by the United States Customs Service and destroyed, and that such drugs may be counterfeit, unapproved, unsafe, or ineffective;

(3) with regard to the suspension and termination of any registration of a registered importer or exporter under such section 804; and

(4) with regard to the availability at domestic retail pharmacies of qualifying drugs imported under such section 804 by domestic wholesalers and pharmacies registered with and approved by the Food and Drug Administration.

(h) EFFECT ON ADMINISTRATION PRACTICES.—Notwithstanding any provision of this title (and the amendments made by this title), the practices and policies of the Food and Drug Administration and Bureau of Customs and Border Protection, in effect on January 1, 2004, with respect to the importation of prescription drugs into the United States by an individual, on the person of such individual, for personal use, shall remain in effect.

(i) REPORT TO CONGRESS.—The Federal Trade Commission shall, on an annual basis, submit to Congress a report that describes any action taken during the period for which the report is being prepared to enforce the provisions of section 804(n) of the Federal Food, Drug, and Cosmetic Act (as added by this title), including any pending investigations or civil actions under such section.

SEC. 10005. DISPOSITION OF CERTAIN DRUGS DENIED ADMISSION INTO UNITED STATES.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.), as amended by section 10004, is further amended by adding at the end the following section:

''SEC. 805. DISPOSITION OF CERTAIN DRUGS DENIED ADMISSION.

''(a) IN GENERAL.—The Secretary of Homeland Security shall deliver to the Secretary a shipment of drugs that is imported or offered for import into the United States if—

''(1) the shipment has a declared value of less than $10,000; and

''(2)(A) the shipping container for such drugs does not bear the markings required under section 804(d)(2); or

''(B) the Secretary has requested delivery of such shipment of drugs.

''(b) NO BOND OR EXPORT.—Section 801(b) does not authorize the delivery to the owner or consignee of drugs delivered to the Secretary under subsection (a) pursuant to the execution of a bond, and such drugs may not be exported.

''(c) DESTRUCTION OF VIOLATIVE SHIPMENT.—The Secretary shall destroy a shipment of drugs delivered by the Secretary of Homeland Security to the Secretary under subsection (a) if—

''(1) in the case of drugs that are imported or offered for import from a registered exporter under section 804, the drugs are in violation of any standard described in section 804(g)(5); or

''(2) in the case of drugs that are not imported or offered for import from a registered exporter under section 804, the drugs

are in violation of a standard referred to in section 801(a) or 801(d)(1).

''(d) CERTAIN PROCEDURES.—

''(1) IN GENERAL.—The delivery and destruction of drugs under this section may be carried out without notice to the importer, owner, or consignee of the drugs except as required by section 801(g) or section 804(i)(2). The issuance of receipts for the drugs, and recordkeeping activities regarding the drugs, may be carried out on a summary basis.

''(2) OBJECTIVE OF PROCEDURES.—Procedures promulgated under paragraph (1) shall be designed toward the objective of ensuring that, with respect to efficiently utilizing Federal resources available for carrying out this section, a substantial majority of shipments of drugs subject to described in subsection (c) are identified and destroyed.

''(e) EVIDENCE EXCEPTION.—Drugs may not be destroyed under subsection (c) to the extent that the Attorney General of the United States determines that the drugs should be preserved as evidence or potential evidence with respect to an offense against the United States.

''(f) RULE OF CONSTRUCTION.—This section may not be construed as having any legal effect on applicable law with respect to a shipment of drugs that is imported or offered for import into the United States and has a declared value equal to or greater than $10,000.''.

(b) PROCEDURES.—Procedures for carrying out section 805 of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall be established not later than 90 days after the date of the enactment of this Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 90 days after the date of enactment of this Act.

SEC. 10006. WHOLESALE DISTRIBUTION OF DRUGS; STATEMENTS REGARDING PRIOR SALE, PURCHASE, OR TRADE.

(a) STRIKING OF EXEMPTIONS; APPLICABILITY TO REGISTERED EXPORTERS.—Section 503(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(e)) is amended—

(1) in paragraph (1)—

(A) by striking ''and who is not the manufacturer or an authorized distributor of record of such drug'';

(B) by striking ''to an authorized distributor of record or''; and

(C) by striking subparagraph (B) and inserting the following:

''(B) The fact that a drug subject to subsection (b) is exported from the United States does not with respect to such drug exempt any person that is engaged in the business of the wholesale distribution of the drug from providing the statement described in subparagraph (A) to the person that receives the drug pursuant to the export of the drug.

''(C)(i) The Secretary shall by regulation establish requirements that supersede subparagraph (A) (referred to in this subparagraph as 'alternative requirements') to identify the chain of custody of a drug subject to subsection (b) from the manufacturer of the drug throughout the wholesale distribution of the drug to a pharmacist who intends to sell the drug at retail if the Secretary determines that the alternative requirements, which may include standardized anti-counterfeiting or track-and-trace technologies, will identify such chain of custody or the identity of the discrete package of the drug from which the drug is dispensed with equal or greater certainty to the requirements of subparagraph (A), and that the alternative requirements are economically and technically feasible.

''(ii) When the Secretary promulgates a final rule to establish such alternative requirements, the final rule in addition shall, with respect to the registration condition established in clause (i) of section 804(c)(3)(B), establish a condition equivalent to the alternative requirements, and such equivalent condition may be met in lieu of the registration condition established in such clause (i).'';

(2) in paragraph (2)(A), by adding at the end the following: ''The preceding sentence may not be construed as having any applicability with respect to a registered exporter under section 804.''; and

(3) in paragraph (3), by striking ''and subsection (d)—'' in the matter preceding subparagraph (A) and all that follows through ''the term 'wholesale distribution' means'' in subparagraph (B) and inserting the following: ''and subsection (d), the term 'wholesale distribution' means''.

(b) CONFORMING AMENDMENT.—Section 503(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(d)) is amended by adding at the end the following:

''(4) Each manufacturer of a drug subject to subsection (b) shall maintain at its corporate offices a current list of the authorized distributors of record of such drug.

''(5) For purposes of this subsection, the term 'authorized distributors of record' means those distributors with whom a manufacturer has established an ongoing relationship to distribute such manufacturer's products.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by paragraphs (1) and (3) of subsection (a) and by subsection (b) shall take effect on January 1, 2012.

(2) DRUGS IMPORTED BY REGISTERED IMPORTERS UNDER SECTION 804.—Notwithstanding paragraph (1), the amendments made by paragraphs (1) and (3) of subsection (a) and by subsection (b) shall take effect on the date that is 90 days after the date of enactment of this Act with respect to qualifying drugs imported under section 804 of the Federal Food, Drug, and Cosmetic Act, as added by section 10004.

(3) EFFECT WITH RESPECT TO REGISTERED EXPORTERS.—The amendment made by subsection (a)(2) shall take effect on the date that is 90 days after the date of enactment of this Act.

(4) ALTERNATIVE REQUIREMENTS.—The Secretary shall issue regulations to establish the alternative requirements, referred to in the amendment made by subsection (a)(1), that take effect not later than January 1, 2012.

(5) INTERMEDIATE REQUIREMENTS.—The Secretary shall by regulation require the use of standardized anti-counterfeiting or track-and-trace technologies on prescription drugs at the case and pallet level effective not later than 1 year after the date of enactment of this Act.

(6) ADDITIONAL REQUIREMENTS.—

(A) IN GENERAL.—Notwithstanding any other provision of this section, the Secretary shall, not later than 18 months after the date of enactment of this Act, require that the packaging of any prescription drug incorporates—

(i) a standardized numerical identifier unique to each package of such drug, applied at the point of manufacturing and repackaging (in which case the numerical identifier shall be linked to the numerical identifier applied at the point of manufacturing); and

(ii)(I) overt optically variable counterfeit-resistant technologies that—

(aa) are visible to the naked eye, providing for visual identification of product authenticity without the need for readers, microscopes, lighting devices, or scanners;

(bb) are similar to that used by the Bureau of Engraving and Printing to secure United States currency;

(cc) are manufactured and distributed in a highly secure, tightly controlled environment; and

(dd) incorporate additional layers of non-visible convert security features up to and including forensic capability, as described in subparagraph (B); or

(II) technologies that have a function of security comparable to that described in subclause (I), as determined by the Secretary.

(B) STANDARDS FOR PACKAGING.—For the purpose of making it more difficult to counterfeit the packaging of drugs subject to this paragraph, the manufacturers of such drugs shall incorporate the technologies described in subparagraph (A) into at least 1 additional element of the physical packaging of the drugs, including blister packs, shrink wrap, package labels, package seals, bottles, and boxes.

SEC. 10007. INTERNET SALES OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503B the following:

''SEC. 503C. INTERNET SALES OF PRESCRIPTION DRUGS.

''(a) REQUIREMENTS REGARDING INFORMATION ON INTERNET SITE.—

''(1) IN GENERAL.—A person may not dispense a prescription drug pursuant to a sale of the drug by such person if—

''(A) the purchaser of the drug submitted the purchase order for the drug, or conducted any other part of the sales transaction for the drug, through an Internet site;

''(B) the person dispenses the drug to the purchaser by mailing or shipping the drug to the purchaser; and

''(C) such site, or any other Internet site used by such person for purposes of sales of a prescription drug, fails to meet each of the requirements specified in paragraph (2), other than a site or pages on a site that—

''(i) are not intended to be accessed by purchasers or prospective purchasers; or

''(ii) provide an Internet information location tool within the meaning of section 231(e)(5) of the Communications Act of 1934 (47 U.S.C. 231(e)(5)).

''(2) REQUIREMENTS.—With respect to an Internet site, the requirements referred to in subparagraph (C) of paragraph (1) for a person to whom such paragraph applies are as follows:

''(A) Each page of the site shall include either the following information or a link to a page that provides the following information:

''(i) The name of such person.

''(ii) Each State in which the person is authorized by law to dispense prescription drugs.

''(iii) The address and telephone number of each place of business of the person with respect to sales of prescription drugs through the Internet, other than a place of business that does not mail or ship prescription drugs to purchasers.

''(iv) The name of each individual who serves as a pharmacist for prescription drugs that are mailed or shipped pursuant to the site, and each State in which the individual is authorized by law to dispense prescription drugs.

''(v) If the person provides for medical consultations through the site for purposes of

providing prescriptions, the name of each individual who provides such consultations; each State in which the individual is licensed or otherwise authorized by law to provide such consultations or practice medicine; and the type or types of health professions for which the individual holds such licenses or other authorizations.

''(B) A link to which paragraph (1) applies shall be displayed in a clear and prominent place and manner, and shall include in the caption for the link the words 'licensing and contact information'.

''(b) INTERNET SALES WITHOUT APPROPRIATE MEDICAL RELATIONSHIPS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a person may not dispense a prescription drug, or sell such a drug, if—

''(A) for purposes of such dispensing or sale, the purchaser communicated with the person through the Internet;

''(B) the patient for whom the drug was dispensed or purchased did not, when such communications began, have a prescription for the drug that is valid in the United States;

''(C) pursuant to such communications, the person provided for the involvement of a practitioner, or an individual represented by the person as a practitioner, and the practitioner or such individual issued a prescription for the drug that was purchased;

''(D) the person knew, or had reason to know, that the practitioner or the individual referred to in subparagraph (C) did not, when issuing the prescription, have a qualifying medical relationship with the patient; and

''(E) the person received payment for the dispensing or sale of the drug.

For purposes of subparagraph (E), payment is received if money or other valuable consideration is received.

''(2) EXCEPTIONS.—Paragraph (1) does not apply to—

''(A) the dispensing or selling of a prescription drug pursuant to telemedicine practices sponsored by—

''(i) a hospital that has in effect a provider agreement under title XVIII of the Social Security Act (relating to the Medicare program); or

''(ii) a group practice that has not fewer than 100 physicians who have in effect provider agreements under such title; or

''(B) the dispensing or selling of a prescription drug pursuant to practices that promote the public health, as determined by the Secretary by regulation.

''(3) QUALIFYING MEDICAL RELATIONSHIP.—

''(A) IN GENERAL.—With respect to issuing a prescription for a drug for a patient, a practitioner has a qualifying medical relationship with the patient for purposes of this section if—

''(i) at least one in-person medical evaluation of the patient has been conducted by the practitioner; or

''(ii) the practitioner conducts a medical evaluation of the patient as a covering practitioner.

''(B) IN-PERSON MEDICAL EVALUATION.—A medical evaluation by a practitioner is an in-person medical evaluation for purposes of this section if the practitioner is in the physical presence of the patient as part of conducting the evaluation, without regard to whether portions of the evaluation are conducted by other health professionals.

''(C) COVERING PRACTITIONER.—With respect to a patient, a practitioner is a covering practitioner for purposes of this section if the practitioner conducts a medical evaluation of the patient at the request of a practitioner who has conducted at least one in-person medical evaluation of the patient and is temporarily unavailable to conduct the evaluation of the patient. A practitioner is a covering practitioner without regard to whether the practitioner has conducted any in-person medical evaluation of the patient involved.

''(4) RULES OF CONSTRUCTION.—

''(A) INDIVIDUALS REPRESENTED AS PRACTITIONERS.—A person who is not a practitioner (as defined in subsection (e)(1)) lacks legal capacity under this section to have a qualifying medical relationship with any patient.

''(B) STANDARD PRACTICE OF PHARMACY.—Paragraph (1) may not be construed as prohibiting any conduct that is a standard practice in the practice of pharmacy.

''(C) APPLICABILITY OF REQUIREMENTS.—Paragraph (3) may not be construed as having any applicability beyond this section, and does not affect any State law, or interpretation of State law, concerning the practice of medicine.

''(c) ACTIONS BY STATES.—

''(1) IN GENERAL.—Whenever an attorney general of any State has reason to believe that the interests of the residents of that State have been or are being threatened or adversely affected because any person has engaged or is engaging in a pattern or practice that violates section 301(l), the State may bring a civil action on behalf of its residents in an appropriate district court of the United States to enjoin such practice, to enforce compliance with such section (including a nationwide injunction), to obtain damages, restitution, or other compensation on behalf of residents of such State, to obtain reasonable attorneys fees and costs if the State prevails in the civil action, or to obtain such further and other relief as the court may deem appropriate.

''(2) NOTICE.—The State shall serve prior written notice of any civil action under paragraph (1) or (5)(B) upon the Secretary and provide the Secretary with a copy of its complaint, except that if it is not feasible for the State to provide such prior notice, the State shall serve such notice immediately upon instituting such action. Upon receiving a notice respecting a civil action, the Secretary shall have the right—

''(A) to intervene in such action;

''(B) upon so intervening, to be heard on all matters arising therein; and

''(C) to file petitions for appeal.

''(3) CONSTRUCTION.—For purposes of bringing any civil action under paragraph (1), nothing in this chapter shall prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of such State to conduct investigations or to administer oaths or affirmations or to compel the attendance of witnesses or the production of documentary and other evidence.

''(4) VENUE; SERVICE OF PROCESS.—Any civil action brought under paragraph (1) in a district court of the United States may be brought in the district in which the defendant is found, is an inhabitant, or transacts business or wherever venue is proper under section 1391 of title 28, United States Code. Process in such an action may be served in any district in which the defendant is an inhabitant or in which the defendant may be found.

''(5) ACTIONS BY OTHER STATE OFFICIALS.—

''(A) Nothing contained in this section shall prohibit an authorized State official from proceeding in State court on the basis of an alleged violation of any civil or criminal statute of such State.

''(B) In addition to actions brought by an attorney general of a State under paragraph (1), such an action may be brought by officers of such State who are authorized by the State to bring actions in such State on behalf of its residents.

''(d) EFFECT OF SECTION.—This section shall not apply to a person that is a registered exporter under section 804.

''(e) GENERAL DEFINITIONS.—For purposes of this section:

''(1) The term 'practitioner' means a practitioner referred to in section 503(b)(1) with respect to issuing a written or oral prescription.

''(2) The term 'prescription drug' means a drug that is described in section 503(b)(1).

''(3) The term 'qualifying medical relationship', with respect to a practitioner and a patient, has the meaning indicated for such term in subsection (b).

''(f) INTERNET-RELATED DEFINITIONS.—

''(1) IN GENERAL.—For purposes of this section:

''(A) The term 'Internet' means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected world-wide network of networks that employ the transmission control protocol/internet protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio.

''(B) The term 'link', with respect to the Internet, means one or more letters, words, numbers, symbols, or graphic items that appear on a page of an Internet site for the purpose of serving, when activated, as a method for executing an electronic command—

''(i) to move from viewing one portion of a page on such site to another portion of the page;

''(ii) to move from viewing one page on such site to another page on such site; or

''(iii) to move from viewing a page on one Internet site to a page on another Internet site.

''(C) The term 'page', with respect to the Internet, means a document or other file accessed at an Internet site.

''(D)(i) The terms 'site' and 'address', with respect to the Internet, mean a specific location on the Internet that is determined by Internet Protocol numbers. Such term includes the domain name, if any.

''(ii) The term 'domain name' means a method of representing an Internet address without direct reference to the Internet Protocol numbers for the address, including methods that use designations such as '.com', '.edu', '.gov', '.net', or '.org'.

''(iii) The term 'Internet Protocol numbers' includes any successor protocol for determining a specific location on the Internet.

''(2) AUTHORITY OF SECRETARY.—The Secretary may by regulation modify any definition under paragraph (1) to take into account changes in technology.

''(g) INTERACTIVE COMPUTER SERVICE; ADVERTISING.—No provider of an interactive computer service, as defined in section 230(f)(2) of the Communications Act of 1934 (47 U.S.C. 230(f)(2)), or of advertising services shall be liable under this section for dispensing or selling prescription drugs in violation of this section on account of another person's selling or dispensing such drugs, provided that the provider of the interactive computer service or of advertising services does not own or exercise corporate control over such person.

''(h) NO EFFECT ON OTHER REQUIREMENTS; COORDINATION.—The requirements of this section are in addition to, and do not supersede, any requirements under the Controlled

Substances Act or the Controlled Substances Import and Export Act (or any regulation promulgated under either such Act) regarding Internet pharmacies and controlled substances. In promulgating regulations to carry out this section, the Secretary shall coordinate with the Attorney General to ensure that such regulations do not duplicate or conflict with the requirements described in the previous sentence, and that such regulations and requirements coordinate to the extent practicable.''.

(b) INCLUSION AS PROHIBITED ACT.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by inserting after paragraph (k) the following:

''(l) The dispensing or selling of a prescription drug in violation of section 503C.''.

(c) INTERNET SALES OF PRESCRIPTION DRUGS; CONSIDERATION BY SECRETARY OF PRACTICES AND PROCEDURES FOR CERTIFICATION OF LEGITIMATE BUSINESSES.—In carrying out section 503C of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall take into consideration the practices and procedures of public or private entities that certify that businesses selling prescription drugs through Internet sites are legitimate businesses, including practices and procedures regarding disclosure formats and verification programs.

(d) REPORTS REGARDING INTERNET-RELATED VIOLATIONS OF FEDERAL AND STATE LAWS ON DISPENSING OF DRUGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, pursuant to the submission of an application meeting the criteria of the Secretary, make an award of a grant or contract to the National Clearinghouse on Internet Prescribing (operated by the Federation of State Medical Boards) for the purpose of—

(A) identifying Internet sites that appear to be in violation of Federal or State laws concerning the dispensing of drugs;

(B) reporting such sites to State medical licensing boards and State pharmacy licensing boards, and to the Attorney General and the Secretary, for further investigation; and

(C) submitting, for each fiscal year for which the award under this subsection is made, a report to the Secretary describing investigations undertaken with respect to violations described in subparagraph (A).

(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out paragraph (1), there is authorized to be appropriated $100,000 for each of the first 3 fiscal years in which this section is in effect.

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect 90 days after the date of enactment of this Act, without regard to whether a final rule to implement such amendments has been promulgated by the Secretary of Health and Human Services under section 701(a) of the Federal Food, Drug, and Cosmetic Act. The preceding sentence may not be construed as affecting the authority of such Secretary to promulgate such a final rule.

SEC. 10008. PROHIBITING PAYMENTS TO UNREGISTERED FOREIGN PHARMACIES.

(a) IN GENERAL.—Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) RESTRICTED TRANSACTIONS.—

''(1) IN GENERAL.—The introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system is prohibited.

''(2) PAYMENT SYSTEM.—

''(A) IN GENERAL.—The term 'payment system' means a system used by a person described in subparagraph (B) to effect a credit transaction, electronic fund transfer, or money transmitting service that may be used in connection with, or to facilitate, a restricted transaction, and includes—

''(i) a credit card system;

''(ii) an international, national, regional, or local network used to effect a credit transaction, an electronic fund transfer, or a money transmitting service; and

''(iii) any other system that is centrally managed and is primarily engaged in the transmission and settlement of credit transactions, electronic fund transfers, or money transmitting services.

''(B) PERSONS DESCRIBED.—A person referred to in subparagraph (A) is—

''(i) a creditor;

''(ii) a credit card issuer;

''(iii) a financial institution;

''(iv) an operator of a terminal at which an electronic fund transfer may be initiated;

''(v) a money transmitting business; or

''(vi) a participant in an international, national, regional, or local network used to effect a credit transaction, electronic fund transfer, or money transmitting service.

''(3) RESTRICTED TRANSACTION.—The term 'restricted transaction' means a transaction or transmittal, on behalf of an individual who places an unlawful drug importation request to any person engaged in the operation of an unregistered foreign pharmacy, of—

''(A) credit, or the proceeds of credit, extended to or on behalf of the individual for the purpose of the unlawful drug importation request (including credit extended through the use of a credit card);

''(B) an electronic fund transfer or funds transmitted by or through a money transmitting business, or the proceeds of an electronic fund transfer or money transmitting service, from or on behalf of the individual for the purpose of the unlawful drug importation request;

''(C) a check, draft, or similar instrument which is drawn by or on behalf of the individual for the purpose of the unlawful drug importation request and is drawn on or payable at or through any financial institution; or

''(D) the proceeds of any other form of financial transaction (identified by the Board by regulation) that involves a financial institution as a payor or financial intermediary on behalf of or for the benefit of the individual for the purpose of the unlawful drug importation request.

''(4) UNLAWFUL DRUG IMPORTATION REQUEST.—The term 'unlawful drug importation request' means the request, or transmittal of a request, made to an unregistered foreign pharmacy for a prescription drug by mail (including a private carrier), facsimile, phone, or electronic mail, or by a means that involves the use, in whole or in part, of the Internet.

''(5) UNREGISTERED FOREIGN PHARMACY.—The term 'unregistered foreign pharmacy' means a person in a country other than the United States that is not a registered exporter under section 804.

''(6) OTHER DEFINITIONS.—

''(A) CREDIT; CREDITOR; CREDIT CARD.—The terms 'credit', 'creditor', and 'credit card' have the meanings given the terms in section 103 of the Truth in Lending Act (15 U.S.C. 1602).

''(B) ACCESS DEVICE; ELECTRONIC FUND TRANSFER.—The terms 'access device' and 'electronic fund transfer'—

''(i) have the meaning given the term in section 903 of the Electronic Fund Transfer Act (15 U.S.C. 1693a); and

''(ii) the term 'electronic fund transfer' also includes any fund transfer covered under Article 4A of the Uniform Commercial Code, as in effect in any State.

''(C) FINANCIAL INSTITUTION.—The term 'financial institution'—

''(i) has the meaning given the term in section 903 of the Electronic Transfer Fund Act (15 U.S.C. 1693a); and

''(ii) includes a financial institution (as defined in section 509 of the Gramm-Leach-Bliley Act (15 U.S.C. 6809)).

''(D) MONEY TRANSMITTING BUSINESS; MONEY TRANSMITTING SERVICE.—The terms 'money transmitting business' and 'money transmitting service' have the meaning given the terms in section 5330(d) of title 31, United States Code.

''(E) BOARD.—The term 'Board' means the Board of Governors of the Federal Reserve System.

''(7) POLICIES AND PROCEDURES REQUIRED TO PREVENT RESTRICTED TRANSACTIONS.—

''(A) REGULATIONS.—The Board shall promulgate regulations requiring—

''(i) an operator of a credit card system;

''(ii) an operator of an international, national, regional, or local network used to effect a credit transaction, an electronic fund transfer, or a money transmitting service;

''(iii) an operator of any other payment system that is centrally managed and is primarily engaged in the transmission and settlement of credit transactions, electronic transfers or money transmitting services where at least one party to the transaction or transfer is an individual; and

''(iv) any other person described in paragraph (2)(B) and specified by the Board in such regulations,

to establish policies and procedures that are reasonably designed to prevent the introduction of a restricted transaction into a payment system or the completion of a restricted transaction using a payment system

''(B) REQUIREMENTS FOR POLICIES AND PROCEDURES.—In promulgating regulations under subparagraph (A), the Board shall—

''(i) identify types of policies and procedures, including nonexclusive examples, that shall be considered to be reasonably designed to prevent the introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system; and

''(ii) to the extent practicable, permit any payment system, or person described in paragraph (2)(B), as applicable, to choose among alternative means of preventing the introduction or completion of restricted transactions.

''(C) NO LIABILITY FOR BLOCKING OR REFUSING TO HONOR RESTRICTED TRANSACTION.—

''(i) IN GENERAL.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, and any participant in such payment system that prevents or otherwise refuses to honor transactions in an effort to implement the policies and procedures required under this subsection or to otherwise comply with this subsection shall not be liable to any party for such action.

''(ii) COMPLIANCE.—A person described in paragraph (2)(B) meets the requirements of this subsection if the person relies on and complies with the policies and procedures of a payment system of which the person is a member or in which the person is a participant, and such policies and procedures of the

payment system comply with the requirements of the regulations promulgated under subparagraph (A).

''(D) ENFORCEMENT.—

''(i) IN GENERAL.—This subsection, and the regulations promulgated under this subsection, shall be enforced exclusively by the Federal functional regulators and the Federal Trade Commission under applicable law in the manner provided in section 505(a) of the Gramm-Leach-Bliley Act (15 U.S.C. 6805(a)).

''(ii) FACTORS TO BE CONSIDERED.—In considering any enforcement action under this subsection against a payment system or person described in paragraph (2)(B), the Federal functional regulators and the Federal Trade Commission shall consider the following factors:

''(I) The extent to which the payment system or person knowingly permits restricted transactions.

''(II) The history of the payment system or person in connection with permitting restricted transactions.

''(III) The extent to which the payment system or person has established and is maintaining policies and procedures in compliance with regulations prescribed under this subsection.

''(8) TRANSACTIONS PERMITTED.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, is authorized to engage in transactions with foreign pharmacies in connection with investigating violations or potential violations of any rule or requirement adopted by the payment system or person in connection with complying with paragraph (7). A payment system, or such a person, and its agents and employees shall not be found to be in violation of, or liable under, any Federal, State or other law by virtue of engaging in any such transaction.

''(9) RELATION TO STATE LAWS.—No requirement, prohibition, or liability may be imposed on a payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, under the laws of any state with respect to any payment transaction by an individual because the payment transaction involves a payment to a foreign pharmacy.

''(10) TIMING OF REQUIREMENTS.—A payment system, or a person described in paragraph (2)(B) that is subject to a regulation issued under this subsection, must adopt policies and procedures reasonably designed to comply with any regulations required under paragraph (7) within 60 days after such regulations are issued in final form.

''(11) COMPLIANCE.—A payment system, and any person described in paragraph (2)(B), shall not be deemed to be in violation of paragraph (1)—

''(A)(i) if an alleged violation of paragraph (1) occurs prior to the mandatory compliance date of the regulations issued under paragraph (7); and

''(ii) such entity has adopted or relied on policies and procedures that are reasonably designed to prevent the introduction of restricted transactions into a payment system or the completion of restricted transactions using a payment system; or

''(B)(i) if an alleged violation of paragraph (1) occurs after the mandatory compliance date of such regulations; and

''(ii) such entity is in compliance with such regulations.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the day that is 90 days after the date of enactment of this Act.

(c) IMPLEMENTATION.—The Board of Governors of the Federal Reserve System shall promulgate regulations as required by subsection (h)(7) of section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333), as added by subsection (a), not later than 90 days after the date of enactment of this Act.

SEC. 10009. IMPORTATION EXEMPTION UNDER CONTROLLED SUBSTANCES IMPORT AND EXPORT ACT.

Section 1006(a)(2) of the Controlled Substances Import and Export Act (21 U.S.C. 956(a)(2)) is amended by striking ''not import the controlled substance into the United States in an amount that exceeds 50 dosage units of the controlled substance.'' and inserting ''import into the United States not more than 10 dosage units combined of all such controlled substances.''.

SEC. 10010. SEVERABILITY.

If any provision of this title, an amendment by this title, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this title, the amendments made by this title, and the application of the provisions of such to any person or circumstance shall not affected thereby.

SA 2794. Mr. LEAHY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

SEC. 4403. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS.

(a) IN GENERAL.—Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended—

(1) in subsection (g), by striking paragraph (4) and inserting the following:

''(4) An entity described in this paragraph is—

''(A) a public or non-profit private entity receiving Federal funds under section 330; or

''(B) a free clinic defined under subsection (o)(3)(A).''; and

(2) in subsection (o)(6)(A), by inserting ''and officers, governing board members, employees, and contractors of free clinics'' after ''free clinic health professionals''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and apply to any act or omission which occurs on or after that date.

SA 2795. Mr. LEAHY (for himself, Mr. REID, Mr. KERRY, Mr. ROCKEFELLER, Mr. LIEBERMAN, Mrs. FEINSTEIN, Mr. FEINGOLD, Mr. WYDEN, Mr. SCHUMER, Ms. CANTWELL, Mr. LAUTENBERG, Mrs. MCCASKILL, Mr. WHITEHOUSE, Mr. BURRIS, Mr. KAUFMAN, Mr. BENNETT, and Mr. FRANKEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table, as follows:

On page 377, after line 14, insert the following:

SEC. 1561A. HEALTH INSURANCE INDUSTRY ANTITRUST ENFORCEMENT ACT OF 2009.

(a) SHORT TITLE.—This section may be cited as the ''Health Insurance Industry Antitrust Enforcement Act of 2009''.

(b) PURPOSE.—It is the purpose of this section to ensure that health insurance issuers and medical malpractice insurance issuers cannot engage in price fixing, bid rigging, or market allocations to the detriment of competition and consumers.

(c) PROHIBITION OF ANTI-COMPETITIVE ACTIVITIES.—Notwithstanding any other provision of law, nothing in the Act of March 9, 1945 (15 U.S.C. 1011 et seq., commonly known as the ''McCarran-Ferguson Act''), shall be construed to permit health insurance issuers (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) or issuers of medical malpractice insurance to engage in any form of price fixing, bid rigging, or market allocations in connection with the conduct of the business of providing health insurance coverage (as defined in such section) or coverage for medical malpractice claims or actions.

(d) APPLICATION TO ACTIVITIES OF STATE COMMISSIONS OF INSURANCE AND OTHER STATE INSURANCE REGULATORY BODIES.—Nothing in this section shall apply to the information gathering and rate setting activities of any State commission of insurance, or any other State regulatory entity with authority to set insurance rates.

SA 2796. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the resolution S. Res. 71, condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights; as follows:

Strike all after the resolving clause and insert the following:

That the Senate—

(1) condemns the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights;

(2) calls on the Government of Iran to immediately release the seven leaders and all other prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi; and

(3) calls on the President and Secretary of State, in cooperation with responsible nations, to immediately condemn the Government of Iran's continued violation of human rights and demand the immediate release of prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi.

SA 2797. Mr. DURBIN (for Mr. WYDEN) proposed an amendment to the

resolution S. Res. 71, condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights; as follows:

Strike the preamble and insert the following:

Whereas, in 1982, 1984, 1988, 1990, 1992, 1994, 1996, 2000, 2006, and 2008, Congress declared that it deplored the religious persecution by the Government of Iran of the Baha'i community and would hold the Government of Iran responsible for upholding the rights of all Iranian nationals, including members of the Baha'i faith;

Whereas, in November 2007, the Iranian Ministry of Information in Shiraz jailed Baha'is Ms. Raha Sabet, age 33, Mr. Sasan Taqva, age 32, and Ms. Haleh Roohi, age 29, for ostensibly ''indirectly teaching the Baha'i Faith'' and ''engaging in anti-government propaganda'' while educating underprivileged children and gave them 4-year prison terms, which they are serving;

Whereas Ms. Sabet, Mr. Taqva, and Ms. Roohi were targeted solely on the basis of their religion;

Whereas, on January 23, 2008, the Department of State released a statement urging the Government of Iran to release all individuals held without due process and a fair trial, including the 3 young Baha'is being held in an Iranian Ministry of Intelligence detention center in Shiraz;

Whereas, in March and May of 2008, Iranian intelligence officials in Mashhad and Tehran arrested and imprisoned Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, and Mr. Vahid Tizfahm, the members of the coordinating group for the Baha'i community in Iran;

Whereas these seven leaders have been imprisoned for well over a year and are yet to stand trial, the trial having been delayed multiple times;

Whereas official Iranian media has announced that they will face charges of ''espionage for Israel, insulting religious sanctities and propaganda against the Islamic Republic'';

Whereas these seven Baha'i leaders were targeted solely on the basis of their religion; and

Whereas the Government of Iran is party to the International Covenants on Human Rights: Now, therefore, be it

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Energy. The hearing will be held on Tuesday, December 8, 2009, at 2:30 p.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the following bills:

H.R. 957, Green Energy Education Act of 2009;

H.R. 2729, To authorize the designation of National Environmental Research Parks by the Secretary of Energy, and for other purposes;

H.R. 3165, Wind Energy Research and Development Act of 2009;

H.R. 3246, Advanced Vehicle Technology Act of 2009; H.R. 3585, Solar Technology Roadmap Act;

S. 737, A bill to amend the Energy Independence and Security Act of 2007 to authorize the Secretary of Energy to conduct research, development, and demonstration to make biofuels more compatible with small non-road engines, and for other purposes;

S. 1617, To require the Secretary of Commerce to establish a program for the award of grants to States to establish revolving loan funds for small and medium-sized manufacturers to improve energy efficiency and produce clean energy technology, and for other purposes;

S. 2744, A bill to amend the Energy Policy Act of 2005 to expand the authority for awarding technology prizes by the Secretary of Energy to include a financial award for separation of carbon dioxide from dilute sources; and

S. 2773, A bill to require the Secretary of Energy to carry out a program to support the research, demonstration, and development of commercial applications for offshore wind energy, and for other purposes.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150, or by e-mail to Rosemarie Calabro@energy.senate.gov.

For further information, please contact Jonathan Epstein or Rosemarie Calabro.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON FOREIGN RELATIONS

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 1, 2009, at 10 a.m.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 1, 2009, at 2:30 p.m.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 1, 2009, at 12 p.m.

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

COMMITTEE ON THE JUDICIARY

Mr. LEAHY. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 1, 2009, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Judicial Nominations.''

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. LEAHY. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 1, 2009, at 2:30 p.m.

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

SUBCOMMITTEE ON AVIATION OPERATIONS, SAFETY, AND SECURITY

Mr. LEAHY. Mr. President, I ask unanimous consent that the Subcommittee on Aviation Operations, Safety, and Security of the Committee on Commerce, Science, and Transportation be authorized to hold a meeting during the session of the Senate on December 1, 2009, at 10:15 a.m. in room 253 of the Russell Senate Office Building.

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

PRIVILEGES OF THE FLOOR

Mrs. SHAHEEN. Mr. President, I ask unanimous consent that Manny Jimenez, a fellow in my office, be granted floor privileges for the duration of the consideration of H.R. 3590.

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

CONDEMNING THE PERSECUTION OF THE BAHA'I MINORITY IN IRAN

Mr. DURBIN. I ask unanimous consent that the Foreign Relations Committee be discharged from further consideration of S. Res. 71 and the Senate proceed to its immediate consideration.

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

The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 71) condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. I ask unanimous consent that a Wyden amendment to the resolution, which is at the desk, be agreed to; the resolution, as amended, be agreed to; that a Wyden amendment to the preamble, which is at the desk, be agreed to; the preamble, as amended, be agreed to; the motions to reconsider be laid upon the table, with no intervening action or debate; and any

statements related to the resolution be printed in the RECORD.

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

The amendment (No. 2796) was agreed to, as follows:

(Purpose: In the nature of a substitute)

Strike all after the resolving clause and insert the following:

That the Senate—

(1) condemns the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights;

(2) calls on the Government of Iran to immediately release the seven leaders and all other prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi; and

(3) calls on the President and Secretary of State, in cooperation with responsible nations, to immediately condemn the Government of Iran's continued violation of human rights and demand the immediate release of prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi.

The amendment (No. 2797) was agreed to, as follows:

Strike the preamble and insert the following:

Whereas, in 1982, 1984, 1988, 1990, 1992, 1994, 1996, 2000, 2006, and 2008, Congress declared that it deplored the religious persecution by the Government of Iran of the Baha'i community and would hold the Government of Iran responsible for upholding the rights of all Iranian nationals, including members of the Baha'i faith;

Whereas, in November 2007, the Iranian Ministry of Information in Shiraz jailed Baha'is Ms. Raha Sabet, age 33, Mr. Sasan Taqva, age 32, and Ms. Haleh Roohi, age 29, for ostensibly ''indirectly teaching the Baha'i Faith'' and ''engaging in anti-government propaganda'' while educating underprivileged children and gave them 4-year prison terms, which they are serving;

Whereas Ms. Sabet, Mr. Taqva, and Ms. Roohi were targeted solely on the basis of their religion;

Whereas, on January 23, 2008, the Department of State released a statement urging the Government of Iran to release all individuals held without due process and a fair trial, including the 3 young Baha'is being held in an Iranian Ministry of Intelligence detention center in Shiraz;

Whereas, in March and May of 2008, Iranian intelligence officials in Mashhad and Tehran arrested and imprisoned Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, and Mr. Vahid Tizfahm, the members of the coordinating group for the Baha'i community in Iran;

Whereas these seven leaders have been imprisoned for well over a year and are yet to stand trial, the trial having been delayed multiple times;

Whereas official Iranian media has announced that they will face charges of ''espionage for Israel, insulting religious sanctities and propaganda against the Islamic Republic'';

Whereas these seven Baha'i leaders were targeted solely on the basis of their religion; and

Whereas the Government of Iran is party to the International Covenants on Human Rights: Now, therefore, be it

The resolution (S. Res. 71), as amended, was agreed to.

The preamble, as amended, was agreed to.

The resolution, as amended, with its preamble, as amended, was agreed to, as follows:

S. RES. 71

Whereas in 1982, 1984, 1988, 1990, 1992, 1994, 1996, 2000, 2006, and 2008, Congress declared that it deplored the religious persecution by the Government of Iran of the Baha'i community and would hold the Government of Iran responsible for upholding the rights of all Iranian nationals, including members of the Baha'i faith;

Whereas in November 2007, the Iranian Ministry of Information in Shiraz jailed Baha'is Ms. Raha Sabet, age 33, Mr. Sasan Taqva, age 32, and Ms. Haleh Roohi, age 29, for ostensibly ''indirectly teaching the Baha'i Faith'' and ''engaging in anti-government propaganda'' while educating underprivileged children and gave them 4-year prison terms, which they are serving;

Whereas Ms. Sabet, Mr. Taqva, and Ms. Roohi were targeted solely on the basis of their religion;

Whereas on January 23, 2008, the Department of State released a statement urging the Government of Iran to release all individuals held without due process and a fair trial, including the 3 young Baha'is being held in an Iranian Ministry of Intelligence detention center in Shiraz;

Whereas in March and May of 2008, Iranian intelligence officials in Mashhad and Tehran arrested and imprisoned Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, and Mr. Vahid Tizfahm, the members of the coordinating group for the Baha'i community in Iran;

Whereas these seven leaders have been imprisoned for well over a year and are yet to stand trial, the trial having been delayed multiple times;

Whereas official Iranian media has announced that they will face charges of ''espionage for Israel, insulting religious sanctities and propaganda against the Islamic Republic'';

Whereas these seven Baha'i leaders were targeted solely on the basis of their religion; and

Whereas the Government of Iran is party to the International Covenants on Human Rights: Now, therefore, be it

Resolved, That the Senate—

(1) condemns the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights;

(2) calls on the Government of Iran to immediately release the seven leaders and all other prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi; and

(3) calls on the President and Secretary of State, in cooperation with responsible nations, to immediately condemn the Government of Iran's continued violation of human rights and demand the immediate release of prisoners held solely on account of their religion, including Mrs. Fariba Kamalabadi, Mr. Jamaloddin Khanjani, Mr. Afif Naeimi, Mr. Saeid Rezaie, Mr. Behrouz Tavakkoli, Mrs. Mahvash Sabet, Mr. Vahid Tizfahm, Ms. Raha Sabet, Mr. Sasan Taqva, and Ms. Haleh Roohi.

WREATHS ACROSS AMERICA DAY

Mr. DURBIN. I ask unanimous consent that the Judiciary Committee be discharged from further consideration of and the Senate now proceed to S. Res. 358.

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

The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 358) designating December 12, 2009, as ''Wreaths Across America Day.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table.

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

The resolution (S. Res. 358) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 358

Whereas 18 years ago, the Wreaths Across America project began an annual tradition, during the month of December, of donating, transporting, and placing Maine balsam fir holiday wreaths on the graves of the fallen heroes buried at Arlington National Cemetery;

Whereas since that tradition began, through the hard work and generosity of the individuals involved in the Wreaths Across America project, hundreds of thousands of wreaths have been sent to national cemeteries and veterans memorials in every State and to locations overseas;

Whereas in 2008, wreaths were sent to 372 locations across the United States, as well as 24 sites overseas;

Whereas in December 2009, the Patriot Guard Riders, a motorcycle and motor vehicle group that is dedicated to patriotic events and includes more than 177,000 members nationwide, will continue their tradition of escorting a tractor-trailer filled with donated wreaths from Harrington, Maine, to Arlington National Cemetery;

Whereas thousands of individuals volunteer each December to escort and lay the wreaths;

Whereas, December 13, 2008, was previously designated by the Senate as ''Wreaths Across America Day''; and

Whereas the Wreaths Across America project will continue its proud legacy on December 12, 2009, bringing 15,000 wreaths to Arlington National Cemetery on that day: Now, therefore, be it

Resolved, That the Senate—

(1) designates December 12, 2009, as ''Wreaths Across America Day'';

(2) honors the Wreaths Across America project, the Patriot Guard Riders, and all of the volunteers and donors involved in this worthy tradition; and

(3) recognizes the sacrifices our veterans, servicemembers, and their families have made, and continue to make, for our great Nation.

50TH ANNIVERSARY OF THE ANTARCTIC TREATY

Mr. DURBIN. I ask unanimous consent the Senate proceed to the immediate consideration of S. Res. 365 submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 365) recognizing the 50th anniversary of the signing of the Antarctic Treaty.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements related to the resolution be printed in the RECORD.

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

The resolution (S. Res. 365) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 365

Whereas the Antarctic Treaty was signed by 12 nations in Washington, DC, on December 1, 1959, ''with the interests of science and the progress of all mankind'';

Whereas the Antarctic Treaty was established to continue and develop international ''cooperation on the basis of freedom of scientific investigation in Antarctica as applied during the International Geophysical Year'';

Whereas the Antarctic Treaty came into force on June 23, 1961, after its unanimous ratification by the seven countries (Argentina, Australia, Chile, France, New Zealand, Norway, and the United Kingdom) with territorial claims in the region and five other countries (Belgium, Japan, South Africa, the Soviet Union, and the United States), which had collaborated in Antarctic research activities during the International Geophysical Year from July 1, 1957, through December 31, 1958;

Whereas the Antarctic Treaty now has 47 nations as signatories that together represent nearly 90 percent of humanity;

Whereas Article IV of the Antarctic Treaty states that ''no acts or activities taking place while the present Treaty is in force shall constitute a basis for asserting, supporting or denying a claim to territorial sovereignty in Antarctica'';

Whereas the 14 articles of the Antarctic Treaty have provided a lasting foundation for maintaining the region south of 60 degrees south latitude, nearly 10 percent of the Earth's surface, ''for peaceful purposes only'';

Whereas the Antarctic Treaty prohibits ''any measure of a military nature'';

Whereas the Antarctic Treaty has promoted international nuclear cooperation by prohibiting ''any nuclear explosions in Antarctica and the disposal there of radioactive waste material'';

Whereas the Antarctic Treaty provides a framework for the signatories to continue to meet ''for the purpose of exchanging information, consulting together on matters of common interest pertaining to Antarctica, and formulating and considering, and recommending to their Governments, measures in furtherance of the principles and objectives of the Treaty'';

Whereas common interests among the Antarctic Treaty nations facilitated the development and ratification of the Convention on the Conservation of Antarctic Marine Living Resources;

Whereas the international cooperation represented by the Antarctic Treaty offers humankind a precedent for the peaceful governance of international spaces;

Whereas in celebration of the 50th anniversary of the International Geophysical Year, the Antarctic Treaty Parties in their Edinburgh Declaration recognized the current International Polar Year for its contributions to science worldwide and to international cooperation; and

Whereas the International Polar Year program has endorsed the Antarctic Treaty Summit that will convene in Washington, DC, at the Smithsonian Institution on the 50th anniversary of the Antarctic Treaty: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes that the Antarctic Treaty has greatly contributed to science and science cooperation worldwide and successfully ensured the ''use of Antarctica for peaceful purposes only and the continuance of international harmony'' for the past half century; and

(2) encourages international and interdisciplinary collaboration in the Antarctic Treaty Summit to identify lessons from 50 years of international cooperation under the Antarctic Treaty that have legacy value for humankind.

ORDERS FOR WEDNESDAY, DECEMBER 2, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m. tomorrow, Wednesday, December 2; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, for debate only, with no amendments or motions in order; and that the time until 11:30 a.m. be equally divided, with alternating blocks of time, with the Republicans controlling the first 30 minutes, the majority controlling the second 30 minutes; further that the Senate recess from 11:30 a.m. to 12:30 p.m.

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

PROGRAM

Mr. DURBIN. Mr. President, rollcall votes are expected to occur throughout the day.

ORDER FOR ADJOURNMENT

Mr. DURBIN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order, following the remarks of Senators ENZI and INHOFE.

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

The Senator from Wyoming.

HEALTH CARE REFORM

Mr. ENZI. Mr. President, after the speech by the Senator from Illinois, I feel compelled to make a few comments. One, he challenged us a little bit to do a bill in 2,000 pages or less. I am one of those people who do not think it can be done in less. I do not think there are nearly enough pages there to solve the biggest problem in the United States for every American.

People are not comprehending how big health care is. The bill we are doing will affect 100 percent of the people in America. I do not know if we have ever had a bill before that affected 100 percent of the people—100 percent of the people, 100 percent of the professions, 100 percent of the businesses. This is big. Everybody has a role in health care, and we are trying to condense it into 2,000 pages and make it seem a lot simpler than it is.

The reason our side has been saying you need to take this a step at a time and get it right is because that gives up some of the right. There are over 200 references in the 2,000 pages that say the Secretary of Health and Human Services will solve that particular problem; in other words, put in the details. We do not have nearly the details in there to actually run health care for America. Without the details, we do not know what the devil is, and that is the difficulty. So we really ought to break it down a step at a time.

One step I really think would calm America down is if we did Medicare as a separate step. That way we could assure seniors that Medicare was going to be for Medicare. Yes, there are savings in Medicare. Yes, Medicare is going broke. Use the savings for Medicare. It seems pretty simple to me.

One of the things they are complaining about is the doc fix we have. We are not paying doctors adequately to be willing to take Medicare patients. Of course, we are not paying them adequately to take Medicaid patients either. But we are not paying them right. It would cost about $250 billion to fix that.

Well, if we are talking about $464 billion worth of savings in Medicare, why

not use that $250 billion to fix that problem so we have doctors. I do not care what kind of insurance you have, I do not care how much you pay for the insurance, if you cannot see a doctor, you really do not have insurance. That is what seniors are being faced with. That is what Medicaid people are being faced with.

Medicaid—well, that is another piece that ought to be maybe a step because 40 percent of the doctors will not take a Medicaid patient because they are not being paid adequately for it. If you are not paid adequately, you go broke. They are small businesses. They are affected by this bill in more than one way. They have to provide what we are saying is a government requirement for the minimum insurance they have, and they also have to live with whatever rules we put in there and whatever pay fixes we put in there.

On the government option, one of the things CBO said was, the only way that would ever bring down costs is if the government fixes prices for the doctors, for the hospitals. Well, we are kind of doing that in this bill for Medicare because we are telling nursing homes they are going to take a big cut. Nursing homes do not have a lot of margin, and if nursing homes go broke, people have to go a long ways, sometimes—in Wyoming, anyway, and Colorado, wherever we have rural populations—they may have to go a long way to see their loved one. They may not even be able to do it. So we have to keep those small nursing homes in business as well.

So we ought to do this in steps and get it right. That is one of the problems that the Group of 6 ran into. We were not given the time. We allocated about 13 different areas to go through. I think we made it through 5 completely and probably 3 fairly completely, and the rest we were just asking basic questions. With any business, it looks pretty easy until you scratch the surface a little bit, and when you scratch the surface, you find out that every job out there is fairly complicated. If you have never done it before, and you are trying to come up with 2,000 pages worth of laws to govern that, you are probably going to get it wrong.

That is what the doctors are telling us. That is what the other providers are telling us. This bill has it wrong, in a lot of places, enough places that it is going to cause a crisis in America if this bill passes the way it is.

We have never passed a major bill in this body with just one side voting for it. If that were to happen, the other side would take potshots at anything that turned out to be something that had not been comprehended when the bill was written. And there will be plenty of that in here.

But just as important, the American people will not have confidence in it. They do not have confidence in us now—either side. I think that is what the elections in Virginia and New Jersey said. That is what the tea parties are saying. They are saying: We don't trust any of you. Throw the whole bunch out. Start over.

Well, we need to stop and get their confidence. Just steamrolling from one side, even if they have the 60 votes, is not going to do that. I have been saying that since we started. It is something so important that we have to get it right, and we do not have it right in this bill because there are a whole bunch of things, over 200, where we said to the Secretary of Health and Human Services: You figure that one out. Well, that is going to be thousands of pages, and it is going to be done by an unelected bureaucrat. It is not going to be approved by this body.

We ought to take the responsibility for getting those things right. And we can. Yes, it takes time. Yes, we have a lot of things to do. But I am in agreement that health care is the most important thing we have to do. But we ought to take the time to get it right.

There are a lot of ideas out there that would—in fact, one of the things that always upsets me when they say: So where is the Republican version? Well, I have been working on this thing for about 4 years. I have been working on it, actually—health care—ever since I got on the committee over 13 years ago, but for the last 4 years pretty intensively.

Senator Kennedy and I sat down and worked out principles we wanted to have. The principles are still the principles we are talking about around here. We want to make sure people are covered in catastrophic situations. We want to make sure preexisting conditions are taken care of. We want to make sure they have portability when they go from one job to another. The list goes on and on. We reached agreement. He was busy working on the Higher Education Act because it was way past due for being reauthorized, so I was kind of released to go talk to everybody on health care. I worked that. I worked both sides of the aisle, finding out ideas they had, and boiled it down to a 10-step plan.

I did a tour with my 10-step plan to see what kind of problems there were with it and was really pleased with the reception. Yes, I learned some things that needed to be done differently than what I thought. But if you will check my Web site, there is a 10-step plan that is a bill that covers the things we have been promising people they would have. I would not suggest doing it in one package. I would suggest doing it in several steps, not necessarily 10 steps, which are what are in there. But it would bring down the cost of health care insurance. That is the biggest thing I hear from people out there: Bring down my cost.

Now, everybody has been real pleased with this CBO clarification that came out that said the costs were not going to rise. They did not say: Don't let them rise. They said: Bring them down. Bring them down. They said: We don't mind covering a whole bunch of other people, but don't increase my costs as a result. This bill increases their costs as a result.

There is a way to do it. There are four different bills on the Republican side. And then there is a really bipartisan bill that Senator WYDEN and Senator BENNETT worked out, and I think there are about 15 cosponsors on both sides of the aisle. Those are all ways that this could be solved. But they are not in the bill. Since Senator WYDEN was left out of that part of the process, I am not even sure it could be considered partisan because you have to include all from one party.

But, at any rate, there are alternates out there. When we did the health care bill, which took weeks of doing the amendments, because it is very hard to do something in an amendment process and get it right—it is easier in the committee than it is here on the floor—but in the committee, we put up one of those as an alternative. We only took one vote to vote the whole thing down. They only had to criticize about 3 parts of 20 to get enough enthusiasm against it to be able to win. All the votes were 13 to 10, pretty much.

So we said: Wait a minute. That is not a good idea for us. They should have to take a look at these germs of ideas that are in all these different sections. So we started putting them up one at a time. We still lost most of them 13 to 10. There were a couple of them that did finally pass.

But we need to get into a mode of working across the aisle, like Senator Kennedy and I did on so many bills. In fact, I think we set some records, probably, not just when I was chairman of the committee but when he was chairman of the committee. We were on our way to getting a bunch done.

Anyway, deficit reduction. I heard Senator DURBIN talk about deficit reduction, and if this bill reduces the deficit. You have to be honest. If you use phony accounting, you can show huge deficits being reduced. That means leaving out some things that aren't in the bill, but they are going to be costs we have to cover. For instance, the doc fix, $250 billion. It is not in there. They say we will fix it for 1 year and then we will hold them hostage again for another year so we can get them to join us on something else. That is not the right way to do business. We ought to fix the thing and if we have all of this extra money in Medicare, that would solve some problems for Medicare.

On Medicaid, we are about to dump a whole bunch more people onto the Medicaid system. It is nice we are going to be able to do that, but there are some

other ways we can take care of those same people and make sure they have insurance, and they would have insurance that didn't have the same stigma as Medicaid. One of the stigmas I am talking about is the doctors not willing to take them. If you can't see a doctor, you don't have insurance. If we dump all of these people on a system that already won't take the patients, how many of them are going to be able to see a doctor? So we could eliminate that stigma. In fact, that is what we did in the SCHIP in Wyoming. We made a provision so that it could go through the private market. When they go through the private market—or when they don't go through the private market, a problem a kid has if their dad is working, they have insurance; if he is not working, they don't have insurance, or if it is mom. Under the Wyoming one, when they go through the private market they know they have it for a year. That is the way it ought to be. That is the way Medicaid should be. Of course, you have to sign up for it. Right now you don't have to sign up. You go to the hospital, you get your fix, and we pay for it, or the State pays their share. We are dumping a huge liability on the States, so it is a real problem.

The States are very concerned. Right now they are having budget problems almost across the entire United States. They are saying, so what are you going to dump on us? Well, our Gang of 6 asked that question and we got this overall CBO score on how much it was going to cost the States as a whole, but we didn't want to know how much it was going to cost as a whole. Every one of us has to answer to our State, so we asked for it to be broken down and they broke it down. It was kind of interesting. I had to call my Governor and explain to him how much he was going to have to come up with, even under the extra protection we were trying to build in for States. But the next day we got another breakdown. I said, so did CBO change their score? No, they didn't, but we manipulated the numbers a little bit differently. Well, they manipulated the numbers for Nevada and New York, and I think that is in the bill too. Their excuse for it was that Nevada and New York are particularly hard hit by the recession. Well, one of our complaints—and part of the phony accounting—is that this doesn't even go into effect for 4 more years, so how would we know that in 4 more years Nevada and New York would be the hardest hit? How do we know it won't be Wyoming and Colorado? So the formulas ought to be formulas that are going to work for everybody all of the time, not just for some of the leadership.

There are some flaws in here we need to take a look at and we need to clear up. I am not going to keep everybody much longer because I want to go hear the President speak too and I apologize for the time I have taken. But once in a while a speech gets me kind of concerned and I have to expound a little bit on it and I think the people of America need to know. Actually, I think the people of America have figured this out. I think that is why there were problems in August and I think that is why we are not going home on the weekends, because we don't want people to hear what the people at home are saying. I was home over the Thanksgiving weekend and I got an earful, and I like what I am doing. I don't think I like what is happening in the bill.

So with that, I yield the floor and thank the President, so the Senator from Oklahoma can speak.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. INHOFE. I thank the Senator from Wyoming.

Mr. President, the Senator from Wyoming made some references to the August recess and what happened during that time. I admire the Senator from Wyoming so much for the time he has spent on this issue. I, frankly, have not spent much time on this issue. We are kind of a product of our own committees in the Senate, but I do remember—and some people have forgotten—that during the August recess it was not just health care, it was also the cap-and-trade bill, because these are the bills that were passed right down party lines.

I have to disagree with the Senator from Wyoming in one respect and that is the people during the August recess were not upset with the Republicans. They were upset with the Democrats because the one bill in my State of Oklahoma is referred to as socialized medicine. They have a hard time believing that the government is going to be able to run anything better than what we have today. I know those in this Chamber who represent States up in the far north recognize that the hospitals, the Mayo Clinics, and some of those in the northern tier, are filled with people from Canada. They have come down to America because they can't get what they wanted in Canada. So I kind of looked around and the people in Oklahoma seem to understand that if it doesn't work in Denmark, if it doesn't work in the United Kingdom, and if it doesn't work in Canada, why would it work in the United States? The answer is clearly that it wouldn't.

The other issue that was prominent at that time was the issue of global warming. Six years ago I made the statement that the notion that manmade gases, anthropogenic gases, CO_2, cause global warming is probably the greatest hoax ever perpetrated on the American people. I know that more and more people are using the hoax statement now. The reason that was such a big issue was it passed again in the House, right down party lines—this was the Waxman-Markey bill—that would have been a tax increase on the American people of well over $300 billion a year. That translates in my State of Oklahoma to about $3,000 a family, a tax-paying family. It is something we were not going to let happen and we still are not, but that is a reality. I wish to remind my fellow Senators: You may think that August is a long time ago. You may think that since we have been in the shelter of these halls here in the Senate that people have forgotten about those two issues, and they haven't forgotten. However, I have to say that is not why I am here tonight.

TRIBUTE TO BILLY JOE DAUGHERTY

Mr. INHOFE. Mr. President, I lost a very dear friend of mine named Billy Joe Daugherty a few days ago. I never thought I could sit in one chair for 4 hours, but I did this past Monday. Yesterday they had a memorial for Billy Joe.

He is a guy who as a very young man came to Tulsa, OK. He built one of the largest churches in the Nation. He has been all throughout the Soviet Union—at that time it was the Soviet Union—and throughout the world, and he has been saving souls. This guy was just fantastic. When he died last week, he was only 57 years old. I sat there—I actually sat there, I say to the Chair, for 4 hours in one chair. I didn't think I would be able to do that because I normally am not that patient. But as people started giving talks and the eulogies, the best was saved until last. Billy Joe Daugherty was married for 35 years or so to his wife Sharon. She gave the most beautiful, long speech about her life with Billy Joe Daugherty. Then, one by one, the kids—four kids: John, Paul, Sarah, and Ruthie—stood up and gave tributes. I was thinking: My prayer is that when—my wife and I have been married—two weeks from now it will be 50 years. We have 20 kids and grandkids. By the way, we had all 20 kids and grandkids at one table for Thanksgiving, something that many people are not aware is even possible in this day and age. But my prayer is that when my time comes and I am gone, that my kids will revere me as much as Billy Joe Daugherty's kids revered him.

I remember back in 1978—Billy Joe died last week when he was 57—he would have been about 26, 27 years old. I was mayor of the city of Tulsa. I was elected for the first time. I served three 2-year terms. I am a morning person. I don't do very well at night. In the morning I perform pretty well. I had a policy—and I lived it all the way through those three terms as mayor of Tulsa—that I would open up the city hall at 6 o'clock in the morning and I

would make sure no one else was there—no security, nobody else—and stay until 8 o'clock so that everyone knew they could come down and visit with the mayor for 2 hours every day if anyone wanted.

Not many of them got up that early. The first visitor I had back in 1978 was kind of a skinny kid, who came in and said, ''I'm Billy Joe Daugherty, and I want to pray with you.'' That is the first time I ever met the guy. I cannot tell you that he came by every week for those 6 years, but he was a regular who was always showing up. We did pray for each other, for our families, and for the city of Tulsa.

I can remember a favorite verse that he used most of the time, a most common verse, the 23rd Psalm:

The Lord is my Shepherd; I shall not want.
He maketh me to lie down in green pastures:
He leadeth me beside still waters.
He restoreth my soul:
He leadeth me in the paths of righteousness for His name sake.

The path of righteousness. Billy Joe was led by Jesus down the path of righteousness probably two, three decades ago. I cannot tell you how many thousands of people Billy Joe has led down that path of righteousness.

Yea, though I walk through the valley of the shadow of death,
I will fear no evil: For thou art with me;
Thy rod and thy staff, they comfort me.

I am sure that when Billy Joe went through that valley of the shadow of death, he probably, knowing him, wasn't even walking. He was probably running because he knew what was on the other side.

Thou preparest a table before me in the presence of mine enemies;
Thou annointest my head with oil; My cup runneth over.

Here was the good part. Billy Joe said this:

Surely goodness and mercy shall follow me all the days of my life.

He might have changed that and said: Surely goodness and mercy and Sharon will follow me all the rest of my days. Whatever it was, they did it together. He led a life—in 57 short years—that accomplished more than most people who will live to be a hundred.

The final words of that verse were:

And I will dwell in the House of the Lord forever.

I could look at you folks here today and tell you I don't think Billy Joe Daugherty is in heaven, I know Billy Joe Daugherty is in heaven. He is looking down at us and thinking two things. First, he is saying: If you only knew what I know now. And then you have to keep in mind the other thing—Billy Joe is in a different time zone now, and he probably said that in just a wink of time, we will all be together. I have every expectation that will happen.

So this is not to say goodbye to Billy Joe Daugherty; this is to say, so long, we will see you soon.

I yield the floor.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:30 a.m. tomorrow.

Thereupon, the Senate, at 8:14 p.m., adjourned until Wednesday, December 2, 2009, at 9:30 a.m.

CONFIRMATION

Executive nomination confirmed by the Senate, Tuesday, December 1, 2009:

THE JUDICIARY

JACQUELINE H. NGUYEN, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA.

HOUSE OF REPRESENTATIVES—*Tuesday, December 1, 2009*

The House met at 2 p.m. and was called to order by the Speaker pro tempore (Mr. JACKSON of Illinois).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
December 1, 2009.

I hereby appoint the Honorable JESSE L. JACKSON, Jr. to act as Speaker pro tempore on this day.

NANCY PELOSI,
Speaker of the House of Representatives.

PRAYER

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

Seasonal cold winds and the hesitancy to name deep-seated fears draw us inward, Lord God.

It is time for outdoor furniture and some plants to be brought inside. Oil and gas are no longer for movement away from hard realities, but remain costly for the comforts of home. Barren trees silhouette some loneliness as family values take priority.

Be with us, Lord, as the stripping winter approaches. Clothe us anew with the garment of hope as we prepare for Your future coming of more light, integrity, and peace.

For You are Lord of all and in all. So we repeatedly call upon Your holy name now and forever.

Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

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

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Maryland (Mr. HOYER) come forward and lead the House in the Pledge of Allegiance.

Mr. HOYER led the Pledge of Allegiance as follows:

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

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, November 23, 2009.

Hon. NANCY PELOSI,
The Speaker, The Capitol, House of Representatives, Washington, DC.

DEAR MADAM SPEAKER: Pursuant to the permission granted in clause 2(h) of rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on November 23, 2009, at 9:26 a.m.:

That the Senate agreed to without amendment H. Con. Res. 214.

Appointments:

Ronald Reagan Centennial Commission

With best wishes, I am

Sincerely,

LORRAINE C. MILLER,
Clerk of the House.

HONORING ABE POLLIN

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

Mr. HOYER. Mr. Speaker, our Capital City is mourning the death of one of its leading citizens, a man I was proud to call my friend: Abe Pollin. Our thoughts and sympathy are with his wife, Irene, and his sons, Robert and Jim.

Abe Pollin's business skill, his philanthropy, and his civic spirit changed Washington, D.C., for the better; and, indeed, his legacy extends far beyond this city. It is a legacy that will long outlive Abe Pollin himself, but I rise today to honor the man behind it.

Abe was the son of a Russian immigrant who came to this country speaking no English, and he rose to become one of this city's most successful developers.

He was a boy whose fondest memories were of paying 25 cents to sit in the bleachers at Washington Senators games. And even when he had brought basketball and hockey teams to Washington, he kept his childhood passion for sports.

The same work ethic that sent him to local railroad yards at 4 in the morning to buy supplies for his father's contracting business helped make him a fortune building housing for thousands. For some that would have been enough, but for Abe it was only the beginning.

Like his father, Morris, whose generosity earned him the nickname ''Charity'' in the Washington Jewish community, Abe Pollin has a proud place in the great American and Jewish traditions of philanthropy. There are thousands and thousands who owe him thanks, whether or not they knew him firsthand. They are sons and daughters of 9/11 victims whose education Abe helped pay for, D.C. families who live in affordable housing that Abe built.

Speaking in 1997 of the arena that was the centerpiece of Washington's downtown rebirth, Abe said this:

''I walk through that building and I get tears in my eyes. I've got everything I've ever done in my life on the line.''

It was his money that paid to build that arena.

''My advisers think I'm nuts. But I wanted to do something special for my town.''

Indeed, Abe Pollin's life was something special for this town, for sports not only in this town but in America, and for his country.

LETTER FROM GREG HOLLOWAY

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

Mr. SMITH of Texas. Mr. Speaker, as part of a nationwide effort to pass the right kind of health care reform, a constituent from Austin, Greg Holloway, has written an open letter to Congress. He represents the organization Common Sense Texans:

''My name is Greg Holloway. I speak not only for myself and my family but also for over a hundred thousand other Texans with whom I collaborate and who I know share my views.

''You tell us that you are concerned about health care for our disadvantaged citizens. We are too. We wrote a plan, published by the Austin American-Statesman, that would immediately allow up to $100 billion annually to be sent directly to private health care and health insurance for the needy without a raise in taxes. You ignore any of our alternatives and instead raise taxes, increase costs, and draft a bill that excludes millions and provides no meaningful health care benefits until 2013.

''Stop this bill and give us health care reform that will help, not hurt, our country and its citizens.''

JOBS

(Mrs. KIRKPATRICK of Arizona asked and was given permission to address the House for 1 minute.)

Mrs. KIRKPATRICK of Arizona. Mr. Speaker, the holiday season should be

a joyous time for all as we celebrate with our loved ones and count our blessings.

Unfortunately, many families have been hit hard by the downturn and are feeling the pinch during this special time. Far too many people in my district are out of work and even more are making due with less. It will be a challenge for them to make sure their children have a memorable holiday. I am confident they will make do and remind their families what's really important: faith, family, and health.

But this should remind us how important it is for Congress to help create jobs. Partisan bickering cannot stand in the way of creating jobs and helping these families.

There is much we can do to create new opportunities in Arizona and across the country, and we can't just wish for things to get better. We must actively work to make things better, and that must be our top priority.

30TH ANNIVERSARY OF MICHELIN'S LEXINGTON COUNTY PLANT

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

Mr. WILSON of South Carolina. Mr. Speaker, 30 years ago on November 28, 1979, I was honored to help break ground on the Michelin Tire Corporation plant in Lexington, South Carolina, recruited by Governor Jim Edwards.

Michelin, the French tire manufacturer, has annual sales of $7.25 billion, and they employ close to 18,000 American workers. Over 7,000 of those jobs are in my home State.

For over 30 years, Michelin plants have been successful due to hard-working South Carolinians, and today they specialize in world-class car and Earth-mover tires. In addition to providing jobs, Michelin is an involved corporate citizen.

Another extraordinary achievement, yesterday we broke ground on the Ameresco biomass cogeneration project at the Savannah River site. CEO George Sakellaris has pioneered the development of alternative energy projects.

In conclusion, God bless our troops, and we will never forget September the 11th in the global war on terrorism.

THE ESCALATION IN AFGHANISTAN

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

Mr. KUCINICH. Today our President will announce an escalation in Afghanistan: as many as 35,000 additional troops, costing an additional $35 billion to prop up a government which most acknowledge is indefensibly corrupt.

We need to redefine our national security. Our national security will not be found in occupations which fuel insurgencies. Our national security will not be found through paying off contestants in Afghanistan who are with us one day and who shoot at our soldiers the next.

We can secure our borders without expanding them across the world. And we can redefine our national security by making sure that every able-bodied person in America has a job, by helping people save their homes and protect their savings and their investments and their retirement security.

We need new thinking and a new course of action, not further into Afghanistan but out. Not further away from the concerns of the American people, but focusing on what's important here at home.

CONGRESS MUST REPEAL THE DEATH TAX

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

Mr. SMITH of Nebraska. Mr. Speaker, the estate tax, also known as the death tax, has been a drag on America's family-owned small businesses for decades. It threatens our Nation's farms and ranches, the very businesses which produce 86 percent of U.S. agricultural products.

Farmers and ranchers work their entire lives to build their land and equipment for their operations; yet the existence of the death tax could take it all away.

The death tax impedes economic growth because it lowers incentives for small family businesses to invest capital in their own economic endeavors. In other words, it punishes success.

This flies in the face of the very principles upon which our country was founded.

The estate tax is inappropriate, and it needs to be eliminated once and for all. Doing so in the right way would lift a tremendous weight off the shoulders of America's family-owned small businesses, farms, and ranches.

CELEBRATING THE 100TH BIRTHDAY OF THE TOWN OF WAKE FOREST, NORTH CAROLINA

(Mr. MILLER of North Carolina asked and was given permission to address the House for 1 minute.)

Mr. MILLER of North Carolina. Mr. Speaker, I rise to celebrate the 100th birthday of Wake Forest, North Carolina.

The State legislature officially chartered the town on February 20, 1909; but the community really dates from 1832 when Dr. Calvin Jones sold 613 acres of land to the North Carolina Baptist Convention to establish the Wake Forest Manual Labor Institute to train future ministers. The institution later became Wake Forest College.

Dr. Jones described Wake Forest as "one of the best communities in the State. The inhabitants, without, I believe, a single exception, are sober, moral, and thriving in their circumstances, and not a few are educated and intelligent."

That is still true of Wake Forest. Although Wake Forest College moved to Winston-Salem in 1956, the Southern Baptist Convention located its new seminary in Wake Forest, maintaining Wake Forest's reputation as a town of higher learning and faith.

Wake Forest is now a progressive community of more than 27,000 residents. Forbes Magazine recently listed Wake Forest as the 20th fastest-growing suburb in America. The residents of Wake Forest now boast a vibrant town with more than 100 businesses and a rich and well-maintained historical district.

I join the residents of Wake Forest in their centennial celebration.

NAVY SEALS CAPTURE FALLUJAH TERRORIST

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

Mr. POE of Texas. Mr. Speaker, the Navy's elite commando unit, the SEALs, have captured one of the most notorious terrorists in Iraq. This terrorist planned the murder of four Americans in Fallujah. He had their bodies burned and hung from a bridge.

But instead of celebrating and honoring their bold accomplishment, the military has decided to court-martial the three SEALs.

The terrorist they captured says the Navy SEALs punched him in the mouth. And now he's whining about a fat lip. Even if the Navy SEALs punched this murderer in the mouth, the military brass is overreacting. After all, we're in the middle of a war. Punching is allowed. So is shooting. Instead of a court-martial, the SEALs should be getting medals.

It seems the military is more concerned about this captured criminal's bruised lip than they are about the SEALs doing their job.

The job of the American military is to fight wars. They're supposed to defeat the enemy. They break things. That's what they do.

The military needs to be trying this terrorist for the murder of Americans instead of court-martialing the SEALs for successfully accomplishing their mission.

And that's just the way it is.

□ 1415

CONGRATULATING UNIVERSITY OF ARKANSAS DISTINGUISHED PROFESSOR GREGORY SALAMO ON 2009 U.S. PROFESSOR OF THE YEAR

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

Mr. BOOZMAN. Mr. Speaker, I rise today to congratulate Dr. Gregory Salamo for being named a 2009 United States Professor of the Year. Dr. Salamo, distinguished professor of physics and a Fellow of the Optical Society of America, joined the faculty at the University of Arkansas in 1975. Since then he has regularly demonstrated extraordinary leadership and commitment to his students and area of study. He continuously works to expand interdisciplinary research and education by establishing new degree programs and courses which have provided greater educational and career opportunities for students and faculty. His research is widely published, and his hard work makes him a model of success for students as well as for fellow educators.

I commend Dr. Salamo for his passion for educating and wish him success in all future endeavors. I ask my colleagues to join me in honoring an educator whose accomplishments and devotion to the University of Arkansas have not gone unnoticed.

IT'S ALL ABOUT MONEY AND POWER

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

Mr. DUNCAN. Mr. Speaker, according to press reports, we are now going to send 34,000 more troops to Afghanistan, in addition to the 68,000 already there. The Pentagon tells us it costs $1 million a year for each soldier there, or $1 billion for each 1,000. This means we will be spending over $100 billion a year on top of the almost half a trillion we've spent on the 8-year-old Afghanistan war already.

I know that, like any gigantic bureaucracy, the Defense Department always wants more money and more employees, but this is getting ridiculous. And fiscal conservatives should be the ones most horrified by all this spending. On top of all this, we still have 120,000 troops in Iraq and are still spending megabillions there. And the Pentagon is so bureaucratic that we are told it will take several years to fully withdraw, if we ever do.

President Eisenhower warned us about the military industrial complex, but I think even he would be shocked. This is all about money and power, but we can no longer afford to lose so many lives and spend and borrow so much money.

MICROMANAGEMENT OF THE MILITARY

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

Mr. GOHMERT. Mr. Speaker, I was at Fort Benning when, in 1979, the President ordered a rescue mission. But he micromanaged. He dictated. They didn't need 12 helicopters; just go in with 8. They knew if they didn't get there with six, they'd have to abort. Well, they got there with five, and the aborted mission cost us lives. Back in the 1960s, President Johnson tried to micromanage Vietnam from Washington. What a terrible mistake. And now, it appears that the President will need to fire General McChrystal, because it is imperative that the President have generals he can trust.

General McChrystal says, "The impact of time on our effort in Afghanistan has been underappreciated, and we require a new way of thinking about it." He said, "I believe the short-term fight will be decisive. Failure to gain the initiative and reverse insurgent momentum in the near-term (next 12 months)—while Afghan security capacity matures—risks an outcome where defeating the insurgency is no longer possible."

Fire him if you don't trust him. Should have been acted on 3 months ago.

HONORING WORLD AIDS DAY

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

Ms. PELOSI. Mr. Speaker, I rise today to recognize the 21st annual World AIDS Day, and to remember, reflect on those we have lost, and recommit to ending HIV/AIDS. This year's theme, "Universal Access and Human Rights," is a call to action, a sign of the continued urgency of this moral challenge, and a reminder that HIV/AIDS is still with us in a very major way. The fight to end this disease must go on. The moral case alone is reason to act, but we also know that the spread of infectious diseases, especially HIV/AIDS, can destroy the very fabric of nations and create a fury of despair.

American leadership is essential to preventing suffering and instability in the developing world. Since the first World AIDS Day in 1988, we have made enormous progress. We have dramatically increased resources for both domestic and international HIV/AIDS prevention, care, treatment, and research. These investments have provided lifesaving anti-retroviral treatment to millions of people while also taking critical steps to prevent millions of new HIV cases.

Reiterating our commitment, Congress recently passed, in a bipartisan way, and President Obama signed into law the Ryan White HIV/AIDS Treatment Extension Act, continuing this essential lifeline of care, treatment, and support for more than half a million low-income Americans living with this disease. And around the same time, the President lifted the ban on entry of individuals with HIV/AIDS into our country. This was good news for all who were concerned about the global AIDS conference that's going to be held in the United States in 2012.

When Congress and the President make the dream of health insurance reform a reality for all Americans, we will improve access to lifelong medications and open the door of high-quality medical care to more low-income, uninsured, HIV-positive individuals before they confront the nightmare of full-blown AIDS. This is better for their health and lowers costs for all of us.

Today, on World AIDS Day, we remember all that we have lost but also all that we have to hold on to, our hope, our optimism, our steadfastness, and our determination to fight against this disease, to respond to the needs of the people who have it, and one day, and hopefully that will be soon, to end the HIV/AIDS disease.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

HOUSE OF REPRESENTATIVES,
Washington, DC, November 30, 2009.

Hon. NANCY PELOSI,
The Speaker, The Capitol, House of Representatives, Washington, DC.

DEAR MADAM SPEAKER: Pursuant to the permission granted in Clause 2(h) of rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on November 30, 2009, at 10:53 a.m.:

That the Senate passed S. 1472.

With best wishes, I am,

Sincerely,

LORRAINE C. MILLER,
Clerk of the House.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

HOUSE OF REPRESENTATIVES,
Washington, DC, November 20, 2009.

Hon. NANCY PELOSI,
The Speaker, The Capitol, House of Representatives, Washington, DC.

DEAR MADAM SPEAKER: Pursuant to the permission granted in Clause 2(h) of rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on November 20, 2009, at 11:48 a.m.:

Appointments: Social Security Advisory Board.

With best wishes, I am,

Sincerely,

LORRAINE C. MILLER,
Clerk of the House.

COMMUNICATION FROM LEGISLATIVE ASSISTANT, THE HONORABLE ROBERT C. "BOBBY" SCOTT, MEMBER OF CONGRESS

The SPEAKER pro tempore laid before the House the following communication from Mohamed Abbamin, legislative assistant, the Honorable ROBERT C. "BOBBY" SCOTT, Member of Congress:

HOUSE OF REPRESENTATIVES,
Washington, DC, November 24, 2009.

Hon. NANCY PELOSI,
Speaker, House of Representatives,
Washington, DC.

DEAR MADAME SPEAKER: This is to notify you formally, pursuant to Rule VIII of the Rules of the House of Representatives, that I have been served with a subpoena for testimony issued by the United States District Court for the Eastern District of Virginia in connection with a criminal case now pending in the same court.

After consultation with the Office of the General Counsel, I have determined that compliance with the subpoena is consistent with the precedents and privileges of the House.

Sincerely,

MOHAMED ABBAMIN,
Legislative Assistant.

COMMUNICATION FROM LEGISLATIVE ASSISTANT, THE HONORABLE ROBERT C. "BOBBY" SCOTT, MEMBER OF CONGRESS

The SPEAKER pro tempore laid before the House the following communication from Nkechi George-Winkler, legislative assistant, the Honorable ROBERT C. "BOBBY" SCOTT, Member of Congress:

HOUSE OF REPRESENTATIVES,
Washington, DC, November 24, 2009.

Hon. NANCY PELOSI,
Speaker, House of Representatives,
Washington, DC.

DEAR MADAME SPEAKER: This is to notify you formally, pursuant to Rule VIII of the Rules of the House of Representatives, that I have been served with a subpoena for testimony issued by the United States District Court for the Eastern District of Virginia in connection with a criminal case now pending in the same court.

After consultation with the Office of the General Counsel, I have determined that compliance with the subpoena is consistent with the precedents and privileges of the House.

Sincerely,

NKECHI GEORGE-WINKLER,
Legislative Assistant.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Record votes on postponed questions will be taken after 6:30 p.m. today.

CONGRATULATING THE WARNER ROBINS LITTLE LEAGUE TEAM

Mr. LYNCH. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 742) congratulating the Warner Robins Little League softball team from Warner Robins, Georgia, on winning the 2009 Little League Softball World Series.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 742

Whereas, on August 19, 2009, the Warner Robins Little League softball team from Warner Robins, Georgia, defeated the Crawford Little League softball team from Crawford, Texas, by a score of 14–2 to win the 2009 Little League Softball World Series Championship in Portland, Oregon;

Whereas the 2009 Warner Robins Little League Softball World Championship team consists of players Carson Carriker, Sierra Stella, Chelsea Whaley, Caitlin Parker, Melissa Cox, Kelly Warner, Sabrina Doucette, Hanna Livingston, Kaylee Albritton, Ashley Killebrew, Avery Lamb, and Sydney Barker;

Whereas the 2009 Warner Robins Little League Softball World Championship team is led by Manager Emily Whaley, Coach Roger Stella, Coach Patti Carriker, and President Kenneth Hathaway;

Whereas with this title, the Warner Robins Little League becomes the first little league to have won both a baseball and softball World Series Championship;

Whereas the championship victory of the Warner Robins Little League softball team sets an example of sportsmanship, dedication, and a "never give up" spirit for men and women all across the country; and

Whereas the achievement of the Warner Robins Little League softball team is the cause of enormous pride for the Nation, the State of Georgia, and the city of Warner Robins: Now, therefore, be it

Resolved, That the House of Representatives—

(1) congratulates the Warner Robins Little League softball team from Warner Robins, Georgia, on winning the 2009 Little League Softball World Series Championship; and

(2) respectfully requests that the Clerk of the House transmit an enrolled copy of this resolution to the City of Warner Robins and each player, manager, and coach of the Warner Robins Little League softball team.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Massachusetts (Mr. LYNCH) and the gentleman from Utah (Mr. CHAFFETZ) each will control 20 minutes.

The Chair recognizes the gentleman from Massachusetts.

GENERAL LEAVE

Mr. LYNCH. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and add any extraneous materials.

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

There was no objection.

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

Mr. Speaker, on behalf of the Committee on Oversight and Government Reform, I am pleased to present H. Res. 742 for consideration. This resolution congratulates the Warner Robins Little League softball team from Warner Robins, Georgia, on winning the 2009 Little League Softball World Series.

The measure before us was introduced by my friend and colleague, Representative JIM MARSHALL of Georgia, on September 14, 2009, and favorably reported out of the Oversight Committee on November 18, 2009, by unanimous consent. Notably, this measure enjoys the support of over sixty Members of Congress.

Mr. Speaker, H. Res. 742 applauds the Warner Robins Little League softball team for their championship run during the 2009 Little League Softball World Series.

Led by manager Emily Whaley, coach Roger Stella, coach Patti Carriker and president Kenneth Hathaway, this group of talented young women clinched their first Little League Softball World Series title and helped the Warner Robins Little League become the first Little League to have won both the baseball and softball Little League World Series championships.

In the championship game in Portland, Oregon, the Georgia club convincingly beat the formidable Crawford Little League softball team from Crawford, Texas by a score of 14 to 2. Throughout their championship run, these young women demonstrated the type of teamwork, camaraderie, and never-say-never spirit necessary to succeed in all facets of life.

I also want to take this opportunity to applaud the Little League Softball World Series organizers for orchestrating another successful tournament.

First held in 1974 in Freeport, Long Island, the Little League Softball World Series began with four teams from U.S. regions East, West, Central and South. Since that inaugural year, 236 teams have participated in the Little League Softball World Series, including teams from over 25 States and 13 countries worldwide. Today, the Little League Softball World Series is a tremendous sporting event that continues to instill the values of hard work, dedication, and sportsmanship in today's youth.

In closing, let us, as a body, take this opportunity to congratulate the Warner Robins Little League Softball Team for their spectacular achievement and also congratulate the organizers of Little League Softball World Series for coordinating another resoundingly successful tournament.

I encourage all of my colleagues to join me in supporting this measure.

Mr. Speaker, I would like to yield at this point to the lead sponsor of this resolution, Mr. MARSHALL of Georgia, for 5 minutes.

Mr. MARSHALL. Mr. Speaker, I don't think it will take me 5 minutes to cover this one. The resolution simply congratulates the Warner Robins

Little League girls softball team on winning the 2009 Little League Softball World Series. Their victory follows fairly hard on the heels of a victory in 2007 by the Warner Robins Little League boys team in the Little League Baseball World Series, and so it's really quite a treat that Warner Robins now is the only city in the United States that has had teams successful on both the girls side and the boys side as Little League world champions.

I think it's particularly poignant that not only do all members of the Georgia delegation cosponsor, as original cosponsors, this bill, but many Members of Congress are also cosponsors of this bill. And I want to specifically recognize DEBBIE WASSERMAN SCHULTZ. She, at the time that she signed on to the bill, was suffering from an injury that she incurred playing softball in the, I hope to be annual, but it was the first annual softball game to raise money for charity among women here in the House of Representatives.

So we're all softball fans, we're baseball fans. We're delighted that the Warner Robins girls team was successful this year. We hope they have great success in the future in their individual lives. No doubt they value their education very highly, and they're focused on school as much or more so probably than athletics.

Mr. CHAFFETZ. Mr. Speaker, I yield myself such time as I may consume. –Mr. Speaker, I rise today to congratulate the 2009 Little League Softball World Championship team from Warner Robins, Georgia. The Warner Robins Little League softball team competed against six other teams from the United States and teams from around the world, including Italy and Canada. The Warner Robins team went undefeated throughout tournament play, and they clinched the championship by defeating the team from Crawford, Texas. Congratulations to that team as well.

These players showed tremendous desire to win and demonstrated true sportsmanship while ultimately going on to win the Softball World Series. There were many notable achievements on the field because of the remarkable efforts by the entire team and leadership of their dedicated manager and coaches. This victory was the culmination of hundreds of hours of practice and playing and winning many games during the regular season.

The win was of considerable interest to the citizens of Warner Robins, Georgia, because it made the community the first with a Little League to have won both a baseball and a softball world series championship. We should be proud of these young women who showed that teamwork and the ''never give up'' spirit can accomplish much, not only in the game of softball but also as a winning strategy in life. With so much turmoil in the world, it's great to see young women step up and achieve such significance. I hope they carry that through the rest of their lives and recognize this great moment and the team effort that it takes to truly be successful.

Mr. Speaker, I reserve the balance of our time.

Mr. LYNCH. Mr. Speaker, we have no further speakers at this time. But I continue to reserve.

Mr. CHAFFETZ. Mr. Speaker, we have no further speakers, and would yield back the balance of our time.

Mr. LYNCH. Mr. Speaker, in closing, I just want to ask Members on both sides to support Mr. MARSHALL in his resolution to congratulate the Warner Robins, Georgia, 2009 Little League Softball World Series winner from his hometown.

Mr. GINGREY of Georgia. Mr. Speaker, I rise today as a proud cosponsor of H. Res. 742, a resolution recognizing the accomplishments of the 2009 Warner Robins Little League Softball World Championship Team.

The Little League Softball World Series has long been a competitive outlet for our young women, providing them an arena for personal and athletic advancement. Their mission states, "I trust in God. I love my country and will respect its laws. I will play fair and strive to win, but win or lose I will always do my best." No matter what the outcome for each team, I am positive that the opportunity to be a part of this competition is a valuable experience for every participant and provides them with memories that will last a lifetime.

Today, however, I am pleased to recognize the victorious Warner Robins Little League Softball Championship Team as they defeated the Crawford, Texas Little League Softball Team to become the World Champions on August 19, 2009. This victory distinguishes the Warner Robins Little League as the first little league to claim a baseball and softball championship.

On behalf of the 11th Congressional District of Georgia, it is my honor to congratulate the players, their coaches, and the managers who led them to this success. Your hard work and dedication have not only made you winners on the softball field, but will also be instrumental to your future successes. The 2009 Warner Robins Little League Softball Team is an example to America's youth of the values of teamwork and sportsmanship, and I urge all of my colleagues to support this resolution.

Mr. BISHOP of Georgia. Mr. Speaker, I rise in support of H.R. 742 which congratulates the Warner Robins American Little League Softball Team from Warner Robins, Georgia, on winning the 2009 Softball World Series Championship.

Although Warner Robins is technically no longer a part the 2nd Congressional District of Georgia which I represent, I continue to claim the residents of Warner Robins as my constituents as I have represented them in previous sessions of Congress.

All of us in southwest Georgia are proud of this accomplishment. I would like to recognize and applaud the commitment to excellence, dedication, and determination shown by the players, parents, coaches, and managers who worked so diligently to accomplish a worthy goal. The city of Warner Robins and the State of Georgia should be commended for the outstanding loyalty and support they displayed for their team throughout the season.

The 2009 Champion Warner Robins Little League Softball Team consists of Carson Carriker, Sierra Stella, Chelsea Whaley, Caitlin Parker, Melissa Cox, Kelly Warner, Sabrina Doucette, Hanna Livingston, Kaylee Albritton, Ashley Killebrew, Avery Lamb and Sydney Barker. They were successfully managed and coached by Emily Whaley and Roger Stella.

As most of my colleagues know, Warner Robins Air Force Base is located in the city of Warner Robins. I have no doubt that members of the Warner Robins Softball team have parents or siblings serving in the military. We salute not only the team, but also their family members serving proudly in the military.

On behalf of my constituents in Georgia's Second Congressional District, I offer my congratulations on a job well done.

Mr. LYNCH. I yield back the balance of our time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and agree to the resolution, H. Res. 742.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

□ 1430

GEORGE KELL POST OFFICE

Mr. LYNCH. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3634) to designate the facility of the United States Postal Service located at 109 Main Street in Swifton, Arkansas, as the ''George Kell Post Office''.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3634

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

SECTION 1. GEORGE KELL POST OFFICE.

(a) DESIGNATION.—The facility of the United States Postal Service located at 109 Main Street in Swifton, Arkansas, shall be known and designated as the ''George Kell Post Office''.

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility referred to in subsection (a) shall be deemed to be a reference to the ''George Kell Post Office''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Massachusetts (Mr. LYNCH) and the gentleman from Utah (Mr. CHAFFETZ) each will control 20 minutes.

The Chair recognizes the gentleman from Massachusetts.

GENERAL LEAVE

Mr. LYNCH. Mr. Speaker, I ask unanimous consent that all Members may

have 5 legislative days within which to revise and extend their remarks and add any extraneous materials.

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

There was no objection.

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

Mr. Speaker, as chairman of the House subcommittee with jurisdiction over the United States Postal Service, I am pleased to present H.R. 3634 for consideration. This measure will designate the facility of the United States Postal Service located at 109 Main Street in Swifton, Arkansas, as the ''George Kell Post Office.''

This bill was sponsored solely and principally by my friend Representative MARION BERRY of Arkansas, and I would like to yield to him for 5 minutes for presenting this resolution.

Mr. BERRY. I thank the gentleman from Massachusetts.

Mr. Speaker, I rise today in support of H.R. 3634. My bill would name the U.S. Post Office in Swifton, Arkansas, for George Kell, a native son of Arkansas' First Congressional District.

Throughout his life, George Kell distinguished himself as an athlete, a broadcaster, a businessman, and a public servant. He enjoyed a long career in Major League Baseball with the Athletics, Tigers, Red Sox, White Sox, and Orioles.

During his 15-year playing career, Kell made the All-Star team 10 times and established himself as one of the greatest third basemen in the American League. For his accomplishments, he was inducted into the Baseball Hall of Fame.

After his retirement from baseball, Kell returned to the Detroit Tigers organization as their TV announcer, a position he held for almost 40 years. His broadcasting career allowed him to connect with generations of new fans who were too young to ever see him play the game.

Despite all of his accomplishments in baseball, George Kell was simply a good friend and neighbor to those who knew him best. Throughout his life, he kept returning to his hometown of Swifton, a place he loved like no other. He was an active and respected member of the community, serving on the Arkansas Highway Commission for 10 years, and his career gave him the opportunity to see it all. He knew there was no place like home.

Kell died in Swifton in March of this year at the age of 86. It was a tremendous loss that was felt by his friends and family and the State of Arkansas. George Kell's enduring popularity is evidenced by the fan mail he continued to receive long after his retirement.

It is a fitting tribute that we name the Swifton post office, where he went regularly to correspond with his fans across the country, after this great citizen. It's the least we can do for a friend and a native son of the First Congressional District of Arkansas, and I urge that the House pass H.R. 3634.

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

Mr. Speaker, I rise today in support of H.R. 3634 which designates the United States postal facility located at 109 Main Street in Swifton, Arkansas, as the ''George Kell Post Office.''

George Kell played baseball for 15 years and, in that time, established his place in history as one of baseball's greatest third basemen. Over the span of his career, he played with the Philadelphia Athletics, the Detroit Tigers, the Boston Red Sox, the Chicago White Sox, and the Baltimore Orioles. Not only was he a 10-time All Star player, but Mr. Kell is one of only 11 third basemen elected to the Hall of Fame.

Even after he retired, Kell's passion for the game continued. It led him to becoming a broadcaster for the Detroit Tigers. He broadcasted every game from 1959 to 1996, missing only one season in 1964. He was well loved and respected by fans and players alike. It's appropriate that we honor this local icon by supporting H.R. 3634.

Mr. Speaker, I reserve the balance of my time.

Mr. LYNCH. Mr. Speaker, whenever a former member of the Red Sox is recognized, I have to join in those accolades, and I am very pleased to support the resolution offered by my friend Mr. BERRY from Arkansas.

George Clyde Kell distinguished himself as an exceptional professional baseball player over the course of 15 major league seasons and in his later life, as has been mentioned, as a beloved broadcaster for the Detroit Tigers.

Mr. Kell made his major league debut with the Philadelphia Athletics in 1943, playing in one game, and became a consistent starter over the following two seasons. Notably, Mr. Kell was traded to the Detroit Tigers early in the 1946 season, which he finished with a .322 batting average and thereby began establishing himself as a Hall of Fame-caliber third baseman.

Over the course of his distinguished professional baseball career, Mr. Kell was selected as an All-Star 10 times, as has been mentioned, and hit at least .300 in nine major league seasons and led the American League's third basemen in fielding percentage seven times. Mr. Kell's finest season came in 1950 when he led the American League with 218 hits, 56 doubles, and set a career high with 101 runs batted in and 114 runs scored.

In addition, Mr. Kell holds the distinction of winning the closest batting crown race in Major League Baseball history. Mr. Kell captured the American League batting crown in 1949 on the final day of the regular season during which he went two for three against future Hall of Famer Bob Lemon of the Cleveland Indians and succeeded in edging out Boston Red Sox legend Ted Williams for the batting title by two-thousandths of a point.

After hitting for a .319 batting average in 1951, Mr. Kell was traded to my own Boston Red Sox in 1952 in a multiplayer deal, and the next season set a career high in home runs. Following his stint with the Red Sox, Mr. Kell played for the Chicago White Sox and concluded his playing career in 1957 with the Baltimore Orioles.

During his two seasons with the Orioles, Mr. Kell helped to groom his successor at third base, fellow Arkansas native Brooks Robinson, who would later join Mr. Kell as an inductee into the Major League Baseball Hall of Fame in 1983. It was during their Cooperstown induction ceremony that Mr. Kell noted how incredible it was that two Arkansas natives had traveled the same path to the same place.

Although Mr. Kell ended his playing career in 1957, he never truly left the game, as has been noted here. In 1958, he began broadcasting on CBS's Game of the Week and the following year joined the Detroit Tigers' broadcast crew, teaming with Van Patrick and Ernie Harwell, and later, Tigers' Hall of Fame outfielder Al Kaline. Mr. Kell continued to cover the Tigers until retiring after the 1996 season.

Mr. Speaker, regrettably, George Kell passed away in his hometown of Swifton, Arkansas, on March 24 of this year at the age of 86. And although he is no longer with us, Mr. Kell's memory will live on through his beloved family, including his wife, Carolyn, and his brother, former major leaguer Everett ''Skeeter'' Kell, as well as the countless baseball fans that he entertained as both a player and a broadcaster.

Let us honor Mr. Kell by designating the postal facility in his hometown of Swifton, Arkansas, as the ''George Kell Post Office,'' and I urge my colleagues on both sides of the aisle to join us and join Mr. BERRY in sponsoring and supporting his resolution.

Mr. CHAFFETZ. Mr. Speaker, I'd like to yield as much time as he may consume to the distinguished gentleman from Arkansas (Mr. BOOZMAN).

Mr. BOOZMAN. Mr. Speaker, I rise today in support of H.R. 3634, to designate the facility of the United States Postal Service located at 109 Main Street in Swifton, Arkansas, as the ''George Kell Post Office.'' I want to thank my friend and colleague and the senior member of the Arkansas delegation in the House for bringing this forward, and this is very, very important and certainly very well deserved.

As has been noted, George Kell, as a professional baseball player, broadcaster, businessman, and family man from Swifton, Arkansas, made literally

a household name for himself in Arkansas as one of the greatest third basemen in the 1940s and 1950s. In 1957, to be closer to his family, he retired. He then went on to become a Detroit Tigers broadcaster for nearly 40 years. In 1983, he joined the baseball greats when he was nominated for the National Baseball Hall of Fame by the Veterans Committee.

During his career, George always kept Arkansas close to his heart. During his time in the majors, he bought farmland in Swifton, which he worked on in the off-seasons, and continued farming after he retired from playing baseball. Even when he was broadcasting for the Detroit Tigers, he still called Swifton home, commuting 1,000 miles from Arkansas for games.

George remained committed to his home in Arkansas and helped his community. In 1962, he bought a car dealership in Newport, Arkansas, and later became sole owner of this budding business. After hearing Dale Bumpers speak in the city during his 1970 campaign, George jumped on the campaign trail helping the little-known candidate win the Governor's race. George was then appointed to the State Highway Commission where he served for 10 years, 4 of which as chairman.

George was an Arkansan through and through and certainly a favorite son, so it couldn't be more fitting to honor him by naming the Swifton postal facility in his honor. He will be missed by family and friends.

And again, I want to thank Congressman BERRY for his work in bringing this recognition forward.

Mr. LYNCH. Mr. Speaker, I don't believe we have any more speakers on our side, but I continue to reserve.

Mr. CHAFFETZ. Mr. Speaker, with no other speakers, we would yield back the balance of our time.

Mr. LYNCH. Mr. Speaker, just very briefly, I ask all of our colleagues on both sides of the aisle to join with Mr. BERRY and Mr. BOOZMAN in support of this resolution, and I yield back the balance of our time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and pass the bill, H.R. 3634.

The question was taken.

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

Mr. LYNCH. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

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

The point of no quorum is considered withdrawn.

CLYDE L. HILLHOUSE POST OFFICE BUILDING

Mr. LYNCH. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3667) to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the "Clyde L. Hillhouse Post Office Building".

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3667

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

SECTION 1. CLYDE L. HILLHOUSE POST OFFICE BUILDING.

(a) DESIGNATION.—The facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, shall be known and designated as the "Clyde L. Hillhouse Post Office Building".

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility referred to in subsection (a) shall be deemed to be a reference to the "Clyde L. Hillhouse Post Office Building".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Massachusetts (Mr. LYNCH) and the gentleman from Utah (Mr. CHAFFETZ) each will control 20 minutes.

The Chair recognizes the gentleman from Massachusetts.

GENERAL LEAVE

Mr. LYNCH. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend any remarks and include any extraneous materials.

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

There was no objection.

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

Mr. Speaker, as chairman of the House subcommittee with jurisdiction over the United States Postal Service, I am pleased to present H.R. 3667 for consideration. This measure will designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the "Clyde L. Hillhouse Post Office Building."

H.R. 3667 was introduced by my friend and colleague Representative ANDER CRENSHAW of Florida on September 29, 2009, and was favorably reported out of the House Oversight Committee by unanimous consent on October 29, 2009. In addition, H.R. 3667 enjoys the support of the entire Florida House delegation.

A native of the town of White Springs, Florida, Clyde L. Hillhouse dedicated his life to public service as a distinguished member of the United States Army Air Corps during World War II and, later in his life, as postmaster of his beloved White Springs community.

Shortly after joining the United States military in 1940, Mr. Hillhouse was deployed to the Pacific theater of operations during World War II. Notably, Mr. Hillhouse participated in the heroic defense of Corregidor Island by the American and Filipino military forces against Japanese forces seeking to advance on Manila Bay.

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Despite the valiant efforts of the American and Filipino soldiers, the island fell to Japanese forces in mid-1942 and Mr. Hillhouse subsequently became one of approximately 75,000 American and Filipino prisoners of war taken in the Bataan Peninsula. During his over-3 years in captivity, Mr. Hillhouse bravely survived the infamous Bataan death march, as well as periods of slave labor in the Philippines and on the Japanese mainland.

In recognition of wounds that he received during action in the Philippines, Mr. Hillhouse was awarded the Purple Heart in 1984, also received the Bronze Star for his distinguished military service.

Following the end of World War II and his return to White Springs, Mr. Hillhouse continued his commitment to public service as a dedicated employee of the United States Postal Service for nearly 30 years. Specifically, Mr. Hillhouse served as postmaster of White Springs from July 14, 1947, until his retirement on January 19, 1973.

In addition to his service as postmaster, Mr. Hillhouse was active in the White Springs community as a longtime volunteer fire chief and as a member of the Veterans of Foreign Wars Service Organization.

Regrettably, Mr. Hillhouse passed away in his home in White Springs on April 26, 1998, at the age of 84.

Mr. Speaker, Clyde Hillhouse's life stands as a testament to the bravery and dedication exhibited by the men and women of the United States military, and it is my hope that we can honor this exceptional soldier and public servant through the passage of this legislation to designate the White Springs Post Office in his honor.

Mr. Speaker, I ask my colleagues on both sides of the aisle to join in supporting H.R. 3667, along with Mr. CRENSHAW, the lead sponsor.

I reserve the balance of my time.

Mr. CHAFFETZ. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. CRENSHAW).

Mr. CRENSHAW. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 3667. As has been pointed out, it is a bill to honor Clyde L. Hillhouse by designating the post office at 16555 Springs Street, White Springs, Florida, after this World War II hero who devoted his life to public service.

Clyde Leroy Hillhouse was born on February 11, 1914, in Hamilton County,

Florida, a small county halfway between Jacksonville and Tallahassee. On October 10, 1940, when he was only 25 years old, he answered the call to serve his Nation in patriotic service. He enlisted in the United States Army Air Corps.

Mr. Hillhouse was assigned to the 27th Bomb Group and departed with his unit for duty in the Philippines in November of that year. Mr. Hillhouse and his fellow airmen from the 27th Bomb Group were trained as infantry soldiers and fought in defense of Bataan and Corregidor Island from the invading Japanese forces. After the eventual fall of Corregidor Island, Mr. Hillhouse was captured and held as a POW by the Japanese forces and survived the infamous Bataan death march where it is estimated that 30 percent of all of the prisoners were brutally killed by their captors.

For over 2 years, Mr. Hillhouse was assigned to slave labor unloading ships in Manila. In July 1944, he was sent to Japan on a freighter where he was kept as a prisoner until his release at the end of the war.

Like so many people in his generation, Mr. Hillhouse returned to his life and family after the war in White Springs with little discussion about the torture and the atrocities that he had endured and witnessed as a prisoner of war for 3½ years. In fact, Mr. Hillhouse continued his public service and became an employee of the United States Postal Service.

Both he and his wife, Sarah, worked at the White Springs Post Office from July 14, 1947, until his retirement on January 19, 1973.

Mr. Speaker, I believe as elected Members of Congress we have an obligation and duty to honor and protect the veterans of our Nation. Those who put their lives on the line so we as Americans can have the security and freedom that we enjoy in this great country deserve the utmost recognition, and I believe the designation of this post office is a fitting tribute to a man who valiantly served in the armed services, survived slave labor and POW camps, and continued to serve his Nation as postmaster. I urge my colleagues to vote in favor of this legislation.

Mr. CHAFFETZ. Mr. Speaker, Mr. Hillhouse was obviously a great American, one of our best. We urge the adoption of H.R. 3667.

I yield back the balance of my time.

Mr. LYNCH. Mr. Speaker, in closing, I ask Members on both sides of the aisle to support Mr. CRENSHAW and his bill.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and pass the bill, H.R. 3667.

The question was taken.

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

Mr. LYNCH. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

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

The point of no quorum is considered withdrawn.

EXPRESSING SUPPORT FOR GREATER AWARENESS OF OVARIAN CANCER

Mr. LYNCH. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 727) supporting the goals and ideals of National Ovarian Cancer Awareness Month, as amended.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 727

Whereas ovarian cancer is the deadliest of all gynecological cancers, and the reported mortality of ovarian cancer is increasing over time;

Whereas ovarian cancer is the 5th leading cause of cancer deaths among women in the United States;

Whereas the mortality rate for ovarian cancer has not significantly decreased in the almost 40 years since the ''War on Cancer'' was declared;

Whereas all women are at risk for ovarian cancer, and 90 percent of women diagnosed with ovarian cancer do not have a family history that puts them at higher risk;

Whereas the Pap test is sensitive and specific to the early detection of cervical cancer, but not to ovarian cancer;

Whereas there is currently no reliable early detection test for ovarian cancer;

Whereas many people are unaware that the symptoms of ovarian cancer often include bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, and urinary symptoms, among several other symptoms that are easily confused with other diseases;

Whereas the first national consensus statement on ovarian cancer symptoms was developed in June 2007 to provide consistency in describing symptoms to make it easier for women to learn and remember them;

Whereas due to the lack of a reliable screening test, 75 percent of ovarian cancer cases are diagnosed in an advanced stage when the five-year survival rate is below 45 percent;

Whereas if ovarian cancer is diagnosed and treated at an early stage before the cancer spreads outside of the ovary, the survival rate is as high as 90 percent;

Whereas there are factors that are known to reduce the risk for ovarian cancer and play an important role in the prevention of the disease;

Whereas awareness and early recognition of ovarian cancer symptoms are currently the best way to save women's lives;

Whereas the Ovarian Cancer National Alliance, during the month of September, holds a number of events to increase public awareness of ovarian cancer; and

Whereas the goals and ideals of National Ovarian Cancer Awareness Month should be promoted to increase the awareness of the public regarding the cancer: Now, therefore, be it

Resolved, That the House of Representatives expresses support for greater awareness of ovarian cancer.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Massachusetts (Mr. LYNCH) and the gentleman from Utah (Mr. CHAFFETZ) each will control 20 minutes.

The Chair recognizes the gentleman from Massachusetts.

GENERAL LEAVE

Mr. LYNCH. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and add any extraneous materials.

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

There was no objection.

Mr. LYNCH. Mr. Speaker, at this point I would like to yield to the gentleman from New York (Mr. ISRAEL) for 5 minutes.

Mr. ISRAEL. Mr. Speaker, I rise in support of this resolution. I am very proud to have sponsored it. I am very proud to serve as a co-Chair of the Congressional Cancer Caucus.

Mr. Speaker, this year 21,500 women will be diagnosed with ovarian cancer; 14,600 will have lost their lives. Some of those women who will have lost their lives could have been saved with advanced diagnosis of their ovarian cancer. This is a silent killer, and the sad fact is that if you are fortunate enough to receive advanced diagnosis of ovarian cancer, the survival rate is as high as 90 percent. But if you receive your diagnosis in the latter stages of the disease, the survival rate falls to less than 45 percent.

Mr. Speaker, in addition, 75 percent of all ovarian cancer cases are diagnosed in the latter stages of the disease, and that is too late for too many women in America today.

Mr. Speaker, several years ago I sponsored similar legislation and ran into a woman at a rally. She said: Congressman ISRAEL, I am in stage 4 of ovarian cancer. Your resolution may be too late for me. I am here because I hope it is not too late for my daughter.

Mr. Speaker, no mother in America should have to think in those terms, and this resolution provides women with the tools they need to recognize ovarian cancer, to get an advanced diagnosis of ovarian cancer, and to be educated about it.

I want to thank Chairman TOWNS for his support of this resolution; the gentlewoman from Connecticut (Ms. DELAURO) who is an ovarian cancer survivor; the principal cosponsors, the gentleman from California (Mr. ISSA), the gentleman from Indiana (Mr. BURTON); and the Ovarian Cancer National Alliance for their critical help with this legislation.

Mr. LYNCH. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Connecticut (Ms. DELAURO), the lead sponsor of this resolution.

Ms. DELAURO. I thank the gentleman from Massachusetts for this time, and I thank the gentleman from New York for his leadership on this issue. It is an honor to serve with him. He has been a champion of the cause of cancer and particularly ovarian cancer. I strongly urge my colleagues to support the Ovarian Cancer Awareness Month resolution. This is an easy call for me because I know firsthand that awareness saves lives.

Twenty-three years ago, I was diagnosed with ovarian cancer. I was lucky: I had excellent doctors who detected the cancer by chance in stage 1. I underwent radiation treatment for 2½ months, and I am fortunate to say I have been cancer free ever since.

Standing here before you today, I know I am one of the lucky ones. My life was given back to me, and changed at the same time. And I know that had my doctors not caught my cancer at this earliest stage, the final outcome may have been very, very different. That is why it is so important that we pass this resolution and help raise the awareness about ovarian cancer. Ten women in the United States are diagnosed with a gynecological cancer every hour; 26,000 women succumb to these terrible cancers each year. Women who detect their ovarian cancer in stage 1 are more than four times likely to beat it than those who find out in stages 3 or 4.

Of course there are other steps we should also take. We need to re-fund Johanna's Law this year, reauthorize it for future years; and we need to make sure that our Affordable Health Care for America Act becomes the law of the land so all Americans have access to quality, affordable health insurance and can get the cancer screenings that may save their lives.

But today, we can do our part by standing up against ovarian cancer and passing this resolution. Cancer is indiscriminate. It does not care about your age or family, your sex, your race, or religion. It reminds us that we are all human and that, yes, we are vulnerable; and that we must all come together, man and woman, young and old, Democrat or Republican, to fight it on every front. I urge my colleagues to support this resolution, to support life, to help to support saving lives.

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

I thank the gentlewoman from Connecticut (Ms. DELAURO) for the strength and inspiration that she provides to so many women who are having to deal with this. And thank you for sharing your story.

I rise today in support of H. Res. 727, supporting the goals and ideals of National Ovarian Cancer Awareness Month. Ovarian cancer is the deadliest of all gynecological cancers and is the fifth leading cause of death among women in the United States of America. Ovarian cancer will occur in one out of every 57 women. This year, approximately 20,000 women will be diagnosed with ovarian cancer, and more than 15,000 will unfortunately die from it.

Currently, there is no reliable early detection test for ovarian cancer. In June 2007, for the first time a national consensus statement on ovarian cancer symptoms was developed. It described the symptoms, thereby making it easier for women to learn and remember them. However, because of the lack of reliable screening tests, 75 percent of ovarian cancer cases are diagnosed in an advanced stage, resulting in a survival rate of less than 45 percent. This has to change.

It is critical to the victims of ovarian cancer and their loved ones that a reliable screening test be developed to detect this dreaded cancer in its early stages. In the meantime, the Ovarian Cancer National Alliance holds a number of events to increase public awareness of ovarian cancer and educates women about the importance of knowing its common signs and symptoms.

During these events, they stress the importance of routine doctor visits and robust scientific research. During this time and throughout the year, we need to renew our commitment to fighting this illness that devastates all who have been touched by this cancer and takes too many lives of women throughout the United States. I urge my colleagues to support this important resolution, H. Res. 727.

My own mother passed away from breast cancer. Cancer kills too many Americans, roughly 1,500 people a day in this country. I think it is a shame that we don't give more national importance to fighting the war against cancer.

I reserve the balance of my time.

Mr. LYNCH. Mr. Speaker, I thank the gentleman from Utah for his remarks, and I want to thank the gentleman from New York (Mr. ISRAEL) and the gentlewoman from Connecticut (Ms. DELAURO) for their leadership on this resolution.

Mr. Speaker, ovarian cancer is one of the deadliest forms of women's cancer. As noted by the Centers for Disease Control and Prevention, ovarian cancer is now the eighth most common cancer and the fifth leading cause of cancer death among women in the United States.

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As has been noted earlier, in addition, and which has been commented on by the American Cancer Society's annual ''cancer facts and figures,'' over 21,500 new cases of ovarian cancer will have been diagnosed and approximately 14,600 women will have died from ovarian cancer in 2009 alone. Moreover, the American Cancer Society additionally notes that a woman's risk of developing invasive ovarian cancer during her lifetime is about 1 in 71, and estimates that a woman's lifetime chance of dying from invasive ovarian cancer is 1 in 95.

Despite these troubling statistics, with early detection and proper management, ovarian cancer can be highly treatable. As noted by the American Cancer Society, about 3 in 4 women with ovarian cancer survive at least 1 year after diagnosis, and almost half of women with ovarian cancer are still alive at least 5 years after diagnosis. And if ovarian cancer is found and treated before the cancer has spread outside the ovary, the 5-year survival rate is 93 percent.

However, while ovarian cancer is manageable if detected early, we know that less than 20 percent of all ovarian cancer is found at an early stage.

The Ovarian Cancer Coalition notes that ovarian cancer can strike women of any race and at any age, though women who are over the age of 55 and who have never been pregnant, have a family history of breast or ovarian cancer, or have a personal history of cancer, are at higher risk of being diagnosed with the disease.

Accordingly, let us take this opportunity, through the passage of House Resolution 727, to increase the awareness regarding this serious form of cancer and encourage all women to work with their doctors in order to maximize the possibility of early detection. And this resolution has even greater importance in light of the health care debate that goes on in the Senate right now.

Accordingly, I urge my colleagues to join me in supporting House Resolution 727, and I continue to reserve the balance of my time.

Mr. BURTON of Indiana. Mr. Speaker, I rise today in strong support of House Resolution 727, which expresses the House of Representatives' support for the goals and ideals of National Ovarian Cancer Awareness Month. As many of my colleagues hopefully know, on August 31, 2009, President Obama issued a Presidential Proclamation officially declaring September National Ovarian Cancer Awareness Month, and calling on every American to do their part to increase awareness of what Americans can do to prevent and control ovarian cancer. Rising to the challenge, throughout September, all across the Nation, men and women came together for events to both raise awareness of this terrible scourge and to show their support for the women and families struggling with this horrible disease—the deadliest of the gynecologic cancers.

While National Ovarian Cancer Awareness Month may be over for 2009, the fight against ovarian cancer goes on. When it is detected early, ovarian cancer is very treatable; unfortunately, ovarian cancer is one of the most difficult cancers to diagnose because symptoms

are sometimes subtle and may be easily confused with those of other diseases. As a result, only 29 percent of ovarian cancer cases in the U.S. are diagnosed in the early stages. When the disease is detected before it has spread beyond the ovaries, more than 95 percent of women will survive longer than five years. But, in cases where the disease is not detected until it reaches the advanced stage, the five-year survival rate plummets to a devastating 25 percent.

As there is still no reliable and easy-to-administer screening test for ovarian cancer, like the Pap smear for cervical cancer or the mammogram for breast cancer; early recognition of symptoms is clearly the best way to save a woman's life. Increased education and awareness about ovarian cancer, along with recognition of women who are at higher risk for developing ovarian cancer, is the only way that women and their doctors will be able to stop ignoring or misinterpreting the subtle symptoms of the disease.

In 2007, the American Cancer Society and the Ovarian Cancer National Alliance came to a consensus on the identifiable symptoms of ovarian cancer. If a woman experiences any of the following symptoms for at least three weeks—bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, frequent or urgent need to urinate—she should immediately see her gynecologist. I urge all of my colleagues to remember those symptoms and I ask each and every one of you to please make a special point of discussing them with your mothers, your wives and your daughters; and encourage them to talk about these symptoms with other women. The simple fact is that ignorance kills. The more women know what to look for, the more lives we can save. If we love our mothers, our wives and our daughters, and I am sure that we do, then we owe it to them to make the effort to talk with them about ovarian cancer.

The word "cancer" evokes powerful emotions. Along with many of my colleagues, I know firsthand how devastating cancer can be to the individual who has been diagnosed as well as their family. And I would like to pay a small homage to a constituent of mine and a dear friend, Kolleen Stacy, who recently lost her own personal battle with ovarian cancer. Kolleen first brought the issue of ovarian cancer to my attention, and it was her passion to protect other women from the scourge of ovarian cancer that convinced me to champion this cause in the People's House. Today's debate is a victory for all women, but in my mind, the fact that we are having this debate, the fact that in 2009 there is even such a thing as National Ovarian Cancer Awareness Month is a tribute to the dedication and commitment of women like Kolleen Stacy. God bless you Kolleen.

Mr. Speaker, I urge all of my colleagues to support House Resolution 727. It is literally a matter of life and death.

Ms. KILROY. Mr. Speaker, I rise today in support of H. Res. 727, which supports the goals and ideals of National Ovarian Cancer Awareness Month.

We all know someone who has been diagnosed with cancer and understand the devastating impact that diagnosis can have on the patient and his or her family. Although we have made great strides in recent years in finding new treatments for those afflicted with cancer, ovarian cancer continues to be difficult to diagnose and when discovered in later stages, the survival rate is lower than 45 percent. Ovarian cancer silently spreads because we cannot reliably screen for it and because its symptoms are common with other diseases.

As an original cosponsor of H.R. 1816, the "Ovarian Cancer Biomarker Research Act," introduced by my friend and colleague Representative BERMAN, I believe we should encourage collaboration between the federal government and institutions conducting invaluable research on biomarkers for use in risk stratification for, and the early detection and screening of, ovarian cancer. These types of initiatives will ensure that the United States remains a leader in medical breakthroughs and innovations.

We must continue to support funding for research into ovarian cancer, so that we may one day find a cure. We also must devote the necessary resources into developing new screening technology for cancers like ovarian cancer which all too often are found late. Equally important, all women and men need to educate themselves about ovarian cancer so that we save our own lives or those of our loved ones.

I want to commend Representative ISRAEL for introducing this important resolution, and I urge my colleagues to support it.

Mr. HONDA. Mr. Speaker, I rise today to express my strong support for H. Res. 727, emphasizing the need for greater awareness about ovarian cancer and adopting the goals and ideals established by National Ovarian Cancer Awareness Month. Having lost my wife of 36 years, Jeanne, to ovarian cancer in 2004, I am acutely sensitive to the need for reliable early detection programs and effective treatments for late stage ovarian cancer. I am not alone in having lost a loved one to this disease—ovarian cancer is the deadliest of all gynecologic cancers, affecting over 20,000 women a year. Ovarian cancer is the fifth leading cause of cancer death in women, killing nearly 55 percent of those diagnosed within the first 5 years. Despite this tragically high toll, we still remain woefully ignorant of proper prevention strategies for ovarian cancer, and have yet to develop a reliable early detection program.

While over 90 percent of ovarian cancer cases can be prevented with early screening and treatment, many women remain unaware of their risk factors and the early symptoms of ovarian cancer are particularly difficult to accurately diagnose. Because of this, 75 percent of ovarian cancer cases are diagnosed in the advanced stages where it is often too late to prevent the cancer's spread. Awareness and early recognition are the best way to save women's lives.

Congress is making some effort to address the inadequacies in our current system. For example, in November 2005, the House passed the Gynecological Resolution for the Advancement of Ovarian Cancer Education in a bipartisan effort to increase the public's understanding of this deadly disease. The President and nonprofit advocacy groups are also engaged in educating the public. President Obama proclaimed September National Ovarian Cancer Awareness Month and throughout September, the Ovarian Cancer National Alliance held hundreds of events across the country to inform women about the importance of gynecologic exams, and to teach them about the warning signs of ovarian cancer.

Better education, more funding for research, and increased awareness efforts are critical to ensuring that we reduce infection and mortality rates for ovarian cancer in women. I urge my colleagues to continue our efforts to increase research funding to cure ovarian cancer and support public outreach programs on the prevention and treatment of gynecological cancers.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise before you today in support of H. Res. 727, "supporting the goals and ideals of National Ovarian Cancer Awareness Month." I would like to thank my colleague Congressman STEVE ISRAEL for his leadership on this very important issue, as ovarian cancer is the 5th leading cause of cancer deaths among women in the United States.

Ovarian cancer is the deadliest of all gynecological cancers. All women are at risk for ovarian cancer, but older women are more likely to get the disease than younger women. About 90 percent of women who get ovarian cancer are older than 40 years of age, with the greatest number being aged 55 years or older. Additionally, 90 percent of women diagnosed with ovarian cancer do not have a family history that puts them at higher risk. Early detection is vital, only 20 percent of ovarian cancers are found before tumor growth has spread beyond the ovaries. The chance of surviving ovarian cancer is better if the cancer is found early. Unfortunately, there is currently no reliable early detection test for ovarian cancer.

Among women in the United States, ovarian cancer is the eighth most common cancer and the fifth leading cause of cancer death, after lung and bronchus, breast, colorectal, and pancreatic cancers. Ovarian cancer causes more deaths than any other cancer of the female reproductive system. In 2005, 19,842 women in the U.S. learned they had ovarian cancer, and 14,787 women died from the disease.

Ovarian cancer is known as a "silent killer" because it usually isn't found until it has spread to other areas of the body. Unfortunately, there is no simple and reliable way to test for ovarian cancer in women and the Pap test does not check for ovarian cancer. However, new evidence shows that most women may have symptoms even in the early stages, such as: bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, and urinary symptoms, among several other symptoms that are easily confused with other diseases. This new evidence has led to the first national consensus statement on ovarian cancer symptoms to provide consistency in describing symptoms to make it easier for women to learn and remember them. Awareness of symptoms may hopefully lead to earlier detection.

The mortality rate for ovarian cancer has not significantly decreased in the almost 40 years since the 'War on Cancer' was declared. If ovarian cancer is diagnosed and treated at an

early stage before the cancer spreads outside of the ovary, the survival rate is as high as 90 percent. However, due to the lack of a reliable screening test, 75 percent of ovarian cancer cases are diagnosed in an advanced stage when the five-year survival rate is below 45 percent.

I urge my colleagues to support the goals and ideals of National Ovarian Cancer Awareness Month. Education and awareness of ovarian cancer will save the lives of countless women.

Mr. CHAFFETZ. Mr. Speaker, I urge the adoption of House Resolution 727. I thank the chief sponsor, Mr. ISRAEL, and all those who have put their heart and soul behind this, and urge the adoption of this resolution.

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

Mr. LYNCH. Mr. Speaker, having no further speakers on my side, I want to thank Mr. ISRAEL and Ms. DELAURO for their leadership on this, and I urge that all Members support House Resolution 727.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and agree to the resolution, H. Res. 727, as amended.

The question was taken.

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

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

The yeas and nays were ordered.

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

HONORING THE LIFE OF FRANK McCOURT

Mr. LYNCH. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 743) honoring the life of Frank McCourt for his many contributions to American literature, education, and culture.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 743

Whereas Frank McCourt, a great American author, passed away on July 19, 2009;

Whereas Frank McCourt was born on August 19, 1930, in Brooklyn, New York;

Whereas Frank McCourt returned to his parents' homeland of Ireland during the Great Depression where he remained until the age of 19;

Whereas Frank McCourt returned to the United States and served in the United States Army where he was stationed in Germany during the Korean War;

Whereas following his service in the United States Army, Frank McCourt attended New York University on the GI Bill despite never having attended high school;

Whereas following his graduation from New York University, Frank McCourt began teaching English and creative writing in the New York City Public School system where he remained for 27 years;

Whereas Frank McCourt authored an autobiography titled ''Angela's Ashes'' which vividly tells of the poverty, hunger, and alcoholism that challenged his family and others in the town of Limerick, Ireland, where he grew up;

Whereas ''Angela's Ashes'' won the Pulitzer Prize for Biography, the National Book Critics Circle Award, the ABBY Award among others, and has sold over 4,000,000 copies, has been published in 27 countries, and has been translated into 17 languages;

Whereas Frank McCourt also authored other award winning books including, ''Tis'', the follow up to ''Angela's Ashes'', and ''Teacher Man'', about his work in the New York School system;

Whereas his contributions to American literature, education, and culture have impacted millions; and

Whereas Frank McCourt was beloved by his family, friends, and neighbors for his kindness, wit, and generosity: Now, therefore, be it

Resolved, That the House of Representatives honors the life of Frank McCourt for his many contributions to American literature, education, and culture.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Massachusetts (Mr. LYNCH) and the gentleman from Utah (Mr. CHAFFETZ) each will control 20 minutes.

The Chair recognizes the gentleman from Massachusetts.

GENERAL LEAVE

Mr. LYNCH. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and add any extraneous materials.

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

There was no objection.

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

Mr. Speaker, I am pleased to present House Resolution 743 for consideration. This resolution honors the life of Frank McCourt for his many contributions to American literature, education and culture.

The measure before us was introduced on September 14 by my colleagues, Representative CHRIS MURPHY of Connecticut and Mr. JOSEPH COURTNEY from Connecticut, and was favorably reported out of the Oversight Committee on October 29, 2009 by unanimous consent. Notably, this measure enjoys the support of over 50 Members of Congress.

At this point, I would like to yield 5 minutes to one of the lead sponsors of this resolution, Mr. COURTNEY of Connecticut.

Mr. COURTNEY. Mr. Speaker, I thank the gentleman from Massachusetts for his efforts to bring this resolution to the floor today honoring a great American, a great writer and a great human being. As the cosponsorship indicates, there is a Connecticut thread through this resolution because at the time of his passing, Frank lived in Roxbury, Connecticut, where a memorial service was held just a few weeks ago. Congressman CHRIS MURPHY attended that service and would have liked to be here but had some business back in his district, so I want to at least convey his strong support for this resolution because of the strong feeling within northwestern Connecticut where Frank resided and just the love and affection that the people of that State, which was kind of his adopted State, had for Frank.

As the resolution indicates, Frank had an amazing American life. He was born in the U.S. but moved as an infant back to Ireland. He was raised in Limerick which became the subject of ''Angela's Ashes,'' a book that won prizes from all over the world, was translated into 17 languages and was read in over 27 countries. He later moved back to the U.S., served in the U.S. Army, actually through the GI bill got his education, became a teacher, and then, again, an amazing story of becoming an undiscovered pearl as a writer late in life when he published ''Angela's Ashes'' in his sixties, and again became an internationally acclaimed author.

It's a book that's about a very sort of small slice of humanity. It is a story about childhood poverty in Limerick, a relatively small to medium size city in Ireland back in the 1950s. You would think it would have a very small audience. But because of Frank's amazing gifts, he was able to write a story that really touched people from all over the world about the challenges that families face under the most difficult circumstances. And ultimately, although a very harsh account of his life, it is an inspiring book as well about his mother, Angela McCourt.

He then wrote a second book called ''Tis'' which was a story really about immigration coming back to the U.S. really as almost a native Irish citizen at the time and fending his way through America. Again, it is a story which was full of some pretty rough scenes, but at the end of the day, it really is an American story about someone coming to this country, being able to have the opportunity to pursue their dreams and to have the tools and opportunity, again, to become an extremely successful teacher.

And that was the third book, ''Teacher Man,'' which is a story about him going into the public school system of New York City. His story about his first day in the classroom is something that every teacher I have ever talked to has described as one of the most amazingly accurate accounts of the fear that you feel walking into a classroom and trying to figure out a way to connect and in his instance, again, someone with a heavy Irish brogue, a

kind of a timid soul going into a tech school to teach creative writing and English composition, it is hilarious. I recommend it to anyone who has the time to read that amazing story.

Frank, again, as someone who had a second career in life as a writer, was somebody who shared that experience. He raised money for charities all over the U.S. He supported people in the community like CHRIS MURPHY and myself out on the campaign trail.

I would just close by saying that one of my most vivid moments as a new Member of Congress is the day we invited Frank to come to the Hill. We set up a little breakfast at the Members' dining room and invited Members to come. He sat there in a room with complete strangers. Obviously, Members of Congress have pretty big egos and like to talk themselves. But you could have heard a pin drop. He told stories, told jokes and charmed people for an hour and a half. And it was just magic.

That really was what Frank was. He was somebody who because of his amazing imagination and his humanity and sense of humor was able to walk into a room full of strangers and just completely charm them and transform them. It's a memory that I think the Congress does well to memorialize and honor today. As we deal with issues like immigration and education, his example, I think, is an inspiring one for all of us who are involved in these challenges. His life really tells us that we are a great country and we can succeed if we give people the opportunities to blossom and show what they are really made of.

With that, I urge support of the resolution.

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

Mr. Speaker, I hope my colleagues will join us in honoring the late Frank McCourt, best remembered for his Pulitzer Prize-winning memoir, ''Angela's Ashes.''

Born in 1930 in Brooklyn, New York, Mr. McCourt was actually a public school teacher for nearly 30 years who taught English. He was a veteran, drafted into the Army during the Korean War, and used the GI bill to enroll in New York University. He also earned a master's degree from Brooklyn College.

Throughout his nearly 30-year career teaching, Mr. McCourt taught at McKee High School in Staten Island, Stuyvesant High School in New York City, at New York City Technical College and at the City University of New York.

It was only in his mid sixties that Mr. McCourt finally sat down and chronicled his childhood memories. Despite Mr. McCourt's insistence that it was ''a modest book, modestly written,'' ''Angela's Ashes'' became an overnight, word-of-mouth success. It was made into a motion picture in 1999. Mr. McCourt received the Pulitzer Prize and the National Book Critic Circle Award for his work.

Mr. McCourt passed away this past July 19, and today, we honor the contributions he made not only to America's educational system but also to American culture and American literature.

With that, Mr. Speaker, I would like to reserve the balance of my time.

Mr. LYNCH. Mr. Speaker, the measure before us, as eloquently reported by the gentleman from Connecticut (Mr. COURTNEY) and also cosponsored by CHRIS MURPHY, honors Francis ''Frank'' McCourt who was born on August 19, 1930, in the Bedford-Stuyvesant section of Brooklyn where his Irish immigrant parents had hoped to make a better life. In the midst of the Great Depression, Mr. McCourt and his family relocated to Limerick, Ireland, when he was 4 years old, only to sink deeper into poverty.

As noted by Mr. McCourt, his family's circumstances were so dire that he often dreamed of becoming a prison inmate so that he would be guaranteed three meals a day and a warm bed. The death of three of Mr. McCourt's six siblings in early childhood, his father's abandonment, and his family's continued poverty are only some of the hardships that plagued Mr. McCourt's childhood at the age of 19, when Mr. McCourt took his savings and boarded a ship for New York.

Following a number of jobs, Mr. McCourt joined the United States Army and was subsequently stationed in Germany during the Korean War. While his formal education ended at the age of 13, Mr. McCourt nonetheless gained admission to New York University and earned a degree in English education in 1957 on the GI bill. One year later, Mr. McCourt began teaching at the age of 28 at Ralph McKee Vocational High School on Staten Island, thus beginning his 30-year career teaching in the New York City public school system.

After earning a master's degree in English from Brooklyn College in 1967, Mr. McCourt began teaching creative writing at Manhattan's highly selective Stuyvesant High School in 1972 where he remained until his retirement in 1987. Through his popular teaching style and his initial literary endeavors, Mr. McCourt became a beloved teacher at Stuyvesant and was known throughout the school as someone that you needed to meet if you wanted to become a writer. The fact that several of his former students went on to become writers stands as a testament to the impact of Mr. McCourt's teaching.

In 1977, Mr. McCourt and his brother, Malachy, adapted their series of autobiographical sketches into a two-man play that opened off Broadway, and they subsequently took the play to several other cities. This project motivated Mr. McCourt to continue his reflections on his past, and he put pen to paper and began work on his childhood memoirs following his retirement from teaching.

1996 marked the publication of Mr. McCourt's Pulitzer-Prize winning memoir, ''Angela's Ashes.'' Detailing the challenges and impact that his childhood had on his life and the life of the people of Limerick, Mr. McCourt's beautifully written and honest tale struck a powerful chord with people of all ages and backgrounds.

The book's most famous passage begins with Mr. McCourt saying, ''When I look back on my childhood, I wonder how I survived at all. It was, of course, a miserable childhood: The happy childhood is hardly worth your while.''

Not only did his story have an effect on his readers, it also touched Mr. McCourt himself. He said of writing ''Angela's Ashes'' that he ''learned the significance of my own insignificant life.'' He followed ''Angela's Ashes'' with two more books detailing his life, including ''Teacher Man'' about his life as a public school teacher.

Regrettably, Mr. McCourt passed away on July 19, 2009, at the age of 78. He is survived by his wife, Ellen Frey McCourt; his brothers, Malachy, Alphie and Mike; his daughter, Maggie McCourt; and his three grandchildren.

Mr. Speaker, let us remember and honor Frank McCourt for inspiring and influencing millions with his works and for his contributions to education through the passage of this resolution.

I urge all my colleagues to join us in supporting House Resolution 743, and I reserve the balance of my time.

□ 1515

Mr. CHAFFETZ. Mr. Speaker, I reserve the balance of my time.

Mr. LYNCH. At this time I yield 3 minutes to the gentleman from New York (Mr. BISHOP).

Mr. BISHOP of New York. I thank the gentleman from Massachusetts for yielding, and I thank the authors of this resolution.

Frank McCourt is justifiably known to the country and to the world primarily as a writer. I knew him as a teacher. Prior to coming to the Congress, I was the provost of South Hampton College of Long Island University, and we offered a master's in the fine arts program in creative writing. We hired Frank McCourt to teach in that program. He taught in that program every summer from 2002 through 2008, and he was preparing to teach in the summer of 2009 when he died.

To describe him as a great teacher is to not do him justice. He was an extraordinary teacher. He was inspiring, he was inspired, he was engaging, and he was incredibly effective. The workshop that he offered was called Memoir Writing, and it was always the most heavily subscribed of all of the workshops we offered. There was always a

waiting list. Alan Alda worked on his memoirs as a student in Frank McCourt's memoir writing class. Anne Bancroft, prior to her passing, was a student in Frank McCourt's memoir writing class.

That class was really a textbook in how much to teach, how to engage students, how to turn them on to a subject matter, and how to get the most out of them—the very essence of teaching—and he did it with enormous humor, with great charm, and was almost effortless in his ability to connect with students.

So I certainly hope that the Congress will unanimously pass this resolution. He was a man richly deserving of any accolade that he might receive. He will be terribly missed. He serves as an example of what good teaching is and how valuable good teaching is to our Nation's students.

Mr. CHAFFETZ. Mr. Speaker, we have no additional speakers, but I would urge the passage of House Resolution 743. It's an honor for me to participate in these proceedings, and I urge the adoption of this resolution.

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

Mr. LYNCH. I thank the gentleman from Utah for his kind remarks, and I want to thank both the gentlemen from Connecticut, Mr. COURTNEY and Mr. MURPHY, and also the gentleman from New York (Mr. BISHOP) for their wonderful work and leadership on this resolution.

Mr. MCMAHON. Mr. Speaker, I rise in support of H. Res. 743 which honors the life and work of accomplished Pulitzer-prize winning author Frank McCourt. I am proud to be a cosponsor of this important resolution.

Frank McCourt was an exceptional author and educator whose contributions are valued throughout America. He is remembered for his great literary masterpieces, including his well known autobiography, "Angela's Ashes," which tells his story of growing up in the slums of Brooklyn, New York and Limerick City, Ireland.

Frank McCourt's life is the story of a true American Dream. As a child of Irish immigrants, McCourt grew up during the depression and faced many grave challenges. McCourt was abandoned by his father, who was an alcoholic, at an early age. The family had seven children, three of whom died from disease. McCourt found himself struggling to hold down a job in order to feed his mother and surviving siblings. He worked to provide a stable and healthy environment for his family during a time of worldwide economic depression.

McCourt dropped out of school at the age of 13 and worked a series of janitorial jobs in New York hotels. After serving in the United States Army, Frank McCourt was granted a formal education at New York University even though he never received the required high school diploma.

Frank McCourt's professional career began as an educator in 1958 when he landed his first job teaching English at Ralph R. McKee Career & Technical High School (McKee) located in my district of Staten Island, New York. McCourt went on to teach in the New York City Public school system for 27 years. McCourt always had a passion for creative writing and storytelling, and it was through his work at McKee high school where he developed the idea for "Angela's Ashes."

Frank McCourt was once quoted in an interview saying that, "children are the most precious material we have in our country." McCourt was a great example of a dedicated teacher and was an outspoken advocate for education. McCourt viewed teaching as the single most important profession in the country because teachers pave the way for our children's future and enhance their lives.

When Frank McCourt passed away earlier this year, our Nation lost a great man, teacher, author, and friend. Mr. Speaker, I strongly urge my colleagues to support H. Res. 743 to honor the life, work and contributions of Frank McCourt.

Mr. MURPHY of Connecticut. Mr. Speaker, I rise today to celebrate the life of author and educator Frank McCourt.

As many know, Frank McCourt died on July 19 at the age of 78. As an author, he was best known for his best-selling series of memoirs, including the Pulitzer-prize winning 1996 work Angela's Ashes. Years before he became a literary icon, however, he was best known among thousands of New York City high school students as a passionate and committed teacher, holding his classes spellbound with his rapturous stories. But to me, and to so many others who call Northwest Connecticut home, he was a friend.

While Frank was an Irishman and a New York City native to the last, it was in Roxbury, Connecticut, that he spent years with his beloved wife, Ellen, at his side. Frank was dearly-loved throughout his community as a warm, friendly neighbor who was always willing to roll up his sleeves and get involved in local causes and charities. The wit and generous spirit that defined his writing was familiar to anyone who knew Frank—he was a fiery, vital presence.

Frank spent his life shaping young people's minds as a teacher and sharing his writings with the world. This resolution before us today is dedicated to his memory, and to Ellen and the McCourt family. On behalf of myself and Representative COURTNEY, who helped make this resolution possible, as well as the millions around the world whose lives he touched, Frank McCourt will be missed.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and agree to the resolution, H. Res. 743.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

ESTABLISHMENT OF A DEMONSTRATION PROGRAM ON GAS TURBINES

Mr. TONKO. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3029) to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3029

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

SECTION 1. HIGH EFFICIENCY GAS TURBINES.

(a) IN GENERAL.—The Secretary of Energy shall carry out a multiyear, multiphase program of research, development, and technology demonstration to improve the efficiency of gas turbines used in power generation systems and to identify the technologies that ultimately will lead to gas turbine combined cycle efficiency of 65 percent or simple cycle efficiency of 50 percent.

(b) PROGRAM ELEMENTS.—The program under this section shall—

(1) support first-of-a-kind engineering and detailed gas turbine design for megawatt-scale and utility-scale electric power generation, including—

(A) high temperature materials, including superalloys, coatings, and ceramics;

(B) improved heat transfer capability;

(C) manufacturing technology required to construct complex three-dimensional geometry parts with improved aerodynamic capability;

(D) combustion technology to produce higher firing temperature while lowering nitrogen oxide and carbon monoxide emissions per unit of output;

(E) advanced controls and systems integration;

(F) advanced high performance compressor technology; and

(G) validation facilities for the testing of components and subsystems;

(2) include technology demonstration through component testing, subscale testing, and full scale testing in existing fleets;

(3) include field demonstrations of the developed technology elements so as to demonstrate technical and economic feasibility; and

(4) assess overall combined cycle and simple cycle system performance.

(c) PROGRAM GOALS.—The goals of the multiphase program established under subsection (a) shall be—

(1) in phase I—

(A) to develop the conceptual design of advanced high efficiency gas turbines that can achieve at least 62 percent combined cycle efficiency or 47 percent simple cycle efficiency on a lower heating value basis; and

(B) to develop and demonstrate the technology required for advanced high efficiency gas turbines that can achieve at least 62 percent combined cycle efficiency or 47 percent simple cycle efficiency on a lower heating value basis; and

(2) in phase II, to develop the conceptual design for advanced high efficiency gas turbines that can achieve at least 65 percent combined cycle efficiency or 50 percent simple cycle efficiency on a lower heating value basis.

(d) PROPOSALS.—Within 180 days after the date of enactment of this Act, the Secretary shall solicit grant and contract proposals

from industry, universities, and other appropriate parties for conducting activities under this Act. In selecting proposals, the Secretary shall emphasize—

(1) the extent to which the proposal will stimulate the creation or increased retention of jobs in the United States; and

(2) the extent to which the proposal will promote and enhance United States technology leadership.

(e) COMPETITIVE AWARDS.—The provision of funding under this section shall be on a competitive basis with an emphasis on technical merit.

(f) COST SHARING.—Section 988 of the Energy Policy Act of 2005 (42 U.S.C. 16352) shall apply to an award of financial assistance made under this section.

(g) LIMITS ON PARTICIPATION.—The limits on participation applicable under section 999E of the Energy Policy Act of 2005 (42 U.S.C. 16375) shall apply to financial assistance awarded under this section.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary for carrying out this section $85,000,000 for each of fiscal years 2011 through 2014.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. TONKO) and the gentleman from Texas (Mr. HALL) each will control 20 minutes.

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. TONKO. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on H.R. 3029, the bill now under consideration.

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

There was no objection.

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

My bill establishes a research, development, and demonstration program through the Department of Energy to improve the efficiency of natural gas turbines used in electric power generation systems. The Department had a similar public-private partnership research program in the 1990s that led to technologies used in turbines today. Resurrecting this capability is essential if our country is going to be the energy technology leader of the world.

Currently, the United States uses natural gas for nearly 20 percent of our power generation, and with the recent discovery of natural gas in different regions of our country, that percentage is most likely to grow.

Efficiency is paramount in turbines. The most advanced combined-cycle gas turbine systems today are capable of reaching somewhere near 60 percent efficiency. The goal of this bill is to develop systems that achieve up to 65 percent efficiency.

The energy and fuel savings created by more efficient turbines will help ratepayers save more than a billion dollars per year in fuel costs alone. Deployment of 65 percent efficient gas turbines throughout the country would result in significant reductions in fuel use, leading to savings in electricity costs of some $180 billion through the year 2040.

Energy efficiency should be our fuel of choice, a fuel we need to drill and mine like we currently drill for oil and mine coal. That's exactly what this bill does, Mr. Speaker. It makes energy efficiency our fuel of choice.

Just 1 percentage point improvement in efficiency would result in CO_2 emissions reductions of 4.4 million tons per year, as well as palpable reductions in NO_X, SOx, and other harmful emissions.

In addition to the environmental benefits and energy and fuel savings, this bill promotes United States technology leadership, putting our country in a position to assume a greater share of the worldwide energy market by creating and retaining high-value domestic jobs in turbine manufacturing. Furthermore, many technologies developed under this program can be retrofitted onto the existing fleet of turbines.

This program will create thousands of domestic jobs in a variety of technology sectors. There are potential jobs in our labs, jobs in our factories, and jobs in our construction sector. This bill is a positive step toward restoring our energy, economy, creating clean-energy jobs, and enhancing our energy security.

Getting this legislation to the floor today would not have been possible without the help of my colleagues on the House Science and Technology Committee. After the full committee markup of this bill, we continued to work to address the concerns of my colleagues, Mr. HALL, Mr. BILBRAY, and Ms. KOSMAS. With their help and leadership, we were able to expand the scope of this bill to include simple-cycle turbine systems, in addition to combined-cycle.

I want to thank them for their suggestions and working with me to create an even stronger bill. In so doing, we also modestly expanded the authorization levels for the bill to reflect the inclusion of simple-cycle turbine systems.

I want to thank Ranking Member HALL, his staff, and all of my Science and Technology Committee colleagues for continuing to work with me to improve this bill. Our chairman has been most helpful.

Finally, I also want to thank Mr. INGLIS for understanding the importance of this legislation and joining me as a cosponsor of this bill.

Mr. Speaker, I reserve the balance of my time.

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

I rise in support of H.R. 3029, to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined-cycle power generation systems. The bill we're considering on the floor today is a slightly different version than the bill that was passed out of the Committee on Science and Technology on July 29 of this year.

Two changes were made between committee and floor consideration. The first is the addition of simple-cycle gas turbine efficiency to the combined-cycle gas turbine efficiency already called for in the bill. This addition allows for increased competition as well as beneficial efficiencies across the spectrum of gas turbines. The second change increases the annual authorization level from $65 million to $85 million for fiscal years 2011 through 2014. That will expand eligible participants in the R&D program.

Prior to committee consideration of H.R. 3029, the text as introduced on June 24, 2009, was included in H.R. 2454, the American Clean Energy and Security Act of 2009, which passed the House 2 days later. In the event that this version before us here today passes the House, we would prefer that this language be substituted in place of the language that was included in H.R. 2454, should that bill go to conference with the Senate.

Natural gas is the cleanest fossil fuel and is a highly efficient form of energy. It has fewer impurities and its combustion generally results in less pollution and has therefore become a very popular choice for electricity generation. While we currently have an abundant supply of natural gas in our country, we should always strive to use our resources in the most efficient way. This bill will help us do that with this precious domestic resource.

Mr. Speaker, we have no more speakers, and I yield back the balance of my time.

Mr. TONKO. Let me again thank those of the committee and subcommittee respectively, Chairman GORDON and Chairman BAIRD, for their tremendous help in this measure, along with the ranking members on the committee.

Before we close this debate, I think it's important to acknowledge the numerous letters of support that we have received dealing with this legislation. We have letters of support from the Gas Turbine Association, from General Electric, from Solar Turbines, Strategic Power Systems, Inc., and Florida Turbine Technologies, Inc.

Having strong industry support is vital if we're going to be successful, Mr. Speaker, in moving forward with an innovation economy. We all must work together to move our country and our economy forward to a greener and brighter future. The bill before the House is a measure that will obviously underscore the value of energy efficiency and will allow us to make use of

natural gas turbines in a way that promotes that added 5 percent of efficiency that will translate to billions of dollars of savings and economic and environmental savings that will come from the efforts of this bill.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H.R. 3029, "to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems." I support this bill because energy efficiency is of the utmost concern to our security, our economy and our future.

H.R. 3029 would direct the Secretary of Energy to carry out a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems and identify the technologies that will lead to gas turbine combined cycle efficiency of 65 percent. A combined cycle is an attribute of a power producing engine (or plant) that employs more than one thermodynamic cycle. Heat engines, which are still only able to use a portion of the energy their fuel generates (usually less than 50 percent) are a burden on the American consumer who helps support this inefficient system of energy production. The remaining heat (e.g., hot exhaust fumes) from combustion is generally wasted; combining two or more thermodynamic cycles results in improved overall efficiency.

The bill requires that the program support engineering and gas turbine design for utility-scale and megawatt-scale electric power generation. Under the bill, this includes high temperature materials, improved heat transfer capability, manufacturing technology, combustion technology, advanced controls and systems integration, advanced high performance compressor technology, and validation facilities for the testing of components and subsystems. It also requires that the program include technology and field demonstrations, and assess overall combined cycle system performance.

H.R. 3029 sets out specific program goals. In Phase I, the goal is to develop the conceptual design of and demonstrate the technology required for advanced high efficiency gas turbines that can achieve at least 62 percent combined cycle efficiency on a lower heating value basis. In Phase II, the goal is to develop the conceptual design for advanced high efficiency gas turbines that can achieve at least 65 percent combined cycle efficiency.

The bill requires that the Secretary solicit proposals from industry, universities, and other appropriate parties for activities under the program within 180 days of enactment. The bill requires the Secretary, in selecting proposals, to emphasize the extent to which the proposal will stimulate the creation or increased retention of jobs in the United States and the extent to which the proposal will promote and enhance United States technology leadership. Awards shall be made on a competitive basis with emphasis on technical merit. H.R. 3029 authorizes $65 million for each of fiscal years 2011 through 2014 for carrying out the program.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. TONKO) that the House suspend the rules and pass the bill, H.R. 3029, as amended.

The question was taken.

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

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

The yeas and nays were ordered.

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

□ 1530

ENERGY AND WATER RESEARCH INTEGRATION ACT

Mr. TONKO. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3598) to ensure consideration of water intensity in the Department of Energy's energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3598

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Energy and Water Research Integration Act''.

SEC. 2. ENERGY AND WATER RESEARCH AND ASSESSMENT.

(a) IN GENERAL.—The Secretary of Energy shall assess each of the energy research, development, and demonstration programs and projects of the Department of Energy and identify those programs and projects into which it is appropriate to integrate water considerations. In carrying out this section the Secretary shall, as appropriate—

(1) seek to advance energy and energy efficiency technologies and practices that would—

(A) minimize freshwater withdrawal and consumption;

(B) increase water use efficiency; and

(C) utilize nontraditional water sources with efforts to improve the quality of that water;

(2) consider the effects climate variability and change may have on water supplies and quality for energy generation and fuel production; and

(3) improve understanding of the energy required to provide water supplies and the water required to provide reliable energy supplies throughout the United States.

(b) STRATEGIC PLAN.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Energy shall develop a Strategic Plan (in this section referred to as the ''Strategic Plan'') outlining the research, development, and demonstration needs for the programs and projects identified under subsection (a), in accordance with subsections (a) through (c) of this section, as appropriate.

(2) MILESTONES AND SPECIFIC CONSIDERATIONS.—In carrying out the development and updating of the Strategic Plan in accordance with this subsection, the Secretary shall evaluate and, as appropriate, establish technical milestones for—

(A) new advanced cooling technologies for energy generation and fuel production technologies;

(B) performance improvement of existing cooling technologies and cost reductions associated with using those technologies;

(C) innovative water reuse, recovery, and treatment in energy generation and fuel production;

(D) technology development for carbon capture and storage systems that utilize efficient water use design strategies;

(E) technologies that are life-cycle cost effective;

(F) systems analysis and modeling of issues relating to the energy required to provide water supplies and the water required to provide reliable energy supplies throughout the United States;

(G) technologies to treat and utilize produced waters discharged from oil, natural gas, coalbed methane, and mining activities;

(H) advanced materials for the use of nontraditional water sources for energy generation and fuel production;

(I) biomass production and utilization and the impact on hydrologic systems;

(J) technologies that reduce impacts on water from energy resource development;

(K) increases in energy efficiency of water distribution and collection systems;

(L) technologies for energy generation from water distribution and collection systems; and

(M) any other area of the energy-water nexus that the Secretary considers appropriate.

(3) INTERAGENCY COLLABORATION AND NONDUPLICATION.—In carrying out the development and updating of the Strategic Plan in accordance with this subsection, the Secretary shall, where appropriate, work collaboratively with other Federal agencies operating related programs and avoid duplication.

(4) INTRA-AGENCY COORDINATION AND NONDUPLICATION.—In carrying out the development and updating of the Strategic Plan in accordance with this subsection, the Secretary shall coordinate and avoid duplication of activities across programs and projects of the Department of Energy, including with those of the National laboratories.

(5) RELEVANT INFORMATION AND RECOMMENDATIONS.—In carrying out the development and updating of the Strategic Plan in accordance with this subsection, the Secretary shall consider and incorporate, as appropriate, relevant information and recommendations, including those of the National Water Availability and Use Assessment Program under section 9508(d) of the Omnibus Public Land Management Act of 2009 (42 U.S.C. 10368(d)).

(6) NONGOVERNMENTAL PARTICIPATION.—In carrying out the development and updating of the Strategic Plan in accordance with this subsection, the Secretary shall consult and coordinate with a diverse group of representatives from research and academic institutions and industry who have expertise in technologies and practices relating to the energy required to provide water supplies and the water required to provide reliable energy supplies throughout the United States.

(7) SUBMISSION TO CONGRESS.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress the Strategic Plan.

(8) UPDATING THE STRATEGIC PLAN.—Not later than 3 years after the date of enactment of this Act, the Secretary shall utilize relevant information produced by Federal Government agencies, academia, and industry to update the Strategic Plan, and submit a report to Congress describing the changes from the initial Strategic Plan.

(c) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary of Energy shall implement the Strategic Plan, as appropriate, in carrying out energy research, development, and demonstration programs of the Department of Energy.

(2) APPLICATION TO PROJECTS.—Not later than 3 months after the submission of the report to Congress in subsection (b)(7)), the Secretary shall as appropriate apply the Strategic Plan to projects—

(A) identified as the most energy and water intensive; and

(B) with the most potential to achieve the purposes of this section.

(3) DELAY OR DISRUPTION.—In carrying out this subsection, the Secretary shall ensure that no program or project of the Department is unnecessarily delayed or disrupted.

(d) REPORTS.—Not later than 2 years after the date of enactment of this Act, and at least once every 2 years thereafter, the Secretary shall transmit to Congress a report on its findings and activities under this section.

(e) ADDITIONAL ACTIVITIES.—The Secretary may provide for such additional research, development, and demonstration activities as may be appropriate to integrate water considerations into the research, development, and demonstration activities of the Department as described in subsection (a).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Energy for carrying out this section $60,000,000 for each of the fiscal years 2011 through 2015.

SEC. 3. ENERGY-WATER ARCHITECTURE COUNCIL.

(a) IN GENERAL.—The Secretary of Energy, in coordination with other relevant Federal agencies, shall establish an Energy-Water Architecture Council to promote and enable improved energy and water resource data collection, reporting, and technological innovation. The Council shall consist of—

(1) representation from each Federal agency that conducts research related to energy and water resource data; and

(2) non-Federal members, including representatives of research and academic institutions and industry, who have expertise in technologies and practices relating to the energy required to provide water supplies and the water required to provide reliable energy supplies throughout the United States.

(b) FUNCTIONS.—The Council shall—

(1) make recommendations on the development of data collection and data communication standards and protocols to agencies and entities currently engaged in collecting the data for the energy required to provide water supplies and the water required to provide reliable energy supplies throughout the United States;

(2) recommend ways to make improvements to Federal water use data to increase understanding of trends in energy generation and fuel production;

(3) recommend best practices for utilizing information from existing monitoring networks to provide nationally uniform water and energy use and infrastructure data; and

(4) conduct annual technical workshops, including at least one regional workshop annually, to facilitate information exchange among Federal, State, and private sector experts on technologies that encourage the conservation and efficient use of water and energy.

(c) REPORTS.—Not later than 1 year after the date of enactment of this Act, and at least once every 2 years thereafter, the Council, through the Secretary of Energy, shall transmit to the Congress a report on its findings and activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Energy for carrying out this section $5,000,000 for each of the fiscal years 2011 through 2015.

SEC. 4. LIMITATION ON FEDERAL REGULATIONS.

Nothing in this Act shall be construed to allow the establishment of regulations by the Federal Government that would infringe or impair the use of water by State, tribal, or local governments.

SEC. 5. MANDATES.

Nothing in this Act shall be construed to require State, tribal, or local governments to take any action that may result in an increased financial burden to such governments by restricting the use of water by such governments.

SEC. 6. COORDINATION AND NONDUPLICATION.

To the maximum extent practicable, the Secretary of Energy shall coordinate activities under this Act with other programs of the Department of Energy and other Federal research programs.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. TONKO) and the gentleman from Texas (Mr. HALL) each will control 20 minutes.

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. TONKO. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on H.R. 3598, the bill now under consideration.

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

There was no objection.

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

Demand for energy and water resources is stressing our environment and our economy. Innovation and technologies which address the nexus between these two resources is critical to the future of our country. H.R. 3598 requires the Secretary of Energy to consider water-related issues in the Department's energy efficiency and energy technology research programs. Additionally, H.R. 3598 creates an energy-water architecture council that will facilitate the collaboration of industry, of academia, and of the Federal Government in improving energy and water resources data collection, reporting, and technological innovation.

Chairman GORDON and Ranking Member HALL of the Science and Technology Committee have worked hard to improve this bill on its way to the floor. To ensure appropriate use of taxpayer dollars, the bill now includes direction to the Secretary of Energy to develop a strategic plan which will focus the Department's efforts on the most energy- and water-intensive programs and projects with the most potential to achieve the purposes of this bill.

This legislation is the product of recommendations heard in five Science and Technology Committee hearings on water and several reports from the National Academies, the Government Accountability Office, the National Science Technology Council, and the Department of Energy. With letters of support from the Water Innovations Alliance, NanoH2O, Inc., and the Alliance for Water Efficiency, this legislation takes important steps to deal with our country's water and energy resource challenges.

I encourage all of my colleagues to join me in support of H.R. 3598.

Mr. Speaker, I reserve the balance of my time.

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

I rise in support of H.R. 3598, the Energy and Water Research Integration Act, and I agree with Mr. TONKO, the gentleman from New York. As with H.R. 3029, the bill we are considering on the floor today has been amended since it was passed out of the Committee on Science and Technology on October 7 of this year.

I supported the intent of the bill, as introduced, which is to ensure consideration of water intensity in the Department of Energy's research, development, and demonstration programs, and through the process of regular order, H.R. 3598 improved. For example, two amendments which were agreed to during the full committee markup clarified that the language of the bill should not be the basis for any new Federal regulations regarding State, local, or tribal water use and should not trigger any increased financial burden on State, local, or tribal governments. However, a few fundamental concerns remained, and during the markup, Chairman GORDON graciously offered to work with our side of the aisle to make changes and improvements to the committee-passed version. What we're considering today is a result of negotiations to draft a good bill acceptable to all.

This amended version of H.R. 3598 requires the Secretary of Energy to assess the energy research, development, and demonstration programs and projects of the Department of Energy and identify those where it's appropriate to integrate water considerations. The Secretary shall then develop a strategic plan outlining the RD&D needs for the programs and projects identified under the assessment. After this plan is developed, the Secretary would have the authority to apply the strategic plan to those appropriate projects identified as the most

energy and water intensive and with the most potential to minimize freshwater withdrawal and consumption, increase water use efficiency, and utilize nontraditional water sources, among other considerations.

The amended bill also requires interagency nonduplication and coordination. In addition, the amended bill establishes, in coordination with other relevant Federal agencies, an energy-water architecture council that will promote and enable improved energy and water resource data collection, reporting, and technological innovation.

Ensuring adequate water supply for municipal and agricultural use and also energy production should be a primary area of focus for our country. Almost all of our energy sources, including renewable energy, require water to be productive, and, conversely, most water processes require energy to be useful. This bill is timely and needed in order to ensure that we use both resources efficiently and responsibly.

With that, I reserve the balance of my time.

Mr. TONKO. Mr. Speaker, I will continue to reserve the balance of my time.

Mr. HALL of Texas. Mr. Speaker, I yield myself about 2 minutes to close.

Before we end debate today, I want to take a moment to say thank you to a policy adviser of mine that will be going on maternity leave shortly after and likely will not be returning to the Hill for a while.

Elizabeth Kowal Chapel has been on my staff since September 1994 helping me to serve the people of the Fourth Congressional District of Texas. She is originally from my hometown of Rockwall, Texas, and I was happy to hire her way back then as an intern from the University of Texas.

I told her back then that she could be my intern for 3 months, and then we would see where we went from there. At the end of those 3 months, she came to me and asked if she had to leave. I told her, ‘‘Baby Doll, you can stay as long as you like.’’ She must have liked it, because over 15 years later, she is leaving me not for another job on the Hill but for the only job better than helping the folks in Texas—that's motherhood. Elizabeth and her husband, Christopher, are expecting a baby boy at the end of January, and I look forward to meeting him, and I hope that he'll be my intern during the year 2020.

Elizabeth has served in my personal office and as my senior energy policy adviser on the Committee on Science and Technology and the Committee on Energy and Commerce, two committees with some very complex issues. She has done a stellar job with a very heavy workload that she has carried with style and grace. Elizabeth has been a real asset to my staff. She has been a real friend, and she is going to be missed. Her cheerful disposition and commitment to her work have added a great deal to my work on both committees.

I want to take the opportunity to say thank you and wish her the best of luck as a mother. I'm sure she will be just as successful at that job.

I thank the Chair, and I yield back the balance of my time.

Mr. TONKO. Mr. Speaker, let me, on behalf of the Democratic members of our Science and Tech Committee, wish Elizabeth Kowal Chapel the very best in the steps to come. May I also share the sentiment that the child be gifted with a sense of humor that so obviously prevails at the Science and Tech Committee meetings. We wish you the best.

We have no further speakers from our side on behalf of the bill, Mr. Speaker. However, I would like to make this final point of encouraging our colleagues to support H.R. 3598, which would put a primary focus, rightfully so, on water-related issues as the Department of Energy deals with the innovation economy that is sparked by energy efficiency and energy technology research. To do that optimizes the outcome, and I think it's a very strong bill.

I congratulate the Chair and the ranking member on behalf of the work they've done on H.R. 3598.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise before you today in support of H.R. 3598, "Energy and Water Research Integration Act". I would like thank my colleague, Rep. BART GORDON, for introducing this important legislation.

I support this legislation because our country faces immense challenges with increased demand on our energy and water resources. It is for that reason that this bill is a critical component of our country's energy strategy. According to the Department of Energy's National Energy Technology Laboratory, the thermoelectric power sector accounts for 39 percent of total freshwater withdrawal in the United States, and 3.3 percent of total freshwater consumption.

Not only do we need vast quantities of water for energy production, but we also need energy to transport and treat water. Water resource problems are intensifying across all regions of the country. As demand for water continues to rise and supplies dwindle, it has become increasingly apparent that the federal government should create a comprehensive strategy for energy-water research and development of new technologies to ensure sustainable water and energy supplies.

This legislation takes the first steps toward tackling these problems by directing the Secretary of Energy, in carrying out energy research, development, and demonstration programs of the Department of Energy (DOE), to: seek to advance energy and energy efficiency technologies and practices that would minimize freshwater withdrawal and consumption, increase water use efficiency, and utilize nontraditional water sources with efforts to improve the quality of that water; consider the effects climate change may have on water supplies and quality for energy generation and fuel production; and improve understanding of the energy required to provide water supplies and the water required to provide reliable energy supplies throughout the United States.

It further requires the Secretary to incorporate specified considerations, including: New advanced cooling technologies for energy generation and fuel production technologies; innovative water reuse, recovery, and treatment in energy generation and fuel production; and reduction of water resource impacts of fossil fuel resource development.

Finally, this bill directs the Secretary, in coordination with other relevant federal agencies, to establish an Energy-Water Architecture Council to promote and enable improved energy and water resource data collection, reporting, and technological innovation.

This Council would be required to: adopt data collection and communication standards and protocols for the energy required to provide water supplies and the water required to provide reliable energy supplies; make improvements to federal water use data to increase understanding of trends in power plant water use; integrate existing monitoring networks to provide nationally uniform water and energy use and infrastructure data; and conduct an annual technical workshop to facilitate information exchange among experts on technologies that encourage the conservation and efficient use of water energy.

With these first steps, our country will be far better informed about the challenges wrought by increasing demands for water and energy, and so will be better able to face them.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. TONKO) that the House suspend the rules and pass the bill, H.R. 3598, as amended.

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

A motion to reconsider was laid on the table.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess until approximately 6:30 p.m. today.

□ 1830

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. TEAGUE) at 6 o'clock and 30 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Votes will be taken in the following order:

H.R. 3029, by the yeas and nays;

H. Res. 727, by the yeas and nays;

H.R. 3667, de novo.

Remaining unfinished business will be resumed later in the week.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

ESTABLISHMENT OF A DEMONSTRATION PROGRAM ON GAS TURBINES

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill, H.R. 3029, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. TONKO) that the House suspend the rules and pass the bill, H.R. 3029, as amended.

The vote was taken by electronic device, and there were—yeas 266, nays 118, not voting 50, as follows:

[Roll No. 911]

YEAS—266

Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Bartlett
Bean
Becerra
Berkley
Berman
Biggert
Bilbray
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Boccieri
Boren
Boswell
Boucher
Boyd
Brady (PA)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Butterfield
Capito
Capps
Cardoza
Carnahan
Carson (IN)
Castle
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Fattah
Filner
Forbes
Fortenberry
Foster
Frank (MA)
Frelinghuysen
Fudge
Garamendi
Giffords
Gordon (TN)
Granger
Grayson
Green, Al
Green, Gene
Gutierrez
Hall (TX)
Halvorson
Hare
Hastings (FL)
Heinrich
Heller
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inglis
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larson (CT)
LaTourette
Lee (CA)
Lee (NY)
Levin
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Massa
Matheson
Matsui
McCarthy (NY)
McCotter
McDermott
McGovern
McIntyre
McMahon
McNerney
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, Gary
Miller, George
Mitchell
Moore (KS)
Moore (WI)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Nadler (NY)
Napolitano
Neal (MA)
Nye
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Polis (CO)
Pomeroy
Posey
Price (NC)
Putnam
Quigley
Rahall
Rangel
Reichert
Reyes
Richardson
Rodriguez
Rogers (AL)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Ryan (OH)
Salazar
Sánchez, Linda T.
Sarbanes
Schakowsky
Schauer
Schiff
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Space
Speier
Spratt
Stupak
Sutton
Taylor
Teague
Thompson (CA)
Thompson (MS)
Thornberry
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wilson (OH)
Woolsey
Wu
Yarmuth

NAYS—118

Akin
Alexander
Austria
Bachmann
Bachus
Barton (TX)
Bilirakis
Bishop (UT)
Boehner
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Carter
Cassidy
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Dreier
Duncan
Emerson
Fallin
Fleming
Foxx
Franks (AZ)
Gallegly
Garrett (NJ)
Gingrey (GA)
Gohmert
Goodlatte
Guthrie
Harper
Hastings (WA)
Hensarling
Herger
Hoekstra
Hunter
Issa
Jenkins
Johnson, Sam
Jordan (OH)
King (IA)
Kline (MN)
Lamborn
Latham
Latta
Lewis (CA)
Linder
Lucas
Luetkemeyer
Lummis
Mack
Manzullo
Marchant
McCarthy (CA)
McCaul
McClintock
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Pitts
Platts
Poe (TX)
Price (GA)
Roe (TN)
Rogers (KY)
Rooney
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Sensenbrenner
Sessions
Shadegg
Shuster
Simpson
Souder
Stearns
Sullivan
Terry
Thompson (PA)
Tiahrt
Tiberi
Turner
Upton
Walden
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (FL)

NOT VOTING—50

Abercrombie
Aderholt
Barrett (SC)
Barrow
Berry
Blunt
Braley (IA)
Cao
Capuano
Carney
Conyers
Davis (IL)
Davis (KY)
Deal (GA)
Dicks
Dingell
Farr
Flake
Gerlach
Gonzalez
Graves
Griffith
Grijalva
Hall (NY)
Harman
Kingston
Kirk
Larsen (WA)
Lungren, Daniel E.
Marshall
McCollum
Meek (FL)
Minnick
Mollohan
Moran (KS)
Moran (VA)
Murphy (CT)
Murtha
Oberstar
Payne
Radanovich
Rehberg
Rush
Sanchez, Loretta
Shimkus
Stark
Tanner
Wamp
Wexler
Young (AK)

□ 1858

Messrs. LEWIS of California, MACK, CAMP, CRENSHAW and Mrs. MCMORRIS RODGERS changed their vote from "yea" to "nay."

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

The title was amended so as to read: "A bill to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle and simple cycle power generation systems.".

A motion to reconsider was laid on the table.

MOMENT OF SILENCE IN MEMORY OF FOUR WASHINGTON SLAIN OFFICERS

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

Mr. DICKS. Mr. Speaker, following the tragic shooting that took the lives of four police officers in Lakewood, Washington, early Sunday morning, I strongly believe it is appropriate for the House of Representatives to observe a moment of silence in the Chamber today. These four officers, Mark Renninger, Ronald Owens, Tina Griswold, and Greg Richards, were preparing to start their shift last Sunday morning when they were brutally murdered by an assailant who has now died as police were attempting to apprehend him.

These were dedicated and hardworking members of the city of Lakewood police force in my district. They were senselessly murdered, presumably at random, by a deranged killer, and they each left families and children who deserve our deepest sympathy.

This is a somber moment, Mr. Speaker, and I know my Washington State colleague, Congressman DAVE REICHERT, a former sheriff who spent more than 30 years in law enforcement, understands the human impact of this tragedy and knows the risk that law enforcement officers face each and every day in assuring that all of us are safe in our homes and in our communities.

I yield to Congressman REICHERT.

Mr. REICHERT. I thank the gentleman for yielding. I know sometimes it's hard to pause for just a second in the busy lives that we lead here in the Capitol of this great country, but today we must. We must stop and pause and think about, first of all, how safe we are, and why. Because men and women who are wearing the uniform across this country sacrifice their lives

for us. And on Sunday morning, 2 days ago, three police officers and their sergeant went to work. Went to work. They paused for a moment at a coffee shop, had their laptops out, talking about the day that they were just about to begin. Somebody walked in and took their lives away—all four.

In total, they left behind nine children. This was just 1 month after a Seattle police officer by the name of Timothy Brenton was ambushed and murdered, leaving behind two more children.

All I can say is that we thank them for their service. When you see somebody in uniform, pause, thank them for what they do, express sympathy for the loss of their partners and loved ones. And please, I ask that you keep their families in your thoughts and prayers.

The SPEAKER pro tempore. Members will rise and observe a moment of silence.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Without objection, 5-minute voting will continue.

There was no objection.

EXPRESSING SUPPORT FOR GREATER AWARENESS OF OVARIAN CANCER

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the resolution, H. Res. 727, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and agree to the resolution, H. Res. 727, as amended.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 385, nays 0, not voting 49, as follows:

[Roll No. 912]

YEAS—385

Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Fattah
Filner
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Grayson
Green, Al
Green, Gene
Guthrie
Gutierrez
Hall (TX)
Halvorson
Hare
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mitchell
Moore (KS)
Moore (WI)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stearns
Stupak
Sullivan
Sutton
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—49

Abercrombie
Aderholt
Barrett (SC)
Barrow
Berman
Blunt
Braley (IA)
Capuano
Carney
Conyers
Davis (IL)
Davis (KY)
Deal (GA)
Dingell
Farr
Flake
Gerlach
Gonzalez
Granger
Graves
Griffith
Grijalva
Hall (NY)
Harman
Kingston
Kirk
Larsen (WA)
Lungren, Daniel E.
Marshall
McCollum
Meek (FL)
Minnick
Mollohan
Moran (KS)
Moran (VA)
Murphy (CT)
Murtha
Payne
Rangel
Rehberg
Rush
Sanchez, Loretta
Shimkus
Stark
Tanner
Wamp
Westmoreland
Wexler
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes left in this vote.

□ 1910

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

The result of the vote was announced as above recorded.

The title of the resolution was amended so as to read: ‘‘Expressing support for greater awareness of ovarian cancer.’’.

A motion to reconsider was laid on the table.

CLYDE L. HILLHOUSE POST OFFICE BUILDING

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H.R. 3667.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and pass the bill, H.R. 3667.

The question was taken.

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

RECORDED VOTE

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

A recorded vote was ordered.

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

The vote was taken by electronic device, and there were—ayes 386, noes 0, not voting 48, as follows:

[Roll No. 913]

AYES—386

Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca

Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Fattah
Filner
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Grayson
Green, Al
Green, Gene
Guthrie
Gutierrez
Hall (TX)
Halvorson
Hare
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mitchell
Moore (KS)
Moore (WI)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Radanovich
Rahall
Rangel
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stearns
Stupak
Sullivan
Sutton
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—48

Abercrombie
Aderholt
Barrett (SC)
Barrow
Blunt
Braley (IA)
Capuano
Carney
Conyers
Davis (IL)
Davis (KY)
Deal (GA)
Dingell
Farr
Flake
Gerlach
Gonzalez
Graves
Griffith
Grijalva
Hall (NY)
Harman
Honda
Kingston
Kirk
Larsen (WA)
Larson (CT)
Lungren, Daniel E.
Marshall
McCollum
Meek (FL)
Minnick
Mollohan
Moran (KS)
Moran (VA)
Murphy (CT)
Murtha
Payne
Quigley
Rehberg
Rush
Sanchez, Loretta
Shimkus
Stark
Tanner
Wamp
Wexler
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1919

So (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. CONYERS. Mr. Speaker, on December 1, 2009, I was called away on personal business. I regret that I was not present for the following votes:

On the passage of H.R. 3029. Had I been present, I would have voted "yea."

On the passage of H. Res. 727. Had I been present, I would have voted "yea."

On the passage of H.R. 3667. Had I been present, I would have voted "yea."

PERSONAL EXPLANATION

Mr. BRALEY of Iowa. Mr. Speaker, I regret missing floor votes on Tuesday, December 1, 2009. If I was present, I would have voted:

"Yea" on rollcall 911, agreeing to H.R. 3029—To establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems.

"Yea" on rollcall 912, agreeing to H. Res. 727—Expressing support for greater awareness of ovarian cancer.

"Aye" on rollcall 913, agreeing to H.R. 3667—To designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the "Clyde L. Hillhouse Post Office Building."

PERSONAL EXPLANATION

Mr. DAVIS of Kentucky. Mr. Speaker, on Tuesday, December 1, 2009, I was unable to vote due to my attendance at the President's speech on Afghanistan at West Point.

Had I been present, I would have voted:

On rollcall No. 911—"nay"—H.R. 3029, to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems.

On rollcall No. 912—"yea"—H. Res. 727, expressing support for greater awareness of ovarian cancer.

On rollcall No. 913—"aye"—H.R. 3667, to designate the "Clyde L. Hillhouse Post Office Building" in White Springs, Florida.

2009 WORLD AIDS DAY

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

Ms. ROS-LEHTINEN. Mr. Speaker, December 1 marks World AIDS Day.

Thirty-three million people live with HIV/AIDS worldwide. This terrible disease is one of the most destructive epidemics of our time. The fight against HIV/AIDS is ultimately about individual lives in our communities.

In south Florida I'm pleased to have strong allies such as UNITY COALITION and its president, Herb Sosa; Men Initiating Action & Mobilization for Impactful Change, otherwise known as MIAMI; Ambiente Magazine; South Beach AIDS Project; Union Positiva; the University of Miami; Care Resource; Pridelines; Jackson Hospital; and all who are in the fight against this global menace.

United, and through greater awareness, research, prevention, and treatment, we will save and improve countless lives and stop the spread of HIV/AIDS.

RECOGNIZING THE UNIVERSITY OF MINNESOTA MEDICAL DEVICES CENTER

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

Mr. PAULSEN. Mr. Speaker, I rise today to recognize a great example of the academic and business communities working together to create new lifesaving technologies.

The Medical Devices Center at the University of Minnesota is a shining

example of what can happen when innovation is encouraged and sought out by an educational institution and aided by partnership.

Last week I visited the University's Medical Devices Center and learned about this unique program that focuses on development of devices that have the strongest lifesaving impacts, partnering with others to also bring these products to market in the fastest manner possible. And you know what? The results speak for themselves.

From just 1 year in the fellowship program, we've had 15 new provisional patents, 12 new available technologies, one licensing deal with a local business, and one new startup among the program's fellows.

The center's collaborative approach between academics and business makes this a valuable program as well as a model for both Minnesota and the entire Nation to follow.

THE PROTRACTED WAR IN AFGHANISTAN

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

Mr. GRAYSON. Mr. Speaker, as we await the President's speech regarding Afghanistan, there's a point that I wanted to make; and as is so often the case, that point is better made by somebody else. So I yield to Chinese General Sun Tzu, who wrote the following words 2,500 years ago:

''In war victory should be swift.

''If victory is slow, men tire, morale sags. Sieges exhaust strength; protracted campaigns strain the public treasury.

''If men are tired, morale low, strength exhausted, treasure spent, then the feudal lords will exploit the disarray and attack. This even the wisest will be powerless to mend.

''I have heard that in war, haste can be folly. But never have I seen a delay that was wise.

''No nation has ever benefited from a protracted war.''

Mr. Speaker, that was true 2,500 years ago, and it's true today. We do not benefit from the protracted war in Afghanistan.

THE PRESIDENT'S SPEECH REGARDING AFGHANISTAN

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

Mr. BURTON of Indiana. Mr. Speaker, tonight the President is going to say in his speech, and I just got part of it, that his sending 30,000 American troops over there is a step in the right direction for stabilizing Afghanistan. But then he goes on and he says it will allow us to begin the transfer of our forces out of Afghanistan in July of 2011.

The one thing that you should never do is telegraph your punch. I can't imagine why the President is saying in his speech tonight he's going to start withdrawing our troops in July of 2011. Even if he plans to do that, he shouldn't say it, because he's telling our enemies exactly what we're going to do, and it's just wrong. And every military officer I have ever met will tell you the same thing.

NATIONAL MEDAL AWARD FOR STARK COUNTY DISTRICT LIBRARY

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

Mr. BOCCIERI. Mr. Speaker, today I rise in recognition of the Stark County District Library, located in Canton, Ohio.

On October 6, 2009, the Institute of Museum and Library Science selected the Stark County District Library to receive the National Medal for Museum and Library Service. This is the Nation's highest recognition for library excellence and service to the surrounding community.

The Stark County District Library has served our county for 125 years, and the staff there set a fine example of leadership throughout that time by responding to the changing needs of our community. I know firsthand the friendly faces that fill the library and the great lengths to which the staff goes to provide resources for our community.

Despite budget cuts and other economic hardships, the Stark County District Library maintains the highest quality of service, making sure our communities have access to materials they want and need. Through early literacy efforts for mothers and their children and theater programs for Stark County kids and employment assistance classes and job fairs, the district library is able to fulfill its mission of inspiring ideas, enriching lives, and creating a stronger community.

This national medal confirms the Stark County District Library's commitment to our community.

WORLD AIDS DAY AND AFGHANISTAN

(Ms. JACKSON-LEE of Texas asked and was given permission to address the House for 1 minute.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I want to acknowledge today, December 1, as World AIDS Day when all of us focus on that devastating disease. I'd like to pay a special tribute to the Thomas Street Clinic in Houston, Texas, that for decades has served the hopeless and sometimes the helpless. I am so very glad that they are giving people life and opportunity.

Thank you, Thomas Street Clinic. And I was delighted to introduce legislation in support of them.

Mr. Speaker, on another topic very quickly, let me suggest that the President has been deliberative and thoughtful. It is interesting that those who criticize created the devastation and the havoc that is going on now in Afghanistan by taking away from our focus on Afghanistan after 9/11 and focusing on Iraq, a distracting war. Yet we love those who served, and we mourn for those we have lost.

We now want not to mourn for more. We want to find a way that we can introduce diplomacy, democracy, and getting the Government in Afghanistan to take care of its own people.

This is a war of insurgents. This is a civil war. And, therefore, we must find a way to handle this in a manner that serves all.

□ 1930

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

CALIFORNIA DEMOCRATS OFFER A BETTER PLAN FOR AFGHANISTAN

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WOOLSEY) is recognized for 5 minutes.

Ms. WOOLSEY. Mr. Speaker, President Obama will talk to the American people about Afghanistan tonight. He is expected to announce a major new escalation of the conflict. I believe President Obama's apparent decision to send tens of thousands more troops to Afghanistan is a mistake, and I believe that because the past years have taught us that there is no military solution to Afghanistan. That's why I've urged the President to change our mission and to emphasize diplomacy, economic development and humanitarian aid as the best way to stop violent extremism in Afghanistan.

As a Californian, I'm proud to say that the California Democratic Party has passed a resolution that also urges President Obama to change course in Afghanistan. I want to recognize, and I want to thank my friends at the Progressive Democrats of America and the State Party's Progressive Caucus for leading the effort to pass the resolution. The resolution states that ''far from eradicating the Taliban and other insurgencies, the presence of foreign troops has instead strengthened them, creating greater insecurity, death and impoverishment of the Afghan people.''

The California Democratic Party's resolution expresses deep concern for the ''honorable American young men

and women who have been killed and wounded'' and the terrible toll of the war on their families. It notes that our involvement in Afghanistan ''continues to cost billions of dollars each month while the United States and particularly the State of California are in an economic crisis without money to fund domestic needs.''

The resolution also calls attention to the plight of the Afghan women who have suffered greatly during the war, and it calls for an end to military action that causes civilian casualties. It urges President Obama to redirect America's ''funding and resources to include an increase in humanitarian and developmental aid.'' It also asks the President to encourage ''multiparty talks aimed at ensuring a Democratic and legitimate representation of the people of Afghanistan, as well as a multiparty regional diplomacy for the safety and stability of neighboring countries.''

Mr. Speaker, the resolution was adopted after the members of the California Democratic Party heard the powerful testimony of Marine veteran Rick Reyes. He has served in both Iraq and Afghanistan, and he said, There is no military solution to Afghanistan. The problems in Afghanistan are social problems, problems that cannot be fixed militarily.

Mr. Speaker, instead of escalating the war and bringing more destruction to Afghanistan, we must devote our resources to improving the lives of the Afghan people. This change in strategy will achieve a number of very important goals. It will give the Afghan people hope for their future. It will give them a reason to reject violent extremism. It will save the lives of our troops, and it will save the lives of Afghan civilians. And it will save money, money that we need to invest in what will truly make our Nation stronger and safer, which includes energy independence, jobs, and reforming health care so that health care doesn't actually strangle our economy.

Mr. Speaker, there is a lot that we should be doing, and this is what the American people want the Obama administration to focus on. That's why I will join with millions of Americans in the days ahead to oppose the escalation of the war in Afghanistan, and to continue to urge our President to change course.

CONGRATULATIONS TO OUR NAVY SEALS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

Mr. POE of Texas. Mr. Speaker, the Navy SEALs are the United States Navy's elite commandos. And last week we learned that they captured one of the most wanted terrorists in all of Iraq. Ahmed Hashim Abed was behind the murder and mutilation of four Blackwater USA security guards in Fallujah in the year 2004. This ringleader of this ambush planned the murder of these four Americans in Fallujah. And these four Blackwater security guards, what they were doing was transporting supplies from one place to another.

So he had planned, Abed had planned an ambush against these individuals. They are ambushed. They are murdered. The bodies of these four murdered Americans were then dragged through the streets, burned and hung from a bridge in Fallujah. Mr. Speaker, I've been to that very bridge in the year 2005, and you still have an eerie feeling knowing that four Americans were hung there in public view. The U.S. military, by the way, has put a plaque on that bridge in honor of those security guards.

And so congratulations are in order to the Navy SEALs who captured the mastermind behind this ambush and the murder of these four Americans. We should be celebrating this achievement, and these Navy SEALs should be getting medals for their work doing what we've asked them to do. But that's not what is happening, Mr. Speaker. The military has decided to court-martial the Navy SEALs. It seems that this terrorist, Abed, claimed that he was punched in the mouth by the Navy SEALs, and he wants justice. He wants American justice.

You know, it's the same mouth that preaches hate in the name of religion, the same mouth that demands death to America, the same big mouth that ordered the murder of the four Americans. So the SEALs must answer to this accusation by a terrorist that they captured. After all, the terrorist must have some of that American justice. Next thing we know, we'll be giving these terrorists on the battlefield their Miranda warnings. Oh, we already do that.

Well, then after that, they're going to want to be tried in civilian courts in the United States. But we're already doing that as well. Have we gone a bit too far with the kid glove treatment that we treat these madmen, these terrorists, these people who kill Americans?

The nation is at war, Mr. Speaker. You know, punching occurs in war. Shooting also occurs in war. Instead of a court-martial, the SEALs should be dispatched to go and capture another terrorist. But that's not happening. They are going to be court-martialed because some terrorist supposedly got a bruised mouth.

The SEALs in question are Matthew McCabe, he's a special operations petty officer second class; Petty Officer Jonathan Keefe; and Petty Officer Julio Huertas. They are going to be court-martialed because some terrorist alleges they got punched in the mouth.

It's ironic, Mr. Speaker, that the SEALs will be arraigned next Monday, December 7. December 7, everybody in the United States Navy remembers that day. See, it's been 68 years since the Navy and America was attacked on December the 7th at Pearl Harbor. And now these individuals, ironically, will be arraigned that day.

Mr. Speaker, can you imagine someone in World War II, a soldier, a marine, somebody in the United States Navy, being tried for punching an enemy combatant in the mouth during World War II? You know, we should be commending the Navy SEALs for doing the job that we've asked them to do. They're the best that we have in this country. We've asked them to do tough assignments, and we should be supporting them. The terrorists ought to be on trial for murdering Americans. And the Navy SEALs ought to be getting medals for doing what we have asked them to do. And I say congratulations to the Navy SEALs for a job well done.

And that's just the way it is.

TRANSPARENCY AT THE FEDERAL RESERVE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. PAUL) is recognized for 5 minutes.

Mr. PAUL. Mr. Speaker, Federal Reserve Chairman Ben Bernanke does not want us to know any the details of the Fed's secret operations. This position is not surprising and has been typical of all central bank chairmen. Bernanke's stated goal is ''to design a system of financial oversight that will provide a robust framework for preventing future crises.''

During its 96 years of existence, the Federal Reserve has played havoc with our economy and brought great suffering to millions through unemployment and price escalation. And it has achieved what only a central bank can: A steady depreciation of our currency. Today's dollar is now worth 4 cents, compared to the dollar entrusted to the Federal Reserve in 1913. Ninety-six years should have been plenty of time for the Fed to come up with a plan for preventing economic crises.

Since the Fed is the source of all economic downturns, it's impossible for any central banker to regulate in such a manner to prevent the problems that are predictable consequences of his own monetary management. The Federal Reserve fixes interest rates at levels inevitably lower than those demanded by the market. This manipulation is a form of price control through credit expansion, and is the ultimate cause of business cycles and so many of our economic problems, generating the malinvestment, excessive debt, stock, bond, commodity, and housing bubbles.

The Federal Reserve's monetary inflation, indeed, does push the CPI upward, but concentrating on the government's reports of the CPI and the PPI is nothing more than the distraction from the other harm done by the Federal Reserve's effort at central economic planning through secret monetary policy operations. Real inflation, the expansion of our money supply, is greatly undercounted by these indices. In response to our latest financial crisis, the Federal Reserve turned on its printing press and literally doubled the monetary base. This staggering creation of dollars has yet to be reflected in many consumer prices, but will ultimately hit the middle class and poor with a cruel devaluation of their savings and real earnings.

The Fed has clearly failed on its mandate to maintain full employment and price stability. It's time to find out what's going on. Instead of assuming responsibility for the Fed's role in the crisis, Bernanke brags about, ''arresting'' the crisis.

I would suggest to Mr. Bernanke that it's too early to brag. Bernanke decries any effort to gain transparency of the Fed's actions to find out just who gets bailed out and who is left to fail. Instead, he proposes giving even more power to the Fed to regulate the entire financial system.

□ 1945

What he does not recognize—nor does he want to admit—is that he is talking about symptoms while ignoring the source of the crisis: the Federal Reserve itself. More regulations will never compensate for all the distortion and excesses caused by monetary inflation and artificially low interest rates. Regulation distracts from the real cause while further interfering with the market forces, thus guaranteeing that the recession will become much deeper and prolonged.

Chairman Bernanke's argument for Fed secrecy is a red herring. It serves to distract so the special interests that benefit from the Fed policy never become known to the public. Who can possibly buy this argument that this secrecy is required to protect the people from political influence?

My bill, H.R. 1207, has nothing to do with interference with monetary policy. This was explicitly stated in the amendment voted on in the Financial Services Committee. Bernanke's argument for protecting the independence of the Fed is his argument for protecting the secrecy of the Fed. Chairman Bernanke concludes that ''America needs a strong''—think cartel—''nonpolitical''—think Goldman Sachs—''and independent''—think secret—''central bank with the tools to promote financial stability, in the midst of a horrendous financial crisis, and to help steer our economy to recovery without inflation.''

This belief is a dream that one day will become a nightmare for all Americans unless we come to our senses, stop our wild spending, runaway deficits, printing press money, massive bureaucratic regulations, and our unnecessary world empire. A crucial step towards fixing these problems will be transparency of the Federal Reserve.

CAP-AND-TRADE

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Michigan (Mrs. MILLER) is recognized for 5 minutes.

Mrs. MILLER of Michigan. Mr. Speaker, earlier this year, this House passed what is known as cap-and-trade legislation which would place limits on the amount of CO_2 that could be emitted into the atmosphere. And the reason given for the need for this legislation is that man-caused global warming poses a very grave threat to the future of our planet.

We have been told that the debate is over, that the science is incontrovertible. We've been told that this action must be taken to save our world, even though it would threaten our economy and cause redistribution of wealth from our Nation to others and would lead to massive job losses and outsourcing from the United States to other nations. Particularly hard hit would be industry, agriculture, and States that rely upon coal for electricity production.

Mr. Speaker, I voted against cap-and-trade because I wasn't convinced of the problem and because the solution to the perceived problem would cause further economic devastation to my constituents. I am from Michigan, where we currently have the highest unemployment in the United States. We also derive two-thirds of our electricity from coal, and our number one industry is industrial manufacturing, and our number two industry is agriculture.

If cap-and-trade were to pass, Michigan's economy would be devastated, but we were told that it had to happen because the alternative is worse.

Well, Mr. Speaker, a few weeks back, a series of emails from within the world's foremost climate change research facility, the Hadley Climate Research Unit at Britain's University of East Anglia, were either hacked or they were leaked by a disillusioned insider, which has blown away the scientific foundation for the manmade global warming theory. It's being called Climategate.

Mr. Speaker, these troubling emails show that some of the most respected and quoted and public scientists used tricks to manipulate data, refused to release the data that is the foundation for their research, and they've attempted to silence any critics of their hypothesis and even expressed dismay that they could not explain recent cooling taking place across the globe. And these scientists seemed to have allies cooperating with them, including some here in the United States.

It has become very clear that the science is, in fact, not settled, that the debate is very much alive, and that the tactics and methods used by the most trusted scientists have, in fact, very serious problems.

One email said this, which suggests a manipulation of data: ''I've just completed Mike's trick of adding in the real temps to each series for the last 20 years and for 1961 for Keith's to hide the decline.'' Hide the decline? An inconvenient truth that temperatures were declining required a trick to hide it.

And then another email expresses frustration that temperatures are actually going down: ''The fact is that we can't account for the lack of warming at the moment, and it is a travesty that we can't.''

Mr. Speaker, another email exposes the attempts to silence dissent: ''I think we need to stop considering 'Climate Research' as a legitimate peer-reviewed journal. Perhaps we should encourage our colleagues in the climate research community to no longer submit to or cite papers in this journal.''

Well, that is absolutely wonderful. Call those who disagree with their hypotheses cranks because they have not been published in peer-reviewed journals, and then when they were, to discredit the journal.

In other words, Mr. Speaker, the fix is in. And most troubling of all is the destruction of raw source data that could be used to verify their work. The leader of the CRU for years refused to release source data, and now they claim the data was ''lost.'' It sounds to me like the old elementary school excuse, ''The dog ate my homework.'' That excuse didn't work for third graders and it certainly is unacceptable from scientists who are asking us to upend our economy.

And even worse, emails exist that suggest that the data wasn't lost but instructs scientists to destroy data which was subject to Britain's freedom of information laws. And that is not just bad science; that is a criminal act. And now we're being asked to radically restructure our economy based largely on the research of these scientists.

Mr. Speaker, Congress needs to hold hearings into this matter. We need to investigate these very troubling revelations. If we are to make policy that will so profoundly impact our Nation, that policy must be made on facts, not on articles of faith or manipulated data.

THE RULE OF LAW

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Texas

(Mr. CARTER) is recognized for 60 minutes as the designee of the minority leader.

Mr. CARTER. Mr. Speaker, again tonight I rise here to talk about the rule of law and the fact that there are those in our society who seem to want to circumvent the rule of law and think because of their position either in Congress or in the government that the law shouldn't pertain to them the way it pertains to other Americans, that they should be treated specially. And even though our President stated that he didn't think that that's what the American people—that he was going to fight to make sure there was no special treatment for people other than everybody get treated equally, we've still got this issue going on. And I've been talking about this, and I've been talking about Chairman RANGEL and his issues with the tax folks and about how the rule of law didn't seem to apply to him, and tonight I am going to talk about Secretary Geithner, the Secretary of the Treasury.

Before I start talking about this, I was thinking, as I was sitting here listening to people talk—and everybody was very informative—that there may be people who really don't understand what I say when I talk about the rule of law.

The rule of law is a very basic concept. It is a prevailing concept that holds our Republic together here in the United States. But in truth and fact, the whole world seeks a system where the rule of law prevails, because it is that system which gives recourse to the ordinary person. So let me just point out some of the things that we're talking about here tonight that the rule of law is part of.

When I say ''recourse,'' the average American citizen, if someone is breaking into their house, if they hear a burglar prying open the back door of their home, they call 911 and ask them to send out a police officer or a sheriff's deputy or someone to protect their home. And they know that we have procedures whereby that officer has the authority to come in and make an arrest of that person, to protect the homestead of the person that is being violated. They know that there's someone they can call who will help and that there are rules that the society they live in has established so that they get treated fairly in being protected by the law. And the person who is accused of breaking the law is also treated fairly, because they know that we have rules that we have all agreed upon. These are the rules that our society will follow. That is the rule of law.

When we talk about Afghanistan—which is an issue that probably, as I am speaking, the President is speaking on some other channel about this—the issue, when you're talking about counterinsurgency cut down to its finest point, is establishing the rule of law in a war zone, if you will. We did it in Iraq. And basically we did it with a civil principle which we've used in New York City to lower the crime rate. We used it in Philadelphia to lower the crime rate. Big cities have used it from time to time everywhere, and that is community policing. That is the idea that there is somebody in your neighborhood you can turn to and say, ''Help me. I need your help.''

And really, counterinsurgency is using the military to train up the local folks in their police force and their army so that their citizens know that they can be protected by their police force and their army and their court system and their government from those who would do them harm. So they don't have to look to the strongest guy in the neighborhood—which may be the Taliban—to protect their interests; they can look to the government and the society that's been established by that government.

And counterinsurgency is basically putting American forces and indigenous forces in place in neighborhoods all over Afghanistan so that the Afghan citizens realize there's someone there permanently to make sure that they are treated right and treated fairly. And so it's the beginning of the establishment of the rule of law.

We in the United States have been blessed for our entire history with a rule of law. And, in fact, we don't salute a king. We don't salute a dictator. We don't salute an individual that sovereignty comes from that individual. We salute a document.

When those of us who are fortunate enough to be elected to Congress and are able to serve our constituents back home here in Congress and we have the opportunity to be here in Congress, we stand up and we take an oath. And that oath is to the Constitution of the United States, that we will preserve, protect, and defend that Constitution from all enemies, foreign and domestic, because the Constitution is that set, beginning set of rules of law that we established this Republic under. So we are a very blessed Nation. We started with the rules of law.

Today, in many nations around this world, there are still folks who don't have some rules that they can feel comfortable will be there to protect their society. And a lot of what happens when you create a counterinsurgency force like we're doing in Afghanistan, we're establishing that security for those people who live in that country. So that is a little bit off subject, but it gets you to the idea of how important it is that a people, whoever the people are, wherever they exist on this Earth, have some set of rules they can feel they will be treated just like their neighbor next door or the guy clear across the country. They're going to be treated fairly, they're going to be treated well, and they're going to have a source that they can get recourse for something that happens to them. It is a very simple concept, but it is the foundation concept of a civil society, of a society that functions properly.

And one of the things that offends the rule of law and that has offended Americans at every stage of our history is when there are those who think, The law doesn't apply to me. It applies to you, but it doesn't apply to me. I am more important than you. I am a big shot or I am a powerful person or I am a rich person, so the law doesn't apply to me. It applies to you.

□ 2000

And there are always going to be those misdirected people in any society who feel that way. But it is our duty when we see people who are taking that position or where a group of people is taking that position on behalf of a individual, that they are above the law, they are above being treated the same as you might be treated or that I might be treated, they are special, they should have special treatment.

Let me show you what the President said about that. President Barack Obama on February 3, 2008 said, ''I campaign on changing Washington and bottom-up politics. I don't want to send a message to the American people that there are two sets of standards: one for powerful people and one for ordinary folks who are working every day and paying their taxes.''

That is what the President of the United States said about the rule of law as it pertains to what he wanted in his Presidency.

There are lots of laws in the United States that pertain to all of us. Most of us don't feel pressure about most laws. The vast majority of Americans citizens are very law abiding. They do what they are supposed to do. They may speed once in a while, and occasionally they get caught and they expect to be treated like everyone else. And they may do some other minor things that they shouldn't do. But the truth is the American people, we are very law-abiding people.

But there is one area that we are all affected by every day, and I would argue that many of us in this country fear, and that is the area of the Internal Revenue and our taxes. Quite frankly, our Tax Code would just about fill this giant room, and we all wonder if anybody could possibly know what is in the Tax Code; and yet we are all supposed to fill out a form and pay our taxes every year. That is why people go to CPAs to help them with their taxes, because they are worried that they might not get it right and they might be punished for not getting it right. Some of them even worry that they might go to jail for not getting it right.

So Americans very diligently spend large amounts of their income every

year to make sure that they get their taxes right. That goes for the ordinary guy and for the Ph.D. at the major university, the smartest guy in town. They all have to deal with the IRS and make sure that they do things right.

Well, everybody makes mistakes and sometimes somebody is going to make a mistake. Some people make those mistakes unintentionally; some, they intentionally do something wrong. The Tax Code has punishments to fit those individuals.

But what I want to talk about tonight is the fact that the man who is the Secretary of the Treasury of the United States, he is the man who is in charge of our money and in charge of our tax system. The IRS reports to Secretary Geithner. Secretary Geithner did not pay some taxes that he was supposed to pay. So let me talk to you a little bit about that.

First, let me explain to you what happened with Mr. Geithner. Mr. Geithner has a master's in international economics from Johns Hopkins University. He is a director of policy development and review for the International Monetary Fund, a senior fellow on the Council of Foreign Relations. He is the U.S. Treasury Secretary, the head of the Internal Revenue Service. The specific tax violation he had was he failed to pay Social Security and Medicare taxes on the IMF earnings for tax years 2001, 2002, 2003, and 2004. The total liability that he owed was approximately $43,200.

Now so you understand what this is, the International Monetary Fund was paying him separate and apart from what he is doing, and he has to be treated like self-employed. A self-employed person has to pay not only his share of payroll taxes, but he has to pay the employer's share of payroll taxes because you are self-employed. Self-employed people pay the employer's share of payroll taxes, which is basically Social Security and Medicare, and they pay their own share. If you look at your check, you will see your payroll taxes and how much you pay every month to the government.

Well, when you are paid by the International Monetary Fund, they give you a check every month or every year, I don't know which it is. It tells you how much you make and how much income taxes they paid on your behalf, and they tell you on that document you are responsible for paying your payroll taxes. It is not like someone didn't tell you. You read it when you get your check, when you get your statement about your income. You read it and it tells you, you have to pay this. We didn't take this out. You have to pay it.

Quite frankly, Mr. Geithner signed off on that document every year that told him that. And that part of the money he was being paid was for the purpose of paying these things. He has admitted that he made a shortfall in doing this. He said it was a mistake. He made a mistake. He had a signed statement. He signed a statement acknowledging that he owed the tax. He paid the taxes. His position with the IMF and his education specifically dealt with the issues of Social Security and Medicare, system integration in the world economy. He paid his taxes, but he didn't pay any—I think he paid his interest on the taxes—but he didn't pay any penalties on the taxes. But if you and I had done the same thing that Mr. Geithner did, we would have paid penalties.

The United States 14th Amendment is the equal protection clause of the United States Constitution. It states, among other things: nor shall any State deprive any person of life, liberty or property without due process of law, or deny any person within its jurisdiction the equal protection of the laws. Equal protection of the laws.

When we are talking about property, money is property just like land is property. Now, the IRS has lately decided to establish certain back tax penalties that you have to pay for failing to pay your taxes. And in fact they have got a program going on right now where they are saying to people who have made money offshore, if you come in and give yourself up because you earned some money offshore that you should have paid taxes on and pay those taxes, we will make you a deal and we will set out in black and white what your interest and penalties are going to be.

This is about penalties. Offshore depositors amnesty offer, what they promised to give them if you turn yourself in, only 20 percent of the amount will be for penalties. Offshore depositors without amnesty would pay 50 percent penalty. The standard taxpayers' negligent disregard, that means he was negligent and disregarded what he should owe, is 20 percent. A standard taxpayer that defrauds the government, the penalties are 75 percent. So that's the rules that are supposed to apply to every American and every American entity, including corporations, partnerships, and so forth.

Secretary Tim Geithner paid zero on $43,200 in taxes that he didn't paid. Chairman RANGEL paid zero. It seems that some taxpayers appear to be more equal than other taxpayers. That's what President Obama told us this administration is all about. No two sets of standards, one for powerful people and one for ordinary folks. That is what we are talking about in the rule of law. That is why I come down here and talk about the rule of law because quite frankly it is supposed to pertain to every one of us. Every one of us is supposed to be treated equally. And, quite frankly, there may be individual citizens that can negotiate this out, but we have asked the questions and we don't have the answers as to why they haven't paid this.

I have written letters to Chairman RANGEL asking him to pay the penalties and interest. I got no reply. A good explanation would probably have prevented all of this, I don't know.

The same thing for Mr. Geithner. He has been asked in committee about this, and he said they didn't assess any penalties. That is kind of like saying the boss didn't punish himself for his malfeasance. I'm sorry, that's like the judge shouldn't punish himself if he did something wrong, and that is not how we operate in this country. People in authority should not be able to give themselves a break because they have authority over the agency that regulates and should regulate their behavior when they have violated the rules.

That is not what the rule of law is all about. That is not what we are trying to teach people in Iraq and Afghanistan with our military forces risking their lives to establish for them the safety and the assurance that the individual citizen in those countries will be treated fairly and will have somebody they can turn to to make sure that they are treated fairly.

This body, this Congress of the United States, should be about making sure that everybody is treated fairly. We should be about maintaining the oath that we took; and that oath said we will preserve, protect, and defend the Constitution of the United States. The oath we take in Texas is not only for the Constitution of the United States, but it is also for the State of Texas and the laws pertaining thereto. And that is our job. When we see things like this, we should be upset about it. We should be concerned about it.

We have introduced, or are going to introduce, a bill in the Congress that we are going to call the Geithner Penalty Waiver Act. This bill is to provide the same penalty rate for taxpayers who voluntarily disclose unreported income from offshore accounts as was afforded Timothy Geithner with respect to his failure to pay self-employment taxes with respect to his compensation from the Monetary Fund. The law pertaining to section 1401 of the Internal Revenue Code of 1986, the key word ''same penalty.''

This formally recognizes the legal precedent already established by the IRS's treatment of U.S. Treasury Secretary Tim Geithner. So what I am saying in this bill that we are going to offer is basically, to all of these tax cheats that they seem to be talking about in the IRS right now that are offshore, if they come in and voluntarily do what they said they should do, let's treat them like we treated the chief tax man of the United States, the top tax guy, treat them like him.

☐ 2015

That's only fair. If he doesn't have to pay the penalties and interest, if he

gets off from those penalties, I don't think any other people should have to pay penalties. Because the truth is, we want to do what the President said. We don't want there to be one set of laws for important people in Washington and another set of laws for the rest of the people in America and those who earn income that are Americans.

It's only fair. It's like the Rangel rule. If you haven't paid your taxes, you can write ''Rangel rule'' on your tax form and won't have to pay any penalty and interest—until Mr. RANGEL does anyway. This is the same concept, it's the same indicator, that there are those, and they are in positions of very high power related to our tax structure, that are being treated differently from the ordinary American, the ordinary Texan that works in the oil fields or works in the computer industry and he fails to pay taxes or he is late on his taxes. He gets penalties and interest. And he pays them, just like any other taxpayer in the country.

When the IRS says you owe penalty and interest, you might question them. When they show you that you owe them and show you the law that pertains to you, we pay them, even if we have to work out a payment schedule, but we pay them. We don't get, Oh, well, I forgot who you were. Oh, I'm sorry. You don't have to pay penalties because I didn't realize you were the Secretary of the Treasury. I didn't realize you were the chairman of the Ways and Means Committee, so just don't worry about it.

We don't get treated that way. I don't get treated that way. And I would argue that no Member of this House gets treated that way, with certain exceptions, and those exceptions are not right. And this political correctness we got going in this country, there are things that are right and there are things that are wrong. And you have to stand up and say, That's not right. That's what we're supposed to be. That's what we're supposed to do here. That's why we're here.

And I'm sure somewhere in this country today, as I'm speaking, there's some family that is almost sweating blood in their relationship with the Internal Revenue Service trying to figure out how they're going to meet the obligations. In some instances, people have messed up so bad in neglecting to pay their taxes that the penalties and interest are as much or more than the taxes that are owed. And sometimes this can be so onerous on a family, it can literally destroy that family because everything they have, or just about, is subject to a tax lien to be seized by the government and to be sold to force the payment of these things. This is serious stuff that happens to American citizens when they don't pay their taxes. And they all know that. Everybody here knows that. And everybody that might be watching this, they understand that failing to pay your taxes is serious business. It can be horrible for you and your family.

I don't want anything horrible to happen to Mr. Geithner, and I don't want anything horrible to happen to Mr. RANGEL. But I want them to be treated like everybody else in the United States that's out there today. I want them to have to meet their obligations to our country just like every American citizen has to meet their obligations. And I will promise you that there are probably thousands of Americans out there today that are worrying where and how they are going to keep their family under the roof with the tax burden and the penalties and interest that have fallen upon them as a result of their failure to pay taxes. It's just not fair. It's just not fair.

More importantly, if you waive the rule for somebody because they're important, they have a title, they are special because you elected them or because somebody you elected appointed them to a job, this law affects every American in the country, the tax law. And so do all the other criminal laws and the other rules in this society. Are you going to let them get away with waiving those other rules, too?

We have talked some about this. We have had issues right here in this Congress about the President of the United States and the White House interfering in the rule of contract, and that's making sure that certain laws don't count for certain people. And that's not right.

When we had the takeover of the automobile industry, when they said the unions get their deal but the bondholders don't get their deal, they circumvented the law. Special privileges were given to special groups. That's wrong. We can't let this continue in this country. We can't continue to let the powerful dictate outside the law. Because where does it stop?

I see that my friend from Georgia (Mr. WESTMORELAND) is here to join me, and I'm proud to have him here, so I will yield to him for comments he may have on this subject.

Mr. WESTMORELAND. I want to thank the gentleman for yielding and for having this special hour. I did want to comment that we are all supposed to be treated equally in this country. It doesn't matter if you're a mayor, a city councilman, a State representative, a State senator, whatever, whatever you're elected to or appointed to, you should be treated the same as every citizen in this country.

I guess it was back in February of 2009 that President Obama made a statement, and I don't know if the gentleman from Texas has talked about this yet or not, but I think this is what the American people were looking for when they elected President Obama because of what he had said on the campaign trail and what I believe people believed to be the truth. I think he was sincere in saying that there would be hope and change. And I think some of the change that people were counting on was to change politics as usual or how they had perceived politics in Washington. Because as the gentleman from Texas knows, in politics, it doesn't matter what the truth is, it's what the perception is. And right now, as I travel around the country, and I'm sure as the gentleman travels through his State and across the country and even into other lands, we hear that, What's wrong with Washington? Why is it that you've got all these different people being accused of these different things of getting special treatment?

The President said, ''I campaigned on changing Washington and bottom-up politics. I don't want to send a message to the American people that there are two sets of standards, one for the powerful people and one for ordinary folks who are working every day and paying their taxes.''

Now that was a quote from President Obama on February 3, 2009. I'm sure as the gentleman mentioned I think in his previous slide about the IRS employees, these are the employees that are under Secretary Geithner, and what it says is ''willful failure to file any return of tax required under the Internal Revenue Code of 1986 on or before the date prescribed therefor (including any extensions) unless such failure is due to reasonable cause and not to willful neglect.''

And we know, from at least the testimony that we've heard, that this was willful neglect, that he had actually been reimbursed this money by the company that he was working for. And so I think it was neglect, and I think this needs to be looked at. I'm not sure what committee or jurisdiction or whatever that this would come through, maybe the gentleman from Texas knows, but this should be something that we demand of somebody that holds an office like Secretary of the Treasury. I have filed for extensions, as I'm sure many people have filed for extensions, and I have never yet had the same treatment or had any constituents that's had the same treatment as the Secretary of the Treasury and while his dealings have been with the Internal Revenue.

I will yield back to the gentleman.

Mr. CARTER. This IRS Restructuring and Reform Act of 1998, section 1203, termination of employment for misconduct, IRS employees can and are terminated for just what my friend from Georgia just read to you, willful failure to file a return or willful neglect.

Mr. Geithner is arguably the head of the IRS. All those beneath him, from the director of the IRS all the way down to the guy who answers the phone and helps you work on your tax return,

if any of those employees do what Secretary Geithner does, by law, it says they can be and are terminated for this action.

Should the Secretary of the Treasury have to comply with the same law as the regular IRS workers? Some employees appear to be more equal than others. That is, if you're the boss, you don't have to comply, and this mandatory fine doesn't pertain to you.

Recently, KEVIN BRADY of Texas called upon the Secretary of the Treasury to resign. And on this issue, I think if there was someone besides the President, I guess the President is above the Secretary of the Treasury, but based on following the same rules that his employees follow, he would be terminated under the law, the IRS Restructuring and Reform Act of 1998.

So you want to know where that rule of law is, there's the rule. And there's what happens—terminated. Except for Mr. Geithner.

Mr. WESTMORELAND. If anybody was watching us tonight, they might think that this is some type of partisan thing that we have. It's not. In fact, it goes well beyond that. In a posting of November 17, 2009, the Huffington Post, which is no conservative posting, had a comment. It said:

''But for his personal tax problems, Tim Geithner would have been a consensus choice of Wall Street for Treasury Secretary last fall. Yet from the outset, Mr. Geithner's appointment compromised the Obama administration-to-be's credibility on ethics. The Treasury Secretary has become a continuing liability for this President.''

So even the most liberal of the blogs and the Web pages understand that this goes against the credibility of what this administration has said about it was going to change Washington. And as the gentleman knows, it's not just this appointment, it was other appointments to where he had to issue waivers of what some of his administration rules or promises were to allow other lobbyists or people to be not only in his Cabinet but appointments of his. I think that it's not just the conservative world or does it have anything to do with partisan politics, I think that everybody, and it seems like especially those that voted for him, are calling Mr. Geithner's credibility into account with the administration.

I think the ultimate bearer of responsibility on this is the President and the administration and I would like to know if he is getting any advice as to why this Secretary is getting special treatment. I just don't think that that's what the American people felt like we were going to get after this last election.

Mr. CARTER. I'm an old history buff. I believe that you learn from history. And in recent history, in the Clinton administration and in the George W. Bush administration, there were prospective Cabinet members who it was discovered had a domestic working for them that was possibly without papers to be in the United States and it caused them not to get confirmed for that position, because why? They were violating the laws as pertaining to illegal aliens. The rule of law. The Labor Secretary under the Bush administration had a domestic that was from another country that didn't have appropriate papers and withdrew the name because the rule of law wasn't being followed in her household. Inadvertently. I'm not saying he did this to be mean, vindictive or cheat the American public. That's kind of between him and the IRS, but I'm saying it happened and he admits it happened. And yet, for some reason, the rule of law is not an interference for him being Secretary of the Treasury. And yet in two previous administrations, violating a rule of law has prevented people from becoming a Cabinet member.

I think we should be concerned as we look at the Obama administration that gave us such glowing promises about nobody is going to be treated differently for their position, to start off and now have a whole year of people in positions where they violated the rule of law and they don't think it applies to them.

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Now I'm sure that somebody sitting out there is saying, Oh, come on, this isn't a big deal. My question is: Where do you draw the line? You back out there at home and most of the Members of Congress and their wives and children here in Washington, we know how scary the IRS can be if they're calling you and sending you letters and talking about tax liability and talking about tax liens and things like that, how scary they can be. And maybe that law doesn't scare everybody, but it sure scares me and a whole lot of people I know.

Now there's other laws that are even more serious, and you would say, Well, they can never be waived. They can never not pertain. How do you know? Once you decide that there are people that are above the law in a country, how far above the law do they have to go? Can they commit embezzlement? Maybe. If they're smart, swindle somebody a little bit. I don't know. How about murder? Are you going to waive the law as to murder? Just pick a bad one—that's a pretty bad one—and say, Does this pertain to everybody in the country equally? It certainly should.

But if you're willing to excuse one law at whatever level, then where do you stop excusing? Does somebody get so powerful and so important in this country when you set this kind of precedent—that somebody gets so powerful and important that we waive those other laws on their behalf? They can break our established laws, and we will waive it because they're so important to our country. We've got to have them, no matter what? I don't think so. I really don't think so.

I really think that's the kind of precedent that you saw starting in one of the most law-and-order places on Earth, Germany in the 1920s. And look what happened when they excused one law and then another and then another and then another. And then if you were a certain party member, it didn't pertain to you. And if you were a certain official, it didn't pertain to you. Then, they made the laws. That's not America.

We have to preserve the rule of law. I think my friend understands this seems to be going way off, but it's not way off. Once you start saying it's okay to do something that's breaking the law, then where do you draw the line at the next thing? Is not paying your taxes and not having the law apply to you here, does that mean the next step is you might take stimulus money and stick it in your pocket? Or you might do something else and we will excuse that because they're really important and they're trying do a good thing for the country, and keep going and going—and what do you have? Lawless society.

I yield back to my friend from Georgia for a comment.

Mr. WESTMORELAND. I thank my friend for yielding. Let me just say this; that there were several appointees that the President made after his election and it was discovered that they had tax problems. One former Senator that was looked at for the Health and Human Services Secretary excused himself because he had tax problems. There were other people that had been appointed that had tax problems that excused themselves.

We need to point out, I think, to my friend from Texas that Mr. Geithner's problems were pointed out prior to his approval or confirmation by the Senate.

Mr. CARTER. That's right.

Mr. WESTMORELAND. And so this brings in another whole new question. Is this something that we're going to accept? Is this something that's supposed to be accepted? I just don't think so. I think of our brethren—I think it was a mistake on their part when they knew exactly what had gone on, and they still went ahead with the confirmation process, whereas they should have just continued to ask questions and got more information on this.

But I think it talks about character when the people that were under nomination—I mean, let's face it. It's quite an honor to be nominated to serve in the Cabinet of any President in this country. What an honor. But with that comes some personal responsibility. I think some of these nominees realize that what they were going to be doing

was going to be a reflection on the administration. And not just the administration, but the rule of law, as you talked about, and how it affects and applies to everybody.

And so it's with that that I think the gentleman from Texas has done a great job. And I've signed, I think, both of the pieces of legislation, the Rangel rule and the Geithner penalty waiver act. I think that's something that we can do to show the American people that we want to see some equal treatment. But I just wanted to bring into account this personal responsibility that people have to recognize; that if they have done something wrong or gotten treatment that was unfair, if they just recuse themselves from the nomination.

Mr. CARTER. And let me just be clear on this from what I previously said. By doing the Rangel rule, which basically says everybody else gets treated the same, it's to give you that equal protection under the law that we promise in our Constitution. I'm not saying it's the right thing to do. I'm saying the right thing to do is for Mr. Geithner to pay the penalties that everybody else pays. I'm saying the right thing to do is for Mr. RANGEL to pay the interest and penalties that everybody else pays. But if that's a precedent being established by this administration at this time, then everybody ought to be treated equally. It's only fair.

I will tell you it's probably a bad precedent. And I would argue that. I'll tell you that I don't expect this to pass. But I do expect us to raise the issue. And that's a way to raise the issue; to say to the American people just what the President said: There's no two sets of standards, one for the powerful and one for the ordinary guy who pays his taxes. It's exactly what this is all about. This is just as simple as those words from our President of the United States. There's no two sets of standards. If we are going to reinforce and continue to reinforce and not call into account the Secretary of the Treasury and the Chairman of the Ways and Means Committee, if we're going to continue to do that, then at some point in time these two bills that I've offered and that my friend has joined me in, that should become the law of the United States, because now we have decided that this particular offense is no longer a violation of the rule of law.

So, from now on, we pay our taxes when we get around to it, and there's no punishment attached to it. Maybe that is fair. Maybe we'd all be happy with that. Probably would. But I'm not advocating that as good policy. I'm advocating good policy is everybody be treated equally. That's what I'm advocating.

Mr. WESTMORELAND. Isn't it ironic that the chairman of the committee that writes the tax laws and the Secretary who is head of the Treasury, that is really the boss of the IRS, are the two with the tax problems. Mr. RANGEL being chairman of the Ways and Means Committee, I felt it was interesting when he admitted that he didn't realize what the law was. I can't remember his exact quote, but basically he didn't realize that he was breaking the law. But from the constituents that have called me, and I don't know about the gentleman, what your calls have been like, they have told me that the Internal Revenue Service tells them that ignorance is no excuse.

Mr. CARTER. That's right.

Mr. WESTMORELAND. That ignorance is no excuse. It doesn't matter if you know that that was a tax law or not. If you don't pay, and if you don't file correctly, you're going to pay penalty and interest.

Now the chairman also made a comment that he got his accountant to figure up what he felt like he owed and send the Internal Revenue a check for that. Now here, again, I have had my constituents tell me that they have never had the IRS tell them, Look, you just figure up what you think you owe us and send us a check and we're all square. They typically send a bill and tell you what you owe them, plus what the penalty is, plus what the interest is.

Now it's up to the taxpayer to prove that they don't owe that. It's not the responsibility of the Internal Revenue to show you why you do owe that tax or why you do owe that penalty or interest. It's up to the taxpayers. It's the taxpayer's responsibility to tell you why you don't. So talking about the double standards. When you find yourself in that situation and you say, Well, I'll get my accountant to figure up what I think that I owe you, and I'll send you a check, and we'll all be square—that doesn't square with the typical taxpayer and how they're treated by the Internal Revenue Service.

So we've got the gentleman that actually writes the laws and the rules that govern the IRS and what our tax code is that said, I don't understand it. But, according to IRS and every other citizen, ignorance is no excuse.

Mr. CARTER. Reclaiming my time for a moment, that's exactly right, and I agree with my friend from Georgia. I will say this. This all started when Chairman RANGEL stood at that podium right there and told us about his problems. And, actually, I took it as a very courageous—if I had been his lawyer, it would have made me a little nervous—statement by Mr. RANGEL, that he was laying it all out in front of us. And nothing about what he said really concerned me. I thought he was trying to work through the issues and let somebody determine whether or not what he had done had been a violation of our ethic rules or the law. But he paid the taxes and he would pay penalties and interest, if assessed, and it popped into my head, There's no option. I have never ever known anybody to have an option. They're going to be assessed.

You might bargain your way out of something, depending on the numbers. You might make a little bit of a deal of with them. I've never known anybody that didn't get the letter that my friend from Georgia just described that told you what the penalties are and what the interest is for what you have to pay. In fact, I think most CPAs that are doing your work for you are going to tell you, You should have paid on the 15th. You're going to owe some penalty, and you're going to owe some interest. Bottom line. When I heard that, I waited to see if that was going to occur. And when it didn't, that's how this all started.

This also has an easy solution. It really does. That easy solution is: Pay the money. These are not poor people. Pay the money. Or at least show the world that due process had something to do with this and everybody has this opportunity to have this due process. I certainly think, at the minimum, when you're talking to that IRS agent who's talking to you about some taxes you failed to pay, you should very politely say, Can you explain to me how I go about getting treated the same way as Mr. Geithner and Mr. RANGEL got treated by the IRS? Don't be insulting. Don't make those people mad at you. No telling what they'll do to you. Might audit you.

Mr. WESTMORELAND. If you would yield for just a minute.

Mr. CARTER. I yield back.

Mr. WESTMORELAND. I was going to say that at least Mr. RANGEL said that he had forgotten that he owned this property or that this rental income had come in. And so that was his explanation. Mr. Geithner, I don't think, had that same explanation, because if I understand the information correctly and the evidence correctly, he was actually told by that company that he was being paid this additional money to pay those taxes that was due from the money he had received. I'm not sure what the gentleman has got up there.

Mr. CARTER. This is exactly what you're talking about. At the bottom it said—this is something that Mr. Geithner signed when he got his money from—his statements and all this stuff from the International Monetary Fund. In accordance with General Administrative Order No. 5, revision so and so and so and so, I wish to apply for a tax allowance from the U.S. Federal and State income taxes and the differences between the self-employed and employed obligation of the United States Social Security, and I will pay on my Fund income. I authorize the Fund or

any of the staff members designated by it for the purpose of ascertaining from the appropriate tax authorities whether tax returns were received. And he certifies that he will pay those taxes.

Mr. WESTMORELAND. Is that false swearing?

Mr. CARTER. Well, that is false swearing.

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Mr. WESTMORELAND. Isn't that against the law? I think it is in Georgia.

Mr. CARTER. In Texas, that's against the law.

I will stop. We're talking on top of each other. I'm sorry. I have learned a long time ago from court reporters that talking on top of each other is a cardinal sin for court reporters. I have worked with them now going on 30 years of my life.

Seriously, that is exactly right. There is another crime in false swearing on a Federal form. And you know what, it may be a mistake. I'm not saying Mr. Geithner wasn't so busy—he is a busy man—that he forgot. He forgot? Well, it's convenient. If you read the newspaper report, when they caught him on '03, '04, he took care of it.

Now he should have had a memory jolt when he got caught on '03 and '04 that he really didn't do it on '01 and '02, but he didn't have that memory jolt. He paid that and then got ready to be Secretary of the Treasury. Somebody said, Oops. Wait a minute. What about '01 and '02? Well, he went back and paid that. So I don't know. It looks like special privileges to me.

Once again, just like I started off saying, this is about the rule of law. It keeps our society together. And if we start waiving it for individuals or groups or whatever, once we start down that path, who makes that decision, and what does it do to the rest of us? Do we ever want to get into a situation like that which was gotten into in Nazi Germany and in Communist Russia where, for certain people, the laws didn't apply to them at all. For certain organizations, the law didn't apply to them. Do we want to go there?

You say, That's crazy. It's like that leak in that dike over there in Holland that we got that story about. Once that little trickle past the rule of law starts, where does it stop? If you don't plug that hole, what happens next? It's what happens next that Americans seem to be worried about.

I will yield back to my friend from Georgia.

Mr. WESTMORELAND. Well, I just want to say this to my friend from Texas, in closing, I appreciate you taking the leadership on this. I know this is not an easy subject for you to broach every week when you come down here, but we have to be serious about this. We are a country of laws, and regardless of whether some people think they can disregard them or not, that's not the way we operate. We all fall victim to this, but I think it's our responsibility to continually point it out and to point the way that we need to be going on this. I just want to tell you how much I appreciate you doing this week in and week out. I feel honored to be able to join you tonight.

Mr. CARTER. I thank you for joining me and being always loyal to come up here and help me out. I do appreciate that, and I appreciate the others that do too.

I think it's time to wrap up our time here today by saying that you're right. There is nothing easy about talking about your colleagues. I'm the first to say that people make mistakes. I have made mistakes, and every human being that's ever been around, I think, has made some kind of mistake, with possibly one exception. I won't go into that.

But the facts are that the rule of law is such an important part of keeping America what we are. You know, we brag about the land of the free and the home of the brave. We're only free and we only have the freedom to do the things we want to do because we establish rules that we're all willing to live by. So when you go out and you try to work on something, you know there are rules that pertain, and if you follow those rules, you can go forward. The only restriction that you have on your freedom to go forward in your life is that you've agreed to certain rules under the law. And you who abide by those rules should be horribly offended when some big shot, some politician gets special treatment.

I don't want to be a part of a group where somebody is accused of getting special treatment. I don't think any Member of this House really wants to be in that position. It's difficult to talk about these things, but somebody's got to do it.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. ABERCROMBIE (at the request of Mr. HOYER) for today.

Mr. BARROW (at the request of Mr. HOYER) for today and the balance of the week on account of a death in the family.

Mr. DAVIS of Illinois (at the request of Mr. HOYER) for today.

Ms. MCCOLLUM (at the request of Mr. HOYER) for today and until 11 a.m. December 2.

Mr. DAVIS of Kentucky (at the request of Mr. BOEHNER) for today on account of attending the President's speech at West Point.

Mr. KIRK (at the request of Mr. BOEHNER) for today on account of attending the President's speech at West Point.

Mr. SHIMKUS (at the request of Mr. BOEHNER) for today on account of attending the President's speech at West Point.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Ms. WOOLSEY) to revise and extend their remarks and include extraneous material:)

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

(The following Members (at the request of Mr. POE of Texas) to revise and extend their remarks and include extraneous material:)

Mr. WOLF, for 5 minutes, today, December 2, 3 and 4.

Mr. POE of Texas, for 5 minutes, today, December 2, 3, 4 and 7.

Mr. PAUL, for 5 minutes, today and December 2.

Mrs. MILLER of Michigan, for 5 minutes, today.

Mr. JONES, for 5 minutes, today, December 2, 3, 4 and 7.

Mr. DEAL of Georgia, for 5 minutes, December 7.

BILLS PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House reports that on November 20, 2009 she presented to the President of the United States, for his approval, the following bills.

H.R. 995. To designate the facility of the United States Postal Service located at 10355 Northeast Valley Road in Rollingbay, Washington, as the ''John 'Bud' Hawk Post Office''.

H.R. 1516. To designate the facility of the United States Postal Service located at 37926 Church Street in Dade City, Florida, as the ''Sergeant Marcus Mathes Post Office''.

H.R. 1713. To name the South Central Agricultural Research Laboratory of the Department of Agriculture in Lane, Oklahoma, and the facility of the United States Postal Service located at 310 North Perry Street in Bennington, Oklahoma, in honor of former Congressman Wesley ''Wes'' Watkins.

H.R. 2004. To designate the facility of the United States Postal Service located at 4282 Beach Street in Akron, Michigan, as the ''Akron Veterans Memorial Post Office''.

H.R. 2215. To designate the facility of the United States Postal Service located at 140 Merriman Road in Garden City, Michigan, as the ''John J. Shivnen Post Office Building''.

H.R. 2760. To designate the facility of the United States Postal Service located at 1615 North Wilcox Avenue in Los Angeles, California, as the ''Johnny Grant Hollywood Post Office Building''.

H.R. 2972. To designate the facility of the United States Postal Service located at 115 West Edward Street in Erath, Louisiana, as the ''Conrad DeRouen, Jr. Post Office''.

H.R. 3119. To designate the facility of the United States Postal Service located at 867 Stockton Street in San Francisco, California, as the ''Lim Poon Lee Post Office''.

H.R. 3386. To designate the facility of the United States Postal Service located at 1165

2nd Avenue in Des Moines, Iowa, as the ''Iraq and Afghanistan Veterans Memorial Post Office''.

H.R. 3547. To designate the facility of the United States Postal Service located at 936 South 250 East in Provo, Utah, as the ''Rex E. Lee Post Office Building''.

ADJOURNMENT

Mr. CARTER. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 8 o'clock and 50 minutes p.m.), the House adjourned until tomorrow, Wednesday, December 2, 2009, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of Rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

4746. A letter from the Congressional Review Coordinator, Department of Agriculture, transmitting the Department's final rule — Citrus Canker; Movement of Fruit from Quarantined Areas [Docket No.: APHIS-2009-0023] (RIN: 0579-AC96) received October 22, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4747. A letter from the Assistant General Counsel for Legislation and Regulatory Law, Department of Energy, transmitting the Department's final rule — Production Incentives for Cellulosic Biofuels; Reverse Auction Procedures and Standards (RIN: 1904-AB73) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4748. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Early Warning Reporting Regulations [Docket No.: NHTSA-2008-0169; Notice 2] (RIN: 2127-AK28) received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4749. A letter from the Director, Regulatory Management Divison, Environmental Protection Agency, transmitting the Agency's final rule — Technical Amendment of Cross-Media Electronic Reporting Rule [EPA-HQ-OEI-2003-0001; FRL-8980-7] (RIN: 2025-AA26) received November 10, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4750. A letter from the Chief of Staff, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Section 73.622(i), Final DTV Table of Allotments, Television Broadcast Stations (Jackson and Laurel, Mississippi) [MB Docket No.: 09-156] received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4751. A letter from the Director, Office of Congressional Affairs, Nuclear Regulatory Commission, transmitting the Commission's final rule — Criminal Penalties; Unauthorized Introduction of Weapons [NRC-2008-0458] (RIN: 3150-AI31) received October 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4752. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting the Department's report on progress toward a negotiated solution of the Cyprus question covering the period August 1 through September 30, 2009, pursuant to Section 620C(c) of the Foreign Assistance Act of 1961 and in accordance with Section 1(a)(6) of Executive Order 13313; to the Committee on Foreign Affairs.

4753. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting Transmittal No. DDTC 113-09, certification of a proposed amendment to a manufacturing license agreement for the manufacture of significant military equipment abroad, pursuant to section 36(d) of the Arms Export Control Act; to the Committee on Foreign Affairs.

4754. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting Transmittal No. DDTC 129-09, certification of a proposed technical assistance agreement to include the export of technical data, and defense services, pursuant to section 36(c) of the Arms Export Control Act; to the Committee on Foreign Affairs.

4755. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting Transmittal No. DDTC 099-09, certification of a proposed technical assistance agreement to include the export of technical data, and defense services, pursuant to section 36(c) of the Arms Export Control Act; to the Committee on Foreign Affairs.

4756. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting Transmittal No. DDTC 110-09, certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad, pursuant to section 36(c) and 36(d) of the Arms Export Control Act; to the Committee on Foreign Affairs.

4757. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting a proposed removal from the United States Munitions List of civil aircraft equipped with the Guardian System Aircraft Provisioning Kit (APK), pursuant to Section 38(f)(1) of the Arms Export Control Act; to the Committee on Foreign Affairs.

4758. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting a proposed removal from the United States Munitions List of civil aircraft equipped with the Biz Jet Matador Installation Kit (A-Kit), pursuant to Section 38(f)(1) of the Arms Export Control Act; to the Committee on Foreign Affairs.

4759. A letter from the Chairman of the Council, Council of the District of Columbia, transmitting Transmittal of D.C. ACT 18-232, ''First Congregational United Church of Christ Property Tax Abatement Temporary Act of 2009''; to the Committee on Oversight and Government Reform.

4760. A letter from the Chairman of the Council, Council of the District of Columbia, transmitting Transmittal of D.C. ACT 18-233, ''Neighborhood Supermarket Tax Relief Clarification Temporary Act of 2009''; to the Committee on Oversight and Government Reform.

4761. A letter from the Chairman of the Council, Council of the District of Columbia, transmitting Transmittal of D.C. ACT 18-231, ''Police and Firefighter Post-Retirememt Health Benefits Temporary Amendment Act of 2009''; to the Committee on Oversight and Government Reform.

4762. A communication from the President of the United States, transmitting an alternative plan for locality pay increase payable to civilian Federal employees covered by the General Schedule (GS) and certain other pay systems in January 2010, pursuant to 5 U.S.C. 5305(a)(3); (H. Doc. No. 111–78); to the Committee on Oversight and Government Reform and ordered to be printed.

4763. A letter from the Assistant Secretary for Fish and Wildlife and Parks, Department of the Interior, transmitting the Department's final rule — Migratory Bird Hunting; Approval of Tungsten-Iron-Fluoropolymer Shot Alloys as Nontoxic for Hunting Waterfowl and Coots; Availability of Final Environmental Assessment [Docket No.: FWS-R9-MB-2009-0003] (RIN: 1018-AW46) received October 22, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4764. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Greenland Turbot in the Aleutian Islands Subarea of the Bering Sea and Aleutian Islands Management Area [Docket No.: 0810141351-9087-02] (RIN: 0648-XS03) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4765. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 620 of the Gulf of Alaska [Docket No.: 0910091344-9056-02] (RIN: 0648-XR90) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4766. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Pollock in Statistical Area 630 of the Gulf of Alaska [Docket No.: 0910091344-9056-02] (RIN: 0648-XR91) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4767. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Northeastern United States; Spiny Dogfish Fishery Commercial Period 1 Quota Harvested [Docket No.: 060418103-6181-02] (RIN: 0648-XR84) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4768. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Magnuson-Stevens Fishery Conservation and Management Act Provisions; Fisheries of the Northeastern United States; Atlantic Sea Scallop Fishery; Closure of the Limited Access General Category Scallop Fishery to Individual Fishing Quota Scallop Vessels [Docket No.: 070817467-8554-02] (RIN: 0648-XR58) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4769. A letter from the Deputy Assistant Administrator for Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries in the Western Pacific; Compensation to Federal Commercial Bottomfish and Lobster Fishermen Due to Fishery Closures in the Papahanaumokuakea Marine National Monument, Northwestern Hawaiian Islands [Docket No.: 080304370-91192-02] (RIN: 0648-

AW52) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4770. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Snapper-grouper Fishery of the South Atlantic; Closure of the July-December 2009 Commercial Fishery for Vermilion Snapper in the South Atlantic [Docket No.: 040205043-4043-01] (RIN: 0648-XR06) October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4771. A letter from the Director of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Econonic Zone Off Alaska; Reallocation of Pacific Cod in the Bering Sea and Aleutian Islands Management Area [Docket No.: 0801041351-9087-02] (RIN: 0648-XR71) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4772. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Northeastern United States; Scup Fishery; Adjustment to the 2009 Winter II Quota [Docket No.: 0809251266-81485-02] (RIN: 0648-XQ56) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4773. A letter from the Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Northeastern United States; Northeast Multispecies Fishery; Modification of the Gear Requirements for the U.S./Canada Management Area [Docket No.: 080521698-9067-02] (RIN: 0648-XR42) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4774. A letter from the Acting Assistant Administrator for Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's ''Major'' final rule — Fisheries of the Northeastern United States; Northeast Multispecies Fishery; Secretarial Final Interim Action; Rule Extension [Docket No.: 080521698-9067-02] (RIN: 0648-AW87) received November 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

4775. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's ''Major'' final rule — Oil Pollution Prevention; Spill Prevention, Control, and Countermeasure (SPCC) Rule — Amendments [EPA-HQ-OPA-2007-0584; FRL-8979-8] (RIN: 2050-AG16) November 10, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4776. A letter from the Chief Counsel, Department of Commerce, transmitting the Department's final rule — Revisions to the Trade Adjustment Assistance for Firms Program Regulations and Implementation Regulations for the Community Trade Adjustment Assistance Program [Docket No.: 090429810-91212-02] (RIN: 0610-AA65) received October 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); jointly to the Committees on Transportation and Infrastructure, Financial Services, and Ways and Means.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

[Omitted from the Record of November 19, 2009]

Mr. BERMAN: Committee on Foreign Affairs. H.R. 2194. A bill to amend the Iran Sanctions Act of 1996 to enhance United States diplomatic efforts with respect to Iran by expanding economic sanctions against Iran; with an amendment (Rept. 111–342 Pt. 1). Ordered to be printed.

[Submitted on December 1, 2009]

Mr. GORDON of Tennessee: Committee on Science and Technology. H.R. 3029. A bill to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems; with an amendment (Rept. 111–343). Referred to the Committee of the Whole House on the State of the Union.

Mr. GORDON of Tennessee: Committee on Science and Technology. H.R. 3598. A bill to ensure consideration of water intensity in the Department of Energy's energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources; with an amendment (Rept. 111–344). Referred to the Committee of the Whole House on the State of the Union.

Mr. THOMPSON of Mississippi: Committee on Homeland Security. H.R. 3963. A bill to provide specialized training to Federal air marshals (Rept. 111–345). Referred to the Committee of the Whole House on the State of the Union.

Mr. THOMPSON of Mississippi: Committee on Homeland Security. H.R. 3980. A bill to provide for identifying and eliminating redundant reporting requirements and developing meaningful performance metrics for homeland security preparedness grants, and for other purposes. (Rept. 111–346). Referred to the Committee of the Whole House on the State of the Union.

Mr. THOMPSON of Mississippi: Committee on Homeland Security. House Resolution 28. Resolution expressing the sense of the House of Representatives that the Transportation Security Administration should, in accordance with the congressional mandate provided for in the Implementing Recommendations of the 9/11 Commission Act of 2007, enhance security against terrorist attack and other security threats to our Nation's rail and mass transit lines; with amendments (Rept. 111–347). Referred to the House Calendar.

TIME LIMITATION OF REFERRED BILL

Pursuant to clause 2 of rule XII the following action was taken by the Speaker:

(Omitted from the Record of November 19, 2009)

H.R. 2194. Referral to the Committees on Financial Services, Oversight and Government Reform, and Ways and Means for a period ending not later than December 4, 2009.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. HOLT (for himself, Mr. ELLISON, Mr. VAN HOLLEN, Mr. GRIJALVA, Mr. BACA, Mr. RANGEL, Ms. JACKSON-LEE of Texas, Mr. ISRAEL, Mr. PAYNE, Mr. PRICE of North Carolina, Ms. MCCOLLUM, Mr. GRAYSON, Mrs. CHRISTENSEN, Ms. SCHAKOWSKY, and Ms. DEGETTE):

H.R. 4159. A bill to amend the Federal Insecticide, Fungicide, and Rodenticide Act to require local educational agencies and schools to implement integrated pest management programs to minimize the use of pesticides in schools and to provide parents, guardians, and employees with notice of the use of pesticides in schools, and for other purposes; to the Committee on Agriculture.

By Ms. SLAUGHTER (for herself, Mrs. CAPPS, Mr. ELLISON, Mr. HINCHEY, Ms. MCCOLLUM, Ms. SCHAKOWSKY, Ms. WOOLSEY, Mr. GRIJALVA, Mr. MCGOVERN, Mr. GEORGE MILLER of California, Mr. ISRAEL, Mr. DOGGETT, and Mr. STARK):

H.R. 4160. A bill to amend the Public Health Service Act to authorize the National Institute of Environmental Health Sciences to conduct and coordinate a research program on hormone disruption, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. SLAUGHTER (for herself, Mrs. CAPPS, Mr. ELLISON, Mr. HINCHEY, Ms. MCCOLLUM, Ms. SCHAKOWSKY, Ms. WOOLSEY, Mr. GRIJALVA, Mr. MCGOVERN, Mr. GEORGE MILLER of California, Mr. ISRAEL, Mr. DOGGETT, and Mr. STARK):

H.R. 4161. A bill to amend the Public Health Service Act to authorize the National Institute of Environmental Health Sciences to develop multidisciplinary research centers regarding women's health and disease prevention, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. OLSON:

H.R. 4162. A bill to amend the Water Resources Development Act of 2000 to make permanent the authority of the Secretary of the Army to accept and expend funds contributed by non-Federal public entities to expedite the evaluation of permits under the jurisdiction of the Department of the Army; to the Committee on Transportation and Infrastructure.

By Mr. BACA:

H.R. 4163. A bill to amend the Food and Nutrition Act of 2008 to exclude from income unemployment benefits received for a continuous period exceeding 26 weeks; to the Committee on Agriculture.

By Mr. HERGER:

H.R. 4164. A bill to amend the National Flood Insurance Act of 1968 to provide for a phased-in increase of chargeable premium rates for properties affected by updated Flood Insurance Rate Maps; to the Committee on Financial Services.

By Mr. LARSEN of Washington:

H.R. 4165. A bill to extend through December 31, 2010, the authority of the Secretary of the Army to accept and expend funds contributed by non-Federal public entities to expedite the processing of permits; to the Committee on Transportation and Infrastructure.

By Mr. RODRIGUEZ:

H.R. 4166. A bill to amend title 38, United States Code, to make certain improvements in the laws administered by the Secretary of Veterans Affairs relating to educational assistance for health professionals, and for other purposes; to the Committee on Veterans' Affairs, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. STUPAK:

H.R. 4167. A bill to amend the Communications Act of 1934 to authorize 3 or more Commissioners of the Federal Communications Commission to hold nonpublic collaborative discussions, and for other purposes; to the Committee on Energy and Commerce.

By Mr. TEAGUE (for himself, Mr. BILBRAY, and Mr. INSLEE):

H.R. 4168. A bill to amend the Internal Revenue Code of 1986 to expand the definition of cellulosic biofuel to include algae-based biofuel for purposes of the cellulosic biofuel producer credit and the special allowance for cellulosic biofuel plant property; to the Committee on Ways and Means.

By Ms. LEE of California (for herself, Ms. PELOSI, Mr. WAXMAN, Mr. BERMAN, Mr. PAYNE, Ms. WATERS, Mrs. CHRISTENSEN, Mr. HIMES, Ms. JACKSON-LEE of Texas, Mr. ELLISON, Ms. MCCOLLUM, Ms. BORDALLO, Mr. NADLER of New York, Mr. SERRANO, Mr. HINOJOSA, Mr. RUSH, Mr. GEORGE MILLER of California, Mr. HARE, Mr. GRIJALVA, Mr. MOORE of Kansas, Mrs. NAPOLITANO, Mr. LEWIS of Georgia, Mr. GRAYSON, Ms. SPEIER, Mr. HONDA, Mr. CARSON of Indiana, Ms. BALDWIN, Ms. CASTOR of Florida, Ms. LORETTA SANCHEZ of California, Mr. MARKEY of Massachusetts, Mr. HASTINGS of Florida, and Mr. CLEAVER):

H. Con. Res. 216. Concurrent resolution supporting the goals and ideals of World AIDS Day; to the Committee on Energy and Commerce, and in addition to the Committee on Foreign Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SMITH of Washington (for himself, Mr. DICKS, Mr. REICHERT, Mr. INSLEE, Mr. LARSEN of Washington, Mr. BAIRD, Mrs. MCMORRIS RODGERS, Mr. HASTINGS of Washington, and Mr. MCDERMOTT):

H. Res. 939. A resolution extending condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; to the Committee on the Judiciary.

By Mr. LATTA (for himself, Mr. SHUSTER, Mr. CALVERT, Mr. KIND, Mr. HALL of Texas, Mr. RYAN of Wisconsin, Mr. BISHOP of Georgia, Mr. BUYER, Mr. TAYLOR, Mr. BRADY of Pennsylvania, Mr. LATOURETTE, Mr. WILSON of South Carolina, Mr. MINNICK, Mr. BERRY, Mr. WAMP, Mr. JONES, Mr. MOORE of Kansas, Ms. MOORE of Wisconsin, Mr. PIERLUISI, Mr. RODRIGUEZ, Mr. LAMBORN, Mr. HOEKSTRA, Ms. KAPTUR, Mr. THOMPSON of Pennsylvania, Mrs. MCMORRIS RODGERS, Mr. COURTNEY, Mr. BOCCIERI, Mr. FALEOMAVAEGA, Mr. HOLDEN, Ms. ROS-LEHTINEN, Mr. TEAGUE, Mr. CAO, Ms. MCCOLLUM, Mr. BLUNT, Mr. GINGREY of Georgia, Mr. LOEBSACK, Mrs. DAHLKEMPER, Mr. AUSTRIA, Mr. LOBIONDO, Ms. CORRINE BROWN of Florida, Mr. ALEXANDER, Mr. TURNER, Mrs. MILLER of Michigan, Mr. JORDAN of Ohio, Mrs. NAPOLITANO, Ms. BORDALLO, Mr. BOYD, Mr. ETHERIDGE, Mr. ISSA, Mr. BARTLETT, Ms. ESHOO, Mr. SALAZAR, Mr. WU, Mr. PETERSON, Mr. OBERSTAR, Mr. MCKEON, Mr. CONAWAY, Mr. RAHALL, Mr. PAYNE, Mr. SMITH of Washington, Mr. WITTMAN, Mr. DICKS, Mr. JOHNSON of Georgia, Mr. ROGERS of Kentucky, Mr. GERLACH, Mr. MCMAHON, Mr. WOLF, Mr. PAULSEN, Mr. HUNTER, Mr. SPRATT, Mr. REHBERG, Mr. INGLIS, Mr. BARTON of Texas, Mr. MASSA, Mr. KRATOVIL, Mr. ROONEY, Mr. POMEROY, Mr. MICHAUD, Mr. BOSWELL, Ms. DELAURO, Mr. BOREN, Mr. KLINE of Minnesota, Mr. CUMMINGS, and Ms. NORTON):

H. Res. 940. A resolution recognizing and honoring the National Guard on the occasion of its 373rd anniversary; to the Committee on Armed Services.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 21: Ms. KILPATRICK of Michigan.
H.R. 39: Ms. SLAUGHTER, Ms. DELAURO, Mr. DOYLE, Ms. BALDWIN, and Ms. HARMAN.
H.R. 197: Mr. HEINRICH.
H.R. 205: Mr. ADERHOLT.
H.R. 211: Mr. BOREN, Mr. PETERSON, and Ms. MARKEY of Colorado.
H.R. 235: Mr. SCOTT of Virginia.
H.R. 270: Mr. LANGEVIN.
H.R. 272: Mr. ROE of Tennessee and Mrs. BLACKBURN.
H.R. 303: Mr. STUPAK and Mr. MCCOTTER.
H.R. 444: Mr. HEINRICH and Ms. RICHARDSON.
H.R. 450: Mr. CANTOR.
H.R. 537: Mr. ADLER of New Jersey and Mr. ELLSWORTH.
H.R. 564: Ms. DEGETTE.
H.R. 571: Mr. ELLSWORTH, Ms. SLAUGHTER, and Mr. SARBANES.
H.R. 619: Mr. HOLT.
H.R. 658: Mr. BISHOP of Georgia.
H.R. 678: Mr. BOUCHER, Mr. LUETKEMEYER, Mr. KUCINICH, Mr. CLEAVER, and Mr. PETERSON.
H.R. 682: Mr. ELLSWORTH.
H.R. 690: Mr. MEEK of Florida and Mr. BOUCHER.
H.R. 734: Mr. ETHERIDGE, Mr. YOUNG of Florida, and Mrs. BLACKBURN.
H.R. 789: Ms. EDWARDS of Maryland.
H.R. 840: Ms. ZOE LOFGREN of California.
H.R. 847: Ms. NORTON, Mr. HOLDEN, Mr. CUMMINGS, Ms. SHEA-PORTER, Mr. ROTHMAN of New Jersey, Mrs. NAPOLITANO, Mr. LYNCH, and Mr. CAO.
H.R. 868: Mr. PAYNE.
H.R. 877: Mr. ELLSWORTH.
H.R. 930: Mr. NADLER of New York and Mr. CLEAVER.
H.R. 953: Ms. BALDWIN.
H.R. 980: Mr. HILL.
H.R. 995: Mr. FILNER.
H.R. 1020: Mr. MCNERNEY.
H.R. 1079: Mr. BACA and Mr. BOUCHER.
H.R. 1086: Mr. WAMP and Mr. MCKEON.
H.R. 1126: Mr. GRIJALVA, Mr. BERMAN, and Mr. HONDA.
H.R. 1137: Mr. PETERSON.
H.R. 1175: Mr. BISHOP of New York.
H.R. 1177: Mr. SNYDER.
H.R. 1189: Mr. MCGOVERN.
H.R. 1207: Mr. REYES, Mr. RODRIGUEZ, Ms. KILPATRICK of Michigan, and Mr. BOREN.
H.R. 1326: Mr. JACKSON of Illinois, Mr. MITCHELL, Ms. SUTTON, Mrs. LOWEY, Ms. ROYBAL-ALLARD, and Ms. FUDGE.
H.R. 1454: Mr. ENGEL, Ms. RICHARDSON, and Mr. MCCAUL.
H.R. 1470: Mr. SCHOCK.
H.R. 1517: Ms. RICHARDSON.
H.R. 1523: Mr. WU.
H.R. 1526: Mr. GORDON of Tennessee, Mr. LUJÁN, Mr. LANGEVIN, Mr. BOSWELL, Mr. DAVIS of Illinois, Mr. HARE, Mr. LEWIS of Georgia, and Mr. KENNEDY.
H.R. 1545: Ms. SUTTON, Mr. RUSH, and Mr. MASSA.
H.R. 1549: Mr. SARBANES, Mr. SMITH of Washington, Mr. OLVER, Mrs. LOWEY, Ms. ROYBAL-ALLARD, Mr. MICHAUD, Ms. EDWARDS of Maryland, Ms. ESHOO, Mr. LANGEVIN, and Mr. ELLISON.
H.R. 1552: Mr. ELLSWORTH.
H.R. 1557: Mr. BOUCHER and Mr. FRELINGHUYSEN.
H.R. 1691: Mr. PATRICK J. MURPHY of Pennsylvania.
H.R. 1718: Mr. RUPPERSBERGER.
H.R. 1765: Mr. ROTHMAN of New Jersey.
H.R. 1770: Ms. HERSETH SANDLIN and Mr. MURPHY of New York.
H.R. 1799: Mr. THORNBERRY and Mrs. BLACKBURN.
H.R. 1806: Mr. MINNICK, Mr. BRADY of Pennsylvania, Mr. RAHALL, Mr. CARNAHAN, and Mr. CROWLEY.
H.R. 1826: Mr. SARBANES and Mrs. HALVORSON.
H.R. 1831: Mr. BAIRD.
H.R. 1844: Mrs. NAPOLITANO, Ms. NORTON, Mr. COHEN, and Mr. NADLER of New York.
H.R. 1894: Mr. FRANK of Massachusetts.
H.R. 1912: Ms. DEGETTE and Mr. OBERSTAR.
H.R. 1927: Mr. LATOURETTE.
H.R. 1956: Mr. PERLMUTTER.
H.R. 1987: Mr. PAYNE.
H.R. 2002: Mr. ROTHMAN of New Jersey.
H.R. 2035: Mr. ELLSWORTH.
H.R. 2057: Mrs. CHRISTENSEN, Mrs. NAPOLITANO, and Mr. DOGGETT.
H.R. 2070: Ms. NORTON.
H.R. 2112: Mr. MCDERMOTT, Mr. PETERS, Mr. LEWIS of Georgia, Mr. MORAN of Virginia, and Mr. TIM MURPHY of Pennsylvania.
H.R. 2134: Mr. JACKSON of Illinois.
H.R. 2139: Mr. GUTHRIE.
H.R. 2149: Ms. ROS-LEHTINEN, Mr. BOREN, Mr. KIND, Mr. MCCAUL, and Mr. STARK.
H.R. 2159: Mr. HALL of New York.
H.R. 2190: Mr. MASSA and Ms. SLAUGHTER.
H.R. 2194: Ms. HERSETH SANDLIN and Ms. CLARKE.
H.R. 2254: Mr. GEORGE MILLER of California, Mr. GRIJALVA, Mr. PRICE of North Carolina, Ms. SCHWARTZ, Mr. MCCOTTER, Ms. WATERS, Mr. KLEIN of Florida, and Mr. PETERSON.
H.R. 2279: Mr. BACA, Mr. BISHOP of New York, and Mr. CARNAHAN.
H.R. 2324: Mr. PALLONE, Mr. MCMAHON, Ms. WATSON, Mr. FARR, Mr. GUTIERREZ, Ms. PINGREE of Maine, and Ms. MATSUI.
H.R. 2329: Mr. LEWIS of Georgia, Mr. REYES, and Mr. CUELLAR.
H.R. 2365: Mr. RYAN of Ohio.
H.R. 2377: Ms. WATERS.
H.R. 2378: Mr. BACHUS and Mrs. MILLER of Michigan.
H.R. 2381: Ms. EDWARDS of Maryland.
H.R. 2408: Ms. VELÁZQUEZ and Mr. DENT.
H.R. 2414: Ms. DEGETTE.
H.R. 2450: Mr. BERRY.
H.R. 2455: Ms. BERKLEY.
H.R. 2517: Ms. WATERS, Mr. SCHIFF, and Mr. PERLMUTTER.

H.R. 2528: Mr. WU, Ms. BERKLEY, Ms. PINGREE of Maine, and Mrs. BONO MACK.
H.R. 2555: Mr. CLAY.
H.R. 2568: Mr. ELLSWORTH and Mr. GRIJALVA.
H.R. 2624: Mr. DELAHUNT.
H.R. 2628: Mr. MICHAUD.
H.R. 2697: Mr. PETERSON and Ms. MARKEY of Colorado.
H.R. 2698: Ms. SHEA-PORTER.
H.R. 2699: Ms. SHEA-PORTER.
H.R. 2746: Mr. ISRAEL, Ms. SLAUGHTER, Mr. ENGEL, Mr. COSTELLO, Mr. BISHOP of New York, Mr. SHERMAN, and Mr. HINCHEY.
H.R. 2866: Mr. GINGREY of Georgia.
H.R. 2923: Ms. HIRONO and Mr. MCINTYRE.
H.R. 2969: Ms. DEGETTE.
H.R. 3011: Mr. ELLSWORTH.
H.R. 3012: Mr. HODES and Ms. CORRINE BROWN of Florida.
H.R. 3017: Mr. MATHESON.
H.R. 3019: Mr. RADANOVICH and Mr. MCNERNEY.
H.R. 3026: Ms. NORTON and Mr. FILNER.
H.R. 3027: Ms. NORTON, Mr. FILNER, and Mr. BLUMENAUER.
H.R. 3028: Ms. NORTON and Mr. FILNER.
H.R. 3035: Ms. BALDWIN.
H.R. 3053: Mr. COHEN.
H.R. 3185: Mr. BLUMENAUER.
H.R. 3238: Mr. SCOTT of Virginia.
H.R. 3249: Ms. CHU and Ms. HIRONO.
H.R. 3286: Ms. ESHOO and Mr. MOORE of Kansas.
H.R. 3290: Mr. POLIS of Colorado.
H.R. 3307: Mr. BOYD.
H.R. 3328: Mr. CUMMINGS and Mr. POLIS of Colorado.
H.R. 3336: Ms. MARKEY of Colorado.
H.R. 3339: Ms. DEGETTE and Mr. POLIS of Colorado.
H.R. 3380: Mr. ELLSWORTH.
H.R. 3381: Ms. MCCOLLUM.
H.R. 3382: Ms. JACKSON-LEE of Texas.
H.R. 3402: Mr. MINNICK, Mr. HOLDEN, and Ms. SLAUGHTER.
H.R. 3412: Mr. HOLDEN.
H.R. 3463: Mr. GRIFFITH, Mr. DENT, and Mr. KLINE of Minnesota.
H.R. 3486: Ms. SUTTON.
H.R. 3493: Mr. CARNEY.
H.R. 3535: Mr. ADLER of New Jersey.
H.R. 3554: Ms. ZOE LOFGREN of California.
H.R. 3577: Mr. COURTNEY.
H.R. 3589: Mr. ANDREWS, Mr. SIRES, and Mr. ADLER of New Jersey.
H.R. 3592: Mr. WU.
H.R. 3598: Mr. HALL of Texas, Mr. ROTHMAN of New Jersey, Ms. WOOLSEY, Mr. BAIRD, Mr. WU, Mr. LUJÁN, Mr. LIPINSKI, Mr. MCNERNEY, Ms. GIFFORDS, Mr. HEINRICH, Ms. TITUS, Mr. TONKO, Mrs. DAHLKEMPER, Mr. COSTELLO, Mr. MILLER of North Carolina, and Mr. HOLT.
H.R. 3627: Mr. CARNEY.
H.R. 3652: Mr. MARKEY of Massachusetts.
H.R. 3666: Ms. SHEA-PORTER.
H.R. 3688: Mr. MURPHY of New York.
H.R. 3693: Mr. CARTER, Mrs. BONO MACK, Mr. PLATTS, Mr. UPTON, and Mr. WILSON of South Carolina.
H.R. 3710: Mr. CUMMINGS, Mr. NADLER of New York, and Mr. OLVER.
H.R. 3721: Mr. COHEN and Ms. WASSERMAN SCHULTZ.
H.R. 3731: Ms. SLAUGHTER.
H.R. 3734: Mr. GRIJALVA and Mr. BARROW.
H.R. 3745: Mr. DOGGETT, Mr. HINCHEY, and Mr. ABERCROMBIE.
H.R. 3757: Mr. MORAN of Virginia.
H.R. 3765: Mr. SOUDER and Mr. HOEKSTRA.
H.R. 3778: Mr. CAMP and Mr. BISHOP of New York.
H.R. 3799: Mr. FRANK of Massachusetts.
H.R. 3827: Ms. PINGREE of Maine.
H.R. 3836: Mr. PASCRELL.
H.R. 3837: Mr. HIMES.
H.R. 3852: Mr. GRIJALVA.
H.R. 3856: Mr. FRANK of Massachusetts.
H.R. 3904: Mr. SCHAUER.
H.R. 3905: Mr. WAMP, Mr. BISHOP of Georgia, Mr. ELLSWORTH, Mr. BOUCHER, Mr. MCMAHON, Mr. CARTER, Mr. OWENS, and Mr. LOEBSACK.
H.R. 3907: Mr. REICHERT, Mr. LYNCH, Ms. HERSETH SANDLIN, Mr. SERRANO, Mrs. MCCARTHY of New York, Mr. SCHIFF, Mr. SMITH of Washington, Mrs. DAVIS of California, Mr. SCHOCK, Mr. LANCE, Mr. FARR, Mr. HASTINGS of Florida, Mr. PAYNE, Mr. BOUCHER, and Mr. PLATTS.
H.R. 3918: Mr. KIND.
H.R. 3929: Mr. DAVIS of Alabama.
H.R. 3943: Mr. HIMES, Mr. SABLAN, Mrs. CAPITO, Mr. SCOTT of Virginia, Mr. STARK, and Mr. SMITH of New Jersey.
H.R. 3960: Mr. WEINER and Mr. MASSA.
H.R. 3966: Mr. DELAHUNT and Mr. DOGGETT.
H.R. 3986: Ms. WATERS.
H.R. 3995: Mr. JONES.
H.R. 4021: Mr. SESTAK, Mr. CONYERS, and Mr. PRICE of North Carolina.
H.R. 4034: Mr. BUTTERFIELD.
H.R. 4036: Mr. MASSA and Mr. FILNER.
H.R. 4037: Mr. GRIJALVA and Mr. FATTAH.
H.R. 4046: Mr. ENGEL, Mr. MCMAHON, and Mr. SHULER.
H.R. 4067: Mr. ABERCROMBIE, Mr. CLAY, Ms. GIFFORDS, Mr. POLIS of Colorado, Mr. KIND, Mr. HINCHEY, Mr. POMEROY, and Mr. KAGEN.
H.R. 4072: Mr. BARROW, and Mr. SIMPSON.
H.R. 4075: Mr. BARROW, Mr. GERLACH, and Mr. MILLER of Florida.
H.R. 4090: Mr. JACKSON of Illinois.
H.R. 4100: Mrs. BLACKBURN and Mr. RADANOVICH.
H.R. 4103: Mr. CARTER.
H.R. 4104: Mr. PATRICK J. MURPHY of Pennsylvania and Mr. SHULER.
H.R. 4109: Ms. BERKLEY.
H.R. 4110: Ms. FOXX, Mr. HERGER, and Mr. HOEKSTRA.
H.R. 4114: Mr. COHEN, Mr. JACKSON of Illinois, Mr. BACA, Ms. LEE of California, Ms. HIRONO, and Ms. TITUS.
H.R. 4122: Ms. HIRONO and Mr. BERMAN.
H.R. 4124: Mr. CAO.
H.R. 4126: Mr. MICHAUD and Ms. HIRONO.
H.R. 4127: Mr. CALVERT, Mr. SHUSTER, Mr. MCCLINTOCK, and Mr. SAM JOHNSON of Texas.
H.R. 4130: Mr. RANGEL, Mr. BLUMENAUER, Ms. LEE of California, Mr. MORAN of Virginia, and Mr. HONDA.
H.R. 4138: Mr. CAMP and Mr. RADANOVICH.
H.R. 4140: Mr. JOHNSON of Georgia, Ms. EDWARDS of Maryland, Mr. JACKSON of Illinois, Ms. SCHAKOWSKY, Mr. MCGOVERN, and Ms. LEE of California.
H. Con. Res. 137: Mr. WU and Ms. DELAURO.
H. Con. Res. 197: Mr. POSEY and Mr. MEEK of Florida.
H. Con. Res. 200: Mrs. NAPOLITANO.
H. Con. Res. 204: Mr. ROSKAM, Mr. POSEY, and Mr. POMEROY.
H. Con. Res. 213: Mr. SERRANO and Mr. HONDA.
H. Res. 55: Mr. WEINER, Mrs. CAPPS, Ms. MATSUI, Mr. GENE GREEN of Texas, Ms. BALDWIN, and Ms. SCHAKOWSKY.
H. Res. 111: Mr. HARE.
H. Res. 416: Mr. SERRANO.
H. Res. 494: Mr. SNYDER.
H. Res. 847: Mr. CASTLE.
H. Res. 862: Mr. DAVIS of Illinois, Mrs. BIGGERT, Mr. HARE, and Mr. PATRICK J. MURPHY of Pennsylvania.
H. Res. 879: Mr. BARROW, Mr. PRICE of North Carolina, and Mr. HONDA.
H. Res. 898: Mr. LANGEVIN.
H. Res. 900: Mr. FRANKS of Arizona, Mr. ADERHOLT, Mr. REHBERG, Mr. BARTLETT, Mrs. EMERSON, Mr. ROGERS of Michigan, Mr. WAMP, and Mr. KIRK.
H. Res. 905: Mr. PASCRELL, Mr. SCHAUER, Mr. HALL of New York, Ms. JACKSON-LEE of Texas, Mr. FILNER, Mr. NADLER of New York, Mr. HOLT, and Mr. ENGEL.
H. Res. 907: Mr. ARCURI, Mr. ENGEL, Mr. HINCHEY, Mr. KING of New York, Mr. MCMAHON, Mrs. MALONEY, Mr. NADLER of New York, Mr. PASCRELL, and Mr. TOWNS.
H. Res. 911: Mr. DENT and Mr. BURTON of Indiana.
H. Res. 920: Mr. THORNBERRY.
H. Res. 922: Mr. THORNBERRY and Mr. KLINE of Minnesota.
H. Res. 926: Ms. HIRONO, Mrs. CHRISTENSEN, Mr. JOHNSON of Georgia, Mr. LEWIS of Georgia, and Mr. MARKEY of Massachusetts.
H. Res. 933: Mr. SCHAUER, Mr. KILDEE, and Mrs. MILLER of Michigan.
H. Res. 934: Mr. SCHAUER, Mr. KILDEE, and Mrs. MILLER of Michigan.

PETITIONS, ETC.

Under clause 1 of rule XXII,

84. The SPEAKER presented a petition of City of Miami, Florida, relative to Resolution R–09–0466 urging the U.S. House of Representatives and U.S. Senate to support the ''Humanity and Pets Partnered Through the Years (HAPPY) Act''; which was referred to the Committee on Ways and Means.

EXTENSIONS OF REMARKS

HONORING WARD HUSSEY

HON. NANCY PELOSI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Ms. PELOSI. Madam Speaker, I rise today to honor the life of a great American and public servant, the Legislative Counsel of the House of Representatives, Ward Hussey.

Ward Hussey's career was defined by service. He stood on the front lines of World War II and stormed the beaches of Okinawa. He got little attention in the public eye, but for 43 years in the Office of Legislative Counsel, he was the wordsmith of the House; a core player in the legislative process; a truly indispensible voice and a source of institutional knowledge and intelligence for every Member of Congress.

Ward Hussey held no allegiance to party or partisan causes—only to his country, the Congress, and the people of the United States.

His job was to give form to ideas and to turn vague proposals into concrete pieces of legislation. Always remaining behind the scenes, he called himself a "catalyst," a man who "filled in" the details and made sure all sides were represented. Always an example of hard work, commitment, and duty, his colleagues called him a kind and decent man, who brought an extraordinary knowledge and discipline to the job.

Ward Hussey left a deep imprint on our national identity, our social fabric, and our daily lives. His fingerprints can be found on the Marshall Plan, the interstate highway system, and Medicare. Most significantly, his words and expertise formed the foundation of our modern tax code.

Over more than 4 decades of service, Ward Hussey's, achievements became the cornerstones of our common progress as a country.

I hope it is a comfort to Ward Hussey's children, grandchildren, great-grandchild, family and friends that the House of Representatives mourns the loss of this giant of the Capitol and is praying for them in this sad time. May his legacy live on in our ongoing pursuit of legislative achievement.

RECOGNIZING COACH JIM DREWRY

HON. TRAVIS W. CHILDERS

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CHILDERS. Madam Speaker, I rise today to recognize a very special Mississippian. Coach Jim Drewry of Booneville, Mississippi has been named the winningest coach in Mississippi High School Football history.

Coach Drewry began his coaching career at Kossuth (Miss.) High School in the spring of 1958. He spent two years at Kossuth, then moved to Brandon (Miss.) High School as an assistant coach in 1960. After five years, Coach Drewry took the head coaching job at Booneville (Miss.) High School in 1965, where he led the Blue Devils to three bowl games and a Tombigbee Conference co-championship in 1977.

He returned as head coach at Kossuth High School from 1979 to 1986. Then Coach Drewry retired and was out of coaching for two years. In 1989, he got back into coaching as head coach at Tishomingo (Miss.) High School. After just one season, Coach Drewry returned to Booneville High School in 1990, guiding my alma mater Blue Devils to a Class 2A state title.

Since returning to Booneville High School football, Coach Drewry has led the Blue Devils to win state championships and division championships. He has an overall record of 345-156-5, making him the most successful public school football coach in Mississippi. Coach Drewry was also recognized in the Mississippi Association of Coach Hall of Fame and the National Federation of High School Hall of Fame.

I applaud Coach Jim Drewry's achievements and I hope he will continue to guide the Booneville Blue Devils and victoriously represent Mississippi's First District. I urge my colleagues to join me today in recognizing Coach Jim Drewry for his winning record and for his years of service on and off the field spent mentoring young people in Mississippi.

RECOGNIZING "THE ARMS FORCES" NONPROFIT ORGANIZATION

HON. MARCY KAPTUR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Ms. KAPTUR. Madam Speaker. I rise to recognize The Arms Forces, a nonprofit organization recently created in our region of Northwest Ohio. The Arms Forces develops and maintains a network of volunteers who provide assistance to service men and women who have returned from combat with a traumatic brain injury or PTSD. Life Navigation Coaches are trained to help veterans define, access, and navigate existing supportive services and benefits. Through the group's "Inspirational Listening Tour," wounded warriors are met in their home communities and share their challenges. Volunteers of The Arms Forces are personally attuned to the suffering of TBI and PTSD and understand the impact of these injuries on our veterans. Through the volunteers' efforts, the enable wounded warriors to reach their highest potential and improve the quality of their lives.

The Arms Forces members are passionate and committed in their service. I am proud to share their story.

HONORING DON LAUB

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to honor the life of Don Laub and for his dedication to his family, community, and agriculture. Mr. Laub passed away on Tuesday, October 20, 2009, from injuries suffered in a farm accident, at the age of 76. A memorial service was held for him on Monday, October 26, 2009.

Mr. Don Laub was born on July 22, 1933, in Fresno, California, to a farming family. As a young man he founded Laub Ranches and J & L Vineyards in Easton. The family-run businesses produce top-quality table grapes, raisins, and wine grapes. He was a leader in the agricultural community and was passionate about preserving the family farm and agricultural education for students.

Mr. Laub served as the Fresno County Farm Bureau president from 1986 until 1988. He also served on the California Farm Bureau Federation Board of Directors and served on several advisory committees for both the state and national Farm Bureau organizations. Outside of agriculture and farming, Mr. Laub was dedicated to giving back to the community. He was heavily involved with the Fresno County Affordable Housing Task Force and the Fresno County Public Schools Foundation.

For his efforts, Mr. Laub was named the Greater Fresno Area Chamber of Commerce Agriculturist of the Year in 1994 and was honored with the Distinguished Service Award from the California Farm Bureau Federation in 1996 for his years of working on labor, water, and public utility issues.

Mr. Laub is survived by his wife, Clara; daughters, Debbie and son-in law Ray Jacobsen, Diane Tavares and Donna Laub; son, David Laub; grandchildren, Ryan Jacobsen and his wife Ashley, Megan Jacobsen, Brandon Jacobsen, Jason Allred and his wife Beth, Jared Allred and Dustin Laub; and three great-grandchildren.

Madam Speaker, I rise today to posthumously honor Don Laub. I invite my colleagues to join me in honoring his life and wishing the best for his family.

EARMARK DECLARATION

HON. DENNY REHBERG

OF MONTANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. REHBERG. Madam Speaker, pursuant to the Republican leadership standards on earmarks, I am submitting the following information for publication regarding earmarks I received as part of H.R. 2996—Department of the Interior, Environment, and Related Agencies Appropriations Act of 2010.

Requesting Member: Representative DENNY REHBERG

Bill Number: H.R. 2996

Account: STAG Water and Wastewater Infrastructure Project

Name and Address: Butte-Silver Bow Consolidated Government, 126 West Granite Street, Butte, Montana 59701

Description: Funding will be used to repair, restore and replace the City of Butte's drinking water system—a complex infrastructure to import water from across the Continental Divide and from the mountain creeks surrounding the city. This work is being done to accomplish an overall project goal of providing a safe, reliable and affordable drinking water to Butte citizens.

Requesting Member: Representative DENNY REHBERG

Bill Number: H.R. 2996

Account: STAG Water and Wastewater Infrastructure Project

Name and Address: City of Bozeman, 121 North Rouse Avenue, Bozeman, Montana 59771

Description: Funding will be used to replace the City's existing Water Treatment Plant, WTP, which is over 20 years old with a new larger capacity plant. The mechanized equipment and building structure will soon expire. In addition, rapid population growth has resulted in water demands that are already at the current WTP capacity during peak day use. To meet Bozeman's increasing water demand, the City will construct a 22 Million Gallon per Day, MGD, membrane water filtration plant.

Requesting Member: Representative DENNY REHBERG

Bill Number: H.R. 2996

Account: STAG Water and Wastewater Infrastructure Project

Name and Address: The City of Missoula, 435 Ryman Street, Missoula, Montana 59802.

Description: Funding will be used to upgrade the City of Missoula's Waste Water Treatment Facility for improved liquid waste treatment and disposal. The VVWTF is one of the primary methods of protecting Missoula's sole source water aquifer that provides clean drinking water for the greater Missoula area, and surface waters such as the Clark Fork River. This upgrade needs to be completed within the next two to five years to allow Missoula to continue meeting its Montana Pollution Discharge Elimination System permit.

Requesting Member: Representative DENNY REHBERG

Bill Number: H.R. 2996

Account: US Forest Service—Land Acquisition

Name and Address: The Rocky Mountain Elk Foundation, 2541 Stuart Street, Helena, Montana 59601.

Description: This funding would be used for the U.S. Forest Service to acquire lands critical for providing access to Tenderfoot Creek and to several Forest service trails. In addition, trout from the Smith River use Tenderfoot Creek for spawning. The volume of flow and cold water from the Tenderfoot are critical to the Smith River, particularly in the low flow summer months. Several hundred elk use the Tenderfoot country and it provides winter range for mule deer. Many other wildlife use this drainage which has an elevation drop of 3200 feet from sub-alpine mountains to grass meadows to riparian areas. There is habitat restoration potential if these lands are acquired. Forest Service Management efficiency would also be enhanced.

CONGRATULATING REAL SALT LAKE ON THEIR MLS CHAMPIONSHIP

HON. JASON CHAFFETZ

OF UTAH

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CHAFFETZ. Madam Speaker, we would like to recognize Real Salt Lake for their inspiring MLS Championship victory. Some people had all but lost hope that they would compete in the playoffs, but the playoffs were just the beginning of their Cinderella rise to the top. Beginning with their first win in the playoffs against defending champions Columbus Crew and ending with the final win over the star-studded LA Galaxy, Real Salt Lake proved themselves to be a championship-caliber team.

Rather than relying on a few star players, this team proved the power of teamwork and the value of believing in one another. Led by their first-time coach/former player Jason Kreis and Captain Kyle Beckerman, they validated to the world what they already knew. Never giving up, Real came from behind to win in a high pressure penalty kick. We would like to congratulate Real Salt Lake and thank them for bringing a championship home to Utah.

HONORING NSF INTERNATIONAL'S 65TH ANNIVERSARY

HON. JOHN D. DINGELL

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. DINGELL. Madam Speaker, I rise today to congratulate NSF International and thank them for the great work they have done over the last 65 years. Since 1944, when it was established at the University of Michigan's School of Public Health, in Ann Arbor, NSF International has gone on to reach innumerable achievements.

NSF International has established itself as a leader in the field of drinking water safety, food safety, indoor air, organic certification, toy safety, and many other areas of public health and safety. In 1984 NSF International opened its first office abroad in Brussels, Belgium. Just over 20 years later NSF International now maintains offices and laboratories across North America and Europe, as well as in South America, Africa, and Asia. I believe their selection as a Collaborating Centre on Food and Water Safety as well as Indoor Environment by the World Health Organization speaks to their outstanding international reputation in the field.

Most importantly, NSF International has protected an untold number of consumers over the last 65 years through their testing, certification, education, and other services. Consumer safety is critically important and is an issue I have worked diligently on during my career in the United States House of Representatives. Protecting consumers from dangerous products would not be possible without the role that independent, not-for-profit organizations, such as NSF International, play.

This role is particularly important with our increasingly global marketplace. As more and more products come to the United States from abroad, extra steps must be taken to ensure American consumers are receiving the safest products possible. NSF International has played a key role in certifying products worldwide as well as writing internationally recognized standards. I thank them for the very important work they do.

I am proud to say that an organization with such an outstanding reputation domestically and internationally, and an organization with so many years of experience and achievement, was founded and is still headquartered in the great city of Ann Arbor, Michigan. It is organizations such as NSF International that make Michigan, and Michigan's 15th District, such a wonderful place and make me so proud to represent the area. I ask all my colleagues to join me in congratulating and thanking NSF International.

RECOGNIZING DAN CALLAHAN

HON. JERRY F. COSTELLO

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. COSTELLO. Madam Speaker, I rise today to ask my colleagues to join me in honoring one of my constituents, Dan Callahan, the head baseball coach at Southern Illinois University, and congratulate him on being awarded the Missouri Valley Conference's Most Courageous Award. This award honors those that have demonstrated unusual courage in the face of personal illness, adversity, or tragedy.

In his 16 years at SIU, Coach Callahan has contributed a great deal to the community. He is well-known and respected for not just his coaching skills, but also for his ability to inspire off of the field.

Three years ago, Coach Callahan was diagnosed with a very rare and very serious form of skin cancer. Despite undergoing treatment for the cancer, including surgery, Coach Callahan did not miss a game that season. Sadly, the cancer continued to grow. He faced more intense treatments, but was given hope when his oncologist recommended a new drug, Avastin, that can stop the spread of cancer and in some cases even shrink tumors. His

doctor tried it on him and it worked. However, his insurance company will not cover the cost of the drug that is keeping Dan Callahan alive.

He now has no choice regarding his treatment. He cannot afford what his doctor recommends and his insurance company will not cover it. He cannot get new insurance because of his history of cancer. This could happen to anyone.

His experiences are well documented in the St. Louis Post-Dispatch editorial that I would like added to the RECORD.

I wanted to make my colleagues aware of Dan's situation, congratulate him on his award, and wish him luck on the baseball field and especially in his recovery.

I submit an editorial from the St. Louis Post-Dispatch which was published November 6, 2009, relating to Dan Callahan's case.

COSTLY NEW DRUGS: A CRISIS FOR ONE FAMILY, A QUANDRY FOR U.S.

It began with a little black spot on Dan Callahan's lower lip. He didn't think it was anything to worry about. His doctor thought it was cancer.

The doctor was right.

It was neurotropic melanoma, a very rare—and very serious—type of skin cancer. Even after the little black spot was successfully removed six years ago, the cancer remained. And grew.

Last October, doctors at Barnes-Jewish Hospital began chemotherapy. They used a three-drug cocktail that indudes Avastin, one of a new generation of anti-cancer drugs. It works by blocking the formation of new blood vessels that feed and nourish tumors. Until just a few years ago, that kind of treatment was the stuff of science fiction.

For patients battling advanced cancer like Mr. Callahan, Avastin represents something as important as food or water: It is time in a vial.

This is what it cost: $13,686 per treatment. Mr. Callahan has received six so far. Total price: $82,116.

What's it worth? That's a much more difficult question.

About 10 miles up Illinois Route 13 east of Carbondale, Ill.—just above Crab Orchard Lake—lies a little town called Carterville. Mr. Callahan lives there with his wife, Stacy, and two daughters. Alexa, 18, is a student at the University of Illinois. Carty, 13, is in eighth grade.

You can buy a three-bedroom house in Carterville for about what Mr. Callahan's six infusions of Avastin cost. For about $100,000—the price of a year's treatment—you can get a dassic bungalow with a screened-in front porch, a long, shaded driveway and a two-bedroom cottage out back.

The Callahans both have good jobs and health insurance. Stacy works for a credit union. Dan is the head baseball coach at Southern Illinois University-Carbondale.

Their insurance paid for minor surgery to remove the little black spot from Mr. Callahan's lip. It paid for more extensive surgery in April, when doctors removed the right side of his jaw trying to stop the cancer's spread.

And it paid for yet another operation in September, when infection forced doctors to remove the prosthetic device they had implanted to replace his missing jaw.

But Mr. Callahan's insurance won't pay for Avastin.

The U.S. Food and Drug Administietion approved Avastin in 2004 to treat advanced colon cancer. Since then, it has been cleared for breast and lung cancers. Doctors are free to prescribe it for other forms of cancer. It is being tried on 30 other cancers, induding melanoma, but those uses technically are experimental.

Because many experimental treatments don't pan out, insurance companies in Illinois and most other states do not have to cover them. The major health care bills pending in Congress would not change that. For the first time, they allow generic versions of so-called biologic drugs like Avastin. But only after 12 years on the market, twice as long as other drugs.

For thousands of Americans, including the Callahans, that means many newer cancer drugs are out of reach. "When they told me the insurance wouldn't cover it, I said well just pay for it ourselves," Mrs. Callahan recalled last week. "Then they told me how much it cost."

The Callahans scraped together about $27,000 from friends and family members—enough to cover the cost of two treatments. They got a grant from Washington University to pay for four more. They are appealing the insurance company denial, so far without success. The grant expires at the end of December. After that?

Mrs. Callahan paused. "We don't know what we'll do."

Despite the high prices and higher hopes, Avastin has been shown to extend cancer patients' lives by only a few months.

Many patients and oncologists say it improves quality of life and shrinks tumors—or at least prevents them from growing.

Mr. Callahan's doctor said it has slowed the progression of his tumor.

That is no small achievement for patients with advanced cancer. But stopping the progression of cancer is not the same as curing it. A study published in January followed 53 melanoma patients who received Avastin. After 18 months, 13 were alive.

The company that makes Avastin, Genentech, spent about $2.25 billion to develop it. It spends another $1 billion a year testing it on new cancers. Avastin has been a blockbuster success. It had $2.7 billion in sales in the United States last year and more than $3.5 billion worldwide.

Genentech says Avastin's price reflects its value. Another cancer drug, Erbitus, costs even more, and it hasn't been shown to extend life at all. In March, Swiss pharmaceutical giant Roche agreed to buy Genentech for $46.8 billion. Avastin is a big reason the company was sold for so much money.

Not everyone agrees that Avastin is worth the price. Experts in Britain recommended against covering it. A drug that costs as much as a house and extends life for just a few months isn't worth the money, they said.

Some people go to pieces when they find out they've got cancer. Mr. Callahan went to work.

He has coached the Salukis for 14 years. "I try to carry on like I'm going to be here next week and next month," he said. "I think about coaching in 2010, about going to my daughters' college graduations and their weddings."

His 2009 team finished with 24 wins and 28 losses. Coach Callahan was too sick to travel to away games. But he was in the dugout each time the Salukis took the field in Carbondale.

From the beginning, the Callahans have made it a point not to ask doctors about his prognosis. "We don't want to know it, and we don't want our kids to know it," Mrs. Callahan said. "We just wanted to live our lives as normally as possible, with no time line."

Coach Callahan thinks it is inherently unfair that patients can be denied treatment simply because of a drug's high price. It's like giving one team an extra at-bat.

But the game is not over. Even with two outs in the ninth inning, even with two strikes against you, there's hope. And a question: Who sets the price of victory?

ON THE OCCASION OF THE RETIREMENT OF LIBRARIAN GEORGE KLINE

HON. MARCY KAPTUR

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Ms. KAPTUR. Madam Speaker, I rise today to recognize the life's work of George Kline, a librarian in our Federal Depository Library Program. Mr. Kline, with long and distinguished service in providing U.S. Government information to the citizens of the 9th District of Ohio has retired after providing U.S. Government information to the citizens since he started as government documents librarian in 1971.

In 1981 he became coordinator for the library's federal depository collection, which is one of the more than 1200 Congressionally designated Federal Depository Libraries nationwide, and one of the four depository libraries serving our region. Mr. Kline has been an active and dedicated promoter of the use of government information, and has served with distinction on numerous committees and as president of the Government Documents Round Table of Ohio, which recently honored him with its "Clyde" award for achievement and service.

Daniel Webster said, "Let us develop the resources of our land, call forth its powers, build up its institutions, promote all its great interests, and see whether we also, in our day and generation, may not perform something worthy to be remembered." In his nearly forty year career in service to our nation's government as he carefully kept record of our documents and made them available to all, George Kline has upheld this ideal.

We wish Mr. Kline a retirement much deserved, traveling this new road of his life's journey with those for whom he cares and doing that which he enjoys.

HONORING ST. JAMES EPISCOPAL DAY SCHOOL FOR HAVING BEEN DESIGNATED AS A "BLUE RIBBON SCHOOL OF EXCELLENCE" BY THE UNITED STATES DEPARTMENT OF EDUCATION

HON. BILL CASSIDY

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CASSIDY. Madam Speaker, I rise today in honor of St. James Episcopal Day School, located in the City of Baton Rouge in Louisiana's Sixth Congressional District. It gives me great pleasure to announce that St. James Episcopal Day School has been designated as a "Blue Ribbon School of Excellence" by the United States Department of Education.

The administration, faculty, staff, students, and parents of St. James Episcopal Day School have successfully demonstrated academic excellence in standardized test scores, curriculum, technology, instructional methods, professional development, and school leadership.

St. James Episcopal Day School is a Pre-Kindergarten through Fifth grade elementary school that was founded in 1948. At St. James, students are challenged to reach their full potential; to be active in faith; to be responsible for their learning; and to be accountable for their actions, thus preparing these students to be leaders in facing the demands of their future. With this honor, I can only hope that the school's next sixty years will be even more successful than its first.

CELEBRATING THE 60TH ANNIVERSARY OF HOPKINS COUNTY MEMORIAL HOSPITAL

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. HALL of Texas. Madam Speaker, I rise today to commemorate Hopkins County Memorial Hospital, which just celebrated its 60th Anniversary on September 3, 2009. Hopkins County Memorial Hospital holds a rich history of service and dedication to the citizens of Hopkins County, providing excellence in medical care through its state-of-the-art technology and professionally trained, capable staff.

Original proposals for a hospital bond date back to the 1920's, but it wasn't until 1945 that public sentiment supported community members' proposal. Voters approved funds for a county hospital by a 3-1 majority, and plans for an accessible, competitive hospital were underway. With federal funding approved by 1948, the job was awarded to W.R. McKinney and Sons of Greenville, Texas, and construction began November 1, 1948. By June of the next year, Hopkins County Memorial Hospital was stocked with equipment that would make it one of the most modern in the region—a modern operating table, Heidbrink gas machines for anesthesia, a battery-operated emergency light for backup power during surgery, as well as a staff of about 30 skilled professionals. The hospital held its open house on September 4, and opened the next day. The hospital's most recent renovation includes a new emergency department, lobby, and conversion of all rooms to private rooms.

In January of 2009, the Advanced Heart Care at Memorial cardiac catheterization lab opened. The latest renovations include 27,959 new square feet, 39,098 renovated square feet, a new emergency department, a new front lobby and front desk area, a new and expanded Johnnie Masters Gift Shop, and conversion of all rooms into private rooms.

Hopkins County Memorial Hospital is a testament to the community's ability to band together in pursuit of the common good. Without the collaboration of thought, energy, and hard work by so many people, Hopkins County Memorial Hospital would not have become the success it is today. Madam Speaker, I ask those present today to join me in celebrating Hopkins County Memorial Hospital in its service and success over the past 60 years, and in wishing it many blessings in the years to come.

IN RECOGNITION OF WARSAW, MISSOURI

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. SKELTON. Madam Speaker, let me take this means to acknowledge Warsaw, Missouri, and the efforts of the Parks and Recreation Department to turn this beautiful city into Missouri's most bike-friendly community. Already a destination city for Americans seeking to enjoy Missouri's two largest lakes, Warsaw is working to become a model city for healthy living.

Under the leadership of City Administrator Randy Pogue and Parks and Recreation Director Mac Vorce, Warsaw plans to build a network of 15 to 20 miles of trails that radiate from the city center like the spokes of a wheel. These trails will connect the major area attractions and allow the residents of Warsaw to travel by bicycle to school and work. By building this impressive network of trails, Warsaw is creating a culture of healthy living. Pogue and Vorce hope that these trails will inspire Missourians to get out of the house, put down the television remote, and enjoy the breathtaking beauty of the Fourth District of Missouri.

What began as a dream eight years ago is now close to becoming a reality due to the hard work of Pogue, Vorce, and their visionary team of engineers and staff members. After this House passed the American Recovery and Reinvestment Act in February of this year, Warsaw applied for and received two grants to fund the renovation of Steamboat Landing and the surrounding area. This federal stimulus money, coupled with "handshake funds" from the Corps of Engineers, will allow Warsaw to finish this project and provide greater access to the beauty of this city.

Madam Speaker, Warsaw, which is situated in the heart of the Fourth District, is blessed with the God-given beauty of its natural surroundings. I trust that my fellow members of the House will join me in recognizing Warsaw as a model for healthy living and the promotion of the great outdoors.

EARMARK DECLARATION

HON. BILL POSEY

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. POSEY. Madam Speaker, pursuant to the Republican Leadership standards on earmarks as well as in accordance with Clause 9 of rule XXI, I am submitting the following information regarding earmarks for my Congressional District as a part of H.R. 2996, the Interior and Environment Appropriations Act for Fiscal Year 2010.

Requesting Member: Congressman BILL POSEY (along with Senators Mel Martinez and BILL NELSON)

Project Funding Amount $300,000

Bill Number: H.R. 2996

Account: STAG Water and Wastewater Infrastructure Project

Legal Name of Requesting Entity: St. Johns River Water Management District

Address of Requesting Entity: St. Johns River Water Management District, 525 Community College Pkwy, Palm Bay, Florida.

Description of Request: This funding will be provided to the St. Johns River Water Management District for the East-Central Florida Integrated Water Resources Project to increase enhance water quality and increase the overall supply of water available for use as potable water.

Consistent with Republican Leadership's policy on earmarks, I hereby certify that to the best of my knowledge this request (1) is not directed to any entity or program that will be named after a sitting Member of Congress; (2) is not intended to be used by an entity to secure funds for entities unless the use of the funding is consistent with the specified purpose of the earmark; and (3) meets or exceeds all statutory requirements for matching funds where applicable.

HONORING THE LIFE OF JUDGE FLOYD A. SHUMPERT

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. HALL of Texas. Madam Speaker, I rise today in honor of the life of Judge Floyd A. Shumpert, a public servant and fellow veteran, who passed away on July 17, 2009 at the age of 92. Judge Shumpert was born on March 21, 1917 to A.T. and Edna Shumpert in Kaufman County, Texas.

During World War II, Mr. Shumpert served his country in the 8th Infantry Division, 28th Infantry Regiment, 2nd Battalion of the United States Army, where, in the Hurtgen Forest in Germany, he suffered a severe injury when he stepped on a land mine. This injury required the amputation of his lower leg. For his courage and dedication to the U.S. Army, Mr. Shumpert was awarded both the Silver Star and Purple Heart.

In 1945 Mr. Shumpert retired as a Major from the U.S. Army and returned to his home in Kaufman County, serving as County Clerk for four years. Upon earning his law degree from Baylor University, Judge Shumpert next served as County Judge for eight years before transitioning into private law practice in Kaufman County, and moving to Terrell in 1978. In 1983, Judge Shumpert became the second Judge to ever serve from Kaufman County as an Associate Justice on the Texas Court of Appeals from the Fifth Judicial District in Dallas, Texas. On August 30, 1983, Judge Shumpert was presented with The Key to the City of Terrell, and in 1999, both he and his wife were honored with the Community Service Award.

Along with his service to his country and community, Judge Shumpert served in his

church as an Elder, both at Kaufman and Terrell Church of Christ.

He is survived by his wife of 63 years, Katherine Shumpert, their four children, and numerous grandchildren, great-grandchildren, nieces and nephews. He will be remembered fondly as a loving husband and devoted father, a patriot and public servant. Madam Speaker, I ask those here today to join me in honoring the life of this great American, Judge Floyd A. Shumpert.

ORDER ON GITMO AND YEMENI DETAINEES

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. WOLF. Madam Speaker, this Thursday the House Homeland Security Committee will hold an urgent hearing to investigate the admission of uninvited guests to the recent White House state dinner.

This security lapse certainly merits a full investigation, but it pales in comparison to the gross security lapse that the Obama Administration is committing in releasing scores of detainees from Guantanamo Bay to dangerously unstable countries—including Yemen, Afghanistan, and other al Qaeda strongholds.

Yet neither the Homeland Security Committee, nor any other committee, has seen fit to hold a single hearing on the release of these detainees.

In fact, the majority included a provision in FY2009 spending bills explicitly prohibiting the disclosure of any information to the American people.

If the American people knew who these detainees were, the acts of terror they have committed, or to which countries they were going to be released, they would never stand for it.

This is a dangerous precedent. Given that more than 74 former Guantanamo detainees have returned to active terrorism, there is real concern about the potential for these remaining detainees to return to a life of terror.

The American people deserve the facts. I encourage the public to visit the New York Times "Guantanamo Docket" Web site to review what scant information about these detainees was released by the previous administration.

I believe they will find these summaries deeply troubling.

This Congress has a responsibility and an obligation to the American people to hold hearings, request information, and work with the administration to have an open dialogue over transfer and release policies.

This has not happened. And 10 months after the administration issued an executive order to close Guantanamo, we have no more information about this than we did when the President took office.

Of the many unstable countries to which detainees may be sent, I am most concerned about the impending release of 26 detainees to Yemen—a growing haven for al Qaeda in the Persian Gulf.

It is my understanding that the administration is also preparing to release several other detainees to another country that anyone with a basic understanding of world affairs would agree is unacceptable. Unfortunately, this information has been classified.

Yemen is undoubtedly one of the most unstable countries in the world today—and the country where al Qaeda has reconstituted its operations over the last year.

The director of the National Counterterrorism Center, Michael Leiter, stated in an October Voice of America interview, "In Yemen, we have witnessed the reemergence of al-Qaida in the Arabian Peninsula and the possibility that that will become the base of operations for al-Qaida."

A number of former Guantanamo Bay detainees have returned to Yemen to launch terrorist attacks, including one just 2 months ago.

On October 13, Saudi police prevented an imminent suicide bomb attack as two al Qaeda terrorists slipped across the border from Yemen.

One of the would-be suicide bombers, Yousef Mohammed al Shihri, was a former Guantanamo detainee released in 2007 to Saudi Arabia. He quickly left Saudi Arabia for dangerously unstable Yemen where he rejoined al Qaeda.

In September 2008, another former Guantanamo Bay detainee, Said Ali al Shihri, helped orchestrate the terrorist attack on the U.S. embassy in Sanaa, Yemen, killing 10 guards and civilians.

Since that time, al Qaeda's posture in Yemen has grown stronger with the merger of the Saudi and Yemeni arms of al Qaeda into one group—al Qaeda in the Arabian Peninsula—with Yemen as its base for training and operations.

Yemen is also now home to radical cleric Anwar al-Aulaqi, who influenced alleged Fort Hood gunman Major Nidal M. Hasan and who U.S. intelligence believes to be a critical link in al Qaeda's efforts to radicalize Americans and Europeans.

I have repeatedly urged the President to halt the release of detainees to dangerously unstable countries. The consequences of such releases could cost American lives.

I implore this Congress to get serious about its oversight responsibility. The American people deserve better.

HONORING KEN DIEHL

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to honor Ken Diehl for his tremendous contributions to promoting housing and development in the Central Valley. Mr. Diehl is being honored at The Greater Yosemite Council Boy Scouts of America's annual distinguished citizens dinner on October 28, 2009 in Modesto, California.

Ken Diehl was born and raised in Beaver, Iowa. He attended Iowa Wesleyan College, where he excelled in athletics, lettering in basketball and baseball. He was also involved with the Blue Key (an honorary fraternity) the letter club and Lambda Chi Alpha fraternity. During college, he served in the United States Army and served overseas with the 100th Infantry Division. He spent over a year in combat, where he commanded a light machine gun section. For his efforts and achievements he was awarded the Bronze Star.

After World War II ended, Mr. Diehl made his way to California and settled in Patterson. He married Dorothy Sutherland and they had three children. Although he spent a great amount of time with his family, he was also very involved with professional and community organizations. Mr. Diehl served as the president of The Life Underwriter Association of Central California, chairman of the Heart Association for the Life Underwriters, member of the board of director of Toastmaster International. His mid-life career change to real estate offered him new opportunities to get involved. In his new position, Mr. Diehl was a developer and a builder for his own account; quickly realizing that a real estate investor was more profitable than a real estate agent. With the knowledge he acquired in the profession, he wrote a book, "Affordable Housing".

Mr. Diehl created The Diehl Company; over the years the company bought and sold hundreds of properties, built apartments, strip centers and several sub-divisions. He became very involved with the local Board of Realtors, chaired many committees and served as board president. He was a regional vice president for California Association of Realtors, CAR, where he represented seven local boards. He chaired various committees for CAR including; the Legislative Committee, the Board Presidents Committee, the Policy Committee, and the Regional Vice Presidents Committee. For his service, Mr. Diehl was awarded the Director for Life designation, a prestigious award that is given to only three realtors out of one hundred and fifty thousand.

He also served as the director of the million member National Association of Realtors, representing California for 6 years. He was a chairman of the Federally Assisted Code Enforcement program. With this program he and a group of others were able to save hundreds of homes that were on the verge of being deemed uninhabitable, and made them livable in the City of Modesto and the surrounding areas. Mr. Diehl spent many years as a director of the Community Housing Shelter Service. His primary focus while in the real estate industry was permanent housing for low to moderate income families.

Mr. Diehl is a 58 year member of the Elks Club number 1282 in Modesto. He chaired the United Way for Modesto, served as the director of the California Apartment Association, president of the Apartment Association of Central California and chaired many committees of the Sportsman of Stanislaus. Mr. Diehl served a 3 year term as president of the Yosemite Council of Boy Scouts.

Madam Speaker, I rise today to congratulate Ken Diehl for the impact that he has made on the real estate industry in the Central Valley and the State of California. I invite my colleagues to join me in wishing him continued success.

TRIBUTE TO THE LIFE OF MARINE SGT. JAY M. HOSKINS

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. HALL of Texas. Madam Speaker, I rise today to pay tribute to the life of United States Marine Sergeant Jay Michael Hoskins of Paris, TX, who died August 6, 2009 at the age of 24 in Farah Province, Afghanistan, due to complications from wounds received when his vehicle was hit by a roadside bomb.

Born January 26, 1985 in Paris, Texas to Michelle Sparks-Hoskins and Danny Hoskins, Jay Hoskins attended Aaron Parker Elementary, graduating from North Lamar High School in 2003. Throughout his youth, Sergeant Hoskins was active in baseball and football, and was an active member at Gospel Lighthouse in Powderly, Texas.

Following his graduation from North Lamar High School, Mr. Hoskins joined the United States Marine Corps, graduating from boot camp in San Diego, CA, as a Private 1st Class. In 2004, Sgt. Hoskins was deployed to Iraq where he fought in the Battle of Fallujah with the 1st Battalion, 3rd Marine Regiment. In 2005, he served seven months in the Tora Bora area in the Afghanistan mountains, for which he received the first of his Afghanistan Campaign medals. From 2005 to 2008, Sgt. Hoskins served as a member of a training cadre in infantry tactics for Marine Officers at Marine Corps Base, Quantico, VA, where he was able to employ his background as a martial arts black belt instructor. In 2009, Sgt. Hoskins was assigned to the 2nd Battalion, 3rd Marine Regiment III Marine Expeditionary Force, based out of Marine Corps Base, Kaneohe Bay, HI. He was deployed to Afghanistan in May, along with 1,000 other Marines to Helmand and Farah Provinces.

Sergeant Hoskins received many awards during his service as a United States Marine, including three combat ribbons, three sea service deployment ribbons, an Iraqi Campaign Medal, a Navy Marine Corps Achievement medal, a National Defense Service Medal, a Global War on Terror Service medal, a Good Conduct medal, and a Purple Heart, along with other pending medals, as well as rifle and pistol expert badges.

Known as an unwavering Christian devoted to his wife, his children, his family, and his country, Sergeant Hoskins lived his life with strong moral character, a strong faith, and a strong sense of service. He was loved and respected by those that knew him, and he will not be forgotten.

Sergeant Hoskins is survived by his wife Chandler McRae Hoskins of Paris, Texas, their son Tristen, and a second child due in January; his mother, Michelle Sparks Widner and step-father, Chris Widner; his father, Danny Hoskins; two sisters, Amber Young and Chelsie Hoskins; a brother, Cameron Widner; along with many aunts, uncles, nieces, nephews, and cousins.

Let us all continue to support our troops, and remember that freedom does come at a price. Madam Speaker, I ask those here today to join me in paying tribute to this American patriot, United States Marine Sergeant Jay Michael Hoskins.

RECOGNIZING THE ATHLETIC ACHIEVEMENTS OF THE BOYS SOCCER TEAM AT ST. FRANCIS DESALES HIGH SCHOOL

HON. PATRICK J. TIBERI

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TIBERI. Madam Speaker, I rise today to honor and pay tribute to the many outstanding athletic accomplishments achieved by students at St. Francis DeSales High School in Columbus, Ohio. DeSales High School is in my congressional district, and I am proud to recognize a school that excels in and out of the classroom. Most recently, this fine academic institution won the 2009 Ohio Division II Boys Soccer Team Championship.

As you know, this sort of achievement is earned only through many hours of practice, perspiration and strong commitment. The soccer team, led by Coach Domenic Romanelli finished its remarkable postseason without allowing a single goal. In the championship game, where they beat Bay Village High School 1–0, David Harper scored the lone goal, while keeper Chris Weisgarber finished his accomplished season with yet another shutout. This is the fourth title for the Stallion soccer team, and their first since 1997.

Everyone at DeSales should be extremely proud of this group of student-athletes and the standard they have established. Their accomplishments attest to the outstanding athletic department at DeSales High School. It is an honor to represent such a fine group of young people who have a strong dedication to each other, their sport and their academics. I know every member of this championship team will treasure the memories of their remarkable season and I commend them, and the greater DeSales community, for this truly great achievement.

CELEBRATING A CENTURY WITH THE CHATTANOOGA CHOO-CHOO

HON. ZACH WAMP

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. WAMP. Madam Speaker, I rise today a proud Chattanoogan with the distinct privilege of recognizing the 100th anniversary of the world famous Chattanooga Choo-Choo. As one of the city's oldest and most well-known attractions, the appeal of the Choo-Choo has stood the test of time reaching far beyond the banks of the Tennessee River.

History recalls a bitterly cold winter morning of December 1, 1909, as a crowd of several hundred gathered in the 1400 block of Market Street for the dedication of Chattanooga's ''Gateway''—Terminal Station, and the first train pulled into the station that day. At its pinnacle, the depot grew to serve nearly 50 passenger trains a day. Over the years, the Choo-Choo has welcomed many honored guests including three United States Presidents—Woodrow Wilson, Franklin Roosevelt, and my political role model, Theodore Roosevelt.

This Terminal Station's place in history was literally recorded by the Glenn Miller Orchestra in 1941 in the movie Sun Valley Serenade. Over the years, those words, ''Pardon me boy . . . is that the Chattanooga Choo-Choo,'' have actually become more well known than the movie that introduced the Choo-Choo to the world.

Even though the last train stopped on August 11, 1970, the Chattanooga Choo-Choo has thrived as a unique vacation and business gathering complex. As part of the Centennial Celebration, the Chattanooga Choo-Choo will join the prestigious group of Historic Hotels of America as one of HHA's two-hundred plus unique historic properties, hotels and inns across the country. This is a remarkable accomplishment for a facility that was spared the wrecking ball in 1973 by a group of local businessmen. In 1974, it was most appropriately added to the National Register of Historic Places. The Choo-Choo is a great testament to the citizens of Chattanooga who have remained committed to preserving our city's history for future generations to enjoy.

HONORING WILLIAM J. ROGERS

HON. MICHAEL H. MICHAUD

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. MICHAUD. Madam Speaker, I rise today to recognize the accomplishments of William J. Rogers of Auburn, ME.

Bill Rogers was a model American. He fought to protect our country, was an advocate for veterans and a leader in his community. Bill was born and grew up in Auburn, Maine. He attended Syracuse University, but his education was cut short when he enlisted in the Navy to fight in World War II. During flight school he was classmates with Major League Baseball Hall of Famer Ted Williams and Boston Red Sox great Johnny Pesky. He was roommates with the latter. Bill Rogers flew F6F Hellcat Fighter planes and Lockheed Ventura Submarine hunters in the pacific theatre. When he left the military after the war in 1946, his decorations included the Air Medal and the Presidential Unit Citation.

After the war, he became very active in veterans affairs. He was a founding member of American Legion Post 153 in Auburn, where he held several offices at both the local and state levels including adjutant, vice commander and department commander. On the national level, he was Maine's national executive committeeman, a member of the liaison committee to the National Public Relations Commission and national vice commander from 1965 to 1966. In 1976, he was elected national commander of the American Legion, the first national commander from the State of Maine. In his capacity as commander, he met with Panamanian dictator General Omar Torrijos and then testified before a congressional committee on the process of returning the canal back to Panama.

During his tenure as commander, he also met with Presidents Ford and Carter, Mexico's President Lopez Portillo, Ferdinand Marcos of the Philippines, and President Chieng of the Republic of China. During his year as national commander, he traveled more than 300,000 miles throughout the world representing millions of veterans in all 50 states and 17 countries.

Bill Rogers was a lifelong member of the American Legion, the Army/Navy Club, the Navy League of the U.S., the Veterans of Foreign Wars, and a trustee of the Maine Veterans' Home. Bill was named Auburn Maine's Citizen of the Year in 1995. The State of Maine and the American Legion are honoring his memory and hard work by dedicating American Legion Post 153 to him.

Madam Speaker, please join me in honoring William J. Rogers for his life of dedication and service to his community and his country.

RECOGNIZING THE CHAMPIONSHIP SEASON OF WORTHINGTON CHRISTIAN'S BOYS SOCCER TEAM

HON. PATRICK J. TIBERI

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TIBERI. Madam Speaker, it is with pleasure I congratulate the members of the Worthington Christian Boys Soccer team as they recently won the Division III State Championship.

The soccer team finished its remarkable season by beating Cuyahoga Valley Christian Academy 2–1 when junior midfielder, Trent Smith scored the winning goal in the first overtime. Led by Head Coach Dan Roads, the victory reflects his team's outstanding perseverance as they rebounded from losing in last year's final to win the 2009 championship.

After their winning 2009 season, the school can proudly display their second title in four years. With a history like that, I'm sure the future is bright for this fine soccer program.

This team has set a standard for future Worthington Christian athletes of all sports to strive toward. Everyone at this fine academic institution should be extremely proud of this group of student-athletes, and I'm proud to congratulate this team and join with them in celebrating the history made with their State Championship title.

IN RECOGNITION OF ANN COUSINEAU

HON. JOHN GARAMENDI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. GARAMENDI. Madam Speaker, Representative GEORGE MILLER, Representative MIKE THOMPSON, and I rise today in honor of Ann Cousineau, director of Solano County Library for the last 15 years. As her colleagues, friends and family gather together to celebrate the next chapter of her life, we ask all of our colleagues to join us in saluting this outstanding public servant and supporter of free and public libraries.

Transforming a library system that was teetering on the brink of a financial abyss into one of the premier libraries in the state, Ann did this not by "shushing" exuberant voices and library users, but by embracing the need to bring libraries into the 21st Century. Her legacy is a system of eight libraries that are central to lifelong learning in the communities that they serve, and in changing lives every day.

Ann Cousineau's hard work and vision benefit our next generation as well as generations to come. Three new libraries were built during her tenure. These new library buildings, along with renovations of the five existing buildings, are part of a 20-year facilities master plan to build and renovate libraries in the cities served by Solano County Library.

In 1999, Ann Cousineau served as co-chair of the statewide initiative for the successful passage of Proposition 14, a $350 million statewide library construction bond act. The Fairfield Cordelia Library, which opened in 2006, is one of 45 libraries throughout California that were built with the help of these funds. The next year the California Library Association named her Member of the Year for her achievements in promoting state legislation benefitting libraries.

During her time as director, the Library has developed a telephone assistance center and an award-winning Web site with 24/7 reference services. Streamlined operations, self service functions and a staff trained to handle everything from story-time to computer class are just a few examples of a "new way of doing business" pioneered by Solano County Library and adopted by other libraries throughout California.

Madam Speaker, we are truly honored to pay tribute to our friend and dedicated public servant. We ask all of our colleagues to join with us in wishing Ann continued success and happiness in all of her future endeavors.

CONGRATULATING GILBERT ALVAREZ

HON. HOWARD L. BERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. BERMAN. Madam Speaker, I rise today to congratulate Gilbert Alvarez on the occasion of his retirement from the Hansen Dam Aquatic Center. Mr. Alvarez is being honored by his many colleagues, family and friends for his dedicated career and longtime commitment to the City of Los Angeles.

A resident of Southern California, Gilbert began his career with the City of Los Angeles, at the Department of Recreation and Parks, in the intermittent part-time position of Recreation Assistant. During his eleven years as a part-time employee, he held a myriad of jobs in West Wilshire, El Sereno, Yosemite Pools, served as a supply manager for the Metro Region, and held the positions of Pool Lifeguard and Pool Manager.

On May 23, 1999 he was selected as the first Aquatic Facility Manager in the City and the first supervisor of the newly rebuilt Hansen Dam Aquatic Center.

During Gilbert's tenure as the Manager of the Hansen Dam Aquatic Center, his diligence and oversight of the pool helped detect a leak that would have cost taxpayers millions of dollars had it gone unnoticed.

Furthermore, Mr. Alvarez created the annual Hansen Dam Triathlon, which introduced an activity that has greatly benefitted the community. Among his other achievements during the past thirty-seven years of service to the City of Los Angeles, Gilbert revived the Open Water Junior Lifeguard Program at Hansen Dam and Cabrillo Beach.

I ask my colleagues to join me in wishing Gilbert Alvarez a happy and productive retirement.

RECOGNIZING THE ATHLETIC ACHIEVEMENTS OF KIM MY AND MY LINH LI AT ST. FRANCIS DESALES HIGH SCHOOL

HON. PATRICK J. TIBERI

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TIBERI. Madam Speaker, I rise today to recognize the outstanding accomplishments of two students at St. Francis DeSales High School in Columbus, Ohio. Kim My Li and My Linh Li, who not only are teammates, but sisters, recently won the Ohio Division II State Championship in tennis doubles.

The Li sisters won their championship tennis match in remarkable fashion, playing to a marathon score of 6–2 6–7(7–9), 6–2. This year's tournament was My Linh's first and Kim My's third, and through hours of practice, and true demonstration of teamwork, these sisters were able to end their season on a high note.

This accomplishment attests not only to the sisters' commendable display of commitment, but also to the outstanding athletic department at DeSales High School. I'm proud to congratulate Kim My and My Linh and join with them in celebrating their historic State Championship title!

A TRIBUTE TO MS. JAVANNI AGARD

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Javanni Agard, born July 15, 1991 to Valencia Thorne and Darrelle Agard.

Javanni is a graduate of the Urban Assembly School for Law and Justice. This small setting has worked to her advantage making it easy to obtain exceptional grades and learn how to be professional in the business world. During her sophomore year of high school, she was given the opportunity to participate in an internship at The Brooklyn District Attorney's Office. She worked as an intern for paralegals, assisting them with paperwork, filing, copying and other forms of clerical work.

However, this internship opened her eyes to things she had only seen on television. She was able to visit the Supereme Court and view cases, learing what it was like to be a lawyer in the Courtroom.

During her junior year of high school, she was assigned to help out in the Red Hook Senior Home and at an organization called Furnish a Future. Taking part in these organizations helped her to understand what it meant to help someone else, that it's not always about self, but helping those in need.

Javanni is a member of Berean Baptist Church in Brooklyn, New York, where Rev. Dr. Arlee Griffin, Jr. is her Pastor. She participated in the Ministry of Sacred Dance and the Girl Scouts.

Javanni currently attends John Jay College of Criminal Justice as a first year student. During her college experience, she hopes to participate in internships and possibly take part in study abroad. After her success at John Jay, she will attend Law School.

Madam Speaker, I urge my colleagues to join me in recognizing Ms. Javanni Agard.

IN RECOGNITION OF SAM HAMRA OF SPRINGFIELD, MISSOURI

HON. ROY BLUNT

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. BLUNT. Madam Speaker, I rise today to pay tribute to Sam and June Hamra of Springfield, Missouri. An attorney by professional training, Sam Hamra has been a community and political activist for many years. Sam and June are also philanthropists and civic and community leaders in many worthy causes.

In late October, Sam and June were honored by Wendy's International with the R. David Thomas Founder's Award. The Founder's Award is Wendy's International's highest honor and is presented annually to its outstanding franchisee who best embodies the common-sense business values of Wendy's founder Dave Thomas.

In being honored with Wendy's top franchisee recognition, Hamra and his restaurants were cited for their excellent operations, strong marketing plans, and the value placed on employee development. Another aspect of the award is the support the Hamras give to local civic and charitable activities. In recent years, Hamra has directed the modernization of all 28 restaurants in their Wendy's of Missouri group. Trademarks of Hamra's restaurants are strong management, low employee turnover and increased productivity and store sales. These are not just the restaurant's characteristics, but also reflect the owner's outlook and business acumen.

Sam opened his first Wendy's restaurant on March 15, 1976, in Springfield, Missouri, near the intersection of Sunshine & Campbell. The 206th Wendy's restaurant in the United States, it's still in operation today. His Rolla restaurant was selected as one of the top 14 Wendy's restaurants out of 6,600 in the world for an unprecedented two consecutive years.

Wendy's of Missouri has eight locations in Springfield, three in Branson, two in Jefferson City and Columbia, and locations in Bolivar, Ozark, Nixa, Lebanon, St. Robert, Rolla, Fulton, Lake Ozark, Clinton, Republic, Sedalia, Harrisonville, and Warrensburg.

Congratulations to Sam and June for a job well done.

–IN HONOR OF ALBERT CASWELL AND HIS INSPIRATIONAL POETIC TRIBUTE TO STAFF SGT. EARL GRANVILLE, OF SCRANTON, PENNSYLVANIA, WHO WAS WOUNDED IN ACTION IN THE DEFENSE OF THE UNITED STATES OF AMERICA

HON. PAUL E. KANJORSKI

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. KANJORSKI. Madam Speaker, I rise today to ask you and my esteemed colleagues in the House of Representatives to pay tribute to Mr. Albert Caswell, of Street, Maryland, who is employed as a U.S. Capitol tour guide, and SSG Earl Granville, of Scranton, Pennsylvania, a member of the U.S. Army 109th Field Artillery, Pennsylvania National Guard, who was severely wounded during deployment in Afghanistan.

Mr. Caswell met Sergeant Granville while doing volunteer work at Walter Reed Army Hospital. Mr. Caswell was deeply impressed with Sergeant Granville's devotion to military duty and subsequently wrote a poem to express his appreciation for the sacrifices citizens like Sergeant Granville make in the defense of our Nation and the freedoms we hold dear.

Madam Speaker, please join me in congratulating Mr. Caswell and Sergeant Granville. As a soldier, Sergeant Granville represents our Nation's finest and most courageous citizens, willing to venture into harm's way to protect this nation and ensure that our liberties survive and flourish. And Mr. Caswell represents the gratitude that we all share for our men and women in uniform. May we all be inspired by these two fine Americans.

The poem that Mr. Caswell wrote follows:

STANDING GUARD—IN HONOR OF SSG EARL GRANVILLE, AN AMERICAN HERO, THE PENNSYLVANIA NATIONAL GUARD, THE UNITED STATES ARMY, 28TH ID–1/109TH/INF–103RDAR

(By Albert Carey Caswell)

Standing Guard! Standing Strong!
Standing Hard! Standing long!
On Guard!
A band of brothers another world away, such burdens bear . . .
As into the face of death, they so stare!
As they Stand Guard!
Stand Strong!
As the word Hero to them so belongs . . .
And if ever I have a son, I but pray he could be like this fine one . . .
Who will stand?
And who will fall?
And who will but give their all?
Who will give up their fine lives, and strong arms and legs so freedom can thrive?
For that's only how freedom is made!
By only all those who stay, And Stand Guard!
For as long as our nation has been . . .
There have always been, such splendid men . . .
Men, who must Stand Guard!
Men of honor, with hearts of courage full . . . of steel over evil rule . . .
Men such as Earl Granville, from that great state of Pennsylvania so true . . .
Men of such faith, who death so view . . .
Who for all of us go off to war . . .
But, for this our Country Tis of Thee . . . such burdens bore!
All for our freedom, to insure . . .
As They Stand Guard . . .
With but their fine hearts of courage, pure!
Standing strong, all the more . . .
Who but with only their most heroic hearts . . .
Right all of those wrongs, as is their part!
And all of the ones, who come back home . . .
Without arms and legs, as to them such beautiful hearts belong . . .
As we Witness their most heroic songs.
Teaching us all how faith stands strong.
As up from the ashes they do rise . . .
With but tears of valor all in their eyes . . .
As but the full measure of the word hero comprised . . .
Standing Strong, while blessing all our lives . . .
As they reach us . . . as they teach us . . .
As to great heights their heart's beseech us . . .
As on this day Earl, you so teach us . . .
Even the Angels up in heaven, Wipe the tears from their eyes . . .
For in life, what do we so stand for?
And for what, will we so rise?
To face death, when all upon us so much relies . . .
While, Standing Guard all in time . . .
So but our children might but find a better life realized . . .
All so they will not have to fight. . . .
All so that they might sleep peacefully this night . . .
Because, somewhere out there . . .

A TRIBUTE TO MARK E. EVANS

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Mark E. Evans who was born in Brent, England on September 5, 1968. At the age of twelve, he and his siblings migrated to the United States to live with his parents in Queens Village, New York. He attended PS 109 Junior High School and Newtown High School.

Following his High School graduation in 1987, Mr. Evans enlisted in the United States Army. He completed Basic Training at Fort Leonardwood, Missouri, as well as his advance military occupational skill training as an Interior Electrician. While on active duty, he was stationed in Fort Campbell, Kentucky, South Korea and Fort McClellan, Alabama. He also served six months in the Middle East during Operations Desert Shield and Desert Storm.

In August 1991, after spending four years on active duty, Mark returned home to Queens Village and attended York College in Queens while maintaining his attachment to the Military

as a member of the Army Reserve. He met his wife Sonia through a mutual friend in December 1992 and on August 17, 1997 they were married.

Mark worked full time, attended college and was a Weekend Warrior with the Army Reserve. His hard work and dedication paid off upon receipt of a Bachelor's Degree in Psychology in 1998. In 1999, Mark started the process of becoming a New York City Police Officer. By October 2000, he graduated from the New York City Police Academy, and he was assigned to the 30th Precinct in Harlem. Following 9/11, he was transferred to Manhattan Traffic Task Force, where he would better service the department by effectively managing ground zero. To this day, he continues to patrol the streets of Manhattan.

In his continuation of military service, he served with the 344th Combat Support Hospital in Flushing, New York and 445th Quartermaster Company in Trenton, New Jersey. He was deployed to Iraq where he served one year in support of Operation Iraqi Freedom. He is currently serving with the 411th Civil Affairs Battalion in Danbury, Connecticut as the First Sergeant for Headquarters Company. He is expected to deploy to Afghanistan in 2010.

With twenty-two years of military service and ten years as a New York City Police Officer, he is committed to improving our society by serving our nation both domestically and abroad. His dedication to duty, as a father of two (Gordan and Nyah), husband, Soldier and Police Officer is unwavering.

Madam Speaker, I urge my colleagues to join me in recognizing Mr. Mark E. Evans.

THE ENVIRONMENTAL HORMONE DISRUPTION ACT AND THE WOMEN'S ENVIRONMENTAL HEALTH AND DISEASE PREVENTION ACT

HON. LOUISE McINTOSH SLAUGHTER

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Ms. SLAUGHTER. Madam Speaker, today, I'm proud to reintroduce the Environmental Hormone Disruption Act and the Women's Environmental Health and Disease Prevention Act.

Consider for a moment that a women's lifetime risk of breast cancer is 1 in 7 today, compared to 1 in 22 in the 1940s—over half of the cases are unexplained. And, over the last 30 years, the U.S. has seen a steep rise in the occurrence of childhood cancers, testicular cancer, juvenile diabetes, attention deficit disorder, learning disabilities, thyroid disorders, cognitive impairment, and autoimmune disorders. Autism cases alone rose 210 percent between 1987 and 1998.

About 100,000 chemicals are registered for use in the United States. However, 90 percent of these have never been fully tested for their impact on human health. Scientists have found that exposure to these synthetic chemicals disrupts hormone function and contributes to increased incidences of diseases. We already know the tragic impact that diethylstilbestrol, or DES, has had on the daughters of women who took this anti-miscarriage drug prescribed until 1971.

While the evidence is mounting that there is an association between these chemicals and hormone disruption, research remains limited, particularly on the impact on women and on how long-term, low-dose exposure to environmental pollutants impacts children at critical stages of development.

A few years ago, I participated in a study conducted by the Environmental Working Group to find out what toxic substances I, in particular, and Americans in general, have been exposed to throughout our lives. My stunning test results showed literally hundreds of chemicals pumping through my vital organs every day. These chemicals include PCBs that were banned decades ago, as well as chemicals like Teflon that are currently under federal investigation.

The study also tested ten newborn babies and found that on average, each one had some 200 chemicals in their blood at the time of birth. The fact that we have children coming into this world already polluted and at the same time, do not know what the effects of that pollution will be on their mental and physical development, is both bad policy and immoral. We must test chemicals before they go onto the market, not after they get into our bloodstreams.

For several years, I have called on Congress to enact legislation that would allow NIH to expand its research on the impact of these chemical pollutants on the health of women and children.

Once again, I am introducing two important bills that I hope will advance this research—the Environmental Hormone Disruption Act and the Women's Environmental Health and Disease Prevention Act. The Environmental Hormone Disruption Act authorizes the National Institute of Environmental Health Sciences, NIEHS, to conduct a comprehensive program to research and educate the public on the health effects of hormone-disrupting chemicals. The Women's Environmental Health and Disease Prevention Act authorizes the NIEHS to establish multidisciplinary research centers to investigate how environmental factors may be related to women's health and disease prevention.

Increased investments in research now could prevent and treat a broad range of diseases and disorders in future generations. I urge my colleagues to support these bills today.

MARSHAL J.C. RAFFETY

HON. SHELLEY MOORE CAPITO

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mrs. CAPITO. Madam Speaker, I rise today to inform my colleagues of the pending retirement of Marshal J.C. Raffety from not only his position as United States Marshal for the Northern District of West Virginia, but from an exceptional career in law enforcement that spans the past five decades.

Specifically, on January 1, 2010, after nearly eight years of service as U.S. Marshal, J.C. will graciously relinquish his duties and begin his life anew as a private citizen of the State of West Virginia. Raffety will leave this post with an outstanding legacy of achievement. During his tenure, Marshal Raffety supported the establishment of the Northern District's Mountain State Fugitive Task Force, which has components located in Clarksburg, Martinsburg, and Wheeling, West Virginia. This Task Force, comprised of local, State and Federal law enforcement agencies, is responsible for the apprehension of violent fugitive offenders. In addition, this Task Force participates in Operation FALCON, Federal And Local Cops Organized Nationally, an annual, nationwide fugitive round-up that relies on the combined efforts of Federal, State, and local law enforcement agencies and departments. Under Raffety's capable leadership, the Northern District of West Virginia's efforts involving Operation FALCON netted the arrests of hundreds of fugitives from justice, and stands today as a shining example of effective interagency cooperation and coordination. Additionally, very early into his appointment, Marshal Raffety was selected to serve on the then-USMS Director's Advisory Committee, a testament to his decades of training and experience in the Federal, State, and local law enforcement communities.

President George W. Bush appointed Raffety to the position of U.S. Marshal on March 13, 2002. Prior to that, J.C. served as the Chief of Police for the city of Buckhannon, West Virginia, for approximately two years. During his tenure, Chief Raffety promoted the established concept of community policing and instituted meaningful administrative reforms. Additionally, he strengthened ties with the students and administrators of West Virginia Wesleyan College and enhanced the Neighborhood Watch Program in Buckhannon.

Before his service as Chief of Police in Buckhannon, Raffety spent a remarkable 32-year career with the Federal Bureau of Investigation, FBI, which began in 1966 when, following high school graduation at the age of 18, he relocated to Washington, DC, and began working for the FBI as a GS–2 Clerk. While employed at the FBI, J.C. attended night school full-time towards the attainment of his college degree. After a 2-year break in service to complete his undergraduate education, Raffety was reinstated to the FBI in 1970, and attended the FBI Academy at Quantico, Virginia. Early in his career, J.C. served as an FBI Special Agent in Philadelphia, Pittsburgh, and Erie, Pennsylvania, where his investigative efforts focused on organized crime, racketeering, and public corruption. He later served as a Supervisory Special Agent at FBI Headquarters in Washington, DC, assigned to the Criminal Investigative Division, Organized Crime Section. Subsequently, in 1983, Raffety was assigned to the Clarksburg, West Virginia Resident Agency, and later served as Supervisory Senior Resident Agent for that office, a position he held until his retirement in 2000. Among the highlights of his impressive record in West Virginia, J.C. served as the lead case agent in the 1995–1997 West Virginia Mountaineer Militia investigation, which resulted in the convictions of militia members engaged in a domestic terrorism plot targeting the FBI's Criminal Justice Information Services, CJIS, Center in Clarksburg, as well as the Internal Revenue

Service, IRS, and Bureau of Alcohol, Tobacco, Firearms, and Explosives, BATF, facilities in West Virginia's eastern panhandle.

I am pleased to have had this opportunity to call to the attention of my colleagues the extraordinary accomplishments of J.C. Raffety. I admire his idealism and lifelong commitment to his community, State, and country. I join his wife, Cindy, his two children and two grandchildren, and the grateful citizens of West Virginia in thanking J.C. for his life of service, and in wishing him continued success as he enters this new chapter of his life. Congratulations, Marshal Raffety, on a job well done!

A TRIBUTE TO MRS. SAJDA MUSAWWIR LADNER

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Sajda Musawwir Ladner, an artist, community activist and educator.

She is one of the founders as well as the Artistic/Executive Director of Universal Temple of the Arts (UTA). UTA is a non-profit, community based organization focusing on creative development, education, multicultural and entrepreneurial programs, that has served Staten Island since the late 1960's. These programs are held both on and off site and include classes in the New York City Department of Education system.

She has worked intensively with young people as a Cultural Enrichment Specialist with organizations such as the YMCA, the Comprehensive Employment and Training Act (CETA) Youth Employment Program, Neighborhood Youth Corp, and the Board of Education. Presently, Mrs. Ladner is on the staff of Doing Art Together at the Metropolitan Museum of Art and the Staten Island Museum as an Art Educator.

Sajda Musawwir Ladner is a Fashion/costume designer and owner of Saadia Fine Art Fashions. She has created costumes for many dance companies including Alvin Ailey II, the Fred Benjamin Dance Company, Eleo Pomare Dance Company, The Mary Anthony Dance Theater and the Nanette Bearden Contemporary Dance Theatre where she was resident costume designer and wardroom mistress.

Mrs. Ladner is a professional dancer having had the honor of being asked to perform for President Nelson Mandela of South Africa when he visited New York shortly after his release from prison. She specializes in Jazz Improvisation and has worked with Barrie Harris, Reggie Workman and the Sun Ra Arkestra. Mrs. Ladner is a member of the On the Rock DanceTheatre based on Staten Island.

Mrs. Ladner serves on the Board of Directors of the Northfield Development Corporation and the Children's Harbor Montessori School. She is a member of the National Council of Negro Women, the NAACP and Staten Island Peach Action.

Mrs. Ladner has an administrative background in business and law. She represented Staten Island at the 13th Annual Harlem Mother's Day Parade. The parade honors mothers who work in the community. She has been the recipient of many awards for community service. Sajda Musawwir Ladner is the wife of Edward Ladner and mother of five daughters.

Madam Speaker, I urge my colleagues to join me in recognizing Mrs. Sajda Musawwir Ladner.

HONORING MORTON BLACKWELL

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CANTOR. Madam Speaker, I rise today to honor a true champion of the conservative movement, Morton Blackwell, who just celebrated his 70th birthday.

I have known Morton since the days when he attended meetings in my parents' living room, planning how we would advance the conservative cause in Virginia. We realized the fruits of those talks during the Reagan Revolution in the 1980s, when Virginia—and Morton Blackwell—led the way.

Morton's life thus far has been a testament to the kind of man he is. There is a list of rules that Morton has developed, entitled the Laws of the Public Policy Process, which I always keep close at hand. One of my favorites is number 10, which simply states: "Sound doctrine is sound politics." Morton lives and teaches by this rule. He has dedicated his adult life to serving on the front lines of all the major battles in our nation to ensure that faith, family, and freedom always prevail. I would venture to say that much of Morton's success is due to the fact that he has had a key partner in these efforts in his wife Helen, the president of the Virginia chapter of the Eagle Forum.

In addition to his birthday, Morton also celebrated the thirtieth anniversary of the Leadership Institute. Morton founded LI in 1979 for the sole purpose of teaching conservatives to win. His approach wasn't to sit on the sidelines and analyze policy, as important as that may be. Instead, his strategy was to train people to actually influence that very policy by directly participating in it, through activism and leadership. The more than 76,000 students who have been mentored by Morton are now spread throughout the country, in arenas ranging from grassroots organizations to campaigns at every level to elected office. I don't believe there's a doubt in anyone's mind that Morton has trained more political activists than any other conservative.

This outreach didn't start with the founding of LI, though. Decades before that, Morton worked with fellow Republicans as a leader of College Republicans, and then of local and state Republican party chapters. In a role that any conservative would envy, Morton's hard work and dedication earned him a job as Special Assistant to President Reagan. At nearly 70 years old, Morton still demonstrates the energy and activity of a young man, serving the boards of at least six major conservative organizations, and frequently writes widely published pieces on a variety of conservative issues.

As in the times when I first met Morton, conservatives have recently had plenty of reasons to feel discouraged. Morton's rules, however, also tell us to "remember it's a long ball game." Keeping in mind that the game is not yet over, we continue to fight. I was proud to stand next to Morton on the stage one month ago, as we celebrated Bob McDonnell's election as the next governor of the state we call home. As I said on that same stage, the conservative resurgence begins now, and it begins in Virginia. Americans everywhere can thank Morton Blackwell for that.

RECOGNIZING VITAL BRIDGES FOR 20 YEARS OF SERVICE AND FOR PROVIDING ITS 10 MILLIONTH MEAL

HON. MIKE QUIGLEY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. QUIGLEY. Madam Speaker, I rise today to honor and congratulate VITAL BRIDGES on the occasion of its 20th anniversary. VITAL BRIDGES, originally known as Open Hand Chicago, is a not-for-profit community organization providing food and social services to low-income people with HIV and AIDS in Chicago and Cook County.

On Christmas Eve 1988, a small group of concerned volunteers came together to deliver hot meals to AIDS patients who were too sick or too poor to prepare their own food. From this initial act of charity, Open Hand Chicago was born in January 1989.

For the last two decades and without interruption, Open Hand and its successor VITAL BRIDGES has provided food and social services to men, women and children living with HIV and AIDS.

Today, VITAL BRIDGES provides its services through five grocery centers located on the north, south and west sides of Chicago and in Oak Park and Elk Grove Village in suburban Cook County. Nearly 2,000 people receive services every month.

In addition to food services, VITAL BRIDGES provides nutrition counseling, housing assistance, case management and educational and vocational services.

On October 29, 2009, VITAL BRIDGES reached a milestone: it provided its 10 millionth meal.

Without VITAL BRIDGES, thousands of people in Chicago and Cook County would go without the healthy, balanced meals and the social services that are needed when a person is struggling to live with HIV and AIDS, especially in these economically difficult times.

So, Madam Speaker, I wish to thank Executive Director Debbie Hinde, the staff, board of directors and especially the many dedicated volunteers for 20 years of creating vital bridges of help and hope for thousands of people in our community.

A TRIBUTE TO MS. CERISA HOWARD

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Ms. Cerisa Howard, a native of New York born to William E. Clark and the late Lela F. Clark.

Ms. Howard has worked with St. Nicholas Neighborhood Preservation Corporation for 13 years in various positions. She started as a Youth Coordinator working with at-risk youth in the community where she found jobs, scholarships, facilitated college enrollment, initiated educational trips and acquired funding resources to aid youth. Additionally, Ms. Howard has helped youth with everyday life issues and has always been available to lend a listening ear.

Ms. Howard, also, has worked as a clerical supervisor in the Human Support Department of St. Nicholas High School. In this capacity she managed clients' files, supervised the clerical staff and assisted the nurses with home visit documentation.

Presently, she is the Senior Property Manager of the St. Nicholas Neighborhood Preservation Corporation, now known as the St. Nicks Alliance, Where Opportunity Grows. She manages 275 housing units with a maintenance crew that administers repairs, upkeep, and security.

Ms. Howard is a member of Berean Baptist Church, under the Pastor of Rev. Dr. Arlee Griffin, Jr. She is the Vice Servant Leader of the Pastoral Support Ministry and serves as the coordinator of the annual Thanksgiving Dinner that is served for the homeless and shut-ins on Thanksgiving Day.

Ms. Howard is a loving mother of two sons, William and Raymond, and the proud grandmother of twin grandsons, Ryan and Tylan.

Madam Speaker, I urge my colleagues to join me in recognizing Ms. Cerisa Howard.

THE BIG THICKET NATIONAL RESERVE

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. POE of Texas. Madam Speaker, the Big Thicket National Preserve consists of 100,000 acres of dense pines, hardwoods, and swampland. The area occupies seven counties including Liberty County and Jefferson County, bounded by the San Jacinto River and Neches River.

In 1964 the mayor of Liberty, Dempsie Henley, and local naturalist Lance Rosier founded the Big Thicket Association; their efforts to push for national park status gained the attention of U.S. Senator Ralph Yarborough. After many years of fighting to preserve the Big Thicket a bill by U.S. Representative Charles Wilson to establish the Big Thicket National Preserve was passed by Congress in 1974. The creation of the Big Thicket National Preserve was established to protect the numerous and diverse population of plant and animal species; it was the first preserve established in the National Park System.

The communities that border the Big Thicket National Preserve remain passionate about preserving one of Texas' unique land treasures. Like many true Texans, I remember growing up surrounded by the wild, free piney woods. Many summer days were spent wading in the area creeks, fishing for perch, blazing new trails, or quietly watching turtles sunbathe on logs. The Big Thicket National Preserve continues to play an important role in the lives of the people and families of the Second District of Texas.

Madam Speaker, the Second District of Texas pays tribute to the foresight of our early Texas leaders and their commitment to the preservation of the Big Thicket. I love and appreciate this preserve, and will continue to help protect its natural beauty.

A TRIBUTE TO MS. MARIAN JACKSON

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Marian Jackson a resident of Staten Island, NY for over thirty years and an innovative entrepreneur.

Ms. Jackson is currently the President of MJ Kreavtivy specializing in personal shopping and unique gifts. In addition, Ms. Jackson is a travel consultant with the Our Gang Travel Agency. She is well versed in cruise group venues and has a following of over one hundred dedicated travelers.

Ms. Jackson's businesses have contributed to numerous community organizations including the Universal Temple which supports youth development and education in the arts and heritage awareness on Staten Island.

Prior to starting her own businesses, Ms. Jackson was associated with several entertainment firms such as ARISTA Records, ABC Television, Columbia pictures, and Night Fall Productions as an Associate Producer.

Ms. Jackson has served as Public Relations Chairperson for the National Association of Market Developers and was active in the Democratic political community working with the Obama campaign and other Democratic Party endeavors.

Madam Speaker, I urge my colleagues to join me in recognizing Ms. Marian Jackson.

A TRIBUTE TO AL AND VALERIE BISHOP, NORWOOD, MASSACHUSETTS

HON. RICHARD E. NEAL

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. NEAL of Massachusetts. Madam Speaker, I rise today to congratulate Al and Valerie Bishop who are being recognized by the Friends of St. Nick organization in Norwood, Massachusetts, for their generosity in helping those in need for over 25 years. The Bishops' planes have been on call 24/7 to assist with organ transplants and charitable flights that would not have been possible otherwise.

Norwood is not in the Second Congressional District, but I feel I must add my congratulations to this fine couple, as their good deeds certainly affect people throughout the Commonwealth of Massachusetts. In May of 2007, Carol and Vincent Pietroniro of Feeding Hills, Massachusetts, were trying to help their terminally ill son Michael find a way to realize one of his lifelong wishes—to come to Washington, DC, and see the White House. When contacted about this special request, Al and Valerie Bishop did not hesitate; they supplied the private jet and pilots for Michael and his parents, as well as for 3 physicians and an ICU nurse to make the trip.

Needless to say, the trip was so special for young Michael. Sadly, Michael passed away a few short weeks later. I know that the kindness and generosity of Al and Valerie Bishop will forever be in the hearts and minds of Michael's parents, family and friends. Knowing that their son did get to realize his dream is so comforting to both them.

I.commend the Friends of St. Nick on selecting Al and Valerie Bishop as their Couple of the Year for 2009, and I add my congratulations, best wishes and appreciation for all that they do.

A TRIBUTE TO MRS. BETTIE L. JONES

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Mrs. Bettie L. Jones who has retired after devoting over 25 years as an Associate Director and Human Resources Business Partner for Global Operations, Foreign Exchange Sales & Trading and Fixed Income Trade Support for a leading Investment Banking and Securities firm on Wall Street.

Mrs. Jones was responsible for administrative management, staffing, coaching and employee relations. In this capacity, she delivered, facilitated, and conducted motivational presentations about in-person job readiness workshops, seminars and panels.

During her professional career Mrs. Jones was an active member of several Business Advisory boards such as the Mayor's Office for People with Disabilities, Department of Education Virtual Enterprise Program, JOB, Inc., National Business Disability Council, the New York Academy of Finance, and a member of the Urban Financial Services Coalition.

She was commissioned to facilitate multiple workshops, panel discussions, seminars and focus groups with diversity organizations, including CUNY Graduate Center, Baruch College of Economics and Finance, Academy of Finance, Hunter College, Mission Society Hope Program, National Mentoring Program, Boys and Girls Clubs of America and the New York City Department of Education.

Mrs. Jones partnered and maintained relationships with several non-profit organizations including the Mayor's and Governor's offices resulting in receiving the "NYS NDEAM Regional Employment Alliance" award and the "Governor's VESID Placement Consortium" award in recognition of her dedication and commitment to hiring individuals with disabilities. In addition, Mrs. Jones was awarded the New York City Department of Education Virtual Enterprise "Partner in Leadership Award" in recognition of assisting High School students in career development.

Currently Mrs. Jones is a volunteer consultant with the Workforce 1 Center in Harlem conducting career-readiness workshops for the community training and Employment Resources program.

Mrs. Jones is married to Robert Jones and they have one daughter, Kenya, and two grandchildren, Ejaaz and Amani.

Madam Speaker, I urge my colleagues to join me in recognizing Mrs. Bettie L. Jones.

HONORING CALVIN BRIGHT

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to honor Calvin Bright for his tremendous contributions to promoting housing and development in the Central Valley. Mr. Bright is being honored at the Greater Yosemite Council Boy Scouts of America's Annual Distinguished Citizens Dinner on October 28, 2009, in Modesto, California.

Calvin Bright was born on September 17, 1920, in Beggs, Oklahoma, to Ed and Cora Bright. He was raised on the family farm with his three siblings and a cousin. He spent his childhood in school or working on his family's farm where they raised farm animals, grew row crops, and farmed a large family garden. He graduated from Beggs High School having lettered in football and participated in the 4H Club. He joined the National Guard when he was 14, but due to a hip injury, he was unable to go overseas and fight in the war. Instead, Mr. Bright attended Oklahoma A&M and graduated with a degree in horticulture.

In 1940, Mr. Bright married his high school sweetheart, Marjorie Hensley. They attended Oklahoma A&M together and moved to California in 1942. Upon arriving in California, Mr. Bright built and managed a five-unit apartment complex in Hayward. This was his first California building project. In 1956 Mr. and Mrs. Bright founded Bright Foods in Turlock, which manufactured pre-prepared frozen foods, such as pies and TV dinners. Bright Foods was the first pre-prepared food processing plant of its type west of the Rockies. Bright Foods operated 24 hours a day and employed approximately 400 full-time employees.

Mr. Bright established Western Fruit Packers in Brigham City, Utah, in 1959. The company was a cherry packing plant and provided fruit for his cherry pies manufactured in Turlock, California. The following year he founded C.S.C. Refrigeration, a company that froze and stored the product, and Mistletoe Express, a trucking company that delivered the finished frozen product to 11 western States. In 1966, Bright Foods and FM Stamper Company merged to create a national distribution system. The new company was named Banquet Foods and was sold to RCA in 1969. When Banquet Foods sold, Mr. Bright left the food processing industry and entered the housing industry, full time.

In 1968, Mr. Bright founded B&H Manufacturing, an international company that designs and manufactures high-speed, roll-fed labeling machines that place labels on containers for major companies, such as Coca-Cola, Pepsi, Clorox, and other household products. In 1971, he incorporated Bright Development in Modesto and began to build single family homes, townhomes, and apartment projects throughout the Central Valley. Bright Development has also been active in the construction of commercial office buildings. Woodside Management Group was also established in 1971 by Mr. Bright to professionally manage the apartment projects built by Bright Development. Mr. Bright has been named "Builder of the Year" by the Building Association of Central California, twice. He has been a member of the Building Industry Association of Central California since 1979 and he served over 20 years on the board of directors and is a past president. In 1994 he was honored by the California Building Industry Foundation for his contributions to the professionalism of the industry and has been inducted into the California Building Industry Hall of Fame.

Mr. and Mrs. Bright established the Bright Family Foundation in 1987 for the purpose of making a contribution to the health and wellbeing of youth and families in the Central Valley. Over the years the foundation has provided grants to sponsor the Nature Series on KVIE, medical internships at the University of California Medical Center, Hospice, the Children's Crisis Center, and scholarships for students from local high schools to attend Modesto Junior College, University of California, Merced, and California State University, Stanislaus.

Mr. Bright has been associated with the Yosemite Area Council of Boy Scouts for over 20 years. He has served on the board of directors and has been honored with the Silver Beaver Award in 1994. He was also honored by the Boy Scouts of America in 2004.

Madam Speaker, I rise today to congratulate Calvin Bright for the impact that he has made on the building industry in the Central Valley and the State of California. I invite my colleagues to join me in wishing him continued success.

A TRIBUTE TO MR. DANNY KING

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Mr. Danny King, an exemplary community leader.

Mr. King is a 22 year veteran of the New York City Police Department, Board Member of the Central Brooklyn Coordinating Council Inc., Chairperson of the Neighborhood Advisory Board, Board Member of the New York City Department of Youth Community and Development, to name a few. In addition, he served 8 years as the President of the Atlantic Avenue Housing Development Fund Corporation and served 2 years on the USA Women's Shelter Board. He was a member of the Bedford Avenue Boys and Girls Club for over eight years with great memories and many stories to tell.

As President of Youth on the Move Victory over Violence, he continues to support scholarships and awareness programs to combat violence. He humbly received several leadership awards from company employees such as the 2009 Man of the Year Award, 2008 Exemplary Community Award from New Life Center of Truth, a citation as 2007 Distinguished Humanitarian Award from Senator John Sampson's Office, Cambridge Who's Who 2007, Thomas R. Fortune Exemplary 2004 Service Award, 2003 Martin Luther King Spirit of New York Award, Beacon of Hope Award, Wayside Baptist Church Senior Program Leadership Award and many other awards and achievements.

Mr. King currently serves as the CEO of the Federation of Multicultural Programs Inc., and the Federation of Multicultural Programs of New Jersey, Inc. This company is a service provider of intermediate care group homes, individualized residential alternative homes, community residential homes and programs that include Day Habilitation Programs, a Respite Program, and a Medicaid Service Coordination Program, with services spreading throughout the Boroughs of Brooklyn, Bronx, Manhattan and Counties in the State of New Jersey.

Madam Speaker, I urge my colleagues to join me in recognizing Mr. Danny King.

A TRIBUTE TO THE SACRAMENTO JAPANESE AMERICAN CITIZENS LEAGUE, THE MATSUYAMA SACRAMENTO SISTER CITY CORPORATION, TERI TAKAI AND RANDELL IWASAKI

HON. DORIS O. MATSUI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Ms. MATSUI. Madam Speaker, I rise today to recognize and honor the Sacramento Chapter of the Japanese American Citizens League, the Matsuyama Sacramento Sister City Corporation, Teri Takai and Randell Iwasaki for their contributions to California, Sacramento, and their leadership to Japanese-Americans across the nation.

The Sacramento JACL was formed on October 31, 1931, after the Sacramento Chapter of the American Loyalty League reorganized itself to become the Sacramento Chapter of the Japanese American Citizens League.

Through their programs, the Sacramento JACL is dedicated to advancing the civil rights of all Americans, deterring hate crimes across the Nation, and helping to lead the Japanese-American community for social and economic advancement. At their annual dinner on November 19th, they will honor two outstanding

individuals and one fine organization, Teri Takai; Randell Iwasaki; and the Matsuyama Sacramento Sister City Corporation.

On December 6, 2007, California Governor Arnold Schwarzenegger announced the appointment of Teri Takai as chief information officer for the State of California. As a member of the Governor's Cabinet, she advises him on the strategic management and direction of information technology resources as the state works to modernize and transform the way California does business with its residents and visitors.

Teri also currently serves as practitioner chair of the Harvard Policy Group on Network-Enabled Services and Government. Before serving in the State government, Teri worked for Ford Motor Company for 30 years, where she led the development of the company's information technology strategic plan.

Randell Iwasaki currently serves as the director of the California Department of Transportation, which employs 23,000 people and has an operating budget of $14 billion.

Working for CalTrans for almost 25 years, Randell spearheaded a number of transportation engineering innovations in California including the use of old tires in rubberized asphalt, the installation of LED red lights saving the State taxpayers more than $2 million a year in power costs, and the conversion of the CalTrans equipment fleet to clean burning fuels.

A licensed civil engineer, Randell also serves on a number of national transportation panels and committees helping to develop transportation strategies and innovations such as pavement technology that reduces highway noise.

The Matsuyama Sacramento Sister City Corporation was formed on August 17, 1981, when then Sacramento Mayor Phil Isenberg and Mayor Tokio Nakamura of Matsuyama, Japan, signed the historic sister city agreement.

Since 1981, various organizations from Sacramento and Matsuyama have formed intercontinental relationships for social and economic prosperity. Most notably, the Boy Scout exchange program is one of the Sister City's most successful programs where Scouts from Sacramento visit Matsuyama in even years and the Matsuyama Scouts visit Sacramento in odd years.

Other than a short pause just after September 11th, the Matsuyama-Sacramento Boy Scout exchange program has taken place each year since 1981. Sacramento plans to send its next delegation to Matsuyama in 2010.

Madam Speaker, I hereby recognize and honor the Sacramento Chapter of the Japanese American Citizens League, and the people and organization they are honoring Thursday night: the Matsuyama Sacramento Sister City Corporation, Teri Takai and Randell Iwasaki. Their contributions to the people of California have been immense. I ask all my colleagues to join with me in wishing them continued success.

A TRIBUTE TO MS. JOAN HEVONY LAWRENCE CRAWFORD

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Ms. Joan Hevony Lawrence Crawford who was born in Costa Rica, Central America.

In her young life, Ms. Crawford made the decision to immigrate to the United States with her husband and two young children in order to provide a better life for their family. While in America, she was determined to be a successful educated black woman and she continued her education by completing her high school diploma at the "Boys and Girls" High School in Brooklyn, New York. After receiving her high school diploma she then went on to Borough of Manhattan Community College (BMCC) to further her studies. While in school, she discovered that she has a passion for helping her community and decided to pursue a career in medicine.

Ms. Crawford's passion and dedication was shown everyday of the thirty-five years she worked at Coney Island Hospital. She was always a hard worker and cared very much for her patients. While at Coney Island she received many promotions and eventually retired as a medical/surgical technician.

Even though she retired in 1996 from Coney Island Hospital, her life did not slow down. After retirement, she became very active in her religious life at East New York Seventh-day Church (ENYSDA). At ENYSDA she is a very active deaconess where she volunteers for Vacation Bible School, serves for funerals and performs daily church duties. When Ms. Crawford is not serving her community through her church, she enjoys activities such as bowling, shopping, needlepoint and family gatherings.

Ms. Crawford's family includes her husband Dowel Stewart and two daughters, Sonia and Betty, four granddaughters, Nikita Griffith, Tenesha Lewis, Xiomara Okonkwo and Cherrise Lewis and four great grandchildren, Anaiya Davis, Gyselle Brown, Michael Brown and Laila Davis.

Madam Speaker, I urge my colleagues to join me in recognizing Ms. Joan Hevony Lawrence Crawford.

IN RECOGNITION OF STRAFFORD HIGH SCHOOL FLAMING ARROW INDIAN PRIDE MARCHING BAND

HON. ROY BLUNT

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. BLUNT. Madam Speaker, I rise today with pleasure and pride to pay tribute to the achievements of the Music Department at Strafford High School in Strafford, Missouri. The Strafford High Flaming Arrow Indian Pride marching band and choir will participate in the events surrounding the December 31st, 2009, Chick-fil-A Bowl in Atlanta, Georgia. A long-standing event at the bowl game is the National Chick-fil-A Bowl Band Festival.

The music festival has clinics and competition for choir, concert band, jazz band and marching band. The Strafford marching band and choir will compete against other schools while the marching band will march in the National Chick-fil-A Bowl Parade in downtown Atlanta on New Year's Eve. Game day, the Strafford band will participate in a pre-game and halftime massed band "extravaganza" of 2,000 members performing in the Georgia Dome Olympic Stadium.

Strafford, Missouri, is my hometown, and I graduated from Strafford High. Today, Strafford has a population of 1,845 citizens, and the high school has approximately 400 students. The band and choir are made up of 55 motivated, hardworking teens in concert and marching band, 20 students in jazz band and 36 students in choir. The music department is under the direction of Shane Harmon.

The Strafford High Flaming Arrow Indian Pride marching band consistently ranks among the best bands in Missouri, earning first place at six judged events this year. At the 2007 Outback Bowl in Tampa, Florida, the Strafford concert band, jazz band and marching band each earned a 1st place Silver rating, and the concert choir earned a 1st place Gold rating. These achievements led to the invitation to participate at the band festival at the Chick-fil-A Bowl. This recognition is the result of long hours of practice, and dedication to excellence by Strafford students, faculty and their families.

A TRIBUTE TO DR. LEONEL URCUYO

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Dr. Leonel Urcuyo and his commitment as a physician of mental health.

After graduating college in Nicaragua and medical school in Madrid, the newly titled doctor began an internship at McGill University in Montreal and did his residency in Psychiatry at New York University, Bellevue Medical Center. By 1975, Dr. Urcuyo was a certified Psychoanalyst for the American Institute for Psychoanalysis for the Karen Horney Psychoanalytic Institute and Center in New York City.

For the past 27 years Dr. Urcuyo has held varying positions at Woodhull Hospital including service as Chairman of the Department of Psychiatry and President of the Woodhull Medical Group. Dr. Urcuyo received one of the highest honors from the Woodhull Auxiliary Annual Gala, and the distinguished Health Excellence Award from Addiction Research and Treatment Corporation/Urban Resource Institute. He is also the proud recipient of the Unsung Hero Community Service Award for Helping Hands, and mostly recently received a Service Citation from New York University School of Medicine.

He is the founding member of the Association of Hispanic Mental Health Professionals, and has published and lectured on many topics including: delivery of care issues, language

barriers in evaluating pathology, bilingualism, cross-cultural issues in mental health and chemical dependency, language and psychotherapy, meaning of silence in psychotherapy, elective mutism, cognitive restructuring, depression and suicide.

Dr. Urcuyo is married to Sue Ellen Carney, Ph.D., and is the proud father of two children, Dr. Sergio Urcuyo and Ms. Anya Elena Urcuyo.

Madam Speaker, I urge my colleagues to join me in recognizing Dr. Leonel Urcuyo.

RECOGNIZING MAJOR GENERAL JOHN R. ALISON

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. SKELTON. Madam Speaker, let me take this means to honor Major General John R. Alison, a distinguished Airman, a dedicated public servant, and a true American hero. Major General Alison served in the United States Air Force during World War II and the Korean War and also served as Assistant Secretary of Commerce for Aeronautics under President Harry Truman. Known as the father of Air Force Special Operations, Major General Alison turned 97 on November 21, 2009.

As a boy growing up in central Florida, Major General Alison dreamed of becoming a pilot for the United States. He graduated from the University of Florida School of Engineering in 1936 and soon after joined the United States Army Air Corps. He earned his wings in 1937 at Kelly Field and went on to serve as the assistant Military Attaché in England and the Soviet Union.

During World War II, Major General Alison served as commander of the 75th Fighter Squadron, formerly known as the ''Flying Tigers.'' With seven confirmed victories and numerous probable kills, he ended his tour as a combat ace and earned a Distinguished Service Cross and a Silver Star for his unmatched courage and skill. Major General Alison returned home in May of 1943 only to be recalled to co-command the highly innovative 1st Air Commando Group. This secret flying unit flew over 200 miles into enemy territory in support of some 9,000 Allied forces. For his skill and courage as a pilot, he was inducted into the Air Commando Hall of Fame in 1994.

After the war, President Harry Truman called on Major General Alison to serve as Assistant Secretary of Commerce for Aeronautics. In this role, he developed thoughtful recommendations on U.S. foreign policy relating to the Soviet Union, the Marshall Plan, and the European Recovery Program. These recommendations and other documents from his time as Assistant Secretary are held at the Harry S. Truman Library and Museum.

Madam Speaker, Major General John R. Alison has spent his life fighting for our country as a pilot and a public servant. Never wavering in his commitment to freedom and the ideals of our country, he sets a high standard for all Americans. I am proud to call him my friend, and I trust that my fellow members of the House will join me in recognizing this courageous and talented American.

A TRIBUTE TO MRS. JENNETTE EICHELBERGER WAITERS

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Jennette Eichelberger Waiters who was born in Columbia, South Carolina. Mrs. Waiters migrated to Brooklyn, NY to further her education.

Mrs. Waiters worked at Kings County Hospital as a nurse's aide and then attended Wyckoff Hospital School of Practical Nursing. She returned to Kings County Hospital and attended New York City Community College to obtain her Associate's Degree in Nursing and made the Dean's list. Mrs. Waiters worked as a head nurse in the chest clinic for 14 years. She worked a total of 45 years in Kings County Hospital doing the things she loves most, caring for the sick and the elderly. Mrs. Waiters worked six months with the Department of Health and also was a relief supervisor at the Metropolitan Jewish Geriatric Center on some weekends for 12 years.

Mrs. Waiters is a God-loving person. She does community work assisting the elderly on shopping trips and helping them to keep their doctors' appointments when needed. She belongs to Bethany Baptist Church where she serves on the Senior Ladies Usher Board as Vice President and a member of the Nurses Unit. She is a member of the Stark Senior Center and is Queen of the Red Hat Society. Mrs. Waiters encourages our youth to continue and pursue their highest goals in education so that they can accomplish anything in life.

Mrs. Waiters continues to work at community outreach health fairs, passing on information to senior citizens to enhance their health and well being. She loves giving and sharing with others. Her mission in life is to help others. She is a lady of fashion and participates in numerous fashion shows. She is a member of the acting guild where she has performed in a play called ''The Family Feud.''

She was married to the late Andrew J. Waiters. She has two children, Bernard and Janet. She has four grandchildren and five great-grandchildren. She is affectionately known as ''Grandma'' Waiters by many.

Madam Speaker, I urge my colleagues to join me in recognizing Mrs. Jennette Eichelberger Waiters.

TRIBUTE TO COMMANDER SHANTI SETHI, USN

HON. GENE TAYLOR

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. TAYLOR. Madam Speaker, I rise today to pay tribute to Commander Shanti Sethi, United States Navy, who provided invaluable service to this House on national security issues for the last two years as a liaison officer assigned to the Navy Office of Legislative Affairs and who will soon be on the front lines of our Nation's defense as the commanding officer of a United States Navy destroyer.

Commander Sethi is a native of Reno, Nevada but was raised in Connecticut, New York, Oregon, and California. Her step-father is Hall of Fame drag racer Conrad ''Connie'' Kalitta and she spent many of her formative years at the track honing her mechanical skills. She graduated from Norwich University in 1993 with a degree in International Affairs and commissioned through the NROTC program. She holds a Masters Degree in International Policy and Practice from The George Washington University.

At sea, Commander Sethi served on USS Butte (AE 27) from March 1994 to June of 1996 as Communications Officer and Electrical Officer, making a Mediterranean and Arabian Gulf deployment in support of Operations Deny Flight, Sharp Guard, and Southern Watch. From August of 1996 through October of 1998, she served as the commissioning Navigator onboard USS Hopper (DDG 70). During this tour she supported a Panama Canal transit, accelerated test and trials, and a Middle East Force deployment in support of Operation Southern Watch commencing within one year of the ship's commissioning. She served as the Weapons Officer and Combat Systems Officer on USS Higgins (DDG 76) from March of 2001 until May of 2003. Onboard USS Higgins, she completed an Arabian Gulf deployment for Operations Enduring Freedom and Iraqi Freedom including missile defense tracking and cruise missile operations. She subsequently participated in the first test of crew exchange on destroyers serving as Combat Systems officer on USS Benfold (DDG 65) until her transfer in November of 2003. Commander Sethi was selected for early sea command and assumed command of MHC crew BOLD in April 2006 while embarked in USS Blackhawk (MHC 58). During her command she was responsible for training Greek naval officers in the operation of MHC vessels prior to foreign military exchange. She subsequently assumed command of MHC crew Detector embarked on USS Kingfisher (MHC 56) where her ship provided valuable services to pre-deployment workups for Navy carrier strike groups.

Her shore assignments include serving as the Executive Assistant to the Commandant of Midshipmen at the United States Naval Academy, Resource Officer for Shipboard Protection Systems and Shipboard Radar Systems on the staff of the Chief of Naval Operations where she was instrumental in the rapid fielding of systems to protect warships from small boat and unconventional attacks, and her current assignment as the surface warfare liaison officer assigned to the Navy Office of Legislative Affairs.

In her current assignment Commander Sethi's responsibilities included primary liaison for surface combatant construction, surface ship combat and weapons systems, ballistic missile defense, and a myriad of other logistical and operational issues affecting the surface fleet. CDR Sethi provided invaluable support to me, the Committee on Armed Services, and the various Members and personal staff of the subcommittee on Seapower and Expeditionary Forces. She displayed a unique ability to explain complex military requirements

against the backdrop of uncertain future threats. In this she served this committee well and reflected great credit upon herself and the United States Navy.

Madam Speaker, I have the great honor to inform the House that Commander Sethi has been selected to assume command of the Arleigh Burke class destroyer USS Decatur (DDG 73). When she does so, she will be only the 15th female officer to command a capital ship of the line. For myself and the other Members of the subcommittee we wish Commander Sethi fair winds, following seas, and Godspeed as she leads her crew in the protection of our nation.

68TH ANNIVERSARY OF THE CIVIL AIR PATROL

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise today to recognize the 68th Anniversary of the Civil Air Patrol (CAP). For nearly seven decades CAP has provided for the safety and defense of our nation.

Established on December 1, 1941, CAP responsibilities were initially liaison flying and interdiction of infiltrators on the United States' East Coast and southern border during World War II. CAP's role eventually expanded in response to the German submarine threat, and it began to provide vital coastal surveillance and defense capabilities. The vigilance of CAP pilots successfully deterred enemy submarines from operating along American coasts with relative impunity.

Today, CAP operates as a nonprofit 501(c)(3) corporation and is designated as an all-volunteer civilian auxiliary to the United States Air Force. Since WWII, CAP has adopted a mission dedicated to three core pursuits: Aerospace education, cadet programs and emergency services.

CAP's Aerospace Education Program annually touches more than 900 educators, more than 20,000 cadets and thousands of other youths in classrooms across America. The education program teaches children multidisciplinary aviation concepts that emphasize aviation's connection to history, math, science, government and economics.

CAP provides exceptional educational and growth opportunities for youth through its nearly 22,000 member Cadet Program, which annually provides access to top national summer flight academies and to 30 national programs emphasizing leadership and careers in aviation, as well as flight training in powered and glider aircraft.

CAP's emergency services are its most high profile function and its members are routinely called upon to aid communities in response to natural disasters across the nation. CAP volunteers rose to the occasion during one of our nation's most trying times and provided assistance to rescuers and state agencies immediately following the September 11, 2001 terrorist attacks. Over 100 lives are saved each year by CAP search and rescue missions.

Madam Speaker, I ask that my colleagues join me in commending Civil Air Patrol for its commitment to aerospace education, cadet programs and emergency services. I am greatly appreciative for their contribution to the safety of all Americans.

CONGRATULATING THE INKSTER ALUMNAE CHAPTER OF THE DELTA SIGMA THETA SORORITY INC. ON THE OCCASION OF THEIR 50TH ANNIVERSARY

HON. JOHN D. DINGELL

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. DINGELL. Madam Speaker, I rise today in honor of the Inkster Alumnae Chapter of the Delta Sigma Theta Sorority, Inc. On December 19, 2009, the Inkster Chapter will gather to celebrate their 50th anniversary.

The Delta Sigma Theta Sorority has a remarkable history of service since its creation in 1913. As the largest Greek letter organization for African American women in the country, the Deltas do remarkable work to serve their communities and their nation. Several of our current and former colleagues were proud Delta women. They brought their passion, their vision and their leadership to the House of Representatives and helped make this institution a far better place.

The Inkster Alumnae Chapter has a proud tradition of service and community involvement. They have worked to tutor students and provide them with scholarships, as well as implement innovative service learning programs for middle and high school girls. In addition to these efforts, the Inkster Deltas have held health fairs and greatly enhanced the civic participation of their community. These are all great accomplishments, but the Inkster Deltas have much more in store for the future as they seek to build on and expand their great works.

Once again, I hope my colleagues will join me in congratulating the Inkster Alumnae Chapter of the Delta Sigma Theta Sorority as they gather in celebration of 50 wonderful years of service and accomplishment.

RECOGNIZING CHIEF MASTER SERGEANT TROY J. McINTOSH ON HIS RETIREMENT FROM THE U.S. AIR FORCE

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise today to recognize Chief Master Sergeant Troy J. McIntosh on the occasion of his retirement from the United States Air Force following more than 29 years of dedicated service to our country. In his most recent assignment, he was Superintendent, Physical Disability Board and Review, Office of the Secretary of Defense, the Pentagon. In this role, he is the enlisted representative and adjudicator for vital information specific to the enlisted force when reviewing final board of appeals for physical disability evaluations.

Chief McIntosh enlisted in the Air Force on July 7, 1981 as a Security Forces Specialist. He served for four years in this role prior to cross training into the Personnel career field. He remained on active duty until 1992 at which time he joined the California Air National Guard as a traditional Guardsman for six years. In 1998, Chief McIntosh joined the Air Force Reserve with the Commander's Support Staff for the Chief of Air Force Reserve. Excelling in this role, he was soon assigned as Superintendent, Policy and Integration where he worked as a Congressional Liaison educating members of Congress and their staff on the roles and missions of the Air Force Reserve.

On September 11, 2001 following the terrorist attack on the Pentagon, Chief McIntosh displayed the attributes and core values that many of our men and women in uniform show daily around the globe. Directly after the attack, Chief McIntosh rushed to the impact site to render assistance and immediately started pulling victims to safety—despite the obvious risk to his personal wellbeing. He later helped relocate the same victims when a second aircraft was thought to be inbound, similar to the attacks on the World Trade Center. When Chief McIntosh finally left the area 36 hours later, he had helped secure the safety and treatment of over 150 people. On September 24, 2002 he was awarded the Air Force Airman's Medal for this selfless act of heroism.

Chief McIntosh's patriotism and dedication to our national defense continued as he deployed the following month to Al Udeid AB, Qatar in support of Operation Enduring Freedom. As the Personnel Director for the Joint Forces Special Operations Command, a role traditionally held by a senior officer, he was responsible for ensuring that the right military personnel from all services within the Department of Defense would be provided at the beginning of a war that continues to this day.

Due to his achievements and obvious dedication to his fellow airmen, it was no surprise he was chosen as the thirteenth Command Chief for the Air Force Reserve Command. During his two-year assignment, Chief McIntosh was responsible for advising the Commander on the health, morale, and utilization of over 55,000 assigned airmen. He developed and executed several pivotal programs helping transform the Air Force Reserve enlisted force into the successful Total Force partner they are today.

Chief McIntosh could not have been such a tremendous leader without the love and unfailing support of his mother, Jeannette, his father Connie Joe, his two daughters Tess and Kali, and his beautiful granddaughter Addison Marie.

Madam Speaker, I ask my colleagues to join me in expressing our sincere respect and appreciation to Chief Master Sergeant Troy J. McIntosh for his outstanding service to the United States Air Force and our great nation. We wish him the very best as he transitions into retirement. Chief McIntosh is a true professional and a credit to himself, his family, and the United States Air Force Reserve and we thank him for his service to our country.

CONGRATULATIONS TO THE AMERICAN UNIVERSITY OF BEIRUT MEDICAL CENTER

HON. NICK J. RAHALL II

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. RAHALL. Madam Speaker, I rise today to congratulate the American University of Beirut Medical Center, AUBMC, upon being designated as the first "Magnet" facility in the Middle East by the American Nurses Credentialing Center's Magnet Recognition Program.

The "Magnet" program recognizes nursing excellence in the delivery of care to patients, promoting quality health care services in an environment that supports professional nursing practice, and providing a mechanism for the dissemination of best practices for nursing services. AUMBC is the first health care institution in the Middle East and the third in the world outside the United States to receive this award.

"Magnet" recognized organizations set the global standard for professional nursing care and innovative health care reform that meets the needs of patients, families, and communities. Only five percent of all hospitals in the United States are "Magnet" recognized institutions, including such prestigious hospitals as Cedars Sinai Medical Center and Johns Hopkins Hospitals. Special recognition is in order for Gladys Mouro, Assistant Hospital Director for Patient Care Services, who spearheaded the 6-year effort to secure "Magnet" recognition.

I am absolutely delighted that this extraordinary designation was achieved at a U.S. recognized and supported institution, the prestigious institution of higher learning in the Middle East, the American University of Beirut. Congratulations to the AUB administration, faculty, and the entire AUBMC medical staff for their 6 years of hard work to achieve this goal.

HONORING LAWRENCE J. SUFFREDIN, SR.

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Ms. SCHAKOWSKY. Madam Speaker, I submit this extension of remarks on behalf of myself and my friend and colleague Representative QUIGLEY.

Madam Speaker, we rise today to pay tribute to and remember the life of Lawrence J. Suffredin, Sr. He died on November 23, 2009.

Lawrence J. Suffredin, Sr was born on June 1, 1921 at Garfield Park Hospital to Frank and Isola Suffredin. He was the second of their three children, Mary and the late Vincent. He attended Presentation Grade School, Crain High School, and DePaul University.

A true American hero, Larry, Sr. entered the Army in 1942 and served until 1945, with combat service in Africa and Europe. He was awarded a Bronze Star for valor in the face of the enemy, a Purple Heart, and other combat and campaign medals.

After the war, Larry, Sr. was a Chicago policeman, and then he became the "Printer to South Water Market." As the owner of Chicago Produce Publishing Company, he published numerous reports on the Chicago fruit and vegetable market, and published a newspaper, "The Chicago Fruit and Vegetable Reporter", 5 days a week from 1955 to 1986. He lived in Westchester, where he and his wife raised their family from 1948 until 2000. He was a founder and former president of Westchester Baseball, a former officer of the Holy Name Society of Divine Infant Parish, former co-president of the Parents' Association of Loyola University, and a former 25 year bingo worker for IHM High School. He married the late Patricia Mulrainey Suffredin on July 6, 1946.

A dedicated family man, Larry, Sr. leaves behind eight children: Lawrence, Jr., Genna, Paul, Susanne, Patricia, John, Peter and Michelle and thirteen grandchildren: Tom, Liz, Courtney, Nicholas, Stephen, Kevin and Morgan Suffredin, Andrea and Daniel Erikson, Erin and Bob Brown and Ethan and Henry Moskal. His wife, Patricia, died in December of 1990.

Wherever Larry went, he brought joy and laughter. His joy will be missed by all.

On behalf of our families, and those lives in our districts that Larry, Sr. touched over the years, we send our deepest condolences to his family and friends. He will be missed.

IN RECOGNITION OF ALTHEA THOMPSON THOMAS

HON. MIKE ROGERS

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. ROGERS of Alabama. Madam Speaker, I would like to request the House's attention today to pay recognition to Althea Thompson Thomas of Montgomery, Alabama.

Mrs. Thomas currently serves at Dexter Avenue King Memorial Baptist Church as the church's organist. In June of 1955, she was hired by Dr. Martin Luther King, Jr., and from her unique vantage point seated in the organ pit, she was able to witness his sermons each Sunday with an up close and personal view of the pulpit.

Mrs. Thomas is an accomplished composer, musician, artist, writer and educator. She has written and arranged musical pieces throughout her life and published musical compositions including four musical dramas, eleven books of piano works, three books of organ works and 25 choral works.

She has served as organist for several churches and her artwork has been exhibited across Alabama and the Southeast.

Over the years, she taught band, choral music and art in the Montgomery Public Schools and taught art, organ, piano, music theory and appreciation at Alabama State University and Alabama State Laboratory High School. She most recently worked at Alabama State University as an Adjunct Professor. Since 1982, she has taught piano, organ, wind instruments, percussions and guitar at the Thompson Legacy Studios (House of the Arts).

She is the daughter of the late H.O. Thompson and the late Faustine Hilliard Thompson. She is married to Wiley Thomas, Jr. and the mother of 6 children.

Mrs. Thomas has touched the lives of children and adults alike through her teaching, and I commend her for her dedication. I congratulate her on being honored at Dexter Avenue Memorial King Baptist Church for her contributions to the arts.

CONGRATULATING FIRM OF COONEY, FAULKNER, AND STEVENS ON THEIR 10TH ANNIVERSARY

HON. JEAN SCHMIDT

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mrs. SCHMIDT. Madam Speaker, I rise today to congratulate the accounting firm of Cooney, Faulkner, and Stevens on their 10th Anniversary. In 1999, the firm was founded by partners Thomas Cooney, Crystal Faulkner, and Charles Stevens. Just five years later, in 2004, it was named Small Business of the Year by the Cincinnati USA Regional Chamber of Commerce—the first accounting firm to receive such an honor.

Many Cincinnati institutions have come to rely on the firm's accounting experience and expertise over the past ten years. The firm is also routinely recognized for its many philanthropic and volunteer endeavors. Just recently, the firm participated in the 10th Accounting for Kids Day. Cooney, Faulkner and Stevens founded this event to promote financial literacy.

Many Cincinnatians are familiar with Thomas Cooney and Crystal Faulkner's weekday radio show titled BusinessWise on 89.7 WNKU. And Crystal Faulkner is the weekly host of Business Report on WCPO Channel 9.

Madam Speaker, please join me in congratulating Cooney, Faulkner, and Stevens on their 10th Anniversary and in wishing them continued success in the future.

OUR UNCONSCIONABLE NATIONAL DEBT

HON. MIKE COFFMAN

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. COFFMAN of Colorado. Madam Speaker, this morning our national debt was $12,113,047,538,115.42. We have added $102,485,795,900.21 to the national debt since the last day we were in session, November 19th.

On January 6th, 2009, the start of the 111th Congress, the national debt was $10,638,425,746,293.80.

This means the national debt has increased by $1,474,621,791,821.62 so far this year.

According to the non-partisan Congressional Budget Office, the forecast deficit for this year

is $1.6 trillion. That means that so far this year, we borrowed and spent an average $4.4 billion a day more than we have collected, passing that debt and its interest payments to our children and all future Americans.

A TRIBUTE TO THE HONORABLE FRANCIS P. COSGROVE

HON. ROBERT A. BRADY

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. BRADY of Pennsylvania. Madam Speaker, I rise today to honor the Honorable Francis P. Cosgrove. For 35 years, Judge Cosgrove has served on the Philadelphia Municipal Court, and in December he will celebrate his retirement after decades of service to his community.

Judge Cosgrove served on active duty in the United States Army from 1951 to 1953. He graduated from LaSalle College in 1956 and received his Juris Doctorate from Temple University School of Law in 1963. After his graduation, Judge Cosgrove became a member of the Philadelphia Bar Association and went into private practice from 1964 to 1973. In November of 1973, he was elected judge to the Municipal Court of Philadelphia. Judge Cosgrove served in this capacity from 1974 through 1998. On February 18, 1998, he was appointed to Senior Judge status for the Philadelphia Municipal Court. On December 31, 2009, Judge Cosgrove will retire from the bench after 35 years.

In addition to his service on the Municipal Court, Judge Cosgrove is a member of several committees and organizations dedicated to bettering the Philadelphia community and beyond. He is a part of the Catholic War Veterans, St. Thomas Moore Society, Knights of Columbus, Polish American Citizens League, Polish-America Congress, and is a gold card carrying member of the International Union of Bricklayers and Allied Craft workers.

Judge Cosgrove's long and impressive career showcases his commitment and service to his community. Madam Speaker, I ask that you and my other distinguished colleagues join me in thanking Judge Cosgrove for his work and congratulate him on the occasion of his retirement.

WEST VIRGINIA STATE POLICE 90 YEARS OF SERVICE

HON. NICK J. RAHALL II

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. RAHALL. Madam Speaker, I rise today to honor the ninety years of service by the West Virginia State Police.

Audiences throughout the world have always been transfixed by the American lawman, from the earliest days of radio with the Lone Ranger and Dragnet, to today's televised prolific forensic adventures. In West Virginia this week, we shall go a long way in setting the record right, celebrating the real human spirit, and illuminating the costly sacrifices of the steadfast mission galvanized by the shields worn proudly across our state, ''To Serve and Protect.''

The West Virginia State Police have given the people of West Virginia nine decades of dedication and commitment by an unbroken long line of forest green. This remarkable group of professionals, our nation's fourth oldest state police agency, has a storied history and rich tradition of service.

In acknowledgment and with gratitude, the West Virginia Department of Culture and History is opening a splendid exhibit entitled, ''Celebrating Ninety Years of the West Virginia State Police,'' which will stand as a permanent display in the West Virginia State Museum, in tribute to this fine organization.

Stretching over 90 years of history, born in the trademark forest green uniforms worn today, the West Virginia State Police force armed with 21st century tools, technologies, and expertise is the foundation for law enforcement in our democratic society. Theirs is a story of an admirable path of honor and bravery. It is one of men and women who are known, respected and recognized nationally for their efforts in law enforcement.

Throughout their proud legacy and often in the face of great change, West Virginia State Police officers have been at the ready, answering trouble, turmoil, and even tornadoes of one form or another, with speed, accuracy and more often than not, a deep understanding of those they serve. For all this we are, and will forever be, grateful.

Today, as we celebrate roads well travelled and those yet to be blazed, I share great pride with the people of West Virginia.

And, to all the men and women of the West Virginia State Police—past and present, uniformed and non-uniformed—I express my deepest gratitude and heartfelt thanks for their service and commitment to the safety and security of the people of West Virginia.

I hope my colleagues here in the Congress will join me in congratulating everyone with the West Virginia State Police and their families on their 90th anniversary and offer our sincerest best wishes for their continued success.

RECOGNIZING THE SMART CAR WASH IN WOODBRIDGE, VA

HON. GERALD E. CONNOLLY

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CONNOLLY of Virginia. Madam Speaker, I rise today to recognize a bold and innovative new business breaking ground in my district. The Smart Car Wash is raising the bar for environmental stewardship in the car wash industry with its new LEED certified conveyer car wash in Woodbridge, Virginia.

The new car wash facility will be the first such facility to achieve LEED certification from the United States Green Building Council. The building uses advanced water recycling beyond the industry standard, to include rainwater capture and advanced water cleansing with technology borrowed from the marine industry. This includes reclaiming and reusing over 90% of the water from car wash operations and using car wash chemicals that are bio-friendly. To reduce overall energy consumption by 50% most of the facility's equipment will use Variable Frequency Drive (VFD) technology.

This new venture is just one of the high quality investments businesses are making around the country. The Smart Car Wash received a Small Business Administration (SBA) loan to finance a project that will bring fifteen new jobs to the Woodbridge area. The SBA's 504 lending program recently received funding from the American Recovery Reinvestment Act to provide opportunity's to entrepreneurs hoping to show confidence in the American economy with new investments. The Smart Car Wash stands as a shining example of our nation's commitment to creating jobs and tackling the world's most pressing energy issues.

Madam Speaker, I ask my colleagues to join me in showing our appreciation for the hard work and dedication of The Smart Car Wash team. It is through courageous investments and initiatives like this one that our country will continue to realize a robust and cutting edge economy.

KENTUCKY SPACE JOINS NASA PROJECT FOR EDUCATIONAL AND BUSINESS RESEARCH ON SPACE STATION

HON. BEN CHANDLER

OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. CHANDLER. Madam Speaker, I rise today to congratulate Kentucky Space's role in exciting new developments in space. Recently, this Kentucky enterprise partnered with NanoRacks LLC, a Houston-based aerospace company chosen by NASA to design, coordinate, and conduct research on the International Space Station to further the needs of both educational and commercial clients. Kentucky Space has been called upon by NanoRacks to assist in the design and integration of U.S. research payloads which will fly aboard the international space station starting in mid–2010.

The possibilities of what we can do outside the Earth's atmosphere are endless and include great promise for all nations and all people. This broadening of our current use of the space station opens doors to the endless opportunities for research in technologies ranging from new medical treatments and equipment to alternative clean energy. These technologies will create jobs and can improve quality of life as well as save lives. The need for this expansion is clear, and I am proud that Kentucky Space is a pioneer in this new realm.

Madam Speaker, I proudly ask you to join me in applauding Kentucky Space along with NASA, the Augustine Commission and the White House for their work and support in furtherance of cost-efficient space research. The movement toward new uses of our space station will assure the continued leadership of the U.S. in our exciting exploration of the universe.

RECOGNIZING THOMAS DUGAN

HON. TOM McCLINTOCK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. McCLINTOCK. Madam Speaker, it is my distinct honor to recognize a heroic resident of the 4th District of California, Thomas Dugan of Roseville. This 11-year-old boy scout displayed courage and selflessness when he dove into a pool to save his young neighbor.

On September 20, 2008, while attending a neighbor's birthday party, Tom heard his 2-year-old neighbor, Cine, fall into his neighbor's pool. Without hesitation, Tom dove into the pool to save the drowning girl. Barely able to keep his head above water to breathe, Tom treaded water until he was able to push young Cine out of the pool and onto the deck.

For his bravery, Tom has been awarded the Boys Scouts of America Heroism Award. I am privileged and humbled to represent great constituents like Tom, and I wanted to take this brief opportunity today, Madam Speaker, to let my colleagues know of his great act of courage.

EARMARK DECLARATION

HON. RODNEY ALEXANDER

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. ALEXANDER. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of the Interior Appropriations Act, 2010, H.R. 2996.

Congressman RODNEY ALEXANDER

H.R. 2996

STAG

City of Monroe, Louisiana

Monroe Wastewater Treatment System—$500,000. Portions of the wastewater collection system were constructed in the 1920s and 1930s and are in severe state of deterioration. Even with maintenance, breaks have developed along the pipeline and in manholes. These breaks allow excess rainwater and groundwater to enter the collection system adding extreme pressure to an overtaxed system resulting in Sanitary Sewer Overflows, SSOs, which are violations of the Clean Water Act. The City has entered into a Consent Decree with the Environmental Protection Agency, EPA, that requires the City to pay a fine of $235,000 and implement of a costly sewer rehabilitation program to eliminate SSOs within 11.5 years. The cost of this program is estimated to cost over $150 million. To date the City of Monroe has spent $110 million toward this goal, implementing many of the projects needed to upgrade its wastewater treatment system as mandated by the Consent Decree. This effort has put a severe financial strain on the City's resources limiting chances to fuel economic growth in areas of the City. Funding assistance from the federal government is imperative if the City is to meet the remaining requirements of the EPA Consent Decree, in particular, rehabilitation and general I/I abatement work, SSO corrective action.

EARMARK DECLARATION

HON. ROBERT E. LATTA

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. LATTA. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information for publication in the CONGRESSIONAL RECORD regarding earmarks I received as part of H.R. 2996, the Fiscal Year 2010 Interior, Environment, and Related Agencies Appropriations Act Conference Report.

Requesting Member: Congressman ROBERT E. LATTA

Bill Number: H.R. 2996, Fiscal Year 2010 Interior, Environment, and Related Agencies Appropriations Act

Account: EPA; STAG Water and Wastewater Infrastructure Project

Legal Name of Requesting Entity: City of Fostoria, Ohio

Address of Requesting Entity: 213 South Main Street, Fostoria, OH 44830

Description of Request: $500,000 for the City of Fostoria for the planning, design and construction of a new sanitary pump station and force main. The existing sewer system within the project area is required to be studied in detail. The study will include the investigation of sewer alignments, sizes, catchment areas, and capacity. The study may also include the development of the most economic protocol to full/partial separate sanitary and storm sewers, redirecting inflow to the East Branch of the Portage River. This project will significantly expedite the City's compliance with the Clean Water Act. I certify that neither I nor my spouse has any financial interest in this project.

STATEMENT ON: AFFORDABLE HEALTH CARE FOR AMERICA ACT

HON. JAY INSLEE

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 01, 2009

Mr. INSLEE. Madam Speaker, I rise today to express my support for the Affordable Health Care for America Act. Today marks an historic day for the health of all Americans. Today, this Congress joins with the American people to say that health care is not only a policy issue, but an issue of morality; and no longer will the conscience of this country allow Americans to go without access to affordable, comprehensive health care coverage. I want to thank Speaker PELOSI and the House leadership for their steadfast determination; and Chairmen RANGEL, MILLER, and particularly Chairman WAXMAN of the Energy and Commerce committee on which I am proud to sit, for their thoughtful leadership on this issue.

Access to affordable health care has the power to break the shackles imposed on Americans today who are fearful of leaving their job, starting a new business, or going to the doctor due to their lack of coverage. In my district alone, this bill has the power to provide coverage for 30,000 uninsured residents; improve employer-coverage for 524,000 residents; provide credits to help pay for coverage for up to 120,000 households; improve Medicare for 84,000 beneficiaries, including closing the prescription drug donut hole for 7,400 seniors; allow 20,000 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 18,600 small businesses. Additionally, this legislation will protect up to 1,100 families from bankruptcy due to unaffordable health care costs; and reduce the cost of uncompensated care for hospitals and health care providers by $28 million.

As a member of the Energy and Commerce committee I was able to fight to include several provisions that will improve access to affordable health care in Washington state, the most important of which is President Obama's public health insurance option. Like our President, I believe that it is important to protect the interest of the consumer by providing choices so that people may decide which health insurance solution works best for them and their family. That is one reason I am a strong advocate of a public health insurance option. The President's public health insurance option will be offered in a health insurance exchange, created in this bill, alongside coverage sold by private insurers; thereby using natural market competition to control the rising cost of health coverage while protecting consumer choice. The implementation of this exchange will make insurance affordable for an additional 36 million Americans, raising the share of legal, nonelderly residents with health insurance coverage from 83 percent to 96 percent. The public insurance option will bring competition to the marketplace and consumer interests will be protected by addressing affordability and access issues that plague our current system.

Washington state is a leader in high-quality, efficient health care. Our doctors and hospitals produce some of the country's best health care outcomes. We have a culture of medicine that places emphasis on patient safety, outcomes, and care. And yet for decades we have been penalized for our efficiency by receiving lower reimbursement rates per service under the Medicare fee-for-service reimbursement model. On average our providers are reimbursed fifteen to fifty percent less per service than their counterparts in other parts of the country. The reason for this discrepancy is that our statewide efficiency gives the appearance that it merely costs less to deliver care in the state because our overall patient costs are lower.

Opponents have argued that practice expenses vary by geography. But, on November 5, 2009, the American Medical Association (AMA) released the results of its 2007–2008 study that included physician practice expense information from over seventy medical specialty societies and the Centers for Medicare and Medicaid Services Physician Practice Information (PPI) survey. The results of the study showed that expenses did not differ significantly by either metro location or census region and reconfirmed what providers in

Washington state have known for decades—that the Medicare physician payment formula is flawed.

To this end, I was honored to be one of eight Members chosen by Speaker PELOSI to negotiate a resolution to this geographic disparity issue that has plagued our country for decades. The result, after four months of negotiations, is an agreement that will move the nation to a system that rewards high quality, cost-effective care; reimbursing for the value rather than the volume of services. It will fix existing Medicare geographic payment inequities and will cover both physician and hospital payments. This will provide an historic transformation of the Medicare payment system to ensure better care for patients and reduce health care costs over the long term.

The first part of the agreement addresses the geographic variation in the rates doctors are paid per service. The bill instructs the Institute of Medicine (IOM) to conduct a study to evaluate and make recommendations to improve the geographic adjustment factors in the Medicare reimbursement formulas which will be completed one year after enactment. The Secretary of HHS will then implement a new Medicare payment rate that takes into account the IOM recommendations. An initial investment of $4 billion per year in 2012 and 2013 is allocated to make payment rate adjustments. After 2013 reimbursement adjustments will become budget neutral.

Geographic variation in the utilization of services is addressed in the second IOM study on high value care. The IOM will make recommendations on how to transform the Medicare payment system to reward value and quality of care. Value is defined as the efficient delivery of high quality, evidence-based, patient-centered care. The study will be completed by April 15, 2011. No later than ninety days after the report is completed, the Secretary of HHS will submit to Congress a preliminary implementation plan based on the IOM study, which MedPac and GAO will evaluate within forty-five days. The IOM's quality and value-based payment recommendations will automatically go into effect unless the House and Senate pass joint resolutions of disapproval by May 31, 2012. The goal was to finish all studies and changes before the public option goes into effect in 2013 so the recommendations would be incorporated.

This deal is a real victory for Washington state. Correcting the fundamental inequalities in Medicare reimbursement rates that underpay Washington state physicians will ensure access to Medicare physicians for Washington state seniors and Medicare beneficiaries. Additionally, this provision sets in motion a fundamental shift in the way we will reimburse for medical care going forward; moving away from a fee-for-service model and towards an outcome-based model. This shift will provide real cost containment by incentivizing and reimbursing for the quality, not the quantity, of medical care across the United States; saving the country billions of dollars.

A compounded issue resulting from Medicare reimbursement disparity is the reliance on Medicare Advantage plans by Medicare beneficiaries in low cost areas. Medicare Advantage plans in Washington state have played a critical role in providing seniors with access to care because they have been able to reimburse providers at a higher rate than traditional Medicare, thereby attracting providers into the network who would otherwise be unable to treat Medicare beneficiaries due to cost. It is for this reason that I fought tirelessly to ensure a quality bonus for high-quality, efficient Medicare Advantage plans. Under the language I negotiated in the House bill, four-star rated plans and above, in the bottom thirty percent of costs to the system, would be eligible for a 1.5 percent bonus in 2011; a 3.0 percent bonus in 2012; and a 5.0 percent bonus for each subsequent year. These bonus payments will ensure the continuation of high quality health care for Medicare Advantage recipients in Washington state.

Washington state is not only a leader in patient care, but also in medical innovation. The biotech industry is an important health care partner in Washington state. Across the state roughly 1,060 biotech companies employ 23,047 Washingtonians. The state ranks eighth in National Institute of Health grants and in the past two years academic bioscience research expenditures totaled $685 million. The innovation occurring in the state has lead to some of the leading biologic therapies for life-threatening illnesses such as cancer, multiple sclerosis, diabetes, HIV/AIDS and many serious rare diseases.

Biologics are living organisms, different and more complex than small molecule drugs. Biotech medicines can be determined to be the "same" as the original drug, but science is not yet at a point where they can be determined to be "identical." And even small differences between a copy and an original biologic can cause differences in effectiveness, and, in some cases, serious side effects. Therefore it is necessary that policy reflect the uniqueness of these therapies, and ensure drug efficacy and patient safety. I believe a pathway for the approval of biosimilar biologics is the critical next step to providing patients with increased access to lifesaving therapies. I also believe that we can create a pathway that provides patients with lower-cost medicine without sacrificing safety or eliminating incentives to create breakthrough medicines.

This is why I, joined by my fellow committee members ANNA ESHOO and JOE BARTON, introduced H.R. 1548, the Pathway for Biosimilars Act. The legislation protects patients by ensuring patient safety, recognizing the scientific differences between small-molecule drugs and biologics, maintaining the physician-patient relationship, and preserving incentives for innovation. I was proud to co-sponsor an amendment in the Energy and Commerce Committee markup of H.R. 3200 that incorporated key pieces of our legislation. The amendment includes twelve years of data exclusivity for innovator biologics, ensuring not only that these life-changing and life-saving biologic treatments are more accessible and affordable, but that we also foster continued research and development investment needed to search for new cures and treatments. The strong bipartisan votes in both the House and Senate on this issue demonstrate that Congress is committed to a fair and safe pathway for biosimilars. I commend the House for adopting my legislation as part of HR 3962, and it is my sincere hope that it will be included in the final conference agreement.

A few other provisions that I want to highlight are great examples of how Washington state's health care leadership has helped shape federal health care legislation. Earlier this year the state passed a common sense law that will save billions of dollars in administrative health care costs by standardizing insurance claims and forms processes, and I was proud to fight for the inclusion of similar language in the Affordable Health Care for America Act. Washington state has also been innovative in health care plan structures allowing for the emergence of direct primary care medical home plans that provide low cost coverage of primary care services. This model has granted access to care for a population that has been shut out from traditional health care coverage due to high costs. I was grateful to see the inclusion of this coverage model in the health care reform legislation. I am proud to represent a district and state that is leading the way on health care policy.

Once again I would like thank Speaker PELOSI and the House leadership for their continued determination that brought all facets of the Democratic Caucus to the table and ensured that each member had a voice in the debate. As a result the House of Representatives has produced a health care reform bill that will provide access to affordable health care and bend the cost curve; and I am once again proud to offer my support.

HOUSE OF REPRESENTATIVES—*Wednesday, December 2, 2009*

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

PRAYER

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

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

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

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

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

THE JOURNAL

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

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

PLEDGE OF ALLEGIANCE

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

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

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

ANNOUNCEMENT BY THE SPEAKER

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

OUR PRESENCE IN AFGHANISTAN NOT WANTED

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

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

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

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

CONDITIONAL COMMITMENT

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

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

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

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

And that's just the way it is.

JOBS AND THE ECONOMY

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

Mr. WILSON of Ohio. Madam Speaker, I rise today to address the issue of key importance for my constituents: jobs and the economy. I'm proud of the work that Congress has done to bolster the economy and create new jobs across our country. In Ohio, we continue to see new funds awarded and released every week. Communities across the State and my district have been positively impacted by these funds. To date, over $225 million of recovery funds have been announced to counties I represent along the Ohio River, ranging from improvements in technology investments to education funding, substantial things for our future.

Just last week, $75 million in recovery money was announced in Ohio. These funds include $8.6 million for water projects in 10 of my 12 counties. That investment represents jobs for our workers and clean water for our residents. I'm proud to work for the results that these investments have accomplished. With more than half the money to be spent, I look forward to more of these improvements throughout the State of Ohio as we put America back to work.

HONORING MIAMI-DADE POLICE DIRECTOR ROBERT PARKER

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

Ms. ROS-LEHTINEN. I rise today to extend my sincere thanks to a distinguished south Floridian and a faithful public servant, Miami-Dade Police Director Robert ''Bobby'' Parker. After 33 years of serving our community, it is truly with great sadness that we see such a fine and dedicated police officer retiring.

In 2004, Bobby's long and successful career with the Miami-Dade Police Department culminated in the directorship of the department. Under his leadership, the department saw the implementation of unique and cutting-edge programs such as the Mortgage Fraud Task Force and the Gun Bounty Program. Bobby's foresight and hard work have consistently had a profound and positive impact on all of south Florida. He has always made his greatest efforts for the benefit of others and will be greatly missed by both the department and our community.

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

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

BRINGING A STRONG JOBS BILL

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

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

So as we recover from one of the most severe recessions in our Nation's history, Democrats will focus on helping Americans on Main Street, not Wall Street. We will build upon the momentum we have created for positive growth in our economy and bring to the House floor strong legislation to create jobs. American families are depending on their leaders to focus their attention on job creation and make the difficult decisions necessary to curb employment and begin growing our job force once again. Americans expect nothing less, and House Democrats are committed to bringing to the floor a strong jobs bill and work to turn around our Nation's economy.

HONORING KEVIN LEE MITCHEM OF MATHEWS COUNTY, VIRGINIA

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

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

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

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

JOBS SUMMIT

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

Mr. BACA. Recently, a single parent in my district called my office for help. He lost his good-paying job and the health benefits that went with it. Sadly, he is not alone in this problem. More Americans than ever before are losing their jobs, their livelihood, and their homes. In California, the unemployment rate is 12 percent. In my area, the Inland Empire, unemployment is a staggering 14 percent. We continue to have one of the highest rates of foreclosure in the Nation. The hardworking men and women in my district and throughout the Nation deserve a good-paying job; quality, affordable health care; enough food to put on the table; and a good quality of life.

I commend President Obama for hosting a jobs forum. We need to create jobs so that people can put food on the table and keep their homes and live the American Dream. Instead of pointing fingers and calling names, this is a time when we all need to be working together to find real solutions in creating jobs for the American people right here in the United States and not outsourcing those jobs outside of here.

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

DISPELLING HEALTH CARE MISINFORMATION

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

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

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

WIDER WAR NOT A PATH TO PEACE AND SECURITY

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

Mr. DOGGETT. Madam Speaker, I agree with so much of what President Obama said last night, but not so much what he would do. The path to peace and security will not be found through a wider war. Troop escalation by 40 percent, then de-escalation, all within 18 months, is totally unrealistic. We have been fighting in Afghanistan on the installment plan: a few more troops, a few more months, and many more billions. 2011 will not mark the end of this war. It will just mark the beginning of the next installment in what is a deteriorating 8-year war whose elusive end is always just over the horizon.

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

□ 1015

STIMULATING OUR ECONOMY THROUGH ANOTHER JOBS BILL

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

Mr. WU. Madam Speaker, to form a government requires positive steps, and it is much less about what one is against than about what one is for. Who can forget that sense of free-fall in our economy last fall when we weren't

sure, those of us who had money in money market accounts, that we were going to get 100 pennies back on the dollar that we put into a bank. Who could forget the sense of free-fall in March or April when it wasn't clear where our economy was ever going to go?

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

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

ENFORCE TRADE LAWS TO SAVE JOBS

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

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

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

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

CREATE JOBS BY CUTTING TAXES

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

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

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

THE STIMULUS PLAN IS WORKING

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

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

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

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

NATIONAL EPILEPSY AWARENESS

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

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

Earlier this year, I met a spirited 9-year-old from my district. Since the age of 7, Chad has been living with epilepsy and faces daunting challenges in school because of various misconceptions. Despite major progress in diagnosis and treatment, epilepsy is often misunderstood and overlooked. Contrary to belief, it is not contagious. Some believe epilepsy is curable with medication or treatment when, in fact, over 30 percent of patients suffer uncontrollable seizures despite treatment.

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

A NATIONAL HOME RETROFIT PROGRAM WILL CREATE JOBS NOW

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

Mr. WELCH. Madam Speaker, America faces two very serious challenges today. The first is an economy that continues to struggle. Too many Americans who want to work are out of work. The second is an energy policy that is failing. It's not clean, it's not sustainable, and it's not affordable. We can address the jobs issue by taking on the challenge of a clean energy economy. We can create jobs. We can save homeowners money on their energy bills, and we can reduce our contribution to climate change. We can do that by investing in a national energy efficiency retrofit program.

Recently, 44 of my House colleagues and I wrote to President Obama, urging him to act now, to use his existing authority, to use already appropriated stimulus funds to build a national home retrofit program that will create jobs. Some call it Recovery Through Retrofit. Some call it Cash for Clunkers. I call it a sure-fire way to create jobs, and to create them now.

JOBS AND THE ECONOMY

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

Ms. WATSON. Madam Speaker, Democrats have been focused on helping Main Street, not Wall Street, and momentum continues to build for additional job creation legislation. The Republicans created one of the worst recessions in history and did very little to help a recovery. The Republicans exacerbated the bad economy with tax

cuts that favored the wealthy and did very little to help working people. Democrats acted to save the economy from falling apart, to facilitate a recovery and to put people to work.

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

TIME TO END THE WAR IN AFGHANISTAN

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

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

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

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

SUPPORT FOR SENDING MORE TROOPS TO AFGHANISTAN

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

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

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

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

THE NEW CONGRESSIONAL TASK FORCE ON JOB CREATION

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

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

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

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Record votes on postponed questions will be taken later.

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

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

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 494

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

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

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

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

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

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

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

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

Whereas, in the report prepared for General Dwight D. Eisenhower rating the American combat units that fought in the European Theater, the Army's official historian, S.L.A. Marshall, rated the 30th Division as first among the infantry divisions that had performed the most efficient and consistent battle service, writing that ''It was the combined judgments of the approximately 35 historical officers who had worked on the records and in the field that the 30th had merited this distinction. It was our finding that the 30th has been outstanding in three operations and we could consistently recommend it for citation on any of these occasions. It was further found that it had in no single instance performed discreditably or weakly when considering against the average of the Theater and that in no single operation had it carried less than its share of the

burden or looked bad when compared to the forces on its flanks. We were especially impressed with the fact that it consistently achieved results without undue wastage of its men.'';

Whereas, in recognition of its exemplary service during World War II, the Headquarters Company of the 30th Infantry Division was awarded the Meritorious Unit Commendation and the French Croix de Guerre; and

Whereas the proud fighting tradition of the 30th Infantry Division is perpetuated by the 30th Armored Brigade Combat Team, North Carolina Army National Guard: Now, therefore, be it

Resolved, That the House of Representatives recognizes the exemplary service of the soldiers of the 30th Infantry Division of the United States Army during World War II.

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

The Chair recognizes the gentleman from North Carolina.

GENERAL LEAVE

Mr. KISSELL. Madam Speaker, I request unanimous consent for Members to have the usual 5 days to extend and revise their comments.

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

There was no objection.

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

I rise today with strong and enthusiastic support for House Resolution 494. This resolution honors the history of the 30th Infantry Division of the United States Army, a division that was founded in 1918 during World War I and extends until today with its service in Iraq as we currently speak. I also especially want to point out a particular time during August of 1944 when the 30th Infantry Division was engaged in a battle in Mortain, France, a battle that proved to be pivotal in our securing the invasion of Normandy and a battle which the 30th Division, for whatever reason, has not fully received the credit for their bravery and the dedication they showed.

□ 1030

The infantry division that we call the 30th was originally manned by mostly National Guard folks from North Carolina, South Carolina, Georgia, and Tennessee. They took on the nickname of President Andrew Jackson and called themselves the ''Old Hickory'' Division, a nickname which they maintain today.

This division was reactivated prior to World War II and served from the invasion of Normandy in which the 230th Field Artillery of the 30th Division came ashore on Omaha D-day-plus-1. The rest of the division came ashore D-day-plus-2. The units were reunited and fought almost continuously in the days and weeks that followed our invasion of France.

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

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

And the 30th Division, taking on the multiple panzer divisions of the German Army, did hold. They scattered into individual units and fought bravely for almost a week. They fought as our American soldiers have fought in the past. They fought bravely and were dedicated against great odds, but they held. And General Bradley was able to send General Patton on the flanking maneuver once again known as the St. Lo Breakout that once and for all secured our beachhead and launched us across France toward the end of World War II.

Eisenhower's chief historian, S.L.A. Marshall, called the 30th the ''most efficient fighting division in Europe.'' The German Army paid the 30th a great compliment in referring to them as ''Roosevelt's S.S.''

It's for these reasons that we want to honor the 30th and its history and especially to draw recognition to the battle of Mortain, France, a time in which the 30th held in a most important time period for our invasion to be successful and secured.

Madam Speaker, I reserve the balance of my time.

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

Madam Speaker, today I rise in strong support of House Resolution 494, which recognizes the service and sacrifices of the members of the 30th Infantry Division during World War II. And I want to commend Representative LARRY KISSELL of North Carolina for sponsoring this legislation, for his leadership, and for his deep passion concerning the members of the 30th Infantry.

The 30th Division was a National Guard division made up of men from several States, with many initially coming from North Carolina and Tennessee. These citizen soldiers established a remarkable record in Europe during the operations from 1944 through the end of the war in May of 1945.

So outstanding were their achievements that military historians of the day judged it to be the first among infantry divisions that had performed the most efficient and consistent battle service, achieving results without undue wastage of the lives of men who served in the 30th.

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

I urge every Member to support this resolution.

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

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

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

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

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

But he was just one of many that served our Nation in the 30th and all the other forces during World War II that we call the ''Greatest Generation,'' that came back and did so much

to make this Nation the great Nation that it continues to be today.

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

Mr. ETHERIDGE. Madam Speaker, I rise in strong support of H. Res. 494 as a cosponsor of this important resolution. It honors the 30th Infantry Division of World War II, which included National Guard soldiers from my state of North Carolina, as well as troops from Tennessee. The long history of the 30th Infantry goes back further, though, to include the service of individuals from across the South. Each time they were called to duty, they answered the call with distinction and bravery.

Their service during World War II was particularly exemplary, and I appreciate my colleague Congressman KISSELL, whose father served in this division, for bringing forward a resolution to honor their valiant work. The achievements of the 30th Infantry Division were so exemplary that military historians of the day singled it out for distinction as the first among infantry divisions, noting both "outstanding" battle service and efficiency that preserved the lives of its members. Eisenhower's chief historian, S.L.A. Marshall, called the 30th the "most efficient fighting division in Europe."

Although the 30th Infantry Division was not involved in the actual invasion of Normandy, it engaged in a pivotal battle in Mortain, France that contributed to the Allied victory at Normandy. Serving with bravery and distinction at St. Lo, France, the 30th enabled the Allies to outflank the German Army in what came to be called the St. Lo Breakout. The 30th was also instrumental in breaching the Siegfried Line in October 1944, and the capture of Aachen, Germany. In short, the 30th Division, Old Hickory, played a significant part in our eventual victory over the Axis in WWII.

Today, North Carolina's National Guard soldiers serve with honor in Iraq and Afghanistan, bravely doing their part in defense of our Nation. As they do so, they are part of a valiant heritage that goes back to the founding of our Nation. Each time they are called to service, they do North Carolina and our Nation proud, as they are doing today.

North Carolinians are proud of the service and history of the 30th Infantry Division. We thank soldiers for safeguarding freedom and our way of life, in World War II and today in Afghanistan and Iraq. These courageous soldiers accomplished feats of heroism and bravery which preserved a way of life on two continents. They represent a proud fighting tradition and have earned every accolade we can give.

As a cosponsor of H. Res. 494, I strongly support this legislation, and I urge my colleagues to join me in honoring the soldiers that have and continue to protect our freedom.

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

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

The question was taken.

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

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

The yeas and nays were ordered.

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

CONGRATULATING THE SAILORS OF THE UNITED STATES SUBMARINE FORCE

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

The Clerk read the title of the concurrent resolution.

The text of the concurrent resolution is as follows:

H. CON. RES. 129

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

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

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

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

Whereas the national maritime strategy of the United States recognizes the critical need for strategic deterrence in today's uncertain world;

Whereas the true strength of the ballistic missile submarine lies in the extremely talented and motivated Sailors who have voluntarily chosen to serve in the submarine community; and

Whereas the inherent stealth, unparalleled firepower, and nearly limitless endurance of the ballistic missile submarine provide a credible deterrence for any enemies that would seek to use force against the United States or United States allies: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That Congress—

(1) congratulates the Sailors of the United States Submarine Force upon the completion of 1,000 Ohio-class ballistic missile submarine (SSBN) deterrent patrols; and

(2) honors and thanks the crews of ballistic missile submarines and their devoted families for their continued dedication and sacrifice.

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

The Chair recognizes the gentleman from North Carolina.

GENERAL LEAVE

Mr. KISSELL. Madam Speaker, I request unanimous consent for Members to be able to extend and revise their remarks during the next 5 days.

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

There was no objection.

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

Madam Speaker, it is with great enthusiasm that I rise in support of House Concurrent Resolution 129, and I want to thank Representative DICKS from Washington for his work in bringing this resolution to the floor. It is an opportunity for us as a House of Representatives to congratulate the Navy and the sailors of our ballistic submarine fleet upon the completion of 1,000 missions, that's 1,000 missions of deterrence and protecting our Nation. This silent service, the Ohio-class submarine, the highest of technology, the greatest of sailors, and the most stealthy of operations, has been in service protecting our Nation since the first cruise of the USS *Ohio* in 1982.

This is not an easy service. Only 5 percent of all our sailors are qualified to serve in our ballistic submarine fleet. The highest of technologies and the advancements that we have seen as a Nation are represented in this classification of service also.

Oftentimes, our sailors are on duty for 77 or more straight days and they come back then to work 35 days of maintenance. It puts a tremendous burden upon them. But, once again, these are the highest qualified of individuals that you can find, because when they are on their ship, they have to have the knowledge of the technology to the most minute of details to be able to service the ship as needed and to complete the mission. And they have an A-plus rating for these years of service during the 1,000 missions that they have brought to us.

Madam Speaker, I reserve the balance of my time.

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

Madam Speaker, I rise today to share my colleagues' congratulations to the sailors of the United States Navy's Submarine Force following the completion of the 1,000th Ohio-class ballistic missile submarine deterrent patrol. This is no small feat and has been made possible only through the combined efforts of our dedicated sailors, the talented civilians employed at the Trident Refit and Weapons Facilities, the disciplined workforce of the naval reactors, and the industrial base that

has delivered such reliable submarines and Trident missile systems.

The ballistic missile submarine, or SSBN, is the critical third leg of our nuclear triad, and in many ways this capability is the most stealthy, delivering unparalleled firepower and near limitless endurance that poses a significant deterrent to potential aggressors armed with nuclear weapons. Likewise, our allies have relied on the shield provided by our ballistic missile submarines, which can operate unmolested in virtually any part of the world.

Yet this deterrent capability comes at a significant personal cost to the Submarine Force, its crews, and their families. Since the first patrol of the USS *Ohio* in 1982 through today, these families have endured long periods of noncommunication with their loved ones and tense waiting for their safe return.

Therefore, despite the extraordinary technological achievement and reliability epitomized by the SSBN, the true strength of the ballistic submarine lies in the extraordinarily talented and motivated sailors who have voluntarily chosen to serve in the submarine community and are among the most highly skilled, educated, and trained war fighters in the U.S. military.

Today we thank and honor the crews of the ballistic missile submarines, the civilian and industrial workforces that strive to preserve the submarines' reliability and technological superiority, and the devoted families of the Submarine Force for their continued dedication and sacrifice.

Finally, I would like to thank all of my colleagues who cosponsored this resolution, especially Representative DICKS of Washington for drafting this resolution.

Madam Speaker, I reserve the balance of my time.

Mr. KISSELL. Madam Speaker, I yield such time as he may consume to the gentleman from Washington (Mr. DICKS).

Mr. DICKS. Madam Speaker, I introduced this resolution, H. Con. Res. 129, to recognize the achievements of the U.S. Submarine Force for the completion of the 1,000th Trident strategic deterrent patrol earlier this year. It is fitting that we take a moment to recall the sacrifices made by these submariners and their families to defend our freedoms and protect our way of life.

□ 1045

For over 27 years, Ohio-class ballistic missile means, or SSBNs, have been our most survivable form of deterrence. As a result of the commitment to excellence by everyone associated with the SSBN program, our strategic missile submarines have always been ready and vigilant, reassuring our allies and deterring those who might seek to do us harm. Our ballistic missile submarines provided essential deterrence during the Cold War, and their contributions will forever be a part of our Nation's history. Today, these elite submarines remain on the front lines of freedom. Through their silent patrols, they will preserve peace for many years to come.

The success of the Trident program and the protection it continues to provide is a result of the sacrifices of a broad array of organizations and individuals: the submarine industrial base, which provides the advanced technologies and highest quality equipment for these ships; the maintenance facilities and their technicians and engineers who work to a demanding timeline and under difficult constraints to keep these boats ready for sea; the submarine training facilities which ensure that our sailors are trained and ready to perform their missions under any circumstances; and not least, the sailors and their families who dedicate their lives to supporting our Nation. Their sacrifice year after year is a large part of our Nation's greatness.

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

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

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

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

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

I would just add one thing: this is such an important program—and I have been on the Defense Appropriations Subcommittee for 31 years—that we are now starting a follow-on to the Trident submarine program. And I can remember when we had great debates here in the House on whether we should do a B–2 bomber and whether we should have an MX missile. The one thing that we always understood is that the most survivable element of our strategic triad were these Trident submarines, and I commend Admiral Rickover and all of those who followed him for the great work that they did in inspiring these concepts, and it has been of great value to our country.

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

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

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

This branch of service remains strong. It is a clear deterrent to threats that our Nation may incur. We once again congratulate this branch of service on its 1,000th mission of deterrence and 1,000th successful mission.

I reserve my time.

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

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

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

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

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

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

I yield back my time.

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

The question was taken.

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

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

The yeas and nays were ordered.

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

MILITARY FAMILY MONTH

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

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 861

Whereas military families, through their sacrifices and their dedication to the United States and its values, represent the bedrock upon which the United States was founded and upon which the country continues to rely in these perilous and challenging times; and

Whereas the month of November, which includes the Veterans Day holiday, was declared by the President on October 30, 2009, to be Military Family Month: Now, therefore, be it

Resolved, That the House of Representatives—

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

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

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

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

The Chair recognizes the gentleman from North Carolina.

GENERAL LEAVE

Mr. KISSELL. Madam Speaker, I request unanimous consent for Members to have 5 legislative days in which to extend and modify their remarks.

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

There was no objection.

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

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

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

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

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

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

I reserve my time.

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

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

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

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

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

Mr. KISSELL. Madam Speaker, I once again thank Representative ROONEY for bringing this resolution to the floor. And all of the ideals that he expressed, I thank him so much for.

I've had the opportunity to speak with many of our soldiers; and to a person, they tell me that if they just know their families are being taken care of, what a relief that is for them to concentrate on the duty that we're asking for them to perform in wherever the mission might be.

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

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

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

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

□ 1100

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

During a time of extended conflict, it is imperative not only that we stop and take time to acknowledge the dedications and sacrifices made by our military families every day, but also that

we pause to recognize the strength, commitment, and courage of the military spouse and children of our men and women serving today.

Whether deployed overseas or training at home, the families of our servicemen and -women are the foundation of our military and proudly represent a keystone in a strong national defense. Even though this resolution commemorates 1 month of recognition for our military families, I believe our military families should be praised every day for their selfless service to America. I urge Members to vote in favor of this resolution and American military families.

I yield back the balance of my time.

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

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

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

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

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

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

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

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

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

Ms. JACKSON-LEE of Texas. Madam Speaker, I rise today in support of H. Res. 861, which supports the goals and ideals of National Military Family Month. The fact that our star-spangled banner yet wave is a testament to the courage and honor of our military which is reason enough to thank the men and women of our military for the safety we have here in America; equally important are the loved ones they leave behind each tour, who support them and help keep them going day in and out.

In 1996, the Armed Services YMCA expanded Military Family Week, which usually occurred around Thanksgiving, into Military Family Month. Just like the week grew into a month long celebration in appreciation, so to have military families grown in number. "When I came in the service back in the Dark Ages, most of the troops were single. Everybody was single," said retired Navy Rear Adm. Frank Gallo, director of the Armed Services YMCA. Now, he added, 65 percent to 70 percent of service members are married, many with children. Families are a big part of the military, and the health of those families is also a big part of the readiness of the military, he said.

Military Family Month puts a little extra focus on supporting the families who support the men and women of our military. This has especially been true since the beginning of the conflicts in Afghanistan and Iraq as more of our soldiers are deployed.

The men and women of our military, through trial and tribulation, carry on; which they do in the name of many things, namely freedom, justice, democracy as well as in the name of their family and loved ones. The support necessary to keep a person going in such an atrocious environment is unfathomable, yet their families too, carry on. In my home district, the 18th District of Texas, we currently have, according to the Department of Defense, approximately 400 men and women in the military. With President Obama's planned deployment of 30,000 more troops to Afghanistan, there is bound to be more families left without sons, daughters, brothers, sisters, mothers and fathers here at home. National Military Family Month will help provide encouragement to military families who in turn support our military men and women.

Military families, through their sacrifices and their dedication to the United States and its values, represent the bedrock upon which the United States was founded and upon which the country continues to rely in these perilous and challenging times. The month of November, which includes the Veterans Day holiday, is an appropriate month to observe National Military Family Month, which recognizes the sacrifices and dedication of military families and their contributions to the United States. H. Res 861 will also encourage the people of the United States to observe National Military Family Month with appropriate ceremonies and activities.

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

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

The question was taken.

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

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

The yeas and nays were ordered.

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

RECOGNIZING IMPORTANCE OF TEACHING STUDENTS ABOUT VETERANS

Mr. BISHOP of New York. Madam Speaker, I move to suspend the rules and agree to the resolution (H. Res. 897) recognizing the importance of teaching elementary and secondary school students about the sacrifices that veterans have made throughout the history of the Nation.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 897

Whereas veterans have made innumerable sacrifices for the freedom and welfare of the United States and people worldwide;

Whereas in 2008 there were over 23,000,000 veterans in the United States, but many elementary and secondary school students are

not aware of the efforts veterans have made to protect our freedoms;

Whereas many elementary and secondary schools and teachers have held drives in recent years to collect items to send to veterans, members of the Armed Forces, and families of such members;

Whereas fewer than half of the Nation's high school seniors have a basic knowledge of American history and the contributions veterans have made to the Nation's safety and security;

Whereas it is important for elementary and secondary school students to learn about the history of the Nation and the wars and missions veterans have participated in and sacrificed for; and

Whereas elementary and secondary schools across the Nation host Veterans Day programs to honor and educate students about the sacrifices veterans have made: Now, therefore, be it

Resolved, That the House of Representatives—

(1) recognizes the importance of teaching elementary and secondary school students, on Veterans Day and throughout the school year, about the sacrifices that veterans have made throughout the history of the Nation; and

(2) encourages elementary and secondary schools to engage students in learning about, and honoring, veterans and the sacrifices they have made.

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

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. BISHOP of New York. Madam Speaker, I ask unanimous consent for 5 legislative days during which Members may revise and extend their remarks on H. Res. 897.

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

There was no objection.

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

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

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

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

But today, less than half of the Nation's high school seniors possess the basic knowledge of the contribution veterans have made to our Nation's safety and security, and because of this, I recognize the importance of teaching the sacrifices veterans have made for our Nation in the classroom.

Madam Speaker, I again want to support this resolution and to thank Representative GUTHRIE for bringing this resolution forward. I encourage my colleagues to support this resolution.

I reserve the balance of my time.

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

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

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

As I continued to walk, I went down to the Korean war memorial, and that is one that my family has personal experience with. My uncle, 12 years before I was born, in 1952 was killed. And so my grandfather and grandmother always talked about the sacrifice of veterans, particularly losing their oldest son in the Korean war.

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

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

And then I turned back to get back for an evening meeting. As you head to the Capitol, you understand what it is all about. The thing that you see most and foremost is the dome over the building in which we are standing. I remember walking back after having these moments with veterans and remembering veterans and looking at the dome all of the way walking back and saying, that dome is opportunity, it is freedom, it is hope. But not just for us; it is hope for the world. People look to that dome throughout the world.

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

I have been talking to schools as I mentioned earlier during Veterans Day, and one of the things I talked to them about was about Francis Scott Key and ''The Star-Spangled Banner'' and the history and the actual meaning of those words in that song. I always end it with—I will never pretend that I can improve on Francis Scott Key, but the last line, It is the land of the free and the home of the brave, I would say we need to think it is the land of the free because of the brave.

I think it is important that our students are taught, and in our home State of Kentucky, Veterans Day is a school day, but it is mandated that each school teaches about veterans by being in session on Veterans Day. I think it is important that we do this across this country, and I ask my colleagues to support this resolution.

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

Mr. BISHOP of New York. In closing, I urge my colleagues to support this resolution. I want to once again thank Mr. GUTHRIE for bringing it forward. I urge support of this resolution.

Mr. SOUDER. Madam Speaker, today I rise in support of H. Res. 897 recognizing the importance of teaching elementary and secondary school students about the sacrifices that veterans have made throughout the history of the Nation.

While this resolution is new to the House, in Fort Wayne, Indiana, Holland Elementary School has made a special effort to recognize veterans for years. In November 2001, in response to the terrorist attacks on September 11, 2001, Holland Elementary School started their annual Veterans Day Recognition Program.

Created by Principal Mike Caywood (a Vietnam veteran himself) and music teacher Jane Zwienink, the Veterans Day Recognition Program invites veterans to come to Holland Elementary on Veterans Day and share their stories with students. Principal Caywood has invited veterans from all over the local community and specifically veterans from local senior care homes. Ms. Zwienink has taught students patriotic songs that are performed for guests when they came to school. The veterans have enjoyed seeing the students perform, singing songs and sharing their patriotic message.

Over the years, Holland Elementary has seen a decrease in the number of World War II vets attending and the Korean and Vietnam vets are getting older. In response, the school has proactively reached out to veterans from Desert Storm, Iraq and Afghanistan. They have also had an increase in the number of active duty soldiers participating, including mothers and fathers of students. Many of these veterans come from the school system itself. Fort Wayne Community Schools currently employs over 100 veterans.

Holland Elementary's Veterans Day Recognition Program is a great example of how H. Res. 897 can be implemented. I want to thank Mr. Caywood and Ms. Zweinink for their hard work in recognizing local veterans and making sure elementary students understand the sacrifices of generations before them.

Mr. BISHOP of New York. I yield back the balance of my time.

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

The question was taken.

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

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

The yeas and nays were ordered.

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

AIRLINE FLIGHT CREW TECHNICAL CORRECTIONS ACT

Mr. BISHOP of New York. Madam Speaker, I move to suspend the rules and pass the bill (S. 1422) to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 1422

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Airline Flight Crew Technical Corrections Act''.

SEC. 2. LEAVE REQUIREMENT FOR AIRLINE FLIGHT CREWS.

(a) INCLUSION OF AIRLINE FLIGHT CREWS.—Section 101(2) of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611(2)) is amended by adding at the end the following:

''(D) AIRLINE FLIGHT CREWS.—

''(i) DETERMINATION.—For purposes of determining whether an employee who is a flight attendant or flight crewmember (as such terms are defined in regulations of the Federal Aviation Administration) meets the hours of service requirement specified in subparagraph (A)(ii), the employee will be considered to meet the requirement if—

''(I) the employee has worked or been paid for not less than 60 percent of the applicable total monthly guarantee, or the equivalent, for the previous 12-month period, for or by the employer with respect to whom leave is requested under section 102; and

''(II) the employee has worked or been paid for not less than 504 hours (not counting personal commute time or time spent on vacation leave or medical or sick leave) during the previous 12-month period, for or by that employer.

''(ii) FILE.—Each employer of an employee described in clause (i) shall maintain on file with the Secretary (in accordance with such regulations as the Secretary may prescribe) containing information specifying the applicable monthly guarantee with respect to each category of employee to which such guarantee applies.

''(iii) DEFINITION.—In this subparagraph, the term 'applicable monthly guarantee' means—

''(I) for an employee described in clause (i) other than an employee on reserve status, the minimum number of hours for which an employer has agreed to schedule such employee for any given month; and

''(II) for an employee described in clause (i) who is on reserve status, the number of hours for which an employer has agreed to pay such employee on reserve status for any given month,

as established in the applicable collective bargaining agreement or, if none exists, in the employer's policies.''.

(b) CALCULATION OF LEAVE FOR AIRLINE FLIGHT CREWS.—Section 102(a) of the Family and Medical Leave Act of 1993 (29 U.S.C. 2612(a)) is amended by adding at the end the following:

''(5) CALCULATION OF LEAVE FOR AIRLINE FLIGHT CREWS.—The Secretary may provide, by regulation, a method for calculating the leave described in paragraph (1) with respect to employees described in section 101(2)(D).''.

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

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. BISHOP of New York. Madam Speaker, I ask unanimous consent for 5 legislative days in which Members may revise and extend and insert extraneous materials on S. 1422 into the RECORD.

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

There was no objection.

Mr. BISHOP of New York. Madam Speaker, I yield myself such time as I may consume.

I rise in strong support of S. 1422, the Airline Flight Crew Technical Corrections Act, which is almost identical to H.R. 912 which the House passed in February. I am proud to be the principal author and principal sponsor of H.R. 912, and I was delighted to see it garner such support in the House of Representatives.

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

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

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

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

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

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

□ 1115

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

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

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

I reserve the balance of my time.

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

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

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

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

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

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

With that, I reserve the balance of my time.

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

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

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

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

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

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

A motion to reconsider was laid on the table.

□ 1130

CJ'S HOME PROTECTION ACT OF 2009

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

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 320

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''CJ's Home Protection Act of 2009''.

SEC. 2. CONGRESSIONAL FINDINGS.

The Congress finds that—

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

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

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

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

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

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

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

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

''(i) WEATHER RADIOS.—

''(1) CONSTRUCTION AND SAFETY STANDARD.—The Federal manufactured home construction and safety standards established by the Secretary under this section shall require that each manufactured home delivered for sale shall be supplied with a weather radio inside the manufactured home that—

''(A) is capable of broadcasting emergency information relating to local weather conditions;

''(B) is equipped with a tone alarm;

''(C) is equipped with Specific Alert Message Encoding, or SAME technology; and

''(D) complies with Consumer Electronics Association (CEA) Standard 2009–A (or current revision thereof) Performance Specification for Public Alert Receivers.

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

SEC. 4. ESTABLISHMENT.

Not later than the expiration of the 90-day period beginning on the date of the enactment of this Act, the consensus committee established pursuant to section 604(a)(3) of the National Manufactured Housing Construction and Safety Standards Act of 1974 (42 U.S.C. 5304(a)(3)) shall develop and submit to the Secretary of Housing and Urban Development a proposed Federal manufactured home construction and safety standard required under section 604(i) of such Act (as added by the amendment made by section 3 of this Act). Notwithstanding section 604(a)(5)(B) of such Act, the Secretary of Housing and Urban Development shall issue a final order promulgating the standard required by such section 604(i) not later than the expiration of the 90-day period beginning upon receipt by the Secretary of the proposed standard developed and submitted by the consensus committee.

SEC. 5. STUDY.

The Secretary of Housing and Urban Development shall conduct a study regarding conditioning the applicability of the requirement under the amendment made by section 3 of this Act (relating to supplying weather radios in manufactured homes) on the geographic location at which a manufactured home is placed, but only to the extent that such requirement applies to new manufactured homes and new site-built homes. In conducting such study and making determinations under the study, the Secretary shall take into consideration severe weather conditions, such as high winds and flooding, and wind zones and other severe weather data available from the National Weather Service. Not later than the expiration of the 18-month period beginning on the date of the enactment of this Act, the Secretary shall complete the study and submit a report regarding the results of the study to the Committee on Financial Services of the House of Representatives and to the Committee on Banking, Housing, and Urban Affairs of the Senate.

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

The Chair recognizes the gentlewoman from California.

GENERAL LEAVE

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

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

There was no objection.

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

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

H.R. 320, the CJ's Home Protection Act of 2009, is named after CJ Martin, a 2-year old boy who was killed when an F3 tornado struck his manufactured home in 2005. Over 8 million families rely on manufactured housing to fulfill their housing needs. However, many manufactured homes, particularly those built before 1994, are incapable of withstanding the winds of a tornado, which can reach up to 200 miles. In 2008, 45 percent of tornado-related deaths occurred in manufactured homes.

H.R. 320 would provide a much-needed safety component to manufactured homes by requiring that they be equipped with weather radios that can inform families ahead of time that potentially dangerous weather is on the way. With this information, families can take appropriate action to protect themselves in the event of dangerous weather. These radios can be provided at a minimal cost—less than $50 in most cases—and are a small price to pay for saving even one life.

In addition, given the government's reliance on manufactured housing to meet the temporary housing needs of families displaced by natural disasters such as Hurricane Katrina, this kind of housing is becoming more and more critical to the lives of many Americans. It is crucial that this housing be safe and secure over the long term because, as we have seen in the aftermath of Hurricane Katrina, the Federal Government can be lax in funding and finding permanent housing solutions for families temporarily living in these housing units.

The House already passed this legislation during the 110th Congress, and I hope that the Senate joins us in sending a bill to the President for his signature. I urge my colleagues to support this legislation.

Madam Speaker, I reserve the balance of my time.

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

Madam Speaker, I rise in support of H.R. 320, CJ's Home Protection Act of 2009. I would like to thank the chairman for his assistance in expediting this important bill to the floor. And I'd like to thank my colleague and author of the legislation, the gentleman from Indiana (Mr. ELLSWORTH), for putting this bill together.

This bipartisan bill amends the Manufactured Housing Construction and Safety Standards Act of 1974 by requiring the installation of a National Oceanic and Atmospheric Administration weather radio in all manufactured homes built or sold in the United States. These weather radios will provide immediate broadcast of severe weather warnings and civil emergency messages, including tornado and flood warnings, AMBER alerts for child abductions, and chemical spill notifications.

The legislation is named in memory of CJ Martin, a 2-year-old boy who was killed during a tornado in southwest Indiana in 2005. His mother, Kathryn, helped pass a State law requiring the manufactured housing industry to install NOAA weather radios in all newly built units and spoke at the news conference in support of similar Federal legislation. Manufactured housing in this country has replaced a lot of substandard housing, and it provides very affordable housing. It is clean, and it provides an extraordinarily good home.

Despite rapid advances in tornado warning technologies, residents of manufactured housing communities often do not have adequate access to proper shelter. Many residents of homes have a place to go in the event of a tornado, whether it is a basement or an interior room. That is why Congress passed the Tornado Shelters Act, which was signed into law in 2003. That bipartisan bill authorized communities using community development block grant monies to construct or improve tornado-safe shelters located in manufactured housing parks. Unfortunately, this program is not used often enough.

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

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

With that, Madam Speaker, I reserve the balance of my time.

Ms. WATERS. I yield such time as he may consume to the gentleman from Indiana, the author of this bill, Representative ELLSWORTH.

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

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

CJ, a loving and playful 2-year-old boy, was one of the victims that night. CJ and 24 other victims, including his grandmother and great grandmother, are the reason why I'm here today. His picture is a reminder of the heartbreaking loss that severe weather can

bring to families and communities throughout this country. All too frequently this loss comes with little or no warning.

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

While CJ is the inspiration for this important public safety legislation, Kathryn Martin, CJ's mother, is the leader in the effort. In the months after the storm, Kathryn channeled her pain and suffering toward an effort to pass similar legislation in the State of Indiana. Kathryn would not be denied. She was successful in getting the bill passed, and because of the awareness she raised about weather radios, the people in my hometown of Evansville, Indiana, have the most weather radios in households per capita in the United States.

When I first met Kathryn, I promised her that if I ever came to Congress I would introduce Federal legislation to do the same thing that she was trying to push in our State. The bill before us today is a fulfillment of that promise. CJ's Home Protection Act amends the Federal Manufactured Home Construction and Safety Standard to require that each manufactured home delivered for sale shall be supplied with a weather radio inside the manufactured home.

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

Like a smoke detector, these inexpensive devices can provide families with the warning they need to take action and protect themselves when severe weather strikes. This bill is about improving public safety, plain and simple. It's not about demonizing the manufactured housing industry. Kathryn and John Martin and the other residents of this community love their homes, and the manufactured houses provide affordable, high-quality homes for thousands of American families. I'm a strong supporter of manufactured housing. I see this legislation as adding one more feature to enhance the safety features of these structures.

Before I conclude my remarks, Madam Speaker, I'd like to thank Chairman BARNEY FRANK and his staff at the Financial Services Committee for their efforts to move this legislation forward. This bill would not be where it is today without the strong support of Ranking Member SPENCER BACHUS. He has been a vocal advocate for this cause from the very beginning. Thank you very much. I would also like to thank Congressman DENNIS MOORE and Congresswoman KAY GRANGER for their support as original cosponsors. Finally, I'd like to thank my good friend from Indiana, Congressman JOE DONNELLY, who was helpful throughout the entire process.

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

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

Madam Speaker, in closing, I do want to thank Ranking Member BACHUS. He has done a tremendous job in pushing forth this bill, along with the chairman. And I also want to thank again Mr. ELLSWORTH for his passion and his leadership on this issue. We all know that we dread times of storm. We've just gone through one in Virginia where, luckily, we didn't lose any lives. But we all know that when there are ways to prevent death and destruction, we ought to act in that way. Mr. ELLSWORTH and his leadership, seeing the need, seeing where we can save lives, stood up, assumed that leadership role and has really done, I think, a great thing for folks that have manufactured homes throughout the United States. Again, thank you for your leadership. And thank you again to Mr. BACHUS, the ranking member, for his leadership on this and to the chairman for pushing this important legislation through.

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

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

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

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

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

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from California (Ms. WATERS) that the House suspend the rules and pass the bill, H.R. 320.

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

A motion to reconsider was laid on the table.

TEMPORARY FORBEARANCE FOR FAMILIES AFFECTED BY CONTAMINATED DRYWALL

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

The Clerk read the title of the concurrent resolution.

The text of the concurrent resolution is as follows:

H. CON. RES. 197

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

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

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

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

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

Whereas banks and mortgage servicers can help families affected by contaminated drywall by taking into account, with respect

to their mortgage payments, the financial burdens imposed by the need to respond to this problem: Now, therefore, be it

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

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

The Chair recognizes the gentlewoman from California.

GENERAL LEAVE

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

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

There was no objection.

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

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

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

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

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

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

Madam Speaker, I reserve the balance of my time.

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

I'd like to thank my colleague from Virginia (Mr. NYE) for introducing this legislation to encourage financial and lending institutions to work with homeowners affected by toxic drywall. I would also like to thank the chairman and ranking member of the Financial Services Committee for bringing this resolution to the floor.

As of Friday, November 20, 2009, the Consumer Product Safety Commission had received nearly 2,100 complaints from homeowners in 32 States and the District of Columbia. The Commonwealth of Virginia and particularly the Hampton Roads region has been hit hard, and many homeowners are facing significant health problems and financial ruin because of the presence of toxic drywall in their homes.

The complaints to the Consumer Product Safety Commission, which began sometime in 2006, include a rotten egg smell within the home; health concerns such as irritated and itchy eyes and skin; difficulty in breathing; persistent cough; runny noses; recurrent headaches, sinus infections, nose bleeds, and asthma attacks; and blackened and corroded metal components in electrical systems and air conditioning units.

In October, I toured the homes of several constituents affected by the toxic drywall in the Hollymeade subdivision in Newport News and saw firsthand how toxic drywall has put the health and financial well-being of numerous families at risk. I met with these folks again last week to be updated on their current predicament. These homeowners, many of whom served or who are serving our country in the Armed Forces, cannot afford to carry a mortgage on a home that is uninhabitable and make arrangements to pay rent or pay a mortgage on a second home to keep their families safe. Many of these families are juggling the burdens of having a deployed spouse or a spouse preparing for deployment and an additional financial burden such as a move out of an impacted home, foreclosure, or loss of insurance coverage. All of these would be devastating to these families.

This resolution encourages banks to allow for a temporary forbearance without penalty on payments on their home mortgages. This would give homeowners the time they need to work out a more permanent solution. My office is currently working with seven homeowners who are seeking assistance from their lenders.

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

Madam Speaker, I reserve the balance of my time.

Ms. WATERS. I yield the balance of my time to the gentleman from Virginia (Mr. NYE).

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

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

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

Toxic Chinese drywall can also cause deep coughs, bloody noses, and severe eye irritation. And those are just the short-term health effects that we know about. I wouldn't be surprised if even more serious health effects are soon found. Affected families have been left with an impossible choice: live in a home and put their family at risk, or shell out tens, if not hundreds of thousands of dollars, to replace the drywall. While some more fortunate families have been able to get help from friends, relatives and neighbors, many others have moved into rental housing, forcing them to pay both rent and the mortgage on the contaminated home. At a time when the economy is already

struggling, this hardship is more than families can sustain.

Today, I urge my colleagues to support this resolution encouraging banks and mortgage servicers to work with their customers by allowing a grace period on their mortgage payments until they get back on their feet. Many banking institutions have already voluntarily provided mortgage forbearances for many of their customers, and I applaud the benevolence of these institutions. This can be a lifesaver for affected families.

Madam Speaker, as we work to create long-term solutions, we must also find a way to give these families some relief now. I want to thank my friends Mr. WEXLER and Mrs. MCCARTHY; my colleague from Virginia (Mr. WITTMAN); Mr. BUCHANAN; as well as Ms. WATERS and Chairman FRANK for working with me on this important legislation, and I hope the rest of my colleagues will join me in its support.

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

Mr. WITTMAN. I yield myself the balance of my time.

I want to echo the comments of Mr. NYE from Virginia. Having visited a number of these homes, the health effects from this toxic drywall are very apparent. The sulfur there is pungent. Just in the time that I spent there, I experienced some of the same systems, runny nose, itchy eyes, irritation of the lungs, a cough; and that was just in the very short period of time of about 2 hours. I can only imagine what those families have to endure under those conditions and living in those homes. So our hearts and minds and concerns go out to them.

Last week, the Consumer Product Safety Commission released the results of their most recent study of 51 homes. There was a lot of effort to try to get the Consumer Product Safety Commission to do a study on this toxic drywall. Their study did not find anything now that is conclusive about the health effects of drywall, but the Consumer Product Safety Commission did commit to continue the study because we all believe that just looking at 51 homes doesn't look at the full scope of this problem. This problem is in over 2,100 instances, and we know there are more across 32 States. So they've committed to work continually to identify which compounds could be causing these health problems.

Their study found a strong association between the problem drywall, the hydrogen sulfide level in homes with that drywall, and corrosion in these homes. These two preliminary studies of corrosion of metal components taken from homes containing the problem drywall found copper sulfide corrosion in the initial samples tested, which supports the finding of an association between hydrogen sulfide and the corrosion.

Ongoing laboratory tests continue to investigate the nexus between safety and the short- and long-term effects of such corrosion not only on the homes, but it should also be looking at the effects on individuals that inhabit those homes. Based on these studies completed to date, the interagency task force can begin a new phase by developing a protocol to identify homes with corrosive drywall and a process to address the corrosive drywall and its effects.

I urge the task force to work expeditiously to complete the study phase and to release its protocols for identifying impacted homes and for remediation. This resolution will give homeowners the time they need to make decisions based on the Consumer Product Safety Commission studies and protocols for a more permanent solution to their situation.

Mr. FORBES. Madam Speaker, I rise today in strong support of H. Con. Res. 197, to encourage banks and mortgage servicers to work with families affected by contaminated drywall to allow temporary forbearance without penalty on payment on their home mortgages. I am a proud cosponsor of this Resolution.

Along with thousands of affected homeowners across the country, my constituents are waiting for answers on the potential health and safety hazards posed by toxic drywall imported from China between 2004 and 2007. The corrosion of electrical wiring, home appliance failure, the emission of strong odorous gases, and health problems such as headaches, nausea, and throat irritation, are just some of the commonly reported problems associated with Chinese drywall.

Although a federal Interagency Task Force has been investigating this problem for nearly one year, suffering homeowners have still not been provided federal guidelines for inspection or remediation of their homes containing Chinese drywall. Basic questions remain unanswered, such as whether these homes are safe for people to reside in; whether Chinese drywall may combine with other common home fixtures or chemicals to cause additional harms. Homeowners continue to wait for answers from their government. Despite nearly 2,000 reported cases of Chinese drywall to the Consumer Product Safety Commission, and untold thousands more still unreported, committees in the House of Representatives have yet to hold one investigative hearing on the matter. Members deserve the opportunity to hear from expert witnesses across the spectrum of this growing crisis. Health, financial, safety, and legal ramifications need to be explored in depth so that appropriate action may be taken on behalf of so many American homeowners and affected businesses.

Madam Speaker, H. Con. Res. 197 is a step in the right direction. At this juncture, it is important that all those impacted by this drywall, from homeowners and builders to developers and banks and mortgage companies, work together with understanding until more answers are provided on the effects of this toxic drywall. I urge my colleagues to hold immediate congressional hearings on this issue, and I urge them to demonstrate their support in bringing relief to thousands of Americans whose homes have been so severely affected by Chinese drywall.

Mr. POSEY. Madam Speaker, I am proud to stand in support of this resolution as a cosponsor.

Contaminated drywall mostly manufactured in China and used in new home construction in the last decade, primarily between 2006 and 2007, has had a devastating impact on the housing industry in Florida and more importantly on the lives of thousands of homeowners and their families.

So far the Consumer Product Safety Commission has received more than 2,000 complaints from affected homeowners in at least 32 states and the District of Columbia. More than three-quarters of these complaints come from Florida. While we do not yet know the full extent of this problem, it appears that this concern is likely to grow considerably larger.

Homeowners with contaminated Chinese drywall have experienced a number of household and health problems. The drywall emits sulfuric compounds which cause corrosion in copper fittings commonly used in plumbing and air conditioning as well as electrical components. Many homeowners have had to replace hardware such as air conditioning coils, carbon monoxide detectors, and smoke alarms multiple times in as little as a year. In addition to the corrosive effects of the sulfuric gases, homeowners have experienced a variety of related health issues, which have forced many to move out of their homes. Common symptoms include eye irritation and breathing problems.

As you can imagine, this is financially and emotionally devastating for homeowners. As a result of contaminated drywall, many homes have dropped precipitously in value. Many people have lost their life savings which was invested in a home which they can now neither live in nor sell. Some have become desperate and chosen to walk away from their mortgages in the hope of starting fresh elsewhere. Still others are continuing to pay their mortgages while taking on the added burden of paying for an alternative living arrangement in the hopes that they can hang on long enough for a remediation protocol to be announced.

I recently toured some of these homes in the Antilles community in my district and I met with affected homeowners. Just a few minutes in one of these houses is enough time to start feeling the symptoms that have caused so many homes to become unlivable. Affected homeowners need help and they need help quickly.

I was pleased that the Federal Inter-Agency Drywall Task Force, headed by the CPSC, released the results of their 51-home study this month. I was encouraged to see some signs of progress from the task force. I was particularly encouraged that the task force officially established a scientific link between the contaminated drywall and the resulting corrosion. More importantly, the task force has established an identification and remediation protocol team made up of scientists and engineers. While additional scientific studies continue, the most important next steps for the CPSC are to release the identification and remediation protocols. This will hopefully help

homeowners to begin getting the problems fixed so their homes are once again livable and up to par with market value.

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

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

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

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

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

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

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

Ms. JACKSON-LEE of Texas. Madam Speaker, I rise before you today in support of House Concurrent Resolution 197, "Encouraging banks and mortgage servicers to work with families affected by contaminated drywall to allow temporary forbearance without penalty on payments on their home mortgages". I would like to thank my colleague, Rep. GLENN NYE, for introducing this act of solidarity, as well as the co-sponsors.

Contaminated drywall affects thousands of Americans—since January 2009, over 1,300 cases of this structural condition have been reported from 26 States and the District of Columbia. When in 2006, more than 495 million pounds of drywall was imported into the United States from China, my home city of Houston was one of the major recipients.

Earlier this year, America's Watchdog, a national advocacy group for consumer protection, confirmed defective drywall in homes in Michigan, Virginia, Georgia, Mississippi, Alabama, Louisiana, Texas, Maryland, North and South Carolina, New York and New Jersey, with an estimated 10,000 homes in Florida and more than 100,000 nationwide affected. At least a dozen companies manufactured defective drywall in China and about 100 builders in Florida used the product, dating back to 2004.

Noxious gases released from contaminated drywall can cause serious health effects involving the upper respiratory tract, such as bloody noses, rashes, sore throats, and burning eyes; and toxins released from contaminated drywall can corrode metals inside the home, such as air conditioning coils and electrical wiring.

The dangers and health risks posed by contaminated drywall have forced thousands of families out of their homes and into temporary living situations, and many such families are unable to afford an additional financial burden. Because of this, some Americans who pay their mortgages on time are now suffering from both financial problems and health complications through no fault of their own.

Banks and mortgage servicers can help families affected by this scourge by providing temporary forbearance with respect to their mortgage payments to help such families afford the costs of an additional residence while they are removed from their primary homes. That is why I join this body in encouraging banks and mortgage servicers to work with families affected by contaminated drywall to allow temporary forbearance without penalty on payments on their home mortgages.

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

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

The question was taken.

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

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

The yeas and nays were ordered.

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

ENHANCED S.E.C. ENFORCEMENT AUTHORITY ACT

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

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2873

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Enhanced S.E.C. Enforcement Authority Act".

SEC. 2. NATIONWIDE SERVICE OF PROCESS.

(a) SECURITIES ACT OF 1933.—Section 22(a) of the Securities Act of 1933 (15 U.S.C. 77v(a)) is amended by inserting after the second sentence the following: "In any civil action instituted by the Commission under this title in a United States district court for any judicial district, subpoenas issued to compel the attendance of witnesses or the production of documents or tangible things (or both) at any hearing or trial may be served at any place within the United States. Rule 45(c)(3)(A)(ii) of the Federal Rules of Civil Procedure does not apply to a subpoena so issued.".

(b) SECURITIES EXCHANGE ACT OF 1934.—Section 27 of the Securities Exchange Act of 1934 (15 U.S.C. 78aa) is amended by inserting after the third sentence the following: "In any civil action instituted by the Commission under this title in a United States district court for any judicial district, subpoenas issued to compel the attendance of witnesses or the production of documents or tangible things (or both) at any hearing or trial may be served at any place within the United States. Rule 45(c)(3)(A)(ii) of the Federal Rules of Civil Procedure does not apply to a subpoena so issued.".

(c) INVESTMENT COMPANY ACT OF 1940.—Section 44 of the Investment Company Act of 1940 (15 U.S.C. 80a–43) is amended by inserting after the fourth sentence the following: "In any civil action instituted by the Commission under this title in a United States district court for any judicial district, subpoenas issued to compel the attendance of witnesses or the production of documents or tangible things (or both) at any hearing or trial may be served at any place within the United States. Rule 45(c)(3)(A)(ii) of the Federal Rules of Civil Procedure does not apply to a subpoena so issued.".

(d) INVESTMENT ADVISERS ACT OF 1940.—Section 214 of the Investment Advisers Act

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

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

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

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

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

There was no objection.

Mr. KANJORSKI. Madam Speaker, I yield myself such time as I may consume and rise today to speak in support of H.R. 2873, the Enhanced S.E.C. Enforcement Authority Act, and to congratulate the gentleman from California (Mr. CAMPBELL) for his work on these matters.

□ 1200

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

The U.S. Securities and Exchange Commission currently has nationwide service of process of subpoenas in administrative proceedings. This bill will enhance the Commission's enforcement program by allowing subpoenas to be served nationwide in civil actions brought by the agency in Federal court. Currently, the Commission can issue a subpoena only within the Federal jurisdictional district where a trial takes place or within 100 miles of the courthouse. Witnesses in civil cases brought by the Commission are, however, often located outside of a trial court's subpoena range.

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

H.R. 2873 would fix this problem by allowing the Commission to have nationwide service of process just as it currently has for its administrative proceedings. These changes in subpoena procedures for civil cases would apply to the Securities Exchange Act of 1933, the Securities Exchange Act of 1934, the Investment Company Act of 1940, and the Investment Advisers Act of 1940. Nationwide service of process would produce a number of substantial advantages, including a significant savings in terms of travel costs and staff time.

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

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

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

I reserve the balance of my time.

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

I would like to thank my colleague from Pennsylvania (Mr. KANJORSKI) for his support of this bill and his kind words about this bill. I would also like to thank the Judiciary Committee for working with us on the Financial Services Committee to come up with language that is mutually acceptable and works for everyone on this bill.

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

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

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

So I appreciate the bipartisan support. I appreciate the comments.

I reserve the balance of my time.

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I stand here today in support of H.R. 2873, the Enhanced S.E.C. Enforcement Authority Act, which will give the Securities and Exchange Commission, SEC, nationwide service of process. I support this legislation because I believe that it is important that the agency responsible for oversight of our financial system have the necessary tools for legal action against potential violations of the law.

I would like to first thank my colleague, Congressman JOHN CAMPBELL, for introducing this valuable piece of legislation. On December 11, 2008, nearly one year ago, Bernard Madoff was arrested for securities fraud, money laundering, and perjury in one of the largest Ponzi schemes in the history of this country. Estimates of the magnitude of the Madoff scheme were between $50 and $65 billion. The presiding judge in the case declared the crimes, "extraordinary evil." Congress and the American people were appalled by this scandal. The country wondered how our regulatory agencies could fail to recognize fraud of this magnitude for so long.

In the year since the Madoff scandal first came to light, both the Securities and Exchange Commission and Congress have worked to enhance the ability of the SEC to conduct oversight. Internal procedures have been reformed to make it easier for the SEC to open investigations into violations of securities law. New personnel at the SEC, such as the Director of Enforcement, have been hired to ensure that oversight efforts were carried out with the appropriate level of enthusiasm. Congress has also worked to improve the tools of the SEC to conduct oversight. This bill is in line with the effort to reform the oversight of securities and ensure that massive fraud that was committed on the scale of Bernard Madoff never happens again.

Currently, the Securities and Exchange Commission has to issue subpoenas in the judicial district where the trial takes place or

within a "100-mile bulge" of the courthouse. This unnecessarily burdens the staff, which has to travel to the courts where the trial takes place, wasting both time and money. Furthermore, by requiring the SEC to seek action in remote district courts, civil cases may be weakened. Witnesses in cases filed by the SEC are frequently located outside of the trial court's subpoena range. Because witnesses who are not able to travel would have to provide an alternative to live testimony, such as a videotaped deposition or written testimony, the impact of their statement is lost. Additionally, securities violations using the internet involve persons across jurisdictions.

H.R. 2873 will streamline the SEC's ability to investigate potential cases of violations of securities law. This bill will allow nationwide service of subpoenas in civil actions brought by the SEC in Federal courts. By granting the SEC this authority, this legislation will eliminate repetitive depositions. While the Congressional Budget Office has not scored this legislation, logically, this legislation will reduce costs for the SEC. The costs of creating and presenting videotaped depositions will be reduced. Additionally, SEC staff will no longer have to travel to file motions in remote district courts, saving the staff time and the taxpayer money.

Other agencies with similar mandates have long had the authority for nationwide service. This body has already considered and passed this provision: during the 110th Congress, the House of Representatives passed a law of this nature in Section 19 of H.R. 6513, the Securities Act of 2008. Furthermore, the SEC already has this authority in administrative proceedings.

Mr. CAMPBELL. I will yield back the balance of my time as well.

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

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

A motion to reconsider was laid on the table.

EMERGENCY ECONOMIC STABILIZATION ACT OF 2008 AMENDMENT

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

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1242

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

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

Section 114 of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5224) is amended by adding at the end the following new subsection:

"(c) ADDITIONAL MONITORING AND ACCOUNTABILITY.—

"(1) ELECTRONIC DATABASE.—

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

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

"(i) Regulatory data from any government source.

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

"(iii) Public records.

"(iv) News filings, press releases, and other forms of publicly available data.

"(v) Data collected under subparagraph (C)(v).

"(vi) All other information that is required to be reported under this title by institutions receiving financial assistance or procurement contracts under this title.

"(C) ADMINISTRATION AND USE OF DATABASE.—The Secretary shall—

"(i) ensure that the database uses accurate data structures and taxonomies to allow for easy cross-referencing, compiling, and reporting of numerous data elements;

"(ii) ensure that the database provides for filtering of data content to allow users to screen for the events most relevant to identifying waste, fraud, and abuse, such as management changes and material corporate events;

"(iii) ensure that the database provides geospatial analysis capabilities;

"(iv) make the database available to the Comptroller General of the United States and to the Special Inspector General and the Congressional Oversight Panel established under sections 121 and 125, respectively, to provide them with access to current information on the status of the funds distributed under this title, including funds distributed through procurement contracts;

"(v) collect from each Federal agency on at least a daily basis all data that is relevant to determining the effectiveness of the Troubled Asset Relief Program in stimulating prudent lending and strengthening bank capital, including regulatory filings and data generated by the use of internal models, financial models, and analytics; and

"(vi) compare the data in the database with other appropriate data to identify activities inconsistent with the goals of this title.

"(2) MEETING TARP GOALS.—

"(A) DETERMINATION BY SECRETARY; RECOMMENDATIONS.—If the Secretary determines that a recipient's use of funds distributed under this title is not meeting the goals of this title, the Secretary shall, in coordination with the appropriate Federal agencies, develop recommendations for better meeting such goals, and such agencies shall provide such recommendations to such recipient.

"(B) FUTURE USES OF FUNDS.—If the Secretary determines that the use of funds described in subparagraph (A) does not meet the goals of this title within a reasonable time after the recommendations communicated under such subparagraph, the Secretary shall modify the permitted uses of funds distributed under this title to avoid similar problems in the future.

"(3) PUBLIC ACCESS TO DATABASE.—The Secretary shall, subject to paragraph (4), adopt rules and procedures for public access to the database created by this subsection.

"(4) PROHIBITION AGAINST DISCLOSURE OF CERTAIN INFORMATION.—

"(A) PROHIBITION.—A person or entity shall not disclose to the public information collected under this subsection that is prohibited from disclosure by any Federal or State law or regulation or by private contract or that is considered to be proprietary.

"(B) PROTECTION OF INFORMATION.—The Secretary shall implement reasonable measures to prevent the disclosure of information in violation of subparagraph (A).

"(C) CRIMINAL LIABILITY FOR DISCLOSURE.—A Federal officer or employee, or a contractor of any Federal agency or employee of such contractor, who intentionally discloses to the public or intentionally causes to be disclosed to the public information prohibited from disclosure by subparagraph (A), knowing that such information is prohibited from disclosure, shall be fined under title 18, United States Code, or imprisoned for not more than 1 year, or both.

"(5) REGULATIONS AND PROCEDURES.—The Secretary shall, in consultation with the appropriate Federal agencies, promulgate regulations and establish any other procedures necessary to carry out this subsection.

"(6) IMPLEMENTATION DEADLINES.—

"(A) CONTRACT SERVICES.—Not later than 30 days after the date of the enactment of this subsection, the Secretary shall issue a request for proposal and award contract services as required by this subsection.

"(B) OPERATION OF DATABASE.—The Secretary shall ensure that the database described in paragraph (1)(A) is operational not later than 180 days after the date of the enactment of this subsection.".

SEC. 2. REDUCING TARP FUNDS TO OFFSET COSTS OF PROGRAM CHANGES.

Section 115(a)(3) of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5225(a)(3)) is amended by striking "$700,000,000,000, as such amount is reduced by $1,259,000,000,, as such amount is reduced by $1,244,000,000, outstanding at any one time" and inserting "$700,000,000,000, as such amount is reduced by $1,293,000,000, outstanding at any one time".

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Mrs. MALONEY) and the gentleman from California (Mr. CAMPBELL) each will control 20 minutes.

The Chair recognizes the gentlewoman from New York.

GENERAL LEAVE

Mrs. MALONEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert additional material.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from New York?

There was no objection.

Mrs. MALONEY. Mr. Speaker, I yield myself as much time as I may consume.

I rise in strong support of H.R. 1242, the TARP Accountability and Disclosure Act of 2009. This bill would require the Department of the Treasury to establish an electronic database for tracking all TARP funds. The bill would create a database available to

the public on the Internet that will track in real time the spending of funds in the Federal Government's Troubled Asset Relief Program called TARP. If UPS can track millions of packages clear across the world on any continent at any time, we can certainly track where $700 billion in taxpayers' money has gone. In fact, we have a duty to do so.

When TARP began, the Treasury Department never required the financial institutions it funded to explain what they did with the money. And over a year later, we still do not know. It is past time for us to have a system so that the American people can tell in real time, enhancing its value as a regulatory tool and also as a preventative oversight tool. Taxpayers have a right to know how their tax dollars are being used. I believe that in order to ensure transparency, we should require the use of the technological tools that are available today.

Currently, TARP data are presented in filings in over 25 different agencies, including filings with the Securities and Exchange Commission, Web sites, Federal Reserve registration data, the FDIC data, over-the-counter trades, and Commodities Futures Trading Commission data. The data sources are not only housed in different agencies but are in incompatible systems and formats, making the material unusable. These agencies are unable to share the data with each other and to learn from it.

The bill, which I have coauthored with Representative Peter King and 42 of my colleagues, requires all relevant TARP data, including regulatory filings and public records, to be collected by the Department of the Treasury and put in a consistent standardized format so that TARP funds will be transparent and traceable. This bill would also provide the ability to monitor inconsistencies that may indicate waste, fraud, and abuse at both the corporate and individual officer levels. By using tools that currently exist, individual filings and transactions can be pulled together to create a single view of an institution and provide better management and regulatory oversight.

The basic data elements would include but not be limited to the following: the capture and standardization of every transaction the institution is involved with, wherever possible; news releases, press releases and other sources of public data; counterparty filings; securities transactions; UCC filings in certain cases; and transaction data, including mortgages, debt issuance, and fund participation.

In the simplest terms, my bill allows the question to be answered, Where has the money gone? And this is a question that pundits and taxpayers ask every single day. Recently, Elizabeth Warren, who is one of the oversight regulators, stated in testimony that she has no idea where the TARP money is. This bill would change this. This would put safeguards in to ensure that proprietary information about financial services companies is not disclosed, and this bill does not put any additional burden on industry. It merely puts in a usable form information that is already required by regulators.

There is broad support for this bill from close to 40 groups from across the political field, including the Center for Democracy and Technology, the U.S. Chamber of Commerce, the NAACP, and the Heritage Foundation.

I would like to place into the RECORD the list of supporters from respective organizations.

Groups that have publicly endorsed the bill (or if a 501c(3) support the ''idea or policy goals'' of the legislation since they cannot directly support a specific bill):

United States Chamber of Commerce; Center for Democracy and Technology; OMB Watch; Project On Government Oversight; Taxpayers for Common Sense; OpenTheGovernment.org; Institute for Policy Innovation; Competitive Enterprise Institute; NAACP; Mexican American Legal Defense and Education Fund (MALDEF).

National Puerto Rican Coalition (NPRC); The Hispanic Federation; Information Technology Industry Council; Heritage Foundation; Americans for Tax Reform; Center for Fiscal Accountability; 60 Plus Association; Alabama Policy Institute; American Shareholders Association; Americans for Limited Government.

Americans for Prosperity; Caesar Rodney Institute; Center for Individual Freedom; Center-Right Coalition of Florida; Coalition Opposed to Additional Spending & Taxes; Council for Citizens Against Government Waste; Grassroot Institute of Hawaii; Illinois Alliance for Growth; Illinois Policy Institute; Institute for Liberty.

Maine Heritage Policy Center; Mississippi Center for Public Policy; National Taxpayers Union; Oklahoma Council of Public Affairs, Inc.; Pelican Institute for Public Policy; Pioneer Institute for Public Policy Research; Rhode Island Tea Party; Small Business Hawaii; The Aarons Company; Kentucky Progress; Citizens' Voice for Property Owners.

As we have seen from this time last year, the lack of transparency in terms of how the funds are spent makes this bill necessary. The American people, Members of Congress, and regulators are demanding transparency. It is time that we gave it to them. They are entitled to it.

I would like to thank Members on the other side of the aisle, Mr. KING and others, who have been supportive, and particularly Chairman FRANK for his leadership and STENY HOYER for his support. I urge my colleagues to support it. It's past time for us to have a system so that the American people can tell in real time how their tax dollars are being used. I would add that I also believe that it would build confidence in the system, hopefully a confidence that will be managed in an appropriate way.

I reserve the balance of my time.

Mr. CAMPBELL. I yield myself as much time as I may consume.

Mr. Speaker, I rise to support this bipartisan bill authored by the lady from New York and the gentleman from New York (Mr. KING). You know, this bill is really pretty simple, and it's really just about transparency, disclosure and sunshine. Last year, $700 billion of taxpayer money was made available in order to provide a rescue plan for the financial system, which was troubled at that time. We all know that much of this money has gone out, but what we don't really know is what it has gone to do, what it is actually being used for, where it is being employed.

Now there are those who will say that, well, because there are dollars, if you put dollars into a given financial institution, they're fungible and you don't really know which dollar went to what, and I understand that that argument has some legitimacy. But the point of this bill is, Let's disclose and let's make available what we do know. There is a lot of information out there, as the gentlelady from New York suggested, which is in multiple agencies and multiple places, and it's just simply not available to Members of the House or to Members of Congress so that we can make an effective determination of whether this money has, is, and will be used in a manner consistent with its original objective which was to stabilize the financial system.

This bill, what it really does is, as it says, to make available, ongoing, continuous and close to real-time updates of the status of funds distributed through a standardized electronic database. That's something which technology today enables us to do, and it's something which the taxpayers and the Members of Congress have the right to see in order to better evaluate the use of these funds. So I stand in support of this bill.

I reserve the balance of my time.

Mrs. MALONEY. Mr. Speaker, I have no further speakers. I would just like to say that the program's effectiveness was testified in support of by economist Mark Zandi, who said, While TARP has not been a universal success, it has been instrumental to the stabilization of the financial system and bringing an end to the credit recession, but there are still serious criticisms of the program that should give us concern about its effectiveness, its cost, and how it can be improved. This bill that brings online transparency would move us in that right direction.

I am strongly in support of it, as well as many of my colleagues.

Having no further speakers, I yield back the balance of my time.

Mr. KING of New York. Mr. Speaker, today I rise in support of H.R. 1242, the TARP Accountability and Disclosure Act. As the lead Republican sponsor of this legislation, I have worked closely with Representatives MALONEY

and CANTOR as well as Financial Services Committee Chairman FRANK and Ranking Member BACHUS to bring this important bill to the House floor.

The Emergency Economic Stabilization Act, EESA, created the Troubled Assets Relief Program, TARP, which authorized the Treasury Department to buy $700 billion worth of troubled assets from financial institutions. This money has also been used by Treasury to purchase preferred stock from banks and other financially troubled companies, such as AIG, General Motors, and Chrysler, and in support of programs such as the Targeted Investment Program, Asset Guarantee Program, and Consumer and Business Lending Initiative Investment Program to name a few. While Congress did subsequently place additional conditions on how it could be spent, it has been rather difficult to follow and account for this vast amount of money.

It is also important that not only our government but also the American People know exactly where their taxpayer dollars are going for programs such as TARP. The TARP Accountability and Disclosure Act requires the creation of a database system within the Department of Treasury and provides for additional monitoring and accountability that will provide true transparency of how the TARP funds are used. This system would serve as an efficient mechanism for oversight, audits, and investigations. H.R. 1242 will also require that this database be made publicly available, allow for the daily collection of information and for the filtering of data content. Finally, it will prohibit the disclosure of information that would already be prohibited by any federal or state law or regulation including proprietary information.

So, why is this necessary? Well, not only is this information reported to over 25 different federal agencies, including the SEC, Federal Reserve, FDIC, and Commodities Futures Trading Commission, but the data is located in various systems and formats that are incompatible with one another. The TARP Accountability and Disclosure Act would require all relevant TARP data collected be put in a single standardized format so these funds will be transparent and traceable.

I am pleased to report that this legislation is supported by many organizations including the Chamber of Commerce, the Center for Democracy and Technology, OMB Watch, Taxpayers for Common Sense, Heritage Foundation, Americans for Tax Reform, and the NAACP.

Mr. Speaker, I urge my colleagues to support this legislation.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I stand here today in support of H.R. 1242, which amends the Emergency Economic Stabilization Act of 2008 to provide for additional monitoring and accountability of the Troubled Assets Relief Program, TARP. I support this legislation because I believe that increased accountability will enhance the effectiveness of the TARP funds.

I would like to first thank my colleague, Congresswoman CAROLYN MALONEY, for introducing this valuable piece of legislation. The TARP funds are designated for financial institutions that have complex internal systems and handle a large volume of information from various sources. The nature of the TARP fund recipients makes understanding how TARP funds are used difficult. Moreover, data is currently being submitted in filings to many agencies and databases, including the Securities and Exchange Commission, SEC, Federal Reserve, the Fed, Federal Deposit Insurance Corporation, FDIC, Commodities Futures Trading Commission, and Over the Counter Trade data. That the data is housed in separate agencies and in distinct formats makes it difficult to oversee and interpret the usage data.

H.R. 1242 will require the Treasury Secretary to create a database that will facilitate the monitoring of TARP funds. The bill provides guidance to the Secretary for the structure of the database and what data should be included. The information collected by the database will be collected on a daily basis and reviewed to ensure compliance with the Emergence Economic Stabilization Act of 2008. Data submitted by TARP recipients will be combined with third party data such as indexes, media reports, press releases, and non-governmental financial information to ensure that the information available is comprehensive. The database will be required to have accurate data structures to allow for cross-referencing, filtering of data content, and geospatial analysis capabilities. The database must be made available to oversight bodies such as the Special Inspector General, the TARP Oversight Panel, the Government Accountability Office, GAO, and law enforcement. Additionally, the Secretary of the Treasury must provide the public access to the database, while protecting information that is prohibited from disclosure under current law. Importantly, this legislation begins the implementation of these measures soon after the enactment, allowing for oversight to begin promptly.

Mr. Speaker, the list and diversity of organizations that support this legislation is long. The public demands accountability with regards to taxpayer dollars and this bill provides the necessary reforms to ensure that TARP funds are used properly. The dynamic database outlined by this legislation provides a valuable tool for oversight. By establishing a mechanism for oversight and investigative agencies to review TARP fund usage, we are enhancing accountability.

Mr. LANGEVIN. Mr. Speaker, I rise in strong support of H.R. 1242, which would provide additional and necessary monitoring of Troubled Asset Relief Program funds.

H.R. 1242 would create a database to easily track the status of distributed funds, making it easier for those overseeing the program to spot inconsistencies in spending and ensure the most effective use of the funding. It would also require the Treasury Department to adjust the future use of TARP funds if its intended goals are not being met.

Along with my constituents, I am deeply disappointed that the past administration did not adequately track how taxpayer money was spent to ensure that banks were using it for the intended purposes. Earlier this year, I was pleased to vote for legislation that would have ensured TARP funding was spent responsibly and transparently in an effort to get the economy back on track. Unfortunately, this measure was not taken up by the Senate.

In order to stabilize our economy and get credit flowing again to families and small businesses, we need to fundamentally change the practices of the Troubled Assets Relief Program. By strengthening accountability and increasing transparency, this measure ensures that public resources are being spent correctly and wisely. I urge my colleagues to vote for this measure.

Mr. CAMPBELL. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Mrs. MALONEY) that the House suspend the rules and pass the bill, H.R. 1242, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mrs. MALONEY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

□ 1215

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed.

Votes will be taken in the following order:

H. Res. 494, by the yeas and nays;

H. Con. Res. 129, by the yeas and nays;

H. Res. 861, by the yeas and nays;

H. Res. 897, by the yeas and nays;

H.R. 3634, de novo.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

RECOGNIZING THE EXEMPLARY SERVICE OF THE 30TH INFANTRY DIVISION DURING WORLD WAR II

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the resolution, H. Res. 494, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from North Carolina (Mr. KISSELL) that the House suspend the rules and agree to the resolution, H. Res. 494, as amended.

The vote was taken by electronic device, and there were—yeas 415, nays 0, not voting 19, as follows:

[Roll No. 914]

YEAS—415

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy, Patrick
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—19

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Cao
Capuano
Davis (AL)
Deal (GA)
Gonzalez
Hinchey
Melancon
Moran (VA)
Murphy (NY)
Murphy, Tim
Radanovich
Schock
Schrader
Wexler
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1242

So (two-thirds being in the affirmative) the rules were suspended and the resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. PUTNAM. Mr. Speaker, on rollcall No. 914 had I been present, I would have voted "yea."–

CONGRATULATING THE SAILORS OF THE UNITED STATES SUBMARINE FORCE

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the concurrent resolution, H. Con. Res. 129, on which the yeas and nays were ordered.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from North Carolina (Mr. KISSELL) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 129.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 412, nays 0, not voting 22, as follows:

[Roll No. 915]

YEAS—412

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney

Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schauer
Schiff
Schmidt
Schock
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—22

Aderholt
Barrett (SC)
Barrow
Bilbray
Bishop (UT)
Blackburn
Cao
Capuano
Davis (AL)
Deal (GA)
Gonzalez
King (IA)
Melancon
Moran (VA)
Murphy, Tim
Putnam
Radanovich
Ryan (OH)
Schakowsky
Schrader
Wexler
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1249

So (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MOMENT OF SILENCE IN REMEMBRANCE OF MEMBERS OF ARMED FORCES AND THEIR FAMILIES

The SPEAKER. The Chair would ask all present to rise for the purpose of a moment of silence.

The Chair asks that the House now observe a moment of silence in remembrance of our brave men and women in uniform who have given their lives in the service of our Nation in Iraq and in Afghanistan and their families, and of all who serve in our Armed Forces and their families.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BLUMENAUER). Without objection, 5-minute voting will continue.

There was no objection.

MILITARY FAMILY MONTH

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the resolution, H. Res. 861, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from North Carolina (Mr. KISSELL) that the House suspend the rules and agree to the resolution, H. Res. 861, as amended.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 417, nays 0, not voting 17, as follows:

[Roll No. 916]

YEAS—417

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney

Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—17

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Cantor
Capuano
Davis (AL)
Deal (GA)
Gonzalez
Melancon
Moran (VA)
Murphy, Tim
Myrick
Radanovich
Schrader
Wexler
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1300

So (two-thirds being in the affirmative) the rules were suspended and the resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

The title was amended so as to read: ''Resolution supporting the goals and ideals of Military Family Month''.

A motion to reconsider was laid on the table.

RECOGNIZING IMPORTANCE OF TEACHING STUDENTS ABOUT VETERANS

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the resolution, H. Res. 897, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. BISHOP) that the House suspend the rules and agree to the resolution, H. Res. 897.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 419, nays 0, not voting 15, as follows:

[Roll No. 917]

YEAS—419

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—15

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Cantor
Capuano
Davis (AL)
Deal (GA)
Gonzalez
Melancon
Moran (VA)
Murphy, Tim
Radanovich
Wexler
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining on this vote.

□ 1307

So (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GEORGE KELL POST OFFICE

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H.R. 3634.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and pass the bill, H.R. 3634.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

RECORDED VOTE

Mr. HARE. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 415, noes 0, not voting 19, as follows:

[Roll No. 918]

AYES—415

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd

Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—19

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Cantor
Capuano
Davis (AL)
Deal (GA)
Eshoo
Garamendi
Gonzalez
McMorris Rodgers
Melancon
Moran (VA)
Murphy, Tim
Radanovich
Speier
Wexler
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1314

So (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. TIM MURPHY of Pennsylvania. Mr. Speaker, on rollcall Nos. 914, 915, 916, 917, and 918 I was unavoidably detained.

Had I been present I would have voted "yea" on rollcall No. 914; "yea" on rollcall No. 915; "yea" on rollcall No. 916; "yea" on rollcall No. 917; and "aye" on rollcall No. 918.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H. RES. 648

Mr. POE of Texas. Mr. Speaker, I ask unanimous consent to have my name removed from H. Res. 648.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

□ 1315

REDUNDANCY ELIMINATION AND ENHANCED PERFORMANCE FOR PREPAREDNESS GRANTS ACT

Mr. CUELLAR. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3980) to provide for identifying and eliminating redundant reporting requirements and developing meaningful performance metrics for homeland security preparedness grants, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3980

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Redundancy Elimination and Enhanced Performance for Preparedness Grants Act".

SEC. 2. IDENTIFICATION OF REPORTING REDUNDANCIES AND DEVELOPMENT OF PERFORMANCE METRICS FOR HOMELAND SECURITY PREPAREDNESS GRANT PROGRAMS.

(a) IN GENERAL.—Title XX of the Homeland Security Act of 2002 (6 U.S.C. 601 et seq.) is amended by adding at the end the following new section:

"SEC. 2023. IDENTIFICATION OF REPORTING REDUNDANCIES AND DEVELOPMENT OF PERFORMANCE METRICS.

"(a) IN GENERAL.—The Administrator shall, for grants under sections 2003 and 2004 and any other grants specified by the Administrator, submit a report to the appropriate committees of Congress by not later than 120 days after the date of the enactment of the Redundancy Elimination and Enhanced Performance for Preparedness Grants Act, and by October 1st every 2 years thereafter, that—

"(1) identifies redundant rules, regulations, and requirements for reporting by recipients of such grants, and includes a plan for eliminating such identified redundancies and requirements;

"(2) includes a plan for developing and improving the performance metrics required under section 2022(a)(4) for such grants; and

"(3) includes an assessment of each program under which such grants are awarded.

"(b) PLAN REQUIREMENTS.—Each plan under subsection (a)—

"(1) shall be developed in coordination with State, local, tribal, and territorial governments; and

"(2) shall include a proposed timeline for actions to implement the plan.

"(c) PROGRAM ASSESSMENT REQUIREMENTS.—Each program assessment under subsection (a)(3) shall include—

"(1) a brief summary of the program purposes, objectives, and performance goals, and of the key findings of the assessment;

"(2) an assessment of the quality of the program's performance metrics, and the extent to which necessary performance data are collected;

"(3) a summary of how the program's strengths and weaknesses are impeding or

contributing to its failures or successes, including reasons for any substantial variation from the targeted level of performance of the program;

''(4) a description of the extent to which any trends, developments, or emerging conditions affect the need to change the mission of the program or the way that the program is being carried out;

''(5) an identification of the best practices used in the program for allocating resources in an efficient and effective manner that resulted in positive outcomes and the key reasons why such practices resulted in positive outcomes;

''(6) recommendations for program modifications to improve the results that the program achieves;

''(7) a summary of key results of the program assessment that support maximizing the amount of funds appropriated for the program; and

''(8) an assessment of the quality of customer service offered to recipients of funds under the program and a strategy for improving such service.''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1(b) of such Act is amended by adding at the end of the items relating to title XX the following new item:

''Sec. 2023. Identification of reporting redundancies and development of performance metrics.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. CUELLAR) and the gentleman from Alabama (Mr. ROGERS) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. CUELLAR. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and insert extraneous materials on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. CUELLAR. Mr. Speaker, I rise in support of this bill and yield myself such time as I may consume.

Mr. Speaker, Congress instructed FEMA in the Post-Katrina Emergency Management Reform Act of 2006 and in the Implementing Recommendations of the 9/11 Commission Act of 2007 to develop performance metrics for its homeland security grants programs. As the House Committee on Homeland Security discovered in our October 27 subcommittee hearing I held with my ranking member hearing on emergency communications, these requirements remain poorly implemented and difficult to comprehend. What is most disconcerting is that FEMA still cannot determine our Nation's overall preparedness or how homeland security grants have helped to protect our Nation from acts of terrorism.

It is for these reasons that I come to you today to ask for your support of H.R. 3980, the Redundancy Elimination and Enhancement Performance for Preparedness Grants Act. This legislation would require FEMA to work in conjunction with State, local, tribal and territorial stakeholders to develop a plan to do the following things:

Streamline homeland security grant reporting requirements, rules and regulations to eliminate redundant reporting;

Create a strategy including a timetable for establishing the much-needed performance metrics for grant programs to ensure that the funds are being directed to the areas where they will be best spent;

Require FEMA to take an inventory of each of the homeland security grant programs to include the purpose, objectives and performance goals for each.

The plan will be submitted to the appropriate congressional committees no later than 120 days after the bill's enactment.

It will be updated biannually to ensure that the committee is able to maintain a watchful eye and the oversight on redundancies in the law that might confuse the grant recipients at the local level.

This bill will help identify inefficiencies with the DHS grants programs and this bill will increase the quality of service received by DHS grant recipients.

I urge all of my colleagues to support this important legislation.

HOUSE OF REPRESENTATIVES, COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC, December 1, 2009.

Hon. BENNIE G. THOMPSON,
Chairman, Committee on Homeland Security, Washington, DC.

DEAR CHAIRMAN THOMPSON: I write to you regarding H.R. 3980, the ''Redundancy Elimination and Enhanced Performance for Preparedness Grants Act''.

H.R. 3980 contains provisions that fall within the jurisdiction of the Committee on Transportation and Infrastructure. I recognize and appreciate your desire to bring this legislation before the House in an expeditious manner and, accordingly, I will not seek a sequential referral of the bill. However, I agree to waive consideration of this bill with the mutual understanding that my decision to forgo a sequential referral of the bill does not waive, reduce, or otherwise affect the jurisdiction of the Committee on Transportation and Infrastructure over H.R. 3980.

Further, the Committee on Transportation and Infrastructure reserves the right to seek the appointment of conferees during any House-Senate conference convened on this legislation on provisions of the bill that are within the Committee's jurisdiction. I ask for your commitment to support any request by the Committee on Transportation and Infrastructure for the appointment of conferees on H.R. 3980 or similar legislation.

Please place a copy of this letter and your response acknowledging the Committee on Transportation and Infrastructure's jurisdictional interest in the Committee Report on H.R. 3980 and in the CONGRESSIONAL RECORD consideration of the measure in the House.

I look forward to working with you as we prepare to pass this important legislation.

Sincerely,

JAMES L. OBERSTAR,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC, December 1, 2009.

Hon. JAMES L. OBERSTAR,
Chairman, Committee on Transportation and Infrastructure, House of Representatives, Washington, DC.

DEAR CHAIRMAN OBERSTAR: Thank you for your letter regarding H.R. 3980, the ''Redundancy Elimination and Enhanced Performance for Preparedness Grants Act,'' introduced by Congressman HENRY CUELLAR on November 2, 2009.

I appreciate your willingness to work cooperatively on this legislation. I acknowledge that the Committee on Transportation and Infrastructure has a jurisdictional interest in certain provisions of H.R. 3980. I appreciate your agreement to not seek a sequential referral of this legislation and I acknowledge that your decision to forgo a sequential referral does not waive, alter, or otherwise affect the jurisdiction of the Committee on Transportation and Infrastructure.

Further, I recognize that your Committee reserves the right to seek appointment of conferees on the bill for the portions of the bill over which your Committee has a jurisdictional interest and I agree to support such a request.

I will ensure that this exchange of letters is included in the legislative report on H.R. 3980 and in the CONGRESSIONAL RECORD during floor consideration of the bill. I look forward to working with you on this legislation and other matters of great importance to this nation.

Sincerely,

BENNIE G. THOMPSON,
Chairman.

I reserve the balance of my time, Mr. Speaker.

Mr. ROGERS of Alabama. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in strong support of H.R. 3980, sponsored by my good friend from Texas (Mr. CUELLAR) who I'm pleased to serve with on the Emergency Communications, Preparedness, and Response Subcommittee.

Since 2006, Congress has mandated FEMA to measure the Nation's level of preparedness, as well as the effectiveness of State and local homeland security grant programs administered by FEMA. Both the Post-Katrina Reform Act of 2006 and the 9/11 Act of 2007 require FEMA to develop metrics that can be used to identify and close gaps in preparedness with homeland security resources. These include the Comprehensive Assessment System, the Target Capabilities List, and the State Preparedness Report.

Unfortunately, the various preparedness metrics developed since 2006 have not been properly integrated by FEMA, resulting in duplicative reporting requirements that put an undue burden on State and local governments. State and local homeland security grant programs are essential to achieving and maintaining preparedness capabilities, and they can be strengthened and improved with input from stakeholders and the establishment of sound performance metrics.

This bill seeks to improve the way grant programs are administered and managed by FEMA, and will ensure that Congress is informed of the ongoing planning at FEMA for improving measures of preparedness and eliminating duplicative requirements placed on grantees.

I urge my colleagues to support the measure, and I yield back the balance of my time.

Mr. CUELLAR. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, as you heard, this is commonsense legislation that will streamline FEMA's efforts to enhance our Nation's preparedness and response capacity. All we're trying to do is to make sure that we get rid of any unnecessary rules and regulations that cause our local folks problems. Number two, we're also trying to make sure that we measure the results. If we're going to spend billions of dollars on grants, we've just got to make sure that we measure those particular results.

The bottom line is, Mr. Speaker, we're trying to focus on the customers, and the customers are the recipients of these grants. I certainly want to thank our ranking member, Mr. ROGERS. He's done an outstanding job there in the committee. I look forward to working with him not only on this legislation to make it law but certainly on other pieces of legislation. I urge all my colleagues to vote ''aye.''

Mr. THOMPSON of Mississippi. Mr. Speaker, I rise in support of H.R. 3980, the ''Redundancy Elimination and Enhanced Performance for Preparedness Grants Act.''

This legislation, introduced by Mr. CUELLAR, the Chairman of the Subcommittee on Emergency Communications, Preparedness and Response, requires FEMA to assess the performance of its homeland security grant program and work towards addressing any identified deficiencies.

The legislation was developed based on finding from an October subcommittee hearing where FEMA testified as to the status of the agency's efforts to establish performance measurements for preparedness grants.

At the hearing, we learned that that FEMA's efforts to implement statutory performance metrics-related requirements are fragmented and poorly integrated. As a result, FEMA is unable to measure how the $29 billion in homeland security grants appropriated since 2002 have improved the nation's overall level of preparedness. Without these much needed performance metrics, FEMA continues to impose redundant grant reporting requirements on State and local governments including those in my home State of Mississippi.

Not only are these redundant reporting requirements costly and time-consuming for State and local officials to prepare, but there is significant evidence that, taken together, they still do not provide FEMA with information necessary to measure the return on investment from federal grants.

Although there have been some improvements in FEMA's administration of homeland security grants, such as the improvements in grant guidance and technical assistance provided to State and local applicants, we still have a ways to go.

H.R. 3980 would complement these efforts by directing FEMA to work with State and local stakeholders to identify and eliminate these redundant grant reporting requirements.

Specifically, H.R. 3980 would eliminate much of the red-tape and improve the performance of FEMA grant programs. The bill requires FEMA to develop a strategy, with timelines, to establish performance metrics for its homeland security grants and provides direction to complete a program assessment of its homeland security grants. These steps are designed to improve the agency's performance, productivity and accountability to the taxpayers. It will also provide Congress with better information on FEMA's performance to allow us to conduct more effective oversight and ensure that taxpayer money is being used efficiently and effectively.

Again, thank you for the consideration of this important legislation.

Ms. RICHARDSON. Mr. Speaker, as a member of the Homeland Security Committee, I rise today in strong support of H.R. 3980, the Redundancy Elimination and Enhanced Performance for Preparedness Grants Act. This legislation directs FEMA to streamline its grants reporting process to make it more efficient and informative, and it eliminates redundant requests for information.

I would like to acknowledge Speaker PELOSI and Chairman THOMPSON for their leadership in bringing this important bill to the floor. I would also like to thank my colleague Congressman CUELLAR, who worked so hard authoring this important legislation holding FEMA accountable for our taxpayer dollars.

Mr. Speaker, on October 27, as a member of the Subcommittee on Emergency Communication, Preparedness, and Response, I heard testimony from both FEMA officials and state and local government officials about the new grants tracking program currently being tested. State and local officials, including the mayor of Los Angeles in my home state of California, urged the federal government to reconsider their use of this program. In the words of the mayor, ''all the reports that it generates provide no guidance or value for assessing homeland security investments.''

H.R. 3980 directs FEMA to identify and address the problems it is experiencing with grants reporting and tracking. This legislation is almost a direct response to the concerns raised to Congressman CUELLAR and me by the mayor of Los Angeles about the FEMA grants reporting process. I am proud that this legislation addresses those concerns. When it comes to homeland security and taxpayer dollars, we simply cannot afford to be wasting time or money on programs that offer no guidance or value. So I am pleased to champion H.R. 3980, which addresses this problem.

In conclusion, Mr. Speaker, I support this bill because it will make our grant process more efficient and informative. Redundant reporting requirements will be eliminated, and communities and organizations will be able to better focus on doing the work they need to do to keep our nation safe.

Mr. Speaker, I urge my colleagues to join me in supporting H.R. 3980.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise before you today in support of H.R. 3980, the ''Redundancy Elimination and Enhanced Performance for Preparedness Grants Act''. I would like thank my friend and colleague, Representative CUELLAR, for introducing this act of solidarity, as well as the cosponsor, Representative RICHARDSON.

Congress instructed FEMA in the Post-Katrina Emergency Management Reform Act of 2006 and in the Implementing Recommendations of the 9/11 Commission Act of 2007 to develop performance metrics for its homeland security grants programs. As the House Committee on Homeland Security discovered in our October 27th subcommittee hearing for the Emergency Communications, Preparedness and Response Subcommittee, these requirements remain poorly implemented and difficult to comprehend.

What is most disconcerting is that FEMA still cannot determine our Nation's overall preparedness or how homeland security grants have helped to protect our Nation from acts of terrorism.

It is for these reasons that I come to you today to ask for your support of H.R. 3980, the Redundancy Elimination and Enhanced Performance for Preparedness Grants Act.

This legislation would require FEMA to work in conjunction with state, local, tribal and territorial stakeholders to develop a plan to: Streamline homeland security grant reporting requirements, rules and regulations to eliminate redundant reporting; create a strategy including a set timeline for establishing the much needed performance metrics for grant programs to ensure that the funds are being directed to the areas where they will be best spent; and require FEMA to take inventory of each homeland security grant program to include the purpose, objectives and performance goals for each.

The plan will be submitted to the Committee on Homeland Security no later than 120 days after the bill's enactment. It will be updated biannually to ensure that the Committee is able to maintain a watchful eye on redundancies in the law that might confuse grant recipients. Finally, this bill will help identify inefficiencies with the DHS grant programs and this bill will increase the quality of services received by DHS grant recipients.

It is for these reasons that I rise in support of Representative CUELLAR's legislation before us, and why I encourage my fellow Members to do the same.

Mr. CUELLAR. I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. CUELLAR) that the House suspend the rules and pass the bill, H.R. 3980, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. CUELLAR. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further

proceedings on this motion will be postponed.

ENHANCING SECURITY TO RAIL AND MASS TRANSIT LINES

Ms. JACKSON-LEE of Texas. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 28) expressing the sense of the House of Representatives that the Transportation Security Administration should, in accordance with the congressional mandate provided for in the Implementing Recommendations of the 9/11 Commission Act of 2007, enhance security against terrorist attack and other security threats to our Nation's rail and mass transit lines, as amended.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 28

Whereas the Transportation Security Administration is uniquely positioned to lead the efforts to secure our Nation's rail and mass transit systems and other modes of surface transportation against terrorist attack as a result of expertise developed over six years of securing our Nation's commercial air transportation system;

Whereas the successes of the Transportation Security Administration's National Explosives Detection Canine Team Program has furthered the Transportation Security Administration's ability to secure our Nation's transportation systems against terrorist attack by preventing and protecting against explosives threats;

Whereas each weekday 11,300,000 passengers depend on our Nation's mass transit systems as a means of transportation;

Whereas rail and mass transit systems serve as an enticing target for terrorists and terrorist organizations, such as Al Qaeda, as evidenced by the March 11, 2004, attack on the Madrid, Spain, rail system, the July 7, 2005, attack on the London, England, mass transit system, and the July 11, 2006, and November 26, 2008, attacks on the Mumbai, India, rail system;

Whereas the Transportation Security Administration Authorization Act of 2009, which was passed by the House of Representatives on June 4, 2009, in an overwhelming and bipartisan manner, expresses Congress' commitment to bolstering the security of rail and mass transit systems; and

Whereas securing our Nation's rail and mass transit systems against terrorist attack and other security threats is essential due to their impact on our Nation's economic stability and the continued functioning of our national economy: Now, therefore, be it

Resolved, That it is the sense of the House of Representatives that the Transportation Security Administration should—

(1) continue to enhance security against terrorist attack and other security threats to our Nation's rail and mass transit systems and other modes of surface transportation, including as provided for in the Implementing Recommendations of the 9/11 Commission Act of 2007 (Public Law 110–53) and the Transportation Security Administration Authorization Act of 2009 (H.R. 2200 in the 111th Congress);

(2) continue development of the National Explosives Detection Canine Team Program, which has proven to be an effective tool in securing against explosives threats to our Nation's rail and mass transit systems, with particular attention to the application of its training standards and the establishment of a reliable source of domestically bred canines;

(3) improve upon the success of the Online Learning Center by providing increased person-to-person professional development programs to ensure those responsible for securing our surface transportation systems against terrorist attack are highly trained in both securing those systems against terrorist attack and professional relations with the traveling public; and

(4) continue to secure our Nation's mass transit and rail systems against terrorist attack and other security threats, so as to ensure the security of commuters on our Nation's rail and mass transit systems and prevent the disruption of rail lines critical to our Nation's economy.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Texas (Ms. JACKSON-LEE) and the gentleman from Alabama (Mr. ROGERS) each will control 20 minutes.

The Chair recognizes the gentlewoman from Texas.

GENERAL LEAVE

Ms. JACKSON-LEE of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on the resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in support of this resolution and yield myself such time as I may consume.

Mr. Speaker, House Resolution 28 expresses the sense of the House of Representatives that TSA should increase and enhance its efforts to secure rail and mass transit systems in ways that are consistent with the 9/11 Act and H.R. 2200.

Let me first of all say, Mr. Speaker, that in addition to this legislation, as we stand on the floor today and watch the actions in Afghanistan and Pakistan, as we see the world changing from Mumbai to Madrid, we recognize the crucialness of national security and homeland security. And so this legislation is to emphasize the importance of expanding our oversight and response to the idea of mass transit and rail transportation.

I introduced this resolution because deadlines in the 9/11 Act have passed without being satisfied, which is inexcusable given the risks faced by our Nation's rail and mass transit systems. In addition, I authored H.R. 2200, the TSA authorization bill, which included several elements that sought to enhance TSA's surface transportation efforts. That bill passed in an overwhelmingly bipartisan manner earlier this year. As we wait for our friends in the Senate to act on H.R. 2200, I believe that the House agreeing to this resolution recommits to our goal of TSA securing these modes of transportation.

Let me first of all acknowledge the professional men and women that work for the Transportation Security Administration. I am gratified to know that progress is being made of a new administrator for that agency. I've worked very hard in H.R. 2200 to focus on their professionalism. But they need tools and they need the tools that will allow us to focus on the security of these important elements of transportation, and, as well, the job engine of our community and our Nation.

Many Americans use mass transit. Many Americans use rail. Any irreversible, tragic terrorist act can impact the economy of this Nation. As we were reminded by the tragic events in Russia over the weekend and in other cities around the world over the last several years, rail and mass transit systems are prime targets for terrorist acts. When they're shut down, the economy can shut down.

This resolution recognizes TSA as being uniquely positioned to lead Federal efforts to secure our Nation's rail and mass transit systems, and recognizes the National Explosives Detection Canine Team Program as a valuable resource, which my friend from Alabama has worked on. I might also say that this effort today, this resolution, is also to save lives. As such, it is critical that TSA's security efforts share our commitment to securing these systems.

I urge my colleagues to join me in supporting this resolution and send a message about the importance of protecting our people, our infrastructure, and our economy.

I reserve the balance of my time.

Mr. ROGERS of Alabama. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H. Res. 28, sponsored by my friend and the gentlewoman from Texas (Ms. JACKSON-LEE). We know the Nation's surface transportation systems are designed for accessibility and efficiency, making them vulnerable to terrorist attack. When hardening the transportation sector from terrorist attack, we must construct and finance a system of deterrence, protection and response that effectively reduces the possibility and consequences of another terrorist attack without unduly interfering with travel, commerce and civil liberties.

In the 9/11 Act of 2007, Congress mandated that DHS take certain steps to ensure the security of our Nation's public transportation systems. More than 2 years later, a number of mandates have gone unmet by the department, and this resolution expresses the sense of Congress that DHS should actually implement those mandates. It is time for DHS to move beyond the transportation sector-specific plans that identify and evaluate risk, to implementing risk reduction measures.

This resolution resolves that TSA should continue to enhance the security of mass transit and rail transportation systems, continue the development of the canine explosive detection program, and enhance on-line training programs. The resolution also takes special note that more attention is needed for school transportation systems.

With that, Mr. Speaker, I would urge my colleagues to vote for this, and yield back the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself such time as I may consume.

I'd like to thank the staff of the Homeland Security Committee, and as well, the staff director of the Transportation Security Committee, Mike Beland, and acknowledge the chairman of the committee for working with me and acknowledging the importance of this particular amendment and this bill.

Let me just say, as I close, we have already enunciated the parameters of securing mass transit and rail. We understand that we are behind in that effort.

□ 1330

I know there are committed, dedicated members of the Homeland Security Department and efforts that are ready to go. We need to give them the tools that they can work with. Even over the last couple of days as we look at actions that may be at first glance perceived to be innocent individuals intruding into the parameters of the White House, we know that we have to be on alert, because no action should be taken in a simple or, if you will, non-serious manner.

So I stand today to say that this legislation, though a resolution, is serious because it emphasizes a commitment for tools and saving lives. I am delighted that my colleagues on the committee, in a bipartisan manner, have supported this. I'd like to acknowledge the ranking member of this committee, Mr. DENT; and I'd ask my colleagues to support this legislation, Mr. Speaker.

I believe this is a critical issue. H. Res. 28 addresses the critical issue of surface transportation, and I encourage my colleagues to vote ''aye.''

Mr. THOMPSON of Mississippi. Mr. Speaker, for a second consecutive year, while Americans gathered with family and friends to celebrate the Thanksgiving holiday, terrorists executed deadly attacks on innocent people that were in transit, on foreign rail systems.

Just last week, two separate bombings in Russia underscored that passenger rail systems remain enticing targets for acts of terrorism.

It has been nearly six months since this body overwhelmingly passed the legislation to authorize TSA's rail and mass transit security activities (H.R. 2200).

Unfortunately, to date, the Senate has failed to move on H.R. 2200.

The Senate also has yet to confirm a new TSA Assistant Secretary to fulfill the rail and mass transit security mandates that Congress overwhelmingly approved in 2007, with the passage of the Implementing Recommendations of the 9/11 Commission Act.

Plainly, there is still much to be done to secure rail and mass transit systems in the United States from bombings like the ones that occurred in Russia over the weekend, and other acts of terrorism.

In remembrance of those events, as well as the bombings of passenger rail and mass transit systems in Madrid, Spain; London, England; and Mumbai, India that occurred in recent years, H. Res. 28 instructs TSA to strengthen its efforts to secure rail and mass transit systems across the country and to build on existing programs that have shown promise.

This resolution recognizes TSA as being uniquely positioned to lead Federal efforts to secure rail and mass transit systems in the United States, and identifies the National Explosives Detection Canine Team Program as an effective and valuable resource.

House passage of both the 9/11 Act in 2007 and H.R. 2200 earlier this year by overwhelming majorities has emphasized the House of Representatives' commitment to strengthening security of rail and mass transit systems.

I urge my colleagues to join with me in supporting this resolution and reaffirming our strong commitment to strengthening the security of our rail and mass transit systems.

Ms. RICHARDSON. Mr. Speaker, I rise today in support of House Resolution 28, which expresses the sense of the House of Representatives that the Transportation Security Administration (TSA) should increase and enhance its efforts to secure rail and mass transit systems in ways that are consistent with the 9/11 Act and H.R. 2200.

I would like to acknowledge Speaker PELOSI and Chairman THOMPSON for their leadership in bringing this important resolution to the floor. I would also like to thank my colleague Congresswoman SHEILA JACKSON-LEE, who authored this resolution recognizing TSA and its programs and urging the Administration to continue its efforts protecting the infrastructure of our Nation.

11,300,000 passengers depend on our Nation's mass transit lines as a means of transportation, and more than 25 million children depend on the school transportation system. My district, the 37th district of California, is a key transportation hub as well. Nearly 45 percent of all U.S. imports travel through the District. As such, it is critical that TSA shares our commitment to securing these systems.

H. Res. 28 recognizes TSA for leading Federal efforts to secure our Nation's rail and mass transit systems, the National Explosives Detection Canine Team Program as a valuable resource, and the successful Online Learning Center that ensures those responsible for securing against terrorist attacks on our transportation systems are highly trained. So I am happy to stand in support of H. Res. 28.

In conclusion, Mr. Speaker, I support this resolution because we cannot take the safety of our Nation's infrastructure for granted. We need to urge TSA to take all the action necessary to adequately protect our Nation and expand upon programs with a proven record of success, such as the Online Learning Center.

Mr. Speaker, I urge my colleagues to join me in supporting H. Res 28.

Ms. JACKSON-LEE of Texas. With that, Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Texas (Ms. JACKSON-LEE) that the House suspend the rules and agree to the resolution, H. Res. 28, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Ms. JACKSON-LEE of Texas. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

CRIMINAL INVESTIGATIVE TRAINING RESTORATION ACT

Ms. JACKSON-LEE of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3963) to provide specialized training to Federal air marshals.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3963

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Criminal Investigative Training Restoration Act''.

SEC. 2. FEDERAL AIR MARSHALS.

Section 44917 of title 49, United States Code, is amended by adding at the end the following:

''(e) CRIMINAL INVESTIGATIVE TRAINING PROGRAM.—

''(1) NEW EMPLOYEE TRAINING.—Not later than 30 days after the date of enactment of the Criminal Investigative Training Restoration Act, the Federal Air Marshal Service shall require Federal air marshals hired after such date to complete the criminal investigative training program at the Federal Law Enforcement Training Center as part of basic training for Federal air marshals.

''(2) EXISTING EMPLOYEES.—A Federal air marshal who has previously completed the criminal investigative training program shall not be required to repeat such program.

''(3) ALTERNATIVE TRAINING.—Not later than 3 years after the date of enactment of the Criminal Investigative Training Restoration Act, an air marshal hired before such date who has not completed the criminal investigative training program shall be required to complete a alternative training program, as determined by the Federal Law Enforcement Center, that provides the training necessary to bridge the gap between the mixed basic police training, the Federal air marshal programs already completed by the

Federal air marshal and the criminal investigative training provided through the criminal investigative training program. Any such alternative program shall be deemed to have met the standards of the criminal investigative training program.

''(4) AUTHORIZATION OF APPROPRIATIONS.—Not less than $3,000,000 is authorized to be appropriated for each of fiscal years 2010 and 2011 to carry out this subsection.

''(5) SAVINGS CLAUSE.—Nothing in this subsection shall be construed to reclassify Federal air marshals as criminal investigators.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Texas (Ms. JACKSON-LEE) and the gentleman from California (Mr. DANIEL E. LUNGREN) each will control 20 minutes.

The Chair recognizes the gentlewoman from Texas.

GENERAL LEAVE

Ms. JACKSON-LEE of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in support of this bill and yield myself such time as I may consume.

First of all, I'm grateful to the gentleman from California (Mr. DANIEL E. LUNGREN), who I have worked with before, who's worked tirelessly on this issue. I'm honored to be a cosponsor of this important legislation, and I do applaud his work.

This legislation will help to bolster the effectiveness and morale of the Federal Air Marshal Service, many of whom I visited with over my tenure as a member of the Homeland Security Committee. In my position as chairwoman of the Subcommittee on Transportation Security and Infrastructure Protection, I have promoted the need to keep our modes of transportation secure and to ensure that employees of the Department of Homeland Security have professional growth opportunities and are treated fairly and given the opportunity to exercise their concern and have this Congress and this executive listen to their concerns. This bill works towards both of these important objectives.

The Federal Air Marshal Service had to quickly expand its size and efforts in the wake of attacks on September 11, 2001. This bill helps to restore more training measures in a way that is consistent with that necessary expansion. In addition, this legislation provides for potential promotion opportunities.

I would like to note that this provision was offered and rejected during the markup of H.R. 2200, the TSA authorization bill that I wrote earlier and which passed the House in a bipartisan manner. At that time I did not feel as though it contained the necessary language to ensure that it would not adversely impact the salaries and benefits of Federal air marshals. Working with the gentleman from California, as we have promised, we were able to agree on language that eliminates my concern. I thank the gentleman for his cooperation and collaboration for a very important step forward. Accordingly, I'm confident that Federal air marshals will not—and cannot—be wrongly classified as ''criminal investigators.''

Taken as a whole, this bill demonstrates a commitment to the Federal air marshals who help to keep us safe. This is a well-balanced bill that will improve the security of the traveling public.

I look forward to the bipartisan passage of H.R. 3963 and reserve the balance of my time.

Mr. DANIEL E. LUNGREN of California. Mr. Speaker, I yield myself such time as I may consume. I thank the gentlelady for her gracious comments and her support of this bill. I rise in support of H.R. 3963, the Federal Air Marshals Criminal Investigative Training Restoration Act, a bill that I have authored.

Prior to 9/11, the criminal investigative training program at the Federal Law Enforcement Training Center was an essential part of the training that we have for our Federal air marshals, commonly referred to as FAMs. The events of 9/11, however, necessitated an emergency situation in which we were required to rapidly hire, train, and deploy thousands of new FAMs.

In order to meet these ambitious deployment mandates, the newly hired members of this corps, without prior Federal law enforcement experience, were not required to take the criminal investigative training program. It was not because we did not wish them to have it, but that would have delayed their deployment, and we were under an emergency situation. We realized that additional Federal air marshals were essential to the overall response to the threat we then knew to be real.

It has always been the intent of the Federal Air Marshal Service, however, to resume using the criminal investigative training program as part of the basic training for FAMs. This bill will restore the criminal investigative training program as part of the basic training for the members of this organization.

Crucial to the mission of the Federal air marshals is the ability to detect, deter, and prevent terrorists or other criminal hostile acts targeting our U.S. air carriers, airports, passengers, crew, or other transportation modes. Currently, the FAMs are required to take a mixed basic police training program and a FAMS-specific course at the Federal Law Enforcement Training Center, known as FLETC. Restoring the criminal investigative training will provide FAMs with the additional knowledge and skills required to resolve situations on the ground as well as respond to situations in-flight.

The additional training—it is 12 weeks long—includes law enforcement interview, interrogation, and behavioral assessment skills and techniques. It will, undoubtedly, provide our Federal air marshals with improved law enforcement skills not only to fly missions, but to perform the enhanced roles with our visual intermodal protection and response teams—that is our VIPR teams—and other ground-based law enforcement. It therefore enhances the FAMs' layer of security.

Detection is the principle tool utilized by the VIPR teams to disrupt terrorist operations, and these investigative techniques are not currently taught to our Federal air marshals. It also provides the Department of Homeland Security Secretary and the TSA administrator a highly trained, agile, and motivated workforce capable of meeting the security challenges facing not only our transportation sector, but also the homeland itself.

Now, Mr. Speaker, our Federal air marshals have expressed a strong desire for advancement opportunities within the Service and the opportunity to gain greater investigative experience. This legislation affords these opportunities and is an important step in improving operations at the Federal Air Marshal Service. Restoring the criminal investigative training to the Federal Air Marshal Service would also improve morale tremendously. These are trained individuals who seek to be recognized as essential members of our overall law enforcement communities. This will give them the kind of training that will assist them not only in their job, but should they pursue other lines of employment in the world of law enforcement. This will provide them with the background which will assist in that.

The Federal Air Marshal Service supports the restoration of criminal investigative training to their membership. The Federal Law Enforcement Officers Association also supports it. However, I want to emphasize this bill does not in any way reclassify the Federal air marshals as criminal investigators, known as series 1811 employees. The bill therefore before us states expressly that nothing in the bill would be construed as reclassifying FAMs as criminal investigators. That should clear up any question of a budgetary nature with respect to this bill.

I would ask for House bipartisan support of this legislation, and I reserve the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, at this time I have no further speakers. I would inquire whether the gentleman is prepared to close.

Mr. DANIEL E. LUNGREN of California. I am prepared to close, as I have

no further speakers. I thank the gentlelady for her support on this. I thank both sides of the aisle, both staff and members of the committee. This is a commonsense approach. It's the kind of thing that we ought to be working on together—we have worked on together here—and I hope it will pass unanimously.

With that, I would yield back the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself such time as I may consume.

Let me first of all thank my good friend, Mr. LUNGREN, again, for his cooperation in this effort. I'd like to reemphasize points that he has made that should be reemphasized.

One, we are gratified that we have Federal U.S. Air Marshals, and we thank them for their service. They are peace officers, as we use that terminology in Texas. They are law enforcement officers. We're gratified for that expertise. This legislation will help them add to their portfolio in training on investigation, because there is not a single action that may occur that would require their service that does not require us to have the details and the information in order to bring individuals to justice. This is important.

Might I just add that Federal air marshals have risen to the call of duty. Federal air marshals came to New Orleans, Louisiana, during Hurricane Katrina. Federal air marshals have been called upon in time of disaster, and they have answered the call.

So I think it is important to note as we stand on the floor of the House to present this legislation to enhance their training that we appreciate their service. We thank them for the sacrifice of their families as they travel internationally on behalf of the American people.

Mr. THOMPSON of Mississippi. Mr. Speaker, I rise in support of H.R. 3963, the "Criminal Investigative Training Restoration Act," which has the potential of bolstering the effectiveness and morale of the Federal Air Marshal Service.

Specifically, this is a bipartisan bill adds the Federal Law Enforcement Training Center's criminal investigative training program to the basic training required for Federal Air Marshals.

H.R. 3963 directs the Federal Air Marshal Service to provide criminal investigative training to all newly hired FAMs within 30 days of enactment.

The bill creates a three-year window for all current FAMs to be provided this additional training.

This training was provide to FAMs prior to 2001 but was halted to allow the Federal Air Marshal Service to swiftly ramp up its workforce in response to the September 11th attacks.

Unfortunately, in the eight years since 9/11, the Transportation Security Administration has not moved forward to restore this training.

I have heard that there were some concerns that there was a risk that FAMs, by virtue of taking this course, would be reclassified as "criminal investigators."

The legislation addresses this concern head-on by clearly stating that this such a reclassification will not occur, thereby also ensuring that the pay FAMs receive is not adversely affected.

I thank the gentleman from California, Mr. LUNGREN, for introducing this legislation and . working of my colleagues to include this Important provision.

I urge passage of this bipartisan bill.

Ms. JACKSON-LEE of Texas. I would ask my colleagues to support this very important bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Texas (Ms. JACKSON-LEE) that the House suspend the rules and pass the bill, H.R. 3963.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

☐ 1345

EXTENDING CONDOLENCES TO FAMILIES OF SLAIN WASHINGTON OFFICERS

Mr. COHEN. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 939) extending condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 939

Whereas, on the morning of November 29, 2009, 4 members of the Lakewood Police Department were slain by gunfire in a senseless act of violence while preparing for their shift in Lakewood, Washington;

Whereas the 4 officers have been members of the Lakewood Police Department since its founding 5 years ago, were valuable members of the community, and were deeply respected for their service;

Whereas Sergeant Mark Renninger who served 13 years in law enforcement, first with the Tukwila Police Department and most recently, served with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas Officer Tina Griswold who served 14 years in law enforcement, first with the Lacey Police Department and most recently, served with the Lakewood Police Department, is survived by her husband and 2 children;

Whereas Officer Ronald Owens who served 12 years in law enforcement, first with the Washington State Patrol and most recently, served with the Lakewood Police Department, is survived by his daughter;

Whereas Officer Greg Richards who served 8 years in law enforcement, first with the Kent Police Department and most recently, served with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas the senseless violence against and murder of law enforcement officers, who are sworn to serve, protect, and preserve the peace of the communities, is a particularly heinous crime; and

Whereas in the face of this senseless tragedy, the people of the City of Lakewood, the surrounding communities, and the State of Washington have come together in support of the law enforcement community and the victims' families: Now, therefore, be it

Resolved, That the House of Representatives—

(1) extends its condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; and

(2) stands with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they celebrate the lives and mourn the loss of these four dedicated public servants and law enforcement heroes.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Tennessee (Mr. COHEN) and the gentleman from Texas (Mr. POE) each will control 20 minutes.

The Chair recognizes the gentleman from Tennessee.

GENERAL LEAVE

Mr. COHEN. I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous matter on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Tennessee?

There was no objection.

Mr. COHEN. I yield myself such time as I may consume.

This resolution extends condolences to the families of four Lakewood, Washington, police officers, Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards, who were senselessly slain by gunfire in the line of duty on Sunday, November 29, 2009. These brave and honorable Lakewood Police Department officers were ambushed as they sat in a local coffee shop, catching up on paperwork at the beginning of their Sunday morning shift.

By way of this resolution, the House of Representatives honors the lives and mourns the loss of these Lakewood police officers. We join the city of Lakewood and the entire State of Washington in celebrating the lives and grieving the deaths of these police officers.

Sergeant Mark Renninger was described as a ''tough guy'' who excelled at his job and was regarded as a leader and teacher in the close-knit Lakewood police force. He was married with three children.

Officer Tina Griswold liked to cook, ride her dirt bike, and was a certified diver. Her father is a retired police officer. She began working in law enforcement as a dispatcher and came to Lakewood 5 years ago as an officer. She leaves behind a 21-year-old daughter and a 7-year-old son.

Officer Ronald Owens, known to friends and family as Ronnie, was described as having a fun-loving personality and as someone who made everyone around him feel positive. Officer Owens leaves behind a daughter.

Officer Greg Richards enjoyed music in his spare time, playing drums in a rock band. He liked nothing better than spending time with his wife, Kelly, and his three children.

By passing this resolution, we want the families of these police officers to know that they are not alone in mourning the loss of the Lakewood officers. My first job, Mr. Speaker, was as an attorney for the police department. I served 3½ years as an attorney for the Memphis Police Department, and I relate to the loss that the department and this Nation have suffered.

I urge all my colleagues to support this important resolution.

I reserve the balance of my time.

Mr. POE of Texas. Mr. Speaker, I yield myself such time as I may consume.

First of all, I want to thank the gentleman from Washington (Mr. SMITH) for sponsoring this important legislation, and I rise in support of House Resolution 939. This resolution extends our condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards. These four police officers were members of the Lakewood, Washington, police department and were ambushed by gunfire in a murderous act of violence on November 29, 2009.

These four officers were in uniform and sitting at a table in a coffee shop near their patrol area. They were preparing for their upcoming shift when a gunman with an extensive criminal record who was out on bond for another criminal offense entered the location and suddenly fired gunshots at these officers. Two of the officers were killed immediately, another was shot when he stood up from the table, and the fourth was shot after struggling with the gunman in attempting to prevent his escape. The gunman fled but not before one of the wounded dying officers had shot him.

The gunman was found 2 days later in Seattle after he challenged yet another police officer who approached him. That police officer was a 7-year veteran of the Seattle police force who noticed a parked, stolen car that was running but unoccupied. The officer approached the suspect outside the car and asked him to show his hands, but the suspect refused and started to run around the car. The officer shot and killed the suspect to prevent his escape. The officer had recognized the gunman from photographs and identified him as the main suspect in the murders of these other officers. The gunman was carrying a service weapon taken from one of the slain officers that he had murdered.

Unfortunately, police officers and law enforcement officials sometimes go unnoticed and unappreciated by communities that they protect. So far in 2009, 111 American police officers have lost their lives in the line of duty, protecting the rest of us. These noble men and women deserve respect and gratitude from our entire Nation. Peace officers, like Sergeant Renninger, Officer Griswold, Officer Owens, and Officer Richards perform their jobs every day with the knowledge that there is a possibility that they may give their lives in service to the communities that they protect. That's an awesome sacrifice, Mr. Speaker.

As a Nation, we are grateful to peace officers who readily accept such a tremendous burden and to their families who accept that burden as well. In the wake of this vicious tragedy, we come together in support of the law enforcement community and the families of these individuals.

Sergeant Renninger was a 13-year law enforcement veteran. He is survived by his wife and three children. Officer Griswold, a 14-year police veteran, is survived by her husband, a former deputy sheriff, and two children. Officer Owens, a 12-year veteran, is survived by his daughter. Officer Richards, an 8-year veteran, is survived by his wife and three children.

The four officers were original members of the Lakewood Police Department, which was founded just 5 years ago. They are the first officers from this department to be killed in the line of duty. As the resolution so aptly states, Members of Congress stand with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they honor the lives and mourn the loss of these four dedicated public servants and law enforcement heroes.

I urge my colleagues to support this resolution.

I reserve the balance of my time.

Mr. COHEN. Mr. Speaker, I yield as much time as the gentleman shall consume to Mr. SMITH from the State of Washington.

Mr. SMITH of Washington. I want to thank the Speaker and this Chamber for so quickly bringing this resolution to the floor.

As we have now heard of the tragic events of last Sunday, we are here to offer our condolences to the families, also to honor the lives and the service of the four officers who were so brutally slain, and to express our grief over their loss. They were ambushed early on Sunday morning, simply getting ready to go to work. It is a tragedy that has had a deep impact on our community. And I want to also offer my condolences to all the people in Lakewood, especially their police force and the city officials, who have been so impacted by this tragic event.

The four officers who were killed were part of the police force and all of the police officers in this country who so selflessly serve and protect all of us.

They were Sergeant Mark Renninger, who was a 13-year law enforcement veteran. He started out with the Tukwila Police Department before moving on to Lakewood. He is survived by his wife, two daughters, and a son.

Officer Tina Griswold served 14 years in law enforcement, starting with the Lacey Police Department before moving to Lakewood. She is survived by her husband and two children.

Officer Ronald Owens, who has served 12 years in law enforcement, started off with the Washington State Patrol before moving to Lakewood. He is survived by a daughter.

Officer Greg Richards served 8 years in law enforcement. He began with the Kent Police Department before going to Lakewood. He is survived by his wife and three children.

□ 1400

It is very appropriate that Congress makes clear to the families and to all members of the law enforcement community that we stand with them in grieving their loss and honoring their service. And it is also important that we remember as often as possible what our law enforcement personnel do for us.

I had the opportunity to serve as a prosecutor for a few years and work with many of the members of our law enforcement community, and what a lot of people forget is the constant danger that they are in and the courage that it takes to do their job every day. It's easy to see a police officer on a patrol or on the beat, see them driving around, and think of the job simply in that context. But every second of every day, people who serve as police officers know the risk and danger that they are taking. And the impressive thing is they take it every single day and they do it to protect us, to give us a sense of safety and security in our community despite the danger that they face.

The tragedy in Lakewood makes that all too clear. They were simply sitting down for a cup of coffee to get their paperwork together before going on shift. That makes it clear just how much our officers are always at risk and how willingly they take that risk and protect us.

I thank the House for pausing for a few moments today to remember the service of these four officers, to honor them for that service, to grieve over their deaths, and to express condolences to their families, to all of the people in Lakewood, and to the larger law enforcement community that does so much to protect us and show so much courage in doing so.

Mr. POE of Texas. Mr. Speaker, I yield such time as he may consume to the gentleman from Washington (Mr.

REICHERT), who's familiar with this law enforcement agency and, as a sheriff, represented much of this area.

Mr. REICHERT. I thank the judge for yielding.

Mr. Speaker, I know that most of the people in Washington, D.C., don't know these families that we're talking about today. The people here in Washington, D.C., don't know the children that these officers will no longer be able to parent.

But we do know police officers in Washington, D.C. We do know police officers here, the Capitol Hill Police Department and the D.C. Police Department, and we recognize the job they do every day to protect us.

Sometimes it's hard to make that connection between the men and women who wear the uniform and the sacrifices they make until it happens in your neighborhood, until it happens in your communities, until it happens to one of your neighborhood police officers, until it happens to your mother, your father, one minute sitting having coffee at a coffee shop, the next minute gone. Three fathers and a mother coming to work to protect all of us. It happens every day on the streets of America. They put on the uniform. They know the risk.

So with this resolution today, I think it's right that we pause and think about the sacrifices that our men and women in uniform make here serving our police departments in our communities across this country, to honor the service of Mark Renninger, Tina Griswold, Ronald Owens, and Gregory Richards. We should also mention Timothy Brenton, who was killed 30 days before this event, before this tragedy. He was also assassinated in the city of Seattle and he was sitting in his police car. This can happen at any time, at any moment, to any police officer across this country.

So pausing to honor and to mourn the loss of these four Lakewood, Washington, police officers who were brutally murdered Sunday morning just after Thanksgiving, spending the week with their family, I think it's just and right that all of us here today extend our deepest sympathy, to stand in solidarity and in grief with the families, their fellow officers, their friends, and their community. The entire Nation mourns and our hearts are broken.

To those involved in the hunt for the suspect, we commend you for your hard work and your bravery. Your thorough and effective work saved the lives of other citizens and other officers from harm.

Moving forward, I hope all of you understand how hard this will be for the families. I, unfortunately, have had the duty to notify family members of their loved ones lost. It's pain and emotion that you can't imagine. These families are devastated. So, please, I would ask all of us to remember the families, and don't forget they need your support, your help, your prayers, and your love.

Mr. COHEN. Mr. Speaker, I reserve the balance of my time.

Mr. POE of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, next year on May 15, right here on the Capitol grounds, we will pay tribute and honor to peace officers that have been killed this year in the line of duty. Until this event in Washington State, there were 111 peace officers killed in this country in the line of duty. Now there are 115, and they will be honored and their families will be honored next year.

Having spent most of my career at the courthouse in Houston as a prosecutor and then a criminal court judge, I saw a lot of police officers come down to the courthouse. And sometimes they didn't return, and the reason was because some criminal had decided to take their life. But that is the occupation that they chose, to risk their lives for the rest of us. And we should always be mindful of the men and women that wear the uniform, those who wear the uniform at home to protect us from domestic criminals and those who wear the uniform overseas to protect us from international criminals.

Peace officers, Mr. Speaker, are the last strand of wire in the fence between the people and the lawless. Every day they put on their uniform and they put above their heart on their chest a badge, which is really a shield, a shield that's symbolic of protecting the community from the evildoers. It goes back centuries ago. And yet they wear that shield proudly to protect us from people who wish to do us harm. And when individuals make the decision to harm those that protect us, it is an American tragedy, and the whole country mourns with the families who have lost a police officer.

So I urge that we mourn the loss of these officers, that we honor their lives and their bravery, and that we pass this resolution immediately.

Mr. Speaker, I yield back the balance of my time.

Mr. COHEN. Mr. Speaker, I join with my friend from Texas in urging that we pass this resolution and that we do mourn these brave officers who lost their lives and stand with the people of Lakewood, Washington.

But I would also ask us to think about what happened, why these people lost their lives. And we may never know, but we do know that the person who killed them should have been behind bars. He was a criminal who was released from prison in Arkansas through executive clemency. And while there are certainly people who committed victimless crimes who are unnecessarily kept for long periods of times in incarceration and should have clemency or some type of executive relief, people who commit crimes of violence, as this person did, they should not be released unless there are some extra circumstances that are beyond anybody's thought that it was appropriate.

This gentleman was not reformed. He committed other crimes. He still should have been in jail.

And you've got to think about mental health. The man was a criminal, but he was also mentally ill. He had delusions that he was some type of religious figure. And we've got to think about the mental health laws that we have up here and the opportunity to fund mental health institutions and to get mental health so that people can be treated before they commit some act out of a delusional aspect of their disease.

So there are a lot of other areas we need to look into as we mourn these officers and remember 9/11 and the fire people and the police people who were killed there. And we've got to remember the issues with guns and how this man got access to a gun to commit this crime. So there are other issues that need to be looked at.

I join all the Members of the House and ask that we pass H. Res. 939 and join in morning the loss of these four fine law enforcement officers, but also that we continue our research into the causes of this heinous crime.

Mr. STUPAK. Mr. Speaker, I rise to honor the fallen officers of the Lakewood, Washington, Police Department and to offer my condolences to the families and colleagues of these officers.

The tragic events of November 29, 2009, took the lives of four officers who have served the Lakewood Police Department for many years. This is a loss not only to the police department, but to the law enforcement community across the country.

It is also a solemn reminder that every day, our men and women in uniform face unpredictable threats.

We must work in Congress to ensure that our police departments are always prepared, equipped, and ready to fend off these threats.

Law enforcement officers are on the front lines of protecting our communities, and we must ensure they are protected, too.

As a former police officer and a Michigan State Trooper, and the co-chairman of the Congressional Law Enforcement Caucus, I extend my condolences to the fallen, to the families, and to the police department of Lakewood, Washington.

Our thoughts and prayers are with you.

Mr. PASCRELL. Mr. Speaker, I rise today to honor the memories of the four brave officers whose lives were needlessly cut short this past week in Washington State.

All four officers were members of the Lakewood Police and were slain while preparing for their shift by Maurice Clemons, a career criminal who had been paroled from prison earlier this decade and was later killed by a Seattle police officer after a long manhunt.

We stand with all the police officers in Washington State who despite losing four of their own served with distinction and bravery to bring this killer to "justice."

I have long maintained that our first responders are the first line in our country's national defense. They are out there on the streets every day keeping our communities and our children safe from harm.

This resolution describes violence against law enforcement officers as "particularly heinous," which I think is an understatement. This kind of violence against these brave community servants is not only heinous, it's unimaginable, horrific, and unacceptable.

The Federal Government must do more to protect our police officers from these kinds of violent and malicious criminals.

Congress must look at the ways we can strengthen the penalties for these kinds of horrific crimes committed against our heroes.

Our police officers are out there every day sticking their necks out for us, and we owe it to them to do everything in our power to protect them as well.

Mr. LANGEVIN. Mr. Speaker, I rise to express my deep sorrow and most sincere condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards. These four officers, who so honorably served the Lakewood, Washington, Police Department, were tragically gunned down as they began their shifts last Sunday morning.

I, like all Americans, was shocked and horrified to hear of this brutal crime against four uniformed officers. Having grown up around law enforcement as a young police cadet, I know firsthand the challenges and dangers of the job, and the selflessness of those who wear the uniform and dedicate their lives to protecting their communities.

I come to the floor today to add my voice to all those expressing their grief and their outrage over these senseless killings, and I want to send my thoughts and prayers to the officers' families, especially the children these public servants have left behind. They will need untold strength in the coming days, but I know they will find all they need and more in the memory and example that their courageous parents have left for them.

Let us remember always the service of not only these four officers, but of all those who wear the uniform and make our safety their first priority.

Mr. COHEN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CUELLAR). The question is on the motion offered by the gentleman from Tennessee (Mr. COHEN) that the House suspend the rules and agree to the resolution, H. Res. 939.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

RADIOACTIVE IMPORT DETERRENCE ACT

Mr. GORDON of Tennessee. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 515) to prohibit the importation of certain low-level radioactive waste into the United States, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 515

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Radioactive Import Deterrence Act".

SEC. 2. PROHIBITION OF IMPORTATION.

(a) AMENDMENT.—Chapter 19 of the Atomic Energy Act of 1954 (42 U.S.C. 2015 et seq.) is amended by inserting after section 276 the following new section:

"SEC. 277. IMPORTATION OF LOW-LEVEL RADIOACTIVE WASTE.—

"a. Except as provided in subsection b. or c., the Commission shall not issue a license authorizing the importation into the United States of—

"(1) low-level radioactive waste (as defined in section 2 of the Low-Level Radioactive Waste Policy Act (42 U.S.C. 2021b)); or

"(2) specific radioactive waste streams exempted from regulation by the Commission under section 10 of the Low-Level Radioactive Waste Policy Act (42 U.S.C. 2021j).

"b. Subsection a. shall not apply to—

"(1) low-level radioactive waste being returned to a United States Government or military facility which is authorized to possess the material; or

"(2) low-level radioactive waste resulting from the use in a foreign country of nuclear material obtained by the foreign user from an entity in the United States that is being returned to the United States for management and disposal.

"c. The President may waive the prohibition under this section and authorize the grant of a specific license to import materials prohibited under subsection a., under the rules of the Commission, only after a finding that such importation would meet an important national or international policy goal, such as the use of waste for research purposes. Such a waiver must specify the policy goal to be achieved, how it is to be achieved, and the amount of material to be imported.

"d. A license not permitted under this section that was issued before the date of enactment of this section may continue in effect according to its terms, but may not be extended or amended with respect to the amount of material permitted to be imported.".

(b) TABLE OF CONTENTS AMENDMENT.—The table of contents for the Atomic Energy Act of 1954 is amended by inserting after the item relating to section 276 the following new item:

"Sec. 277. Importation of low-level radioactive waste.".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Tennessee (Mr. GORDON) and the gentleman from Florida (Mr. STEARNS) each will control 20 minutes.

The Chair recognizes the gentleman from Tennessee.

GENERAL LEAVE

Mr. GORDON of Tennessee. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Tennessee?

There was no objection.

Mr. GORDON of Tennessee. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Radioactive Import Deterrence Act is a bipartisan bill that would ban the importation of low-level radioactive waste unless the President provides a waiver.

Low-level radioactive waste is generated by medical facilities, university research labs, and utility companies. This waste is generated all over the United States, but finding permanent disposal sites has proven difficult. Currently, 36 States and the District of Columbia have only one approved site to store all the waste generated by those industries. That site is located in Utah. The site stores 99 percent of the United States' low-level radioactive waste.

However, the Nuclear Regulatory Commission is currently considering the importation of 20,000 tons of Italian low-level waste to be permanently disposed of at the Utah site. This would be the largest importation of foreign waste ever.

The United States stands alone as the only country in the world that imports other countries' radioactive waste for permanent disposal. Other countries are reading the signs that the U.S. is poised to become a nuclear dumping ground. Permit applications are also pending for the importation of Brazilian and Mexican waste.

Foreign waste threatens the capacity that we have set aside in this country for the waste generated by our domestic industries. It is critical that Congress protect that capacity by prohibiting these imports.

I support nuclear power as part of our energy mix. 104 commercial nuclear plants in the United States help to provide 20 percent of our Nation's energy needs. If we are going to support the continued growth of our domestic nuclear industry, we must ban the practice of disposing of other countries' radioactive waste. We must reserve that capacity for our domestic needs.

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The bill is the product of a bipartisan cooperation and has received multiple hearings in the Energy and Commerce Committee. I urge my colleagues to stand firm against the importation of foreign radioactive waste and support this bipartisan bill.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, December 1, 2009.

Hon. HENRY WAXMAN,
Chairman, Committee on Energy and Commerce, Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: I am writing regarding H.R. 515, the "Radioactive Import Deterrence Act." As you know, the Committee on Ways and Means has received a sequential referral on this bill.

To expedite this legislation for floor consideration, the Committee on Ways and Means will forgo action on this bill. This is

being done with the understanding that the Committee on Energy and Commerce will confirm in the legislative history of the bill that the President's discretion to waive section 277(a) of the Atomic Energy Act of 1954 applies to any important national or international policy goal, and is not limited to the use of waste for research purposes.

The Committee on Ways and Means is forgoing action on the bill with the understanding that it does not in any way prejudice the Committee with respect to the appointment of conferees or its jurisdictional prerogatives on this bill or similar legislation in the future.

I would appreciate your response to this letter, confirming this understanding with respect to H.R. 515, and would ask that a copy of our exchange of letters on this matter be included in the Congressional Record during consideration of this bill.

Once again, thank you for your work and cooperation on this legislation.

Sincerely,

CHARLES B. RANGEL,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, December 1, 2009.

Hon. CHARLES B. RANGEL,
Chairman, Committee on Ways and Means, Longworth House Office Building, Washington, DC.

DEAR CHAIRMAN RANGEL: Thank you for your letter regarding H.R. 515, the "Radioactive Import Deterrence Act of 2009." The Committee on Energy and Commerce recognizes the jurisdictional interest of the Committee on Ways and Means in H.R. 515, and I appreciate your effort to facilitate consideration of this bill.

Your letter accurately stated that the report of the Committee on Energy and Commerce on H.R. 515 will confirm that the President's discretion to waive section 277(a) of the Atomic Energy Act of 1954 applies to any important national or international policy goal, and is not limited to the use of waste for research purposes. I also concur that by forgoing action on the bill the Committee on Ways and Means does not in any way prejudice the Committee with respect to its jurisdictional prerogatives on this bill or similar legislation in the future, and I would support your effort to seek appointment of an appropriate number of conferees to any House-Senate conference involving this legislation.

I will include our letters on H.R. 515 in the Congressional Record during floor consideration of the bill and in the Committee report on H.R. 515. Again, I appreciate your cooperation regarding this legislation and I look forward to working with the Committee on Ways and Means as the bill moves through the legislative process.

Sincerely,

HENRY A. WAXMAN,
Chairman.

I reserve the balance of my time.

Mr. STEARNS. Mr. Speaker, I yield myself such time as I may consume.

The gentleman from Tennessee is a scholar and perspicuous individual, very talented, but Shakespeare said, "To err is human," and in this case, the gentleman from Tennessee has erred particularly in this bill. So I stand here not in support of his grand bill.

I think many in Congress are perhaps frustrated that we're not focusing on domestic nuclear waste disposal issues that obviously need to be resolved if we're ever to revitalize our nuclear energy. Instead, we're talking about this bill. In fact, this bill is going to hurt businesses that are trying to create jobs and promote economic growth. It will actually discourage it.

The administration has irresponsibly turned its back on the Yucca Mountain waste repository site, leaving us with no clear plan to dispose of high-level radioactive waste and spent nuclear fuel and leaving taxpayers liable for potentially billions of dollars in damages.

Now this bill, Mr. Speaker, does not focus on high-level radioactive waste, but rather it focuses on what is known as a Class A radioactive waste. Now, my colleagues, this is the lowest of lowest levels of radioactive waste. Now, supporters of this bill will say that we lack sufficient capacity in the United States for this waste. Let's talk about what the GAO says.

They have testified the Class A waste disposal capacity is simply not a problem in the short term or the long term. GAO had some real concerns about disposal capacity for what is known as Class B and C waste, but not Class A waste.

Now, what does this legislation do to deal with spent nuclear fuel or the impending Class B and C waste disposal crisis? Nothing. Nothing is done. Instead, it would prevent U.S. companies from competing in the global marketplace by restraining trade in this very low-level waste.

Now, a lot of us will hear the word "radioactive" and this is perhaps a word that is radioactive to lawmakers, but it should not frighten us once we understand this is the same kind of waste that you find in a home smoke detector. I think everybody in this Chamber, as well as everybody in the House, probably has a smoke detector in their home. So that is the type of low-level waste we're talking about.

I want American companies and American workers to participate fully in the international nuclear renaissance. You know, it's happening in China certainly, including the handling of low-level waste. This is an anti-jobs and anti-trade bill. It would simply ban Americans from the marketplace. And so that's why, reluctantly, many on this side of the aisle oppose this legislation and voted against it when it was before the full Energy and Commerce committee.

I am also concerned that this bill may have negative unintended consequences on top of the intended ones. In addition to restricting the ability of U.S. companies to bid on secure foreign contracts, this bill may prevent U.S. companies in the future from working cooperatively with foreign companies on other nuclear projects. The bill would prohibit the importation of low-level waste into the United States unless it is being sent to a Federal Government or military facility or other limited exceptions.

So I do not believe that the importation of limited amounts of common, very low-level waste raises disposal capacity issues. The GAO didn't think so either. At the same time, I do not believe that if U.S. nuclear companies are to participate in the global nuclear services market and compete effectively with foreign-owned companies, they must simply be able to manage and dispose of the low-level waste incidental to their work and subject to NRC's already strict regulations and requirement. So think about that. We already have in place through the NRC the necessary regulations and requirements. This is going to overlap on that.

So, Mr. Speaker, I'd like to create jobs. We cannot pass new trade barriers that put our own employers and workers at a competitive disadvantage, which I think simply this bill would do.

With that, I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Speaker, I yield such time as he may consume to my friend from Utah (Mr. MATHESON), the coauthor of this bipartisan bill.

Mr. MATHESON. I thank Mr. GORDON for yielding.

Before I begin my comments, I have a copy of a resolution that was passed by the Salt Lake County Council in support of the Writ Act to include in the RECORD.

A RESOLUTION OF THE SALT LAKE COUNTY COUNCIL OPPOSING THE IMPORTATION OF FOREIGN NUCLEAR/RADIOACTIVE WASTE AND ITS DISPOSAL IN THE UNITED STATES

Whereas, the Nuclear Regulatory Commission (NRC) has been asked for a license to import radioactive waste from dismantled nuclear reactors in Italy;

Whereas, Italy, which currently stores its nuclear/radioactive waste at power plants and other sites throughout Italy, has no permanent repository for this waste, has four closed nuclear power stations and other nuclear facilities with nuclear/radioactive waste, and for the past number of years has been unable to construct a waste disposal facility due to strong citizen opposition;

Whereas, due to having closed facilities and citizen opposition to construction of any new facilities, Italy reportedly has no nuclear waste disposal plan and is seeking assistance from other countries to manage different types of nuclear waste;

Whereas, if allowed, foreign radioactive/nuclear waste would be transported and

Whereas, if granted by the NRC, the importation license would allow almost ten times more waste to be imported for disposal than the total amount authorized by prior NRC importation licenses;

Whereas, Utah Governor Jon Huntsman, the Utah Radiation Control Board, and a regional regulatory board, the Northwest Interstate Compact, have opposed this waste being brought into Utah;

Whereas, a declaratory judgment action has been filed and is currently being actively litigated to determine whether the Northwest Interstate Compact has jurisdiction

over the importation of the waste and the legal authority to block the transportation and storage of this foreign waste in Utah;

Whereas, the NRC has delayed making a decision on the proposal until the litigation against the Northwest Interstate Compact has been resolved;

Whereas, nearly four thousand people submitted comments to the NRC, the vast majority overwhelmingly opposing the proposed importation license;

Whereas, granting approval to this or similar proposals could open the door to the United States becoming the world's nuclear/radioactive waste dump and create a disincentive for foreign nations to dispose of their own nuclear/radioactive waste;

Whereas, other contracts have been solicited for additional foreign nuclear/radioactive waste disposal from entities in the United Kingdom, Mexico, Brazil and other countries which would directly impact Salt Lake County;

Whereas, nuclear/radioactive materials will be shipped over oceans, into ports, and, potentially, through Utah cities and counties, including Salt Lake County, with the exact types and classifications of these materials not determined until after they have been imported;

Whereas, dumping large quantities of foreign nuclear/radioactive waste in the U.S. will only constrain further our domestic disposal capacity, result in the need for expanded or new nuclear/radioactive waste dump sites and increase the risk to public health, safety and the environment;

Whereas, neither the United States Congress nor the NRC ever intended that domestic nuclear/radioactive waste sites be used for the commercial importation of foreign nuclear/radioactive waste;

Whereas, importing foreign waste only serves private companies and their shareholders; and

Whereas, many of the probable transportation corridors run through Salt Lake County, risking public health and safety with, every shipment, not to mention the financial responsibility imposed on the County and its residents in preparing for and responding to incidents.

Now, Therefore, the County Council hereby resolves that it supports the prohibition on the transportation of foreign generated nuclear/radioactive waste through Salt Lake County;

Now, Therefore, the County Council further resolves that it urges the NRC to not approve the request to import and dispose of foreign low-level nuclear/radioactive waste; and

Now Therefore, the County Council further resolves that it urges Utah's legislative delegation to support the Radioactive Deterrence Act (RID), HR 515 and S. 232, which would prohibit the importation of foreign nuclear/radioactive waste, thereby alleviating the health and safety risks of transporting such materials through Salt Lake County.

Mr. Speaker, the Energy and Commerce Committee has held two hearings on this issue: one in the previous Congress and one in this Congress. And during those hearings, we really flushed out this issue in a way that I think makes some pretty clear points that justify moving this bill.

First of all, what was established is that there is confusion about what U.S. policy is relative to importation of radioactive waste from foreign countries. There really is a gap in policy here because as our low-level radioactive waste has developed over the last two or three decades, foreign waste wasn't even really considered. It just wasn't conceived that we would even take waste from other countries.

As Mr. GORDON indicated, no other country in the world takes another country's radioactive waste, and I think that appears to have been the assumption in terms of when policies have been determined in this country.

But what has happened in the last few years is that there are efforts and contracts being signed to move waste from Italy; there is discussion about Brazil, Mexico, Great Britain, to move low radioactive waste to this country. The Nuclear Regulatory Commission says we have no authority to determine whether or not waste from foreign countries should be allowed into this country.

So then we turn to the next regulatory body that we have in this country, and that is the system of State-run compacts that was established in Federal law primarily in 1980 and 1985. And the nuclear waste compacts are the ones who also have this role in deciding how to handle low-level radioactive waste.

The State of Utah happens to be a member of the Northwest Compact. When this proposal to move waste from Italy was put before the Compact, the Compact, with the State of Utah opposing the importation of this waste, the Compact agreed with the State of Utah and moved to disallow this shipment. At this point, the matter was taken to the courts. The Federal district courts have ruled the Compact courts have no authority to stop this either. That case is currently on appeal.

But what this points out—and the reason I walk through these steps—is to illustrate that there's a lot of confusion out there and everyone is pointing in a different direction of who's in charge of this issue. It seems to me this issue ought to be addressed by Congress. It's up from a public policy perspective to discuss whether or not as a policy of this country we should accept another country's radioactive waste. I happen to think we shouldn't. No other country in the world does. I don't think we should either. There has been mention that this is a restraint of trade issue in preventing U.S. companies from competing. I don't know of any other country that takes imported waste.

For trade to exist, you have goods and services going in both directions, not just in one. I don't understand how this in any way could be described as a restraint of trade.

Secondly, the capacity of this country for handling low-level waste is an issue because from what I have heard, not many States want to have a nuclear waste site for this low-level waste even though you have heard descriptions that this low-level waste may be no more dangerous than what's in a smoke detector. When you talk about tons and tons of this low-level radioactive waste, not a lot of States are lining up to take it.

And as we move forward as a country in a climate-constrained world where I believe—and I support development of nuclear power plants which, in addition to high-level fuel rods, do generate low-level waste—we need to have a location in this country to dispose of that low-level waste.

When the GAO did analyze the site in Utah to discuss the capacity issue, as was pointed out during the Congressional hearings before the Energy and Commerce Committee, it was pointed out that the GAO only looked at 1 year's worth of data for how much waste was put in, and they just took that volume from that year and projected it out into the future, which I'm a little disappointed that GAO would make such an elementary mistake in terms of how you project a trend, because the 1 year they used, in terms of the volume that was deposited that year, was a particularly low year in terms of volumes of waste.

And in fact, even with that assumption, they projected that it would go out maybe somewhere between 20 and 30 years. That is not necessarily a long amount of time when you talk about storage of low-level waste in this country. That is not a long amount of time when you consider the issue that most States don't want one of these sites located in their State. And I would submit that if you take the longer view of the life cycle of a nuclear power plant, that 20 to 30 years is not an excessively long amount of time, that's the storage capacity we've got at this site.

By the way, the GAO report also did not assume any foreign radioactive waste would be going in the site when it made its analysis of what the capacity was.

So I think this is a good bill. I think this addresses a gap in policy today. I think it will create greater certainty for the future of the nuclear industry in this country. I think it aligns the United States with the rest of the world in how we deal with importation of radioactive waste.

I want to thank Mr. GORDON for his leadership on this issue. I encourage my colleagues to support the bill.

Mr. STEARNS. Mr. Speaker, I ask how much time I have left.

The SPEAKER pro tempore. Sixteen minutes.

Mr. STEARNS. Mr. Speaker, I yield myself as much time as I may consume.

I think if you try to look at this issue in a broad sence, around the world a lot of countries are actually building nuclear power plants and there's also countries that are decommissioning them. There are currently

436 nuclear reactors worldwide with 53 under construction. China currently has 16 reactors under construction. So this renaissance is occurring. It's global.

So I think if you're going to have companies that are involved with the construction and decommission of nuclear power plants and they want to say, Okay, I want to bid, these countries will accept the bid from the United States; but if the United States is limiting them in how they're getting rid of low level radioactive waste, it's going to make it more difficult for that company to compete.

Again, this is not a serious problem. As far as I know, there has not been any indirect harm to individuals because of this. I obviously view this bill—the authors have crafted as a safety measure, and I respect that. But low level radioactive waste, as I mentioned, is in smoke detectors as well as exit signs.

So the implementation of this bill is going to be more regulatory, and the Nuclear Regulatory Commission is already doing this. So why would we need this bill?

And I think, as pointed out earlier in my statement, we have so many other Class B and Class C waste capacity problems that we should really be concentrating on and not this form of class, which is a very low radioactive class.

So I think, Mr. Speaker, that this is not a serious problem. I respect the authors and what they are trying to do; but, I think there's not a need for this kind of regulatory overlay with the Nuclear Regulatory Commission, which has already done a wonderful job for decades.

So with that, Mr. Speaker, I would urge my colleagues not to support and vote ''no'' on the bill, and I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Speaker, I yield myself such time as I may consume.

I have to say that my friend from Florida is making a valiant effort. I just want to talk to you about a couple of things.

First of all, Shakespeare also says ''don't rope a dope me.'' This is not B and C material. We're talking about A material.

We're both pro-nuclear. We would like to see additional nuclear power help us deal with our climate change, but he says this is not a serious problem. Well, it's a very serious problem if you are a lab, if you are a hospital, if you are a utility and you have no place to take your low-level radioactive waste.

□ 1430

For 37 States, there is no place else to go but Utah. And when that runs out, it is out. And so that is a very serious problem.

He says it is going to hurt business. It is not going to hurt business. There is a finite amount of space there. Either you put in American waste or foreign waste; it is the same amount. So there is no business going to be hurt there.

And finally, ''don't worry about it, it is a smoke detector.'' Well, if it is only smoke detectors, why are we putting up barbed wire fence, why do we have guards, and why does it have to stay there permanently? It is much more than that. There are serious problems here. This is a matter of American competitiveness. For that reason, I think that this bipartisan bill does need to pass.

I reserve the balance of my time.

Mr. STEARNS. Mr. Speaker, I reserve the balance of my time because I think the gentleman from Tennessee has additional speakers.

Mr. GORDON of Tennessee. Mr. Speaker, I regret that my friend from Florida has no one here to defend him today, and I yield such time as he may consume to Mr. CHAFFETZ, another person who this will directly impact in Utah.

Mr. CHAFFETZ. Mr. Speaker, I appreciate the work Mr. GORDON has done on this bill with broad, bipartisan support, and I appreciate the leadership of JIM MATHESON, who has led out on this issue for years.

In short, for those of you who are supportive of the nuclear industry, and like me want to see the expansion of the nuclear industry, we need to make sure that we reserve the capacity so we can deal with the waste. We won't be able to have expansion unless we have the capacity to actually store the waste.

And for those of you who don't want to see any sort of expansion of the nuclear industry, then why in the world would you ever want to take nuclear waste from foreign countries?

I am a very strong supporter of nuclear power. Currently, nuclear reactors in America provide the United States with roughly 20 percent of its electricity, yet we have built no new reactors since 1978. That is why I am a cosponsor of the American Energy Act, which establishes the national goal of bringing 100 new nuclear reactors online over the next 20 years. Achieving this goal is important for our economy, our environment, and for energy independence. This is why facilities like the one located in Clive, one of the best in the Nation and really the best in the world, need to dedicate their capacities to storage of American products. Expansion of our nuclear capacity will be nearly impossible if we allow our storage facilities to become saturated with foreign nuclear waste.

I support this bill and oppose the importation of waste into the country based on the basic laws of supply and demand. If the waste generated by Italian companies is so valuable, then why do businesses in Europe not step up to the plate? There is a reason why: With $1 billion on the line, there is not one place in Europe that is willing to step up and take it. It is dangerous. It is very dangerous. The answer, I would argue, is that other European countries do not want to take the risk of importing waste into their country. It is not a risk that I want to take for the State of Utah or for my country. And I believe that by passing this bill, I am confident that market forces will find a place for the waste somewhere other than the United States, and we can continue to propel the nuclear industry forward in the United States of America.

Mr. STEARNS. Mr. Speaker, I yield myself such time as I may consume.

I noticed that the advocates for the opponent all have these people from Utah. I just wonder if that is a coincidence. I see the gentleman from Tennessee has no one except people from Utah. But I am going to reveal a secret to him that perhaps he didn't know and the people from Utah didn't know that fortunately on this side we had the clairvoyance to find out. In checking with the Utah facility, we found that they do, indeed, have the capacity to take this low-level waste, not just for another year, but for decades and decades.

So I know the people on that side say this is not true, but the information we are getting back, which is probably news to the gentleman from Tennessee, is that the facility is capable of taking this type of waste. So I would just indicate that our main concern is that those companies who are trying to do business in this renaissance for nuclear construction are going to be hampered because of this bill.

With that, Mr. Speaker, I yield to the gentleman from Tennessee (Mr. ROE) such time as he may consume.

Mr. ROE of Tennessee. Mr. Speaker, H.R. 515 is a worthy attempt to deal with an issue that deserves a long-term solution: our ability to store processed nuclear waste. I think all Members want to ensure we have adequate storage space, and I commend the gentleman from Tennessee for trying to deal with this complicated issue. I fundamentally support the gentleman's goal, which is to stop the long-term storage of foreign waste in our country. The problem, however, is the bill will stop any operation that safely imports, processes, or exports low-level nuclear material in this country.

A company in my district processes the waste and returns it to its country of origin, which does not impact the long-term domestic storage. This legislation would prohibit them from doing this and impact jobs at a time when jobs are scarce.

I certainly would like to work with my esteemed colleague from Tennessee

to make changes in this legislation that would achieve this goal of halting the permanent storage of foreign waste while allowing companies that safely process and export this material to continue to do so.

Mr. STEARNS. Mr. Speaker, I yield myself 30 seconds to add that the gentleman had a very balanced approach to it in his statement. Also, he is from the great State of Tennessee so we have a balanced opinion from one side to the other from the great State of Tennessee.

I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, my time is coming to an end, but I could share some of my time with my friend from Florida if he would like to volunteer the State of Florida as a repository for some of this low-level radioactive waste.

Mr. STEARNS. Would the gentleman yield?

Mr. GORDON of Tennessee. I yield to the gentleman from Florida.

Mr. STEARNS. I would consider that proposal. Will you withdraw this bill?

Mr. GORDON of Tennessee. Once you get it sited, then this bill may not be necessary.

Mr. STEARNS. During the process we are waiting to get sited in Florida, will you just put this bill onto a back burner?

Mr. GORDON of Tennessee. I don't think that would be the responsible thing to do for our country.

And for that reason, I yield to the gentleman from Utah (Mr. MATHESON) to clarify one of the earlier statements.

Mr. MATHESON. Mr. Speaker, I just wanted to clarify one comment made by the gentleman from Florida about capacity in Utah.

It is interesting the company is telling people that they have so much capacity. They made a commitment to our Governor that they were not going to ask for any increase in the license capacity compared to what they have. It so happens when they came to testify before the Energy and Commerce Committee, in their written testimony they included tables that assumed great expansion of this site. But the State of Utah has not licensed that expansion. They made a commitment to our Governor that they weren't going to apply for an increase in size from the license capacity that exists today.

So I am not sure if they are talking out of both sides of their mouth now, if they are telling the other side that they have plenty of capacity, but I would just put it on the record that that company is on record that they said they would not make a license request to increase the capacity at the site.

Mr. GORDON of Tennessee. If the gentleman would stay there, reclaiming my time, the Northwest Compact, did they volunteer to take this radioactive waste?

Mr. MATHESON. The imported waste?

Mr. GORDON of Tennessee. Yes.

Mr. MATHESON. The Northwest Compact, as I made some reference to in my earlier statement, voted against taking this waste.

Mr. GORDON of Tennessee. And what was the Governor's position?

Mr. MATHESON. The Governor of Utah was opposed to it. The State of Utah was opposed to it.

Mr. GORDON of Tennessee. What action did the company then take?

Mr. MATHESON. The company then took the State and the Northwest Compact to court.

Mr. GORDON of Tennessee. They sued them? You mean they sued them to make them take this?

Mr. MATHESON. They took this action to Federal court because they disagreed with the decision of the State of Utah and the Northwest Compact.

Mr. GORDON of Tennessee. I'm shocked. I reserve the balance of my time.

Mr. STEARNS. Mr. Speaker, I yield myself 1 minute to attempt to reply to my colleagues.

As I understand it, this appeal process went through, and it is still in court, and so the final judgment has not been made. I think the gentleman from Utah sort of illustrates what I think is true: the company says they have the capacity to handle this.

But the overall position, I think, of many of us is that this legislation is going to hurt U.S. companies who are trying to compete with other global nuclear services in the marketplace. And as I pointed out, this is a global and highly technical and competitive industry, and it is growing, and we should not handicap companies who wish to compete in it.

Class A radioactive waste is very minimal. We have been able to take care of it. For decades and decades, the Nuclear Regulatory Commission has been able to take care of it. They have testified that it is not a problem. It is not a problem for the long term or short term.

I have no further speakers, and I yield back the balance of my time.

Mr. GORDON of Tennessee. Mr. Speaker, I yield myself the balance of my time.

I say to my friend from Florida, I am not sure how much water this cup will hold, but when it is full, it is full. Now I am not sure how much, and we can talk about how much radioactive material that the Utah site can hold, but when it is full, it is full, and there will be no more space left. We need to recognize that.

In conclusion, let me just say this is very simple, very simple. There is only one Nation in the world that allows other countries to ship their radioactive waste to that country for permanent disposal, and that is the United States. Quite frankly, it was a loophole because it was never expected that that would happen. So what we are doing with this legislation is simply bringing it into compliance with the rest of the world, saying that our country will not accept radioactive waste, and there are 20,000 tons ready to come in, as well as other countries asking to bring that waste in.

We are simply saying we are going to abide by what all the others countries do, and they say if you have radioactive waste, if you are going to be producing radioactive waste, you need to take care of it, just like every other country. I think that is fair. I think it is reasonable.

Mr. STEARNS. Would the gentleman yield?

Mr. GORDON of Tennessee. I yield to my friend from Florida.

Mr. STEARNS. I thank the gentleman.

To you folks, when you hold up that glass, there is another glass in Texas that is willing to take this low-level radioactive waste. You should know that. We are not just talking about the plant in Utah.

Mr. GORDON of Tennessee. Reclaiming my time, and I will yield right back to you, has that site been certified?

Mr. STEARNS. I think it is in the process of being certified. And there are other States that are willing to do the same thing.

If you don't mind, your colleague from Tennessee has a question for you.

Mr. GORDON of Tennessee. I yield to the gentleman from Tennessee (Mr. ROE).

Mr. ROE of Tennessee. Thank you for yielding.

Is it a problem to have the waste brought into this country and then shipped out back to the country of origin or wherever it is disposed of? We have a company in our district that does that.

Mr. GORDON of Tennessee. Reclaiming my time, I understand that, and I am sympathetic to that. The difficulty is where that waste has been separated. I have talked to them personally, and they have said that they don't ship it all back, that they keep some of it here. And there are difficulties. Once you combine an A level with a B or C level, there are additional problems.

Now I am sympathetic to your concerns. We want to continue with that dialogue. I hope that can be rectified. But so far, we do not have that. And that is not before us today. What we have before us today is a very simple proposition: Is the United States going to be the only country in the world that is going to use our limited storage space to permanently dispose of tons and tons of radioactive waste from other countries? That is the question before us today, and we have a bipartisan bill that tries to answer that.

Mr. STEARNS. I thank my colleague for allowing me the time to speak.

Mr. GORDON of Tennessee. I understand that Mr. TERRY, a member of our committee, is on his way. He is going to have to get here pretty soon. As a cosponsor of this bipartisan bill, I think he would want me to say on his behalf that it is not in the interest of Nebraska, his home State, to have no other place to send their radioactive waste, whether it is from a hospital, from a lab, or anywhere else, but to Utah. And I would say that he would be very concerned with what Nebraska is going to do with that waste if there is no other place to send it. I am sure that he could say it much more eloquently than me.

Mr. MARKEY of Massachusetts. Mr. Speaker, I rise in strong support of H.R. 515, the Radioactive Import Deterrence Act, a bipartisan bill introduced by Congressmen GORDON, MATHESON and TERRY. This important legislation will ban the importation of low-level radioactive waste into the United States. This is a bipartisan bill, cosponsored by 80 House Members, including 20 Democratic and 4 Republican members of the full Energy and Commerce Committee.

H.R. 515 was drafted in response to an attempt to bring 20,000 tons of Italian low-level nuclear waste into the United States to be processed in Tennessee and disposed of in Utah. Italy wants to ship their waste to the United States because they have no disposal capabilities of their own. And Italy is by no means the only country in this position.

In fact, the United States is the only nuclear waste-producing country in the world which allows for the importation and disposal of foreign nuclear waste. No other country does, and for good reason! Why should the United States take Italian nuclear waste if they won't take ours? I think the answer is simple: this House will not allow the United States to be the world's nuclear dumping ground.

H.R. 515 will preserve U.S. low-level nuclear waste disposal sites for U.S. low-level nuclear waste. Today, we have a few sites in the country which dispose of our low-level waste. For the moment, this is adequate. However, it is extremely difficult to establish new disposal sites. It is only practical that we carefully manage our existing domestic low-level nuclear waste disposal capacity to ensure that we do not face a crisis in the future. This will be even more critical if new nuclear reactors are built in this country.

Not only would H.R. 515 preserve existing disposal sites for our own waste, but it would maintain the integrity of the Low Level Waste Compact System, and protect the States from being forced to accept foreign nuclear waste.

When Congress established the Low Level Waste Compact System, we did not intend for the compacts to handle foreign waste. We empowered the States to establish sites for common use within the various regions, and specifically allowed them to exclude waste from outside those regions. This bill will responsibly fix a loophole which was never intended to exist.

If we fail to protect the Low Level Waste Compact System, what were supposed to be domestic disposal sites could be turned into global nuclear waste dumps. If that occurs, we could end up in a position where many States are unable—or unwilling—to participate in these compacts at all, leaving domestic companies with nowhere to go to dispose of their radioactive waste. That would not be a good development for the nuclear industry, or for the Nation.

This bill moved through the Energy and Commerce Committee under regular order, and received bipartisan support. It was reported favorably by the Subcommittee on Energy and the Environment to the full Committee by a voice vote, and the Energy and Commerce Committee sent the bill to this Floor by a strong vote of 34–12.

Mr. Speaker, I urge all of my colleagues to support this important legislation today.

Mr. TERRY. Mr. Speaker, I rise today in support of H.R. 515, the Radioactive Import Deterrence Act. This legislation will preserve our ability to regulate the importation of low-level radioactive waste produced in U.S. facilities such as clothing and items that are used in hospitals, research facilities, and nuclear power plants.

These low-level waste products are generated throughout the country, including Nebraska, which has two nuclear power plants and several medical facilities that generate these low-level waste materials that require processing and storage.

This legislation would bar the NRC from issuing licenses authorizing the importation of foreign low-level radioactive waste, unless waived by the President to meet national or international policy goals. It also exempts waste generated by the U.S. government or the military.

The United States is the only nation that allows imports of low-level radioactive waste from other countries. If we do not impose the ban on importation, the United States could easily become the preferred dumping ground for low-level radioactive waste from around the globe. This could be a problem since 36 states that do not have access to a waste compact—like Nebraska—have access to only one disposal site located in the State of Utah. Also, 94 out of 104 commercial nuclear plants in the United States us the same commercial facility as those 36 states to dispose of their low-level waste.

Mr. Speaker, we should not become the low-level radioactive waste disposal dump for the entire world. Other countries that are now using or developing nuclear power and have medical facilities generating this waste should build and operate their own storage facilities and not put American communities at risk for taking care of this radioactive waste.

I urge my colleagues to vote for H.R. 515.

Mr. GORDON of Tennessee. At this time, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Tennessee (Mr. GORDON) that the House suspend the rules and pass the bill, H.R. 515, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. STEARNS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 2 o'clock and 45 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 1615

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. CUELLAR) at 4 o'clock and 15 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed.

Votes will be taken in the following order:

H.R. 515, by the yeas and nays;

H. Con. Res. 197, by the yeas and nays;

H.R. 1242, by the yeas and nays; and

H.R. 3980, by the yeas and nays.

Remaining postponed votes will be taken later in the week.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

RADIOACTIVE IMPORT DETERRENCE ACT

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill, H.R. 515, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Tennessee (Mr. GORDON) that the House suspend the rules and pass the bill, H.R. 515, as amended.

The vote was taken by electronic device, and there were—yeas 309, nays 112, not voting 13, as follows:

[Roll No. 919]

YEAS—309

Abercrombie	Baca	Berman
Ackerman	Baird	Berry
Adler (NJ)	Baldwin	Bilbray
Altmire	Bean	Bishop (GA)
Andrews	Becerra	Bishop (NY)
Arcuri	Berkley	Blumenauer

Boccieri
Boozman
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown (SC)
Brown, Corrine
Buchanan
Butterfield
Buyer
Camp
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Forbes
Fortenberry
Foster
Frank (MA)
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Goodlatte
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Heller
Herseth Sandlin
Hill
Himes
Hinchey
Hinojosa
Hirono
Holden
Holt
Honda
Hoyer
Hunter
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larson (CT)
LaTourette
Lee (CA)
Lee (NY)
Levin
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Luetkemeyer
Luján
Lummis
Lynch
Maffei
Maloney
Manzullo
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCollum
McCotter
McDermott
McGovern
McIntyre
McKeon
McMahon
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paulsen
Payne
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Platts
Polis (CO)
Pomeroy
Posey
Price (NC)
Putnam
Quigley
Rahall
Rangel
Reichert
Reyes
Richardson
Rodriguez
Rogers (AL)
Rogers (MI)
Rooney
Ros-Lehtinen
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Sherman
Shuler
Shuster
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NAYS—112

Akin
Alexander
Austria
Bachmann
Bachus
Bartlett
Barton (TX)
Biggert
Bilirakis
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boustany
Brady (TX)
Broun (GA)
Brown-Waite, Ginny
Burgess
Burton (IN)
Calvert
Campbell
Carter
Cassidy
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Dreier
Ehlers
Emerson
Fallin
Flake
Fleming
Foxx
Franks (AZ)
Frelinghuysen
Gingrey (GA)
Gohmert
Granger
Graves
Hall (TX)
Harper
Hastings (WA)
Hensarling
Herger
Hoekstra
Inglis
Issa
Jenkins
Johnson, Sam
Jordan (OH)
King (IA)
Kingston
Kline (MN)
Lamborn
Latham
Latta
Lewis (CA)
Linder
Lucas
Lungren, Daniel E.
Mack
Marchant
McCaul
McClintock
McHenry
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy, Tim
Myrick
Nunes
Olson
Paul
Pence
Pitts
Poe (TX)
Price (GA)
Radanovich
Rehberg
Roe (TN)
Rogers (KY)
Rohrabacher
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Simpson
Smith (TX)
Souder
Stearns
Sullivan
Taylor
Thornberry
Tiahrt
Upton
Westmoreland
Whitfield
Wilson (SC)

NOT VOTING—13

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Capuano
Gonzalez
Higgins
Hodes
Larsen (WA)
Melancon
Moran (VA)
Shea-Porter
Young (AK)

□ 1645

Messrs. LUCAS, MILLER of Florida, COLE, BRADY of Texas, BLUNT, SULLIVAN, KINGSTON, WILSON of South Carolina, CRENSHAW, DREIER, Ms. JENKINS, Ms. FALLIN, and Mrs. EMERSON changed their vote from ''yea'' to ''nay.''

Messrs. CANTOR, McCARTHY of California, GOODLATTE, BUCHANAN, WAMP, and Mrs. HALVORSON changed their vote from ''nay'' to ''yea.''

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

TEMPORARY FORBEARANCE FOR FAMILIES AFFECTED BY CONTAMINATED DRYWALL

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the concurrent resolution, H. Con. Res. 197, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from California (Ms. WATERS) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 197, as amended.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 419, nays 1, not voting 14, as follows:

[Roll No. 920]

YEAS—419

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Hill
Himes
Hinchey
Hinojosa
Hirono
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa

Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NAYS—1

McClintock

NOT VOTING—14

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Capuano
Gonzalez
Higgins
Hodes
Larsen (WA)
Melancon
Moran (VA)
Shea-Porter
Tierney
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining on this vote.

□ 1654

So (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

The title was amended so as to read: ‘‘Concurrent resolution encouraging banks and mortgage servicers to work with families affected by contaminated drywall and to consider adjustments to payment schedules on their home mortgages that take into account the financial burdens of responding to the presence of such drywall.’’.

A motion to reconsider was laid on the table.

EMERGENCY ECONOMIC STABILIZATION ACT OF 2008 AMENDMENT

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill, H.R. 1242, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Mrs. MALONEY) that the House suspend the rules and pass the bill, H.R. 1242, as amended.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 421, nays 0, not voting 13, as follows:

[Roll No. 921]

YEAS—421

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Hill
Himes
Hinchey
Hinojosa
Hirono
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—13

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Capuano
Gonzalez
Higgins
Hodes
Larsen (WA)
Melancon
Moran (VA)
Shea-Porter
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1701

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

The title was amended so as to read: ''A bill to amend the Emergency Economic Stabilization Act of 2008 to provide for additional monitoring and accountability of the Troubled Asset Relief Program.''.

A motion to reconsider was laid on the table.

REDUNDANCY ELIMINATION AND ENHANCED PERFORMANCE FOR PREPAREDNESS GRANTS ACT

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill, H.R. 3980, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. CUELLAR) that the House suspend the rules and pass the bill, H.R. 3980, as amended.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 414, nays 0, not voting 20, as follows:

[Roll No. 922]

YEAS—414

Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Braley (IA)
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Heller
Hensarling
Herger
Herseth Sandlin
Hill
Himes
Hinchey
Hinojosa
Hoekstra
Holden
Holt
Honda
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paul
Paulsen
Payne
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Radanovich
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Speier
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman Schultz
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NOT VOTING—20

Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Brady (TX)
Bright
Brown, Corrine
Capuano
Gonzalez
Grijalva
Higgins
Hirono
Hodes
Larsen (WA)
Melancon
Moran (VA)
Pence
Shea-Porter
Waters
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1709

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H. RES. 648

Mr. WILSON of South Carolina. Madam Speaker, I ask unanimous consent to be removed as a cosponsor of H. Res. 648.

The SPEAKER pro tempore (Ms. KOSMAS). Is there objection to the request of the gentleman from South Carolina?

There was no objection.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4154, PERMANENT ESTATE TAX RELIEF FOR FAMILIES, FARMERS, AND SMALL BUSINESSES ACT OF 2009

Mr. POLIS, from the Committee on Rules, submitted a privileged report (Rept. No. 111–350) on the resolution (H. Res. 941) providing for consideration of the bill (H.R. 4154) to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than would benefit from repeal, to retain the estate tax with a $3,500,000 exemption, and for other purposes, which was referred to the House Calendar and ordered to be printed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on the motion to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Any record vote on the postponed question will be taken later.

SATELLITE HOME VIEWER REAUTHORIZATION ACT OF 2009

Mr. CONYERS. Madam Speaker, I move to suspend the rules and pass the

bill (H.R. 3570) to amend title 17, United States Code, to reauthorize the satellite statutory license, to conform the satellite and cable statutory licenses to all-digital transmissions, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3570

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Satellite Home Viewer Reauthorization Act of 2009''.

TITLE I—STATUTORY LICENSES

SEC. 101. REFERENCE.

Except as otherwise provided, whenever in this title an amendment is made to a section or other provision, the reference shall be considered to be made to such section or provision of title 17, United States Code.

SEC. 102. MODIFICATIONS TO STATUTORY LICENSE FOR SATELLITE CARRIERS.

(a) HEADING RENAMED.—

(1) IN GENERAL.—The heading of section 119 is amended by striking ''**superstations and network stations for private home viewing**'' and inserting ''**distant television programming by satellite**''.

(2) TABLE OF CONTENTS.—The table of contents for chapter 1 is amended by striking the item relating to section 119 and inserting the following:

''119. Limitations on exclusive rights: Secondary transmissions of distant television programming by satellite.''.

(b) UNSERVED HOUSEHOLD DEFINED.—Section 119(d)(10) is amended—

(1) by striking subparagraph (A) and inserting the following:

''(A) cannot receive, through the use of a conventional, stationary, outdoor rooftop receiving antenna, an over-the-air signal containing the primary stream, or, on or after January 1, 2013, the multicast stream, originating in that household's local market and affiliated with that network of—

''(i) if the signal originates as an analog signal, Grade B intensity as defined by the Federal Communications Commission in section 73.683(a) of title 47, Code of Federal Regulations, as in effect on January 1, 1999; or

''(ii) if the signal originates as a digital signal, intensity defined in the values for digital television noise-limited service contour, as defined in regulations issued by the Federal Communications Commission (section 73.622(e) of title 47, Code of Federal Regulations), as such regulations may be amended from time to time;'';

(2) in subparagraph (B)—

(A) by striking ''subsection (a)(14)'' and inserting ''subsection (a)(13),''; and

(B) by striking ''Satellite Home Viewer Extension and Reauthorization Act of 2004'' and inserting ''Satellite Home Viewer Reauthorization Act of 2009''; and

(3) in subparagraph (D), by striking ''(a)(12)'' and inserting ''(a)(11)''.

(c) FILING FEE.—Section 119(b)(1) is amended—

(1) in subparagraph (A), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (B), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(C) a filing fee, as determined by the Register of Copyrights pursuant to section 708(a).''.

(d) EMERGENCY MONITORING, PLANNING, OR RESPONDING.—Section 119(a) is amended by adding at the end the following:

''(17) RETRANSMISSION FOR EMERGENCY PREPARATION, RESPONSE, OR RECOVERY.—

''(A) AUTHORITY.—The secondary transmission by a satellite carrier of a performance or display of a work embodied in a primary transmission of a television broadcast station is not an infringement of copyright if such secondary transmission is made—

''(i) to a Federal governmental body designated by the Office of Emergency Communications, in coordination with the Federal Communications Commission, or an organization established with the purpose of carrying out a system of national and international relief efforts and chartered under section 300101 of title 36;

''(ii) to officers or employees of such body or such organization as a part of the official duties or employment of such officers or employees;

''(iii) at the request of the Secretary of Homeland Security; and

''(iv) for the sole purpose of preparing for, responding to, or recovering from an emergency described under subparagraph (B).

''(B) EMERGENCIES.—An emergency is described under this subparagraph if the Secretary of Homeland Security identifies such emergency as a major disaster, a catastrophic incident, an act of terrorism, or a transportation security incident.

''(C) REGULATIONS.—Not later than 6 months after the date of the enactment of this paragraph, the Secretary of Homeland Security, in coordination with the Federal Communications Commission, the National Telecommunications and Information Administration, and the Register of Copyrights, shall issue regulations to protect copyright owners by preventing the unauthorized access to the secondary transmissions described in subparagraph (A).

''(D) REPORTS TO CONGRESSIONAL COMMITTEES.—Not later than one year after the date of the enactment of this paragraph and by September 30 of each year thereafter, the Secretary of Homeland Security, acting through the Office of Emergency Communications, shall submit a report to the Committees on the Judiciary, on Homeland Security, and on Energy and Commerce of the House of Representatives and the Committees on the Judiciary, on Homeland Security, and on Commerce, Science, and Transportation of the Senate describing—

''(i) the manner in which the authority granted under subparagraph (A) is being used, including to whom and for what purposes the secondary transmissions are being provided; and

''(ii) any additional legislative recommendations the Secretary may have.

''(E) DEFINITIONS.—As used in this paragraph:

''(i) TERRORISM.—The term 'terrorism' has the meaning given that term in section 2(16) of the Homeland Security Act of 2002 (6 U.S.C. 101(16)).

''(ii) TRANSPORTATION SECURITY INCIDENT.—The term 'transportation security incident' has the meaning given that term in section 70101 of title 46.

''(iii) CATASTROPHIC INCIDENT.—The term 'catastrophic incident' means any natural disaster, act of terrorism, or other manmade disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the population (including mass evacuations), infrastructure, the environment, the economy, national morale, or government functions in a geographic area.

''(F) EFFECTIVE DATE.—This paragraph shall apply with respect to secondary transmissions described under subparagraph (A) that are made after the end of the 30-day period beginning on the effective date of the regulations issued by the Secretary of Homeland Security under subparagraph (C).''.

(e) LICENSE PROVIDED FOR CERTAIN NETWORKS OF NONCOMMERCIAL EDUCATIONAL BROADCAST STATIONS.—Section 119(a)(2)(C) is amended by adding at the end the following new clause:

''(vi) NETWORKS OF NONCOMMERCIAL EDUCATIONAL BROADCAST STATIONS.—In the case of a system of three or more noncommercial educational broadcast stations licensed by a single State, public agency, or political, educational, or special purpose subdivision of a State, the statutory license provided for in subparagraph (A) shall apply to the secondary transmission of the primary transmission of such system to any subscriber in any county within such State, if such subscriber is located in a designated market area that is not otherwise eligible to receive the secondary transmission of the primary transmission of a noncommercial educational broadcast station located with the State pursuant to section 122(a).''.

(f) DEPOSIT OF STATEMENTS AND FEES; VERIFICATION PROCEDURES.—Section 119(b) is amended—

(1) by amending the subsection heading to read as follows: ''(b) DEPOSIT OF STATEMENTS AND FEES; VERIFICATION PROCEDURES.—'';

(2) in paragraph (1), by striking subparagraph (B) and inserting the following:

''(B) a royalty fee payable to copyright owners pursuant to paragraph (4) for that 6 month period, computed by multiplying the total number of subscribers receiving each secondary transmission of a primary or multicast stream of each non-network station or network station during each calendar year month by the appropriate rate in effect under this subsection''.

(3) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5), respectively;

(4) by inserting after paragraph (1) the following:

''(2) VERIFICATION OF ACCOUNTS AND FEE PAYMENTS.—The Register of Copyrights shall issue regulations to permit interested parties to verify and audit the statements of account and royalty fees submitted by satellite carriers under this subsection.'';

(5) in paragraph (3), as redesignated, in the first sentence—

(A) by inserting ''(including the filing fee specified in paragraph (1)(C))'' after ''shall receive all fees''; and

(B) by striking ''paragraph (4)'' and inserting ''paragraph (5)'';

(6) in paragraph (4), as redesignated—

(A) by striking ''paragraph (2)'' and inserting ''paragraph (3)''; and

(B) by striking ''paragraph (4)'' each place it appears and inserting ''paragraph (5)''; and

(7) in paragraph (5), as redesignated, by striking ''paragraph (2)'' and inserting ''paragraph (3)''.

(g) ADJUSTMENT OF ROYALTY FEES.—Section 119(c) is amended as follows:

(1) Paragraph (1) is amended—

(A) in the heading for such paragraph, by striking ''ANALOG'';

(B) in subparagraph (A)—

(i) by striking ''primary analog transmissions'' and inserting ''primary transmissions''; and

(ii) by striking ''July 1, 2004'' and inserting ''July 1, 2009'';

(C) in subparagraph (B)—

(i) by striking ''January 2, 2005, the Librarian of Congress'' and inserting ''January 4, 2010, the Copyright Royalty Judges''; and

(ii) by striking ''primary analog transmission'' and inserting ''primary transmissions'';

(D) in subparagraph (C), by striking ''Librarian of Congress'' and inserting ''Copyright Royalty Judges'';

(E) in subparagraph (D)—

(i) in clause (i)—

(I) by striking ''(i) Voluntary agreements'' and inserting the following:

''(i) VOLUNTARY AGREEMENTS; FILING.—Voluntary agreements''; and

(II) by striking ''that a parties'' and inserting ''that are parties''; and

(ii) in clause (ii)—

(I) by striking ''(ii)(I) Within'' and inserting the following:

''(ii) PROCEDURE FOR ADOPTION OF FEES.—

''(I) PUBLICATION OF NOTICE.—Within'';

(II) in subclause (I), by striking ''an arbitration proceeding pursuant to subparagraph (E)'' and inserting ''a proceeding under subparagraph (F)'';

(III) in subclause (II), by striking ''(II) Upon receiving a request under subclause (I), the Librarian of Congress'' and inserting the following:

''(II) PUBLIC NOTICE OF FEES.—Upon receiving a request under subclause (I), the Copyright Royalty Judges''; and

(IV) in subclause (III)—

(aa) by striking ''(III) The Librarian'' and inserting the following:

''(III) ADOPTION OF FEES.—The Copyright Royalty Judges'';

(bb) by striking ''an arbitration proceeding'' and inserting ''the proceeding under subparagraph (F)''; and

(cc) by striking ''the arbitration proceeding'' and inserting ''that proceeding'';

(F) in subparagraph (E)—

(i) by striking ''Copyright Office'' and inserting ''Copyright Royalty Judges''; and

(ii) by striking ''December 31, 2009'' and inserting ''December 31, 2014''; and

(G) in subparagraph (F)—

(i) in the heading, by striking ''COMPULSORY ARBITRATION'' and inserting '' COPYRIGHT ROYALTY JUDGES PROCEEDING'';

(ii) in clause (i)—

(I) in the heading, by striking ''PROCEEDINGS'' and inserting ''THE PROCEEDING'';

(II) in the matter preceding subclause (I)—

(aa) by striking ''May 1, 2005, the Librarian of Congress'' and inserting ''May 3, 2010, the Copyright Royalty Judges'';

(bb) by striking ''arbitration proceedings'' and inserting ''a proceeding'';

(cc) by striking ''fee to be paid'' and inserting ''fees to be paid'';

(dd) by striking ''primary analog transmission'' and inserting ''the primary transmissions''; and

(ee) by striking ''distributors'' and inserting ''distributors—'';

(III) in subclause (II)—

(aa) by striking ''Librarian of Congress'' and inserting ''Copyright Royalty Judges''; and

(bb) by striking ''arbitration''; and

(IV) by amending the last sentence to read as follows: ''Such proceeding shall be conducted under chapter 8.'';

(iii) in clause (ii), by amending the matter preceding subclause (I) to read as follows:

''(ii) ESTABLISHMENT OF ROYALTY FEES.—In determining royalty fees under this subparagraph, the Copyright Royalty Judges shall establish fees for the secondary transmissions of the primary transmissions of network stations and non-network stations that most clearly represent the fair market value of secondary transmissions, except that the Copyright Royalty Judges shall adjust royalty fees to account for the obligations of the parties under any applicable voluntary agreement filed with the Copyright Royalty Judges in accordance with subparagraph (D). In determining the fair market value, the Judges shall base their decision on economic, competitive, and programming information presented by the parties, including—'';

(iv) by amending clause (iii) to read as follows:

''(iii) EFFECTIVE DATE FOR DECISION OF COPYRIGHT ROYALTY JUDGES.—The obligation to pay the royalty fees established under a determination that is made by the Copyright Royalty Judges in a proceeding under this paragraph shall be effective as of January 1, 2010.''; and

(v) in clause (iv)—

(I) in the heading, by striking ''FEE'' and inserting ''FEES''; and

(II) by striking ''fee'' and inserting ''fees''.

(2) Paragraph (2) is amended to read as follows:

''(2) ANNUAL ROYALTY FEE ADJUSTMENT.—Effective January 1 of each year, the royalty fee payable under subsection (b)(1)(B) for the secondary transmission of the primary transmissions of network stations and non-network stations shall be adjusted by the Copyright Royalty Judges to reflect any changes occurring in the cost of living as determined by the most recent Consumer Price Index (for all consumers and for all items) published by the Secretary of Labor before December 1 of the preceding year. Notification of the adjusted fees shall be published in the Federal Register at least 25 days before January 1.''.

(h) DEFINITIONS.—

(1) SUBSCRIBER.—Section 119(d)(8) is amended to read as follows:

''(8) SUBSCRIBER; SUBSCRIBE.—

''(A) SUBSCRIBER.—The term 'subscriber' means a person or entity that receives a secondary transmission service from a satellite carrier and pays a fee for the service, directly or indirectly, to the satellite carrier or to a distributor.

''(B) SUBSCRIBE.—The term 'subscribe' means to elect to become a subscriber.''.

(2) LOW POWER TELEVISION STATION.—Section 119(d)(12) is amended by striking ''low power television as'' and inserting ''low power TV station as''.

(3) LOCAL MARKET.—Section 119(d)(11) is amended to read as follows:

''(11) LOCAL MARKET.—The term 'local market' has the meaning given such term under section 122(j).''.

(4) NONCOMMERCIAL EDUCATIONAL BROADCAST STATION.—Section 119(d) is amended—

(A) in paragraph (2)(B), by striking ''(as defined in section 397 of the Communications Act of 1934)''; and

(B) by adding at the end the following:

''(14) NONCOMMERCIAL EDUCATIONAL BROADCAST STATION.—The term 'noncommercial educational broadcast station' means a television broadcast station that—

''(A) under the rules and regulations of the Federal Communications Commission in effect on November 2, 1978, is eligible to be licensed by the Federal Communications Commission as a noncommercial educational television broadcast station and is owned and operated by a public agency or nonprofit private foundation, corporation, or association; or

''(B) is owned and operated by a municipality and transmits only noncommercial programs for education purposes.''.

(5) MULTICAST STREAM.—Section 119(d), as amended by paragraph (4), is further amended by adding at the end the following new paragraph:

''(15) MULTICAST STREAM.—The term 'multicast stream' means a digital stream containing programming and program-related material affiliated with a television network, other than the primary stream.''.

(6) PRIMARY STREAM.—Section 119(d), as amended by paragraph (5), is further amended by adding at the end the following new paragraph:

''(16) PRIMARY STREAM.—The term 'primary stream' means—

''(A) the single digital stream of programming as to which a television broadcast station has the right to mandatory carriage with a satellite carrier under the rules of the Federal Communications Commission in effect on July 1, 2009; or

''(B) if there is no such stream, either—

''(i) the single digital stream of programming associated with the network last transmitted by the station as an analog signal; or

''(ii) the single digital stream of programming affiliated with the network that, as of July 1, 2009, had been offered by the television broadcast station for the longest period of time.''.

(7) CLERICAL AMENDMENT.—Section 119(d) is amended in paragraphs (1), (2), and (5) by striking ''which'' each place it appears and inserting ''that''.

(i) SUPERSTATION REDESIGNATED AS NON-NETWORK STATION.—Section 119 is amended—

(1) by striking ''superstation'' each place it appears in a heading and each place it appears in text and inserting ''non-network station''; and

(2) by striking ''superstations'' each place it appears in a heading and each place it appears in text and inserting ''non-network stations''.

(j) LOW POWER TELEVISION STATIONS.—Section 119(a)(15) is amended to read as follows:

''(15) SECONDARY TRANSMISSIONS OF LOW POWER TELEVISION PROGRAMMING.—

''(A) IN GENERAL.—Notwithstanding paragraph (2)(B), and subject to subparagraphs (B) through (D) of this paragraph, the statutory license provided for in paragraph (1) shall apply to the secondary transmission by a satellite carrier of the primary transmission of the programming of a non-network station that is licensed as a low power television station, to a subscriber who resides within the same designated market area as the station that originates the programming signal.

''(B) NO APPLICABILITY TO REPEATERS AND TRANSLATORS.—Secondary transmissions provided for in subparagraph (A) shall not apply to any low power television station that retransmits the programs and signals of another television station for more than 2 hours each day.

''(C) ROYALTY FEES.—A satellite carrier whose secondary transmission of the primary transmission of the programming of a low power television station is subject to statutory licensing under this section shall be subject to royalty payments under subsection (b)(1)(B) for any transmission to a subscriber outside of the local market of the low power television station.

''(D) LIMITATION TO SUBSCRIBERS TAKING LOCAL-INTO-LOCAL SERVICE.—Secondary transmissions provided for in subparagraph (A) may be made by a satellite carrier only to subscribers who receive secondary transmissions of primary transmissions from that satellite carrier pursuant to the statutory license under section 122.''.

(k) REMOVAL OF SIGNIFICANTLY VIEWED PROVISION.—

(1) REMOVAL OF PROVISION.—Section 119(a), as amended by subsections (d) and (j), is amended by striking paragraph (3) and redesignating paragraphs (4) through (17) as paragraphs (3) through (16), respectively.

(2) CONFORMING AMENDMENTS.—Section 119 is amended—

(A) in subsection (a)—

(i) in paragraph (1), by striking ''(5), (6), and (8)'' and inserting ''(4), (5), and (7)'';

(ii) in paragraph (2)—

(I) in subparagraph (A), by striking ''paragraphs (5), (6), (7), and (8)'' and inserting ''paragraphs (4), (5), (6), and (7)'';

(II) in subparagraph (B)(i), by striking the second sentence; and

(III) in subparagraph (D), by striking clauses (i) and (ii) and inserting the following:

''(i) INITIAL LISTS.—A satellite carrier that makes secondary transmissions of a primary transmission made by a network station pursuant to subparagraph (A) shall, not later than 90 days after commencing such secondary transmissions, submit to the network that owns or is affiliated with the network station a list identifying (by name and address, including street or rural route number, city, State, and 9-digit zip code) all subscribers to which the satellite carrier makes secondary transmissions of that primary transmission to subscribers in unserved households.

''(ii) MONTHLY LISTS.—After the submission of the initial lists under clause (i), the satellite carrier shall, not later than the 15th of each month, submit to the network a list identifying (by name and address, including street or rural route number, city, State, and 9-digit zip code) any persons who have been added or dropped as subscribers under clause (i) since the last submission under clause (i).''; and

(iii) in subparagraph (E) of paragraph (3) (as redesignated)—

(I) by striking ''under paragraph (3) or''; and

(II) by striking ''paragraph (12)'' and inserting ''paragraph (11)''; and

(B) in subsection (b)(1), by striking the final sentence.

(l) MODIFICATIONS TO PROVISIONS FOR SECONDARY TRANSMISSIONS BY SATELLITE CARRIERS.—

(1) PREDICTIVE MODEL.—Section 119(a)(2)(B)(ii) is amended by adding at the end the following:

''(III) ACCURATE PREDICTIVE MODEL WITH RESPECT TO DIGITAL SIGNALS.—Notwithstanding subclause (I), in determining presumptively whether a person resides in an unserved household under subsection (d)(10)(A) with respect to digital signals, a court shall rely on a predictive model set forth by the Federal Communications Commission pursuant to a rulemaking as provided in section 339(c)(3) of the Communications Act of 1934 (47 U.S.C. 339(c)(3)), as that model may be amended by the Commission over time under such section to increase the accuracy of that model. Until such time as the Commission sets forth such model, a court shall rely on the predictive model as recommended by the Commission with respect to digital signals in its Report to Congress in ET Docket N. 05-182, FCC 05-199 (released December 9, 2005).''.

(2) MODIFICATIONS TO STATUTORY LICENSE WHERE RETRANSMISSIONS INTO LOCAL MARKET AVAILABLE.—Section 119(a)(3) (as redesignated) is amended—

(A) by striking ''analog'' each place it appears in a heading and text;

(B) by striking subparagraphs (B), (C), and (D), and inserting the following:

''(B) RULES FOR LAWFUL SUBSCRIBERS AS OF DATE OF ENACTMENT OF 2009 ACT.—In the case of a subscriber of a satellite carrier who, on the day before the date of the enactment of the Satellite Home Viewer Reauthorization Act of 2009, was lawfully receiving the secondary transmission of the primary transmission of a network station under the statutory license under paragraph (2) (in this subparagraph referred to as the 'distant signal'), other than subscribers to whom subparagraph (A) applies, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, and the subscriber's household shall continue to be considered to be an unserved household with respect to such network, until such time as the subscriber elects to terminate such secondary transmissions.

''(C) RULES FOR NEW SUBSCRIBERS AFTER ENACTMENT OF 2009 ACT.—In the case of a person who first seeks to subscribe with a satellite carrier, on or after the date of the enactment of the Satellite Home Viewer Reauthorization Act of 2009, to receive secondary transmissions of the primary transmission of a network station under the statutory license under paragraph (2) (in this subparagraph referred to as the 'distant signal'), the following shall apply:

''(i) Except in a case in which clause (ii) applies, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, and the subscriber's household shall continue to be considered an unserved household with respect to such network, until such time as the satellite carrier makes available to the subscriber and the subscriber receives from the satellite carrier the secondary transmission of the primary transmission of a primary stream or a multicast stream affiliated with that network and located in the subscriber's local market.

''(ii) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, and the subscriber's household shall continue to be considered an unserved household with respect to such network, until such time as the subscriber elects to terminate such secondary transmissions.'';

(C) by redesignating subparagraphs (E), (F), and (G) as subparagraphs (D), (E), and (F), respectively;

(D) in subparagraph (E) (as redesignated), by striking ''(C) or (D)'' and inserting ''(B) or (C)''; and

(E) in subparagraph (F) (as redesignated), by inserting ''9-digit'' before ''zip code''.

(3) STATUTORY DAMAGES FOR TERRITORIAL RESTRICTIONS.—Section 119(a)(6) (as redesignated) is amended—

(A) in subparagraph (A)(ii), by striking ''$5'' and inserting ''$250'';

(B) in subparagraph (B)——

(i) in clause (i), by striking ''$250,000 for each 6-month period'' and inserting ''$2,500,000 for each 3-month period''; and

(ii) in clause (ii), by striking ''$250,000'' and inserting ''$2,500,000''; and

(C) by adding at the end the following flush sentence:

''The court shall direct one half of any statutory damages ordered under clause (i) to be deposited with the Register of Copyrights for distribution to copyright owners pursuant to subsection (b). The Copyright Royalty Judges shall issue regulations establishing procedures for distributing such funds, on a proportional basis, to copyright owners whose works were included in the secondary transmissions that were the subject of the statutory damages.''.

(4) CLERICAL AMENDMENT.—Section 119(a)(2)(B)(iii)(II) is amended by striking ''In this clause'' and inserting ''In this clause,''.

(m) MORATORIUM EXTENSION.—Section 119(e) is amended by striking ''2009'' and inserting ''2014''.

(n) CLERICAL AMENDMENTS.—Section 119 is amended—

(1) by striking ''of the Code of Federal Regulations'' each place it appears and inserting '', Code of Federal Regulations''; and

(2) in subsection (d)(6), by striking ''or the Direct'' and inserting '', or the Direct''.

SEC. 103. MODIFICATIONS TO STATUTORY LICENSE FOR SATELLITE CARRIERS IN LOCAL MARKETS.

(a) HEADING RENAMED.—

(1) IN GENERAL.—The heading of section 122 is amended by striking ''**by satellite carriers within local markets**'' and inserting ''**of local television programming by satellite**''.

(2) TABLE OF CONTENTS.—The table of contents for chapter 1 is amended by striking the item relating to section 122 and inserting the following:

''122. Limitations on exclusive rights: Secondary transmissions of local television programming by satellite.''.

(b) STATUTORY LICENSE.—Section 122(a) is amended to read as follows:

''(a) SECONDARY TRANSMISSIONS INTO LOCAL MARKETS.—

''(1) SECONDARY TRANSMISSIONS OF TELEVISION BROADCAST STATIONS WITHIN A LOCAL MARKET.—A secondary transmission of a performance or display of a work embodied in a primary transmission of a television broadcast station into the station's local market shall be subject to statutory licensing under this section if—

''(A) the secondary transmission is made by a satellite carrier to the public;

''(B) with regard to secondary transmissions, the satellite carrier is in compliance with the rules, regulations, or authorizations of the Federal Communications Commission governing the carriage of television broadcast station signals; and

''(C) the satellite carrier makes a direct or indirect charge for the secondary transmission to—

''(i) each subscriber receiving the secondary transmission; or

''(ii) a distributor that has contracted with the satellite carrier for direct or indirect delivery of the secondary transmission to the public.

''(2) SIGNIFICANTLY VIEWED STATIONS.—

''(A) IN GENERAL.—The statutory license under paragraph (1) shall apply to the secondary transmission of the primary transmission of a network station or a non-network station to a subscriber who resides outside the station's local market but within a community in which the signal has been determined by the Federal Communications Commission to be significantly viewed in such community, pursuant to the rules, regulations, and authorizations of the Federal Communications Commission in effect on April 15, 1976, applicable to determining with respect to a cable system whether signals are significantly viewed in a community.

''(B) LIMITATION.—Subparagraph (A) shall apply only to secondary transmissions of the primary transmissions of network stations or non-network stations to subscribers who receive secondary transmissions from a satellite carrier pursuant to the statutory license under paragraph (1).

''(C) WAIVER.—A subscriber who is denied the secondary transmission of the primary transmission of a network station or a non-network station under subparagraph (B) may request a waiver from such denial by submitting a request, through the subscriber's satellite carrier, to the network station or non-network station in the local market affiliated with the same network or non-network where the subscriber is located. The network station or non-network station shall accept or reject the subscriber's request for a waiver within 30 days after receipt of the request. If the network station or non-network station fails to accept or reject the subscriber's request for a waiver within that 30-day period, that network station or non-network station shall be deemed to agree to the waiver request.

''(3) SECONDARY TRANSMISSION OF LOW POWER PROGRAMMING.—

''(A) IN GENERAL.—Subject to subparagraphs (B) through (D) of this paragraph, the statutory license provided under paragraph (1) shall apply to the secondary transmission by a satellite carrier of the primary transmission of a network station or a non-network station that is licensed as a low power television station, to a subscriber who resides within the same local market as the station that originates the transmission.

''(B) NO APPLICABILITY TO REPEATERS AND TRANSLATORS.—Secondary transmissions provided for in subparagraph (A) shall not apply to any low power television station that retransmits the programs and signals of another television station for more than 2 hours each day.

''(C) LIMITATION TO SUBSCRIBERS TAKING LOCAL-INTO-LOCAL SERVICE.—Secondary transmissions by a satellite carrier provided for in subparagraph (A) may be made only to subscribers who receive secondary transmissions of primary transmissions from that satellite carrier pursuant to the statutory license in paragraph (1), and only in conformity with the requirements under section 340(b) of the Communications Act of 1934, as in effect on the date of the enactment of the Satellite Home Viewer Reauthorization Act of 2009.

''(D) NO IMPACT ON OTHER SECONDARY TRANSMISSIONS OBLIGATIONS.—A satellite carrier that makes secondary transmissions of a primary transmission of a low power television station under a statutory license provided under this section is not required, by reason of such secondary transmissions, to make any other secondary transmissions.''.

(c) REPORTING REQUIREMENTS.—Section 122(b) is amended—

(1) in paragraph (1), by striking ''station a list'' and all that follows through the end and inserting the following: ''station—

''(A) a list identifying (by name in alphabetical order and street address, including county and 9-digit zip code) all subscribers to which the satellite carrier makes secondary transmissions of that primary transmission under subsection (a); and

''(B) a separate list, aggregated by designated market area (by name and address, including street or rural route number, city, State, and 9-digit zip code), which shall indicate those subscribers being served pursuant to subsection (a)(2), relating to significantly viewed stations.''; and

(2) in paragraph (2), by striking ''network a list'' and all that follows through the end and inserting the following: ''network—

''(A) a list identifying (by name in alphabetical order and street address, including county and 9-digit zip code) any subscribers who have been added or dropped as subscribers since the last submission under this subsection; and

''(B) a separate list, aggregated by designated market area (by name and street address, including street or rural route number, city, State, and 9-digit zip code), identifying those subscribers whose service pursuant to subsection (a)(2), relating to significantly viewed stations, has been added or dropped since the last submission under this subsection.''.

(d) VIOLATIONS FOR TERRITORIAL RESTRICTIONS.—

(1) MODIFICATION TO STATUTORY DAMAGES.—Section 122(f) is amended—

(A) in paragraph (1)(B), by striking ''$5'' and inserting ''$250''; and

(B) in paragraph (2), by striking ''$250,000'' each place it appears and inserting ''$2,500,000''.

(2) CONFORMING AMENDMENT FOR SIGNIFICANTLY VIEWED STATIONS.—Section 122 is amended—

(A) in subsection (f), by striking ''section 119 or'' each place it appears and inserting the following: ''section 119, subject to statutory licensing by reason of subsection (a)(2)(A), or subject to''; and

(B) in subsection (g), by striking ''section 119 or'' and inserting the following: ''section 119, subsection (a)(2)(A), or''.

(e) DEFINITIONS.—Section 122(j) is amended—

(1) in paragraph (1), by striking ''which contracts'' and inserting ''that contracts'';

(2) by amending paragraph (2)(A) to read as follows:

''(A) IN GENERAL.—The term 'local market' means—

''(i) in the case of a television broadcast station that is not a low power television station, the designated market area in which such station is located, and—

''(I) in the case of a commercial television broadcast station, all commercial television broadcast stations licensed to a community within the same designated market area are within the same local market; and

''(II) in the case of a noncommercial educational television broadcast station, any station that is licensed to a community within the same designated market area as the noncommercial educational television broadcast station; and

''(ii) in the case of a low power television broadcast station, the area that is both—

''(I) within the designated market area in which such station is located; and

''(II) within the area within 35 miles of the transmitter site of such station, except that in the case of such a station located in a standard metropolitan statistical area that has 1 of the 50 largest populations of all standard metropolitan statistical areas (based on the 1980 decennial census of population taken by the Secretary of Commerce), the area within 20 miles of the transmitter site of such station.'';

(3) in paragraph (3)—

(A) in the heading of such paragraph, by inserting ''NON-NETWORK STATION; NONCOMMERCIAL EDUCATIONAL BROADCAST STATION;'' after ''NETWORK STATION;''; and

(B) by inserting '''non-network station; noncommercial educational broadcast station','' after '''network station','';

(4) by amending paragraph (4) to read as follows:

''(4) SUBSCRIBER.—The term 'subscriber' means a person or entity that receives a secondary transmission service from a satellite carrier and pays a fee for the service, directly or indirectly, to the satellite carrier or to a distributor.''; and

(5) by adding at the end the following:

''(6) LOW POWER TELEVISION STATION.—The term 'low power television station' means a low power TV station as defined under section 74.701(f) of title 47, Code of Federal Regulations, as in effect on June 1, 2004. For purposes of this paragraph, the term 'low power television station' includes a low power television station that has been accorded primary status as a Class A television licensee under section 73.6001(a) of title 47, Code of Federal Regulations.''.

SEC. 104. MODIFICATIONS TO CABLE SYSTEM SECONDARY TRANSMISSION RIGHTS UNDER SECTION 111.

(a) HEADING RENAMED.—

(1) IN GENERAL.—The heading of section 111 is amended by inserting at the end the following: ''**of broadcast programming by cable**''.

(2) TABLE OF CONTENTS.—The table of contents for chapter 1 is amended by striking the item relating to section 111 and inserting the following:

''111. Limitations on exclusive rights: Secondary transmissions of broadcast programming by cable.''.

(b) NATIONAL EMERGENCY MONITORING EXEMPTION.—Section 111 is amended—

(1) in subsection (a)—

(A) in paragraph (4), by striking ''; or'' and inserting ''or section 122;'';

(B) in paragraph (5), by striking the period and inserting ''; or''; and

(C) by adding at the end the following new paragraph:

''(6) the secondary transmission is made by a cable system for emergency preparation, response, or recovery as described under subsection (g).''; and

(2) by adding at the end the following new subsection:

''(g) RETRANSMISSION FOR EMERGENCY PREPARATION, RESPONSE, OR RECOVERY.—

''(1) AUTHORITY.—For purposes of subsection (a)(6), a secondary transmission by a cable system of a performance or display of a work embodied in a primary transmission by a television broadcast station is made for emergency preparation, response, or recovery if such transmission is made—

''(A) by a cable system to a Federal governmental body designated by the Office of Emergency Communications, in coordination with the Federal Communications Commission, or an organization established with the purpose of carrying out a system of national and international relief efforts and chartered under section 300101 of title 36;

''(B) to officers or employees of such body or such organization as a part of the official duties or employment of such officers or employees;

''(C) at the request of the Secretary of Homeland Security; and

''(D) for the sole purpose of preparing for, responding to, or recovering from an emergency described under paragraph (2).

''(2) EMERGENCIES.—An emergency is described under this paragraph if the Secretary of Homeland Security identifies such emergency as a major disaster, a catastrophic incident, an act of terrorism, or a transportation security incident.

''(3) REGULATIONS.—Not later than 6 months after the date of the enactment of this subsection, the Secretary of Homeland Security, in coordination with the Federal

Communications Commission, the National Telecommunications and Information Administration, and the Register of Copyrights, shall issue regulations to protect copyright owners by preventing the unauthorized access to the secondary transmissions described in paragraph (1).

''(4) REPORTS TO CONGRESSIONAL COMMITTEES.—Not later than one year after the date of the enactment of this subsection and by September 30 of each year thereafter, the Secretary of Homeland Security, acting through the Office of Emergency Communications, shall submit a report to the Committees on the Judiciary, on Homeland Security, and on Energy and Commerce of the House of Representatives and the Committees on the Judiciary, on Homeland Security, and on Commerce, Science, and Transportation of the Senate describing—

''(A) the manner in which the authority granted under paragraph (1) is being used, including to whom and for what purposes the secondary transmissions are being provided; and

''(B) any additional legislative recommendations the Secretary may have.

''(5) DEFINITIONS.—As used in this subsection:

''(A) TERRORISM.—The term 'terrorism' has the meaning given that term in section 2(16) of the Homeland Security Act of 2002 (6 U.S.C. 101(16)).

''(B) TRANSPORTATION SECURITY INCIDENT.—The term 'transportation security incident' has the meaning given that term in section 70101 of title 46.

''(C) CATASTROPHIC INCIDENT.—The term 'catastrophic incident' means any natural disaster, act of terrorism, or other man-made disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the population (including mass evacuations), infrastructure, the environment, the economy, national morale, or government functions in a geographic area.

''(6) EFFECTIVE DATE.—This subsection shall apply with respect to secondary transmissions described under paragraph (1) that are made after the end of the 30-day period beginning on the effective date of the regulations issued by the Secretary of Homeland Security under paragraph (3).''.

(c) STATUTORY LICENSE FOR SECONDARY TRANSMISSIONS BY CABLE SYSTEMS.—Section 111(d) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A)—

(i) by striking ''A cable system whose secondary'' and inserting the following: ''STATEMENT OF ACCOUNT AND ROYALTY FEES.—Subject to paragraph (5), a cable system whose secondary''; and

(ii) by striking ''by regulation—'' and inserting ''by regulation the following:'';

(B) in subparagraph (A)—

(i) by striking ''a statement of account'' and inserting ''A statement of account''; and

(ii) by striking ''; and'' and inserting a period; and

(C) by striking subparagraphs (B), (C), and (D), and inserting the following:

''(B) Except in the case of a cable system whose royalty fee is specified in subparagraph (E) or (F), a total royalty fee payable to copyright owners pursuant to paragraph (3) for the period covered by the statement, computed on the basis of specified percentages of the gross receipts from subscribers to the cable service during such period for the basic service of providing secondary transmissions of primary broadcast transmitters, as follows:

''(i) 1.064 percent of such gross receipts for the privilege of further transmitting, beyond the local service area of such primary transmitter, any non-network programming of a primary transmitter in whole or in part, such amount to be applied against the fee, if any, payable pursuant to clauses (ii) through (iv);

''(ii) 1.064 percent of such gross receipts for the first distant signal equivalent;

''(iii) 0.701 percent of such gross receipts for each of the second, third, and fourth distant signal equivalents; and

''(iv) 0.330 percent of such gross receipts for the fifth distant signal equivalent and each distant signal equivalent thereafter.

''(C) In computing amounts under clauses (ii) through (iv) of subparagraph (B)—

''(i) any fraction of a distant signal equivalent shall be computed at its fractional value;

''(ii) in the case of any cable system located partly within and partly outside of the local service area of a primary transmitter, gross receipts shall be limited to those gross receipts derived from subscribers located outside of the local service area of such primary transmitter; and

''(iii) if a cable system provides a secondary transmission of a primary transmitter to some but not all communities served by that cable system—

''(I) the gross receipts and the distant signal equivalent values for such secondary transmission shall be derived solely on the basis of the subscribers in those communities where the cable system provides such secondary transmission; and

''(II) the total royalty fee for the period paid by such system shall not be less than the royalty fee calculated under subparagraph (B)(i) multiplied by the gross receipts from all subscribers to the system.

''(D) A cable system that, on a statement submitted before the date of the enactment of the Satellite Home Viewer Reauthorization Act of 2009, computed its royalty fee consistent with the methodology under subparagraph (C)(iii) or that amends a statement filed before such date of enactment to compute the royalty fee due using such methodology shall not be subject to an action for infringement, or eligible for any royalty refund or offset, arising out of its use of such methodology on such statement.

''(E) If the actual gross receipts paid by subscribers to a cable system for the period covered by the statement for the basic service of providing secondary transmissions of primary broadcast transmitters are $263,800 or less—

''(i) gross receipts of the cable system for the purpose of this paragraph shall be computed by subtracting from such actual gross receipts the amount by which $263,800 exceeds such actual gross receipts, except that in no case shall a cable system's gross receipts be reduced to less than $10,400; and

''(ii) the royalty fee payable under this paragraph to copyright owners pursuant to paragraph (3) shall be 0.5 percent, regardless of the number of distant signal equivalents, if any.

''(F) If the actual gross receipts paid by subscribers to a cable system for the period covered by the statement for the basic service of providing secondary transmissions of primary broadcast transmitters are more than $263,800 but less than $527,600, the royalty fee payable under this paragraph to copyright owners pursuant to paragraph (3) shall be—

''(i) 0.5 percent of any gross receipts up to $263,800, regardless of the number of distant signal equivalents, if any; and

''(ii) 1 percent of any gross receipts in excess of $263,800, but less than $527,600, regardless of the number of distant signal equivalents, if any.

''(G) A filing fee, as determined by the Register of Copyrights pursuant to section 708(a).'';

(2) in paragraph (2), in the first sentence—

(A) by striking ''The Register of Copyrights'' and inserting the following ''HANDLING OF FEES.—The Register of Copyrights'';

(B) by inserting ''(including the filing fee specified in paragraph (1)(G))'' after ''shall receive''; and

(3) in paragraph (3)—

(A) by striking ''The royalty fees'' and inserting the following: ''DISTRIBUTION OF ROYALTY FEES TO COPYRIGHT OWNERS.—The royalty fees'';

(B) in subparagraph (A)—

(i) by striking ''any such'' and inserting ''Any such''; and

(ii) by striking ''; and'' and inserting a period;

(C) in subparagraph (B)—

(i) by striking ''any such'' and inserting ''Any such''; and

(ii) by striking the semicolon and inserting a period; and

(D) in subparagraph (C), by striking ''any such'' and inserting ''Any such'';

(4) in paragraph (4), by striking ''The royalty fees'' and inserting the following: ''PROCEDURES FOR ROYALTY FEE DISTRIBUTION.—The royalty fees''; and

(5) by adding at the end the following new paragraphs:

''(5) 3.75 PERCENT RATE AND SYNDICATED EXCLUSIVITY SURCHARGE NOT APPLICABLE TO MULTICAST STREAMS.—The royalty rates specified in sections 256.2(c) and 256.2(d) of title 37, Code of Federal Regulations (commonly referred to as the '3.75 percent rate' and the 'syndicated exclusivity surcharge', respectively), as in effect on the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, as such rates may be adjusted, or such sections redesignated, thereafter by the Copyright Royalty Judges, shall not apply to the secondary transmission of a multicast stream.

''(6) VERIFICATION OF ACCOUNTS AND FEE PAYMENTS.—The Register of Copyrights shall issue regulations to provide for the confidential verification and audit of the information reported on the semi-annual statements of account filed after the date of the enactment of the Satellite Home Viewer Reauthorization Act of 2009. The regulations shall provide for a single verification procedure, with respect to the semi-annual statements of account filed by a cable system, to be conducted by a qualified independent auditor on behalf of all copyright owners whose works were the subject of a secondary transmission to the public by a cable system of a performance or display of a work embodied in a primary transmission and for a mechanism to review and cure defects identified by any such audit.

''(7) ACCEPTANCE OF ADDITIONAL DEPOSITS.—Any royalty fee payments received by the Copyright Office from cable systems for the secondary transmission of primary transmissions that are in addition to the payments calculated and deposited in accordance with this subsection shall be deemed to have been deposited for the particular accounting period for which they are received and shall be distributed as specified under this subsection.''.

(d) EFFECTIVE DATE OF NEW ROYALTY FEE RATES.—The royalty fee rates established in section 111(d)(1)(B) of title 17, United States

Code, as amended by subsection (c)(1)(C) of this section, shall take effect commencing with the first accounting period occurring in 2010.

(e) DEFINITIONS.—Section 111(f) is amended—

(1) by striking the first undesignated paragraph and inserting the following:,

''(1) PRIMARY TRANSMISSION.—A 'primary transmission' is a transmission made to the public by a transmitting facility whose signals are being received and further transmitted by a secondary transmission service, regardless of where or when the performance or display was first transmitted. In the case of a television broadcast station, the primary stream and any multicast streams transmitted by the station constitute primary transmissions.'';

(2) in the second undesignated paragraph—

(A) by striking ''A 'secondary transmission' '' and inserting the following:

''(2) SECONDARY TRANSMISSION.—A 'secondary transmission' ''; and

(B) by striking '' 'cable system' '' and inserting ''cable system'';

(3) in the third undesignated paragraph—

(A) by striking ''A 'cable system' '' and inserting the following:

''(3) CABLE SYSTEM.—A 'cable system' ''; and

(B) by striking ''Territory, Trust Territory, or Possession'' and inserting ''territory, trust territory, or possession of the United States'';

(4) in the fourth undesignated paragraph, in the first sentence—

(A) by striking ''The 'local service area of a primary transmitter', in the case of a television broadcast station, comprises the area in which such station is entitled to insist'' and inserting the following:

''(4) LOCAL SERVICE AREA OF A PRIMARY TRANSMITTER.—The 'local service area of a primary transmitter', in the case of both the primary stream and any multicast streams transmitted by a primary transmitter that is a television broadcast station, comprises the area where such primary transmitter could have insisted'';

(B) by striking ''76.59 of title 47 of the Code of Federal Regulations'' and inserting the following: ''76.59 of title 47, Code of Federal Regulations, or within the noise-limited contour as defined in 73.622(e)(1) of title 47, Code of Federal Regulations''; and

(C) by striking ''as defined by the rules and regulations of the Federal Communications Commission,'';

(5) by amending the fifth undesignated paragraph to read as follows:

''(5) DISTANT SIGNAL EQUIVALENT.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), a 'distant signal equivalent'—

''(i) is the value assigned to the secondary transmission of any non-network television programming carried by a cable system in whole or in part beyond the local service area of the primary transmitter of such programming; and

''(ii) is computed by assigning a value of one to each primary stream and to each multicast stream (other than a simulcast) that is an independent station, and by assigning a value of one-quarter to each primary stream and to each multicast stream (other than a simulcast) that is a network station or a noncommercial educational station.

''(B) EXCEPTIONS.—The values for independent, network, and noncommercial educational stations specified in subparagraph (A) are subject to the following:

''(i) Where the rules and regulations of the Federal Communications Commission require a cable system to omit the further transmission of a particular program and such rules and regulations also permit the substitution of another program embodying a performance or display of a work in place of the omitted transmission, or where such rules and regulations in effect on the date of enactment of the Copyright Act of 1976 permit a cable system, at its election, to effect such omission and substitution of a nonlive program or to carry additional programs not transmitted by primary transmitters within whose local service area the cable system is located, no value shall be assigned for the substituted or additional program.

''(ii) Where the rules, regulations, or authorizations of the Federal Communications Commission in effect on the date of enactment of the Copyright Act of 1976 permit a cable system, at its election, to omit the further transmission of a particular program and such rules, regulations, or authorizations also permit the substitution of another program embodying a performance or display of a work in place of the omitted transmission, the value assigned for the substituted or additional program shall be, in the case of a live program, the value of one full distant signal equivalent multiplied by a fraction that has as its numerator the number of days in the year in which such substitution occurs and as its denominator the number of days in the year.

''(iii) In the case of the secondary transmission of a primary transmitter that is a television broadcast station pursuant to the late-night or specialty programming rules of the Federal Communications Commission, or the secondary transmission of a primary transmitter that is a television broadcast station on a part-time basis where full-time carriage is not possible because the cable system lacks the activated channel capacity to retransmit on a full-time basis all signals that it is authorized to carry, the values for independent, network, and noncommercial educational stations set forth in subparagraph (A), as the case may be, shall be multiplied by a fraction that is equal to the ratio of the broadcast hours of such primary transmitter retransmitted by the cable system to the total broadcast hours of the primary transmitter.

''(iv) No value shall be assigned for the secondary transmission of the primary stream or any multicast streams of a primary transmitter that is a television broadcast station in any community that is within the local service area of the primary transmitter .'';

(6) by striking the sixth undesignated paragraph and inserting the following:

''(6) NETWORK STATION.—

''(A) TREATMENT OF PRIMARY STREAM.—The term 'network station' shall be applied to a primary stream of a television broadcast station that is owned or operated by, or affiliated with, one or more of the television networks in the United States providing nationwide transmissions, and that transmits a substantial part of the programming supplied by such networks for a substantial part of the primary stream's typical broadcast day.

''(B) TREATMENT OF MULTICAST STREAMS.—The term 'network station' shall be applied to a multicast stream on which a television broadcast station transmits all or substantially all of the programming of an interconnected program service that—

''(i) is owned or operated by, or affiliated with, one or more of the television networks described in subparagraph (A); and

''(ii) offers programming on a regular basis for 15 or more hours per week to at least 25 of the affiliated television licensees of the interconnected program service in 10 or more States.''; and

(7) by striking the seventh undesignated paragraph and inserting the following:

''(7) INDEPENDENT STATION.—The term 'independent station' shall be applied to the primary stream or a multicast stream of a television broadcast station that is not a network station or a noncommercial educational station.'';

(8) by striking the eighth undesignated paragraph and inserting the following:

''(8) NONCOMMERCIAL EDUCATIONAL STATION.—A 'noncommercial educational station' is television station that is a noncommercial educational broadcast station as defined in section 397 of the Communications Act of 1934, as in effect on the date of the enactment of the Satellite Home Viewer Reauthorization Act of 2009.''; and

(9) by adding at the end the following:

''(9) PRIMARY STREAM.—A 'primary stream' is—

''(A) the single digital stream of programming that prior to june 12, 2009 was substantially duplicating the programming transmitted by the television broadcast station as an analog signal; or

''(B) if there is no such stream, the single digital stream of programming transmitted by the station for the longest period of time.

''(10) PRIMARY TRANSMITTER.—A 'primary transmitter' is a television or radio broadcast station licensed by the Federal Communications Commission, or by an appropriate governmental authority of Canada or Mexico, that makes primary transmissions to the public.

''(11) MULTICAST STREAM.—A 'multicast stream' is a digital stream of programming transmitted by a television broadcast station that is not the station's primary stream.

''(12) SIMULCAST.—A 'simulcast' is a multicast stream of a television broadcast station that duplicates the programming transmitted by the primary stream or another multicast stream of such station.

''(13) SUBSCRIBER; SUBSCRIBE.—

''(A) SUBSCRIBER.—The term 'subscriber' means a person or entity that receives a secondary transmission service from a cable system and pays a fee for the service, directly or indirectly, to the cable system.

''(B) SUBSCRIBE.—The term 'subscribe' means to elect to become a subscriber.''.

(f) TIMING OF SECTION 111 PROCEEDINGS.—Section 804(b)(1) is amended by striking ''2005'' each place it appears and inserting ''2015''.

(g) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) CORRECTIONS TO FIX LEVEL DESIGNATIONS.—Section 111 is amended—

(A) in subsections (a), (c), and (e), by striking ''clause'' each place it appears and inserting ''paragraph'';

(B) in subsection (c)(1), by striking ''clauses'' and inserting ''paragraphs''; and

(C) in subsection (e)(1)(F), by striking ''subclause'' and inserting ''subparagraph''.

(2) CONFORMING AMENDMENT TO HYPHENATE NONNETWORK.—Section 111 is amended by striking ''nonnetwork'' each place it appears and inserting ''non-network''.

(3) PREVIOUSLY UNDESIGNATED PARAGRAPH.—Section 111(e)(1) is amended by striking ''second paragraph of subsection (f)'' and inserting ''subsection (f)(2)''.

(4) REMOVAL OF SUPERFLUOUS ANDS.—Section 111(e) is amended—

(A) in paragraph (1)(A), by striking ''and'' at the end;

(B) in paragraph (1)(B), by striking ''and'' at the end;

(C) in paragraph (1)(C), by striking ''and'' at the end;

(D) in paragraph (1)(D), by striking ''and'' at the end; and

(E) in paragraph (2)(A), by striking ''and'' at the end;

(5) REMOVAL OF VARIANT FORMS REFERENCES.—Section 111 is amended—

(A) in subsection (e)(4), by striking '', and each of its variant forms,''; and

(B) in subsection (f), by striking ''and their variant forms''.

(6) CORRECTION TO TERRITORY REFERENCE.—Section 111(e)(2) is amended in the matter preceding subparagraph (A) by striking ''three territories'' and inserting ''five entities''.

(h) EFFECTIVE DATE WITH RESPECT TO MULTICAST STREAMS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the amendments made by this section, to the extent such amendments assign a distant signal equivalent value to the secondary transmission of the multicast stream of a primary transmitter, shall take effect on the date of the enactment of this Act.

(2) DELAYED APPLICABILITY.—

(A) SECONDARY TRANSMISSIONS OF A MULTICAST STREAM BEYOND THE LOCAL SERVICE AREA OF ITS PRIMARY TRANSMITTER BEFORE 2009 ACT.—In any case in which a cable system was making secondary transmissions of a multicast stream beyond the local service area of its primary transmitter before the date of the enactment of this Act, a distant signal equivalent value (referred to in paragraph (1)) shall not be assigned to secondary transmissions of such multicast stream that are made on or before June 30, 2010.

(B) MULTICAST STREAMS SUBJECT TO PREEXISTING WRITTEN AGREEMENTS FOR THE SECONDARY TRANSMISSION OF SUCH STREAMS.—In any case in which the secondary transmission of a multicast stream of a primary transmitter is the subject of a written agreement entered into on or before June 30, 2009, between a cable system or an association representing the cable system and a primary transmitter or an association representing the primary transmitter, a distant signal equivalent value (referred to in paragraph (1)) shall not be assigned to secondary transmissions of such multicast stream beyond the local service area of its primary transmitter that are made on or before the date on which such written agreement expires.

(C) NO REFUNDS OR OFFSETS FOR PRIOR STATEMENTS OF ACCOUNT.—A cable system that has reported secondary transmissions of a multicast stream beyond the local service area of its primary transmitter on a statement of account deposited under section 111 of title 17, United States Code, before the date of the enactment of this Act shall not be entitled to any refund, or offset, of royalty fees paid on account of such secondary transmissions of such multicast stream.

(3) DEFINITIONS.—In this subsection, the terms ''cable system'', ''secondary transmission'', ''multicast stream'', and ''local service area of a primary transmitter'' have the meanings given those terms in section 111(f) of title 17, United States Code, as amended by this section.

SEC. 105. CERTAIN WAIVERS GRANTED TO PROVIDERS OF LOCAL-INTO-LOCAL SERVICE FOR ALL DMAS.

Section 119 is amended by adding at the end the following new subsection:

''(g) CERTAIN WAIVERS GRANTED TO PROVIDERS OF LOCAL-INTO-LOCAL SERVICE TO ALL DMAS.—

''(1) INJUNCTION WAIVER.—A court that issued an injunction pursuant to subsection (a)(7)(B) before the date of the enactment of this subsection shall waive such injunction if the court recognizes the entity against which the injunction was issued as a qualified carrier.

''(2) LIMITED TEMPORARY WAIVER.—

''(A) IN GENERAL.—Upon a request made by a satellite carrier, a court that issued an injunction against such carrier under subsection (a)(7)(B) before the date of the enactment of this subsection shall waive such injunction with respect to the statutory license provided under subsection (a)(2) to the extent necessary to allow such carrier to make secondary transmissions of primary transmissions made by a network station to unserved households located in short markets in which such carrier was not providing local service pursuant to the license under section 122 as of December 31, 2009.

''(B) EXPIRATION OF TEMPORARY WAIVER.—A temporary waiver of an injunction under subparagraph (A) shall expire after the end of the 120-day period beginning on the date such temporary waiver is issued unless extended for good cause by the court making the temporary waiver.

''(C) FAILURE TO MAKE GOOD FAITH EFFORT TO PROVIDE LOCAL-INTO-LOCAL SERVICE TO ALL DMAS.—

''(i) WILLFUL FAILURE.—If the court issuing a temporary waiver under subparagraph (A) determines that the satellite carrier that made the request for such waiver has failed to make a good faith effort to provide local-into-local service to all DMAs and determines that such failure was willful, such failure—

''(I) is actionable as an act of infringement under section 501 and the court may in its discretion impose the remedies provided for in sections 502 through 506 and subsection (a)(6)(B) of this section; and

''(II) shall result in the termination of the waiver issued under subparagraph (A).

''(ii) NONWILLFUL FAILURE.—If the court issuing a temporary waiver under subparagraph (A) determines that the satellite carrier that made the request for such waiver has failed to make a good faith effort to provide local-into-local service to all DMAs and determines that such failure was nonwillful, the court may in its discretion impose financial penalties that reflect—

''(I) the degree of control the carrier had over the circumstances that resulted in the failure;

''(II) the quality of the carrier's efforts to remedy the failure; and

''(III) the severity and duration of any service interruption.

''(D) SINGLE TEMPORARY WAIVER AVAILABLE.—An entity may only receive one temporary waiver under this paragraph.

''(E) SHORT MARKET DEFINED.—For purposes of this paragraph, the term 'short market' means a local market in which programming of one or more of the four most widely viewed television networks nationwide as measured on the date of enactment of this subsection is not offered on the primary stream transmitted by any local television broadcast station.

''(3) ESTABLISHMENT OF QUALIFIED CARRIER RECOGNITION.—

''(A) STATEMENT OF ELIGIBILITY.—An entity seeking to be recognized as a qualified carrier under this subsection shall file a statement of eligibility with the court that imposed the injunction. A statement of eligibility must include—

''(i) an affidavit that the entity is providing local-into-local service to all DMAs;

''(ii) a request for a waiver of the injunction; and

''(iii) a certification issued pursuant to section 342(a) of Communications Act of 1934.

''(B) GRANT OF RECOGNITION AS A QUALIFIED CARRIER.—Upon receipt of a statement of eligibility, the court shall recognize the entity as a qualified carrier and issue the waiver under paragraph (1).

''(C) VOLUNTARY TERMINATION.—At any time, an entity recognized as a qualified carrier may file a statement of voluntary termination with the court certifying that it no longer wishes to be recognized as a qualified carrier. Upon receipt of such statement, the court shall reinstate the injunction waived under paragraph (1).

''(D) LOSS OF RECOGNITION PREVENTS FUTURE RECOGNITION.—No entity may be recognized as a qualified carrier if such entity had previously been recognized as a qualified carrier and subsequently lost such recognition or voluntarily terminated such recognition under subparagraph (C).

''(4) QUALIFIED CARRIER OBLIGATIONS AND COMPLIANCE.—

''(A) CONTINUING OBLIGATIONS.—

''(i) IN GENERAL.—An entity recognized as a qualified carrier shall continue to provide local-into-local service to all DMAs.

''(ii) COOPERATION WITH GAO EXAMINATION.—An entity recognized as a qualified carrier shall fully cooperate with the Comptroller General in the examination required by subparagraph (B).

''(B) QUALIFIED CARRIER COMPLIANCE EXAMINATION.—

''(i) EXAMINATION AND REPORT.—The Comptroller General shall conduct an examination and publish a report concerning the qualified carrier's compliance with the royalty payment and household eligibility requirements of the license under this section. The report shall address the qualified carrier's conduct during the period beginning on the date on which the qualified carrier is recognized as such under paragraph (3)(B) and ending on December 31, 2011.

''(ii) RECORDS OF QUALIFIED CARRIER.—Beginning on the date that is one year after the date on which the qualified carrier is recognized as such under paragraph (3)(B), the qualified carrier shall provide the Comptroller General with all records that the Comptroller General, in consultation with the Register of Copyrights, considers to be directly pertinent to the following requirements under this section:

''(I) Proper calculation and payment of royalties under the statutory license under this section.

''(II) Provision of service under this license to eligible subscribers only.

''(iii) SUBMISSION OF REPORT.—The Comptroller General shall file the report required by clause (i) not later than March 1, 2012, with the court referred to in paragraph (1) that issued the injunction, the Register of Copyrights, and the Committees on the Judiciary of the House of Representatives and the Senate.

''(iv) EVIDENCE OF INFRINGEMENT.—The Comptroller General shall include in the report a statement of whether the examination by the Comptroller General indicated that there is substantial evidence that a copyright holder could bring a successful action under this section against the qualified carrier for infringement. The Comptroller General shall consult with the Register of Copyrights in preparing such statement.

''(v) SUBSEQUENT EXAMINATION.—If the report includes the Comptroller General's statement that there is substantial evidence that a copyright holder could bring a successful action under this section against the qualified carrier for infringement, the Comptroller General shall, not later than 6 months after the report under clause (i) is published, initiate another examination of the qualified carrier's compliance with the royalty payment and household eligibility requirements of the license under this section since the last report was filed under clause (iii). The Comptroller General shall file a report on such examination with the court referred to in paragraph (1) that issued the injunction, the Register of Copyrights, and the Committees on the Judiciary of the House of Representatives and the Senate. The report shall include a statement described in clause (iv), prepared in consultation with the Register of Copyrights.

''(C) AFFIRMATION.—A qualified carrier shall file an affidavit with the district court and the Register of Copyrights 30 months after such status was granted stating that, to the best of the affiant's knowledge, it is in compliance with the requirements for a qualified carrier.

''(D) COMPLIANCE DETERMINATION.—Upon the motion of an aggrieved television broadcast station, the court recognizing an entity as a qualified carrier may make a determination of whether the entity is providing local-into-local service to all DMAs.

''(E) PLEADING REQUIREMENT.—In any motion brought under subparagraph (D), the party making such motion shall specify one or more designated market areas (as such term is defined in section 122(j)(2)(C)) for which the failure to provide service is being alleged, and, for each such designated market area, shall plead with particularity the circumstances of the alleged failure.

''(F) BURDEN OF PROOF.—In any proceeding to make a determination under subparagraph (D), and with respect to a designated market area for which failure to provide service is alleged, the entity recognized as a qualified carrier shall have the burden of proving that the entity provided local-into-local service with a good quality satellite signal to at least 90 percent of the households in such designated market area (based on the most recent census data released by the United States Census Bureau) at the time and place alleged.

''(G) ENFORCEMENT.—Upon motion filed by an interested party, the court recognizing an entity as a qualified carrier shall terminate such designation upon finding that the entity has failed to meet the requirements imposed on the entity under this paragraph.

''(5) FAILURE TO PROVIDE SERVICE.—

''(A) PENALTIES.—If the court recognizing an entity as a qualified carrier finds that such entity has willfully failed to provide local-into-local service to all DMAs, such finding shall result in the loss of recognition of the entity as a qualified carrier and the termination of the waiver provided under paragraph (1), and the court may, in its discretion—

''(i) treat such failure as an act of infringement under section 501, and subject such infringement to the remedies provided for in sections 502 through 506 and subsection (a)(6)(B) of this section; and

''(ii) impose a fine of not more than $250,000.

''(B) EXCEPTION FOR NONWILLFUL VIOLATION.—If the court determines that the failure to provide local-into-local service to all DMAs is nonwillful, the court may in its discretion impose financial penalties for noncompliance that reflect—

''(i) the degree of control the entity had over the circumstances that resulted in the failure;

''(ii) the quality of the entity's efforts to remedy the failure and restore service; and

''(iii) the severity and duration of the service interruption.

''(6) PENALTIES FOR VIOLATIONS OF LICENSE.—A court that finds, under subsection (a)(6)(A), that an entity recognized as a qualified carrier has willfully made a secondary transmission of a primary transmission made by a network station and embodying a performance or display of a work to a subscriber who is not eligible to receive the transmission under this section shall reinstate the injunction waived under paragraph (1), and the court may order statutory damages of not more than $2,500,000.

''(7) LOCAL-INTO-LOCAL SERVICE TO ALL DMAS DEFINED.—For purposes of this subsection:

''(A) IN GENERAL.—An entity provides 'local-into-local service to all DMAs' if the entity provides local service in all designated market areas (as such term is defined in section 122(j)(2)(C)) pursuant to the license under section 122.

''(B) HOUSEHOLD COVERAGE.—For purposes of subparagraph (A), an entity that makes available local-into-local service with a good quality satellite signal to at least 90 percent of the households in a designated market area based on the most recent census data released by the United States Census Bureau shall be considered to be providing local service to such designated market area.

''(C) GOOD QUALITY SATELLITE SIGNAL DEFINED.—The term 'good quality signal' has the meaning given such term under section 342(e)(2) of Communications Act of 1934.''.

SEC. 106. TERMINATION OF LICENSE.

(a) TERMINATION.—Section 119, as amended by this title, shall cease to be effective on December 31, 2014.

(b) CONFORMING AMENDMENT.—Section 4(a) of the Satellite Home Viewer Act of 1994 (17 U.S.C. 119 note; Public Law 103-369) is repealed.

SEC. 107. SURCHARGE ON STATUTORY LICENSES.

(a) SURCHARGES.—The Copyright Royalty Judges shall establish a surcharge or surcharges to be paid, in accordance with subsection (b), by cable systems subject to statutory licensing under section 111(c) of title 17, United States Code, and satellite carriers whose secondary transmissions are subject to statutory licensing under section 119(a) of such title, in addition to the royalty fees paid by such cable systems under section 111(d)(1) of such title and by such satellite carriers under section 119(b)(1) of such title.

(b) AMOUNT AND TIMING OF SURCHARGES.—Surcharges under subsection (a) shall be assessed, during fiscal years 2009 through 2019, in amounts that, in the aggregate, will equal at least $92,000,000.

(c) FUNDS UNAVAILABLE FOR OBLIGATION.—Surcharges collected under this section shall be deposited in the Treasury of the United States and shall not be available for obligation.

(d) AUTHORITIES.—The Copyright Royalty Judges may exercise the authorities such Judges have under chapter 8 of title 17, United States Code, to carry out this section.

SEC. 108. CONSTRUCTION.

Nothing in section 111, 119, or 122 of title 17, United States Code, including the amendments made to such sections by this title, shall be construed to affect the meaning of any terms under the Communications Act of 1934, except to the extent that such sections are specifically cross-referenced in such Act or the regulations issued thereunder.

TITLE II—COMMUNICATIONS PROVISIONS

SEC. 201. REFERENCE.

Except as otherwise provided, whenever in this title an amendment is made to a section or other provision, the reference shall be considered to be made to such section or provision of the Communications Act of 1934 (47 U.S.C. 151 et seq.).

SEC. 202. EXTENSION OF AUTHORITY.

Section 325(b) is amended—

(1) in paragraph (2)(C), by striking ''December 31, 2009'' and inserting ''December 31, 2014''; and

(2) in paragraph (3)(C), by striking ''January 1, 2010'' each place it appears in clauses (ii) and (iii) and inserting ''January 1, 2015''.

SEC. 203. SIGNIFICANTLY VIEWED STATIONS.

(a) IN GENERAL.—Paragraphs (1) and (2) of section 340(b) are amended to read as follows:

''(1) SERVICE LIMITED TO SUBSCRIBERS TAKING LOCAL-INTO-LOCAL SERVICE.—This section shall apply only to retransmissions to subscribers of a satellite carrier who receive retransmissions of a signal from that satellite carrier pursuant to section 338.

''(2) SERVICE LIMITATIONS.—A satellite carrier may retransmit to a subscriber in high definition format the signal of a station determined by the Commission to be significantly viewed under subsection (a) only if such carrier also retransmits in high definition format the signal of a station located in the local market of such subscriber and affiliated with the same network whenever such format is available from such station.''.

(b) RULEMAKING REQUIRED.—Within 180 days after the date of the enactment of this Act, the Federal Communications Commission shall take all actions necessary to promulgate a rule to implement the amendments made by subsection (a).

SEC. 204. DIGITAL TELEVISION TRANSITION CONFORMING AMENDMENTS.

(a) SECTION 338.—Section 338 is amended—

(1) in subsection (a), by striking ''(3) EFFECTIVE DATE.—No satellite'' and all that follows through ''until January 1, 2002.''; and

(2) by amending subsection (g) to read as follows:

''(g) CARRIAGE OF LOCAL STATIONS ON A SINGLE RECEPTION ANTENNA.—

''(1) SINGLE RECEPTION ANTENNA.—Each satellite carrier that retransmits the signals of local television broadcast stations in a local market shall retransmit such stations in such market so that a subscriber may receive such stations by means of a single reception antenna and associated equipment.

''(2) ADDITIONAL RECEPTION ANTENNA.—If the carrier retransmits the signals of local television broadcast stations in a local market in high definition format, the carrier shall retransmit such signals in such market so that a subscriber may receive such signals by means of a single reception antenna and associated equipment, but such antenna and associated equipment may be separate from the single reception antenna and associated equipment used to comply with paragraph (1).''.

(b) SECTION 339.—Section 339 is amended—

(1) in subsection (a)—

(A) in paragraph (1)(B), by striking ''Such two network stations'' and all that follows through ''more than two network stations.''; and

(B) in paragraph (2)—

(i) in the heading for subparagraph (A), by striking ''TO ANALOG SIGNALS'';

(ii) in subparagraph (A)—

(I) in the heading for clause (i), by striking ''ANALOG'';

(II) in clause (i)—

(aa) by striking ''analog'' each place it appears; and

(bb) by striking ''October 1, 2004'' and inserting ''October 1, 2009'';

(III) in the heading for clause (ii), by striking ''ANALOG''; and

(IV) in clause (ii)—

(aa) by striking ''analog'' each place it appears; and

(bb) by striking ''2004'' and inserting ''2009'';

(iii) by amending subparagraph (B) to read as follows:

''(B) RULES FOR OTHER SUBSCRIBERS.—

''(i) IN GENERAL.—In the case of a subscriber of a satellite carrier who is eligible to receive the signal of a network station under this section (in this subparagraph referred to as a 'distant signal'), other than subscribers to whom subparagraph (A) applies, the following shall apply:

''(I) In a case in which the satellite carrier makes available to that subscriber, on January 1, 2005, the signal of a local network station affiliated with the same television network pursuant to section 338, the carrier may only provide the secondary transmissions of the distant signal of a station affiliated with the same network to that subscriber if the subscriber's satellite carrier, not later than March 1, 2005, submits to that television network the list and statement required by subparagraph (F)(i).

''(II) In a case in which the satellite carrier does not make available to that subscriber, on January 1, 2005, the signal of a local network station pursuant to section 338, the carrier may only provide the secondary transmissions of the distant signal of a station affiliated with the same network to that subscriber if—

''(aa) that subscriber seeks to subscribe to such distant signal before the date on which such carrier commences to carry pursuant to section 338 the signals of stations from the local market of such local network station; and

''(bb) the satellite carrier, within 60 days after such date, submits to each television network the list and statement required by subparagraph (F)(ii).

''(ii) SPECIAL CIRCUMSTANCES.—A subscriber of a satellite carrier who was lawfully receiving the distant signal of a network station on the day before the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009 may receive both such distant signal and the local signal of a network station affiliated with the same network until such subscriber chooses to no longer receive such distant signal from such carrier.'';

(iv) in subparagraph (C)—

(I) by striking ''analog'';

(II) in clause (i), by striking ''the Satellite Home Viewer Extension and Reauthorization Act of 2004'' and inserting ''the Satellite Home Viewer Reauthorization Act of 2009''; and

(III) by amending clause (ii) to read as follows:

''(ii) either—

''(I) at the time such person seeks to subscribe to receive such secondary transmission, resides in a local market where the satellite carrier makes available to that person the signal of a local network station affiliated with the same television network pursuant to section 338, and the retransmission of such signal by such carrier can reach such subscriber; or

''(II) receives from the satellite carrier the programming of a network station affiliated with the same network that is broadcast by a local station in the market where the subscriber resides, but such programming is not contained within the local station's primary video.'';

(v) in subparagraph (D)—

(I) in the heading, by striking ''DIGITAL'';

(II) by striking clauses (i), (iii) through (v), (vii) through (ix), and (xi);

(III) by redesignating clause (vi) as clause (i) and transferring such clause to appear before clause (ii);

(IV) by amending such clause (i) (as so redesignated) to read as follows:

''(i) SIGNAL TESTING.—A subscriber shall be eligible to receive a distant signal of a distant network station affiliated with the same network under this section if such subscriber is determined, based on a test conducted in accordance with section 73.686(d) of title 47, Code of Federal Regulations, or any successor regulation, not to be able to receive a signal that exceeds the signal intensity standard in section 73.622(e)(1) of title 47, Code of Federal Regulations.'';

(V) in clause (ii)—

(aa) by striking ''DIGITAL'' in the heading;

(bb) by striking ''digital'' the first two places such term appears;

(cc) by striking ''Satellite Home Viewer Extension and Reauthorization Act of 2004'' and inserting ''Satellite Home Viewer Reauthorization Act of 2009''; and

(dd) by striking '', whether or not such subscriber elects to subscribe to local digital signals'';

(VI) by inserting after clause (ii) the following new clause:

''(iii) TIME-SHIFTING PROHIBITED.—In a case in which the satellite carrier makes available to an eligible subscriber under this subparagraph the signal of a local network station pursuant to section 338, the carrier may only provide the distant signal of a station affiliated with the same network to that subscriber if, in the case of any local market in the 48 contiguous States of the United States, the distant signal is the secondary transmission of a station whose prime time network programming is generally broadcast simultaneously with, or later than, the prime time network programming of the affiliate of the same network in the local market.''; and

(VII) by redesignating clause (x) as clause (iv); and

(vi) in subparagraph (E), by striking ''distant analog signal or'' and all that follows through ''(B), or (D))'' and inserting ''distant signal'';

(2) in subsection (c)—

(A) by amending paragraph (3) to read as follows:

''(3) ESTABLISHMENT OF IMPROVED PREDICTIVE MODEL AND ON-LOCATION TESTING REQUIRED.—

''(A) PREDICTIVE MODEL.—Within 180 days after the date of the enactment of the Satellite Home Viewer Reauthorization Act of 2009, the Commission shall take all actions necessary to develop and prescribe by rule a point-to-point predictive model for reliably and presumptively determining the ability of individual locations, through the use of a conventional, stationary, outdoor rooftop receiving antenna, to receive signals in accordance with the signal intensity standard in section 73.622(e)(1) of title 47, Code of Federal Regulations, including to account for the continuing operation of translator stations and low power television stations. In prescribing such model, the Commission shall rely on the Individual Location Longley-Rice model set forth by the Commission in CS Docket No. 98-201, as previously revised with respect to analog signals, and as recommended by the Commission with respect to digital signals in its Report to Congress in ET Docket No. 05-182, FCC 05-199 (released December 9, 2005). The Commission shall establish procedures for the continued refinement in the application of the model by the use of additional data as it becomes available.

''(B) ON-LOCATION TESTING.—The Commission shall issue an order completing its rulemaking proceeding in ET Docket No. 06-94 within 180 days after the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009.

''(C) STUDY OF TYPES OF ANTENNAS AVAILABLE TO RECEIVE DIGITAL SIGNALS.—

''(i) STUDY REQUIRED.—Not later than 1 year after the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, the Commission shall complete a study regarding whether, for purposes of identifying if a household is unserved by an adequate digital signal under section 119(d)(10) of title 17, United States Code, the digital signal strength standard in section 73.622(e)(1) of title 47, Code of Federal Regulations, or the testing procedures in section 73.686 of title 47, Code of Federal Regulations, such statutes or regulations should be revised to take into account the types of antennas that are available to and used by consumers.

''(ii) STUDY CONSIDERATION.—In conducting the study under clause (i), the Commission shall consider whether to account for the fact that an antenna can be mounted on a roof or placed in a home and can be fixed or capable of rotating.

''(iii) REPORT.—Not later than 1 year after the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, the Commission shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate a report containing—

''(I) the results of the study conducted under clause (i); and

''(II) recommendations, if any, regarding changes to be made to Federal statutes or regulations.'';

(B) by amending paragraph (4)(A) to read as follows:

''(A) IN GENERAL.—If a subscriber's request for a waiver under paragraph (2) is rejected and the subscriber submits to the subscriber's satellite carrier a request for a test verifying the subscriber's inability to receive a signal of the signal intensity referenced in clause (i) of subsection (a)(2)(D), the satellite carrier and the network station or stations asserting that the retransmission is prohibited with respect to that subscriber shall select a qualified and independent person to conduct the test referenced in such clause. Such test shall be conducted within 30 days after the date the subscriber submits a request for the test. If the written findings and conclusions of a test conducted in accordance with such clause demonstrate that the subscriber does not receive a signal that meets or exceeds the requisite signal intensity standard in such clause, the subscriber shall not be denied the retransmission of a signal of a network station under section 119(d)(10)(A) of title 17, United States Code.'';

(C) in paragraph (4)(B), by striking ''the signal intensity'' and all that follows through ''United States Code'' and inserting ''such requisite signal intensity standard''; and

(D) in paragraph (4)(E), by striking ''Grade B intensity''.

(c) SECTION 340.—Section 340(i) is amended by striking paragraph (4).

SEC. 205. APPLICATION PENDING COMPLETION OF RULEMAKINGS.

(a) IN GENERAL.—During the period beginning on the date of the enactment of this Act and ending on the date on which the Federal Communications Commission adopts rules pursuant to the amendments to the Communications Act of 1934 made by sections 203 and 204 of this Act, the Federal Communications Commission shall follow its rules and regulations promulgated pursuant to sections 338, 339, and 340 of the Communications Act of 1934 as in effect on the day before the date of enactment of this Act.

(b) TRANSLATOR STATIONS AND LOW POWER TELEVISION STATIONS.—Notwithstanding subsection (a), for purposes of determining whether a subscriber within the local market served by a translator station or a low power television station affiliated with a television network is eligible to receive distant signals under section 339 of the Communications Act of 1934, the Federal Communications Commission shall follow its rules and regulations for determining such subscriber's eligibility as in effect on the day before the date of enactment of this Act until the date on which the translator station or low power television station is licensed to broadcast a digital signal.

(c) DEFINITIONS.—As used in this title:

(1) LOCAL MARKET; LOW POWER TELEVISION STATION; SATELLITE CARRIER; SUBSCRIBER; TELEVISION BROADCAST STATION.—The terms ''local market'', ''low power television station'', ''satellite carrier'', ''subscriber'', and ''television broadcast station'' have the meanings given such terms in section 338(k) of the Communications Act of 1934.

(2) NETWORK STATION; TELEVISION NETWORK.—The terms ''network station'' and ''television network'' have the meanings given such terms in section 339(d) of such Act.

SEC. 206. PROCESS FOR ISSUING QUALIFIED CARRIER CERTIFICATION.

Part I of title III is amended by adding at the end the following new section:

''SEC. 342. PROCESS FOR ISSUING QUALIFIED CARRIER CERTIFICATION.

''(a) CERTIFICATION.—The Commission shall issue a certification for the purposes of section 119(g)(3)(A)(iii) of title 17, United States Code, if the Commission determines that—

''(1) a satellite carrier is providing local service pursuant to the statutory license under section 122 of such title in each designated market area; and

''(2) with respect to each designated market area in which such satellite carrier was not providing such local service as of the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009—

''(A) the satellite carrier's satellite beams are designed, and predicted by the satellite manufacturer's pre-launch test data, to provide a good quality satellite signal to at least 90 percent of the households in each such designated market area based on the most recent census data released by the United States Census Bureau; and

''(B) there is no material evidence that there has been a satellite or sub-system failure subsequent to the satellite's launch that precludes the ability of the satellite carrier to satisfy the requirements of subparagraph (A).

''(b) INFORMATION REQUIRED.—Any entity seeking the certification provided for in subsection (a) shall submit to the Commission the following information:

''(1) An affidavit stating that, to the best of the affiant's knowledge, the satellite carrier provides local service in all designated market areas pursuant to the statutory license provided for in section 122 of title 17, United States Code, and listing those designated market areas in which local service was provided as of the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009.

''(2) For each designated market area not listed in paragraph (1):

''(A) Identification of each such designated market area and the location of its local receive facility.

''(B) Data showing the number of households, and maps showing the geographic distribution thereof, in each such designated market area based on the most recent census data released by the United States Census Bureau.

''(C) Maps, with superimposed effective isotropically radiated power predictions obtained in the satellite manufacturer's prelaunch tests, showing that the contours of the carrier's satellite beams as designed and the geographic area that the carrier's satellite beams are designed to cover are predicted to provide a good quality satellite signal to at least 90 percent of the households in such designated market area based on the most recent census data released by the United States Census Bureau.

''(D) For any satellite relied upon for certification under this section, an affidavit stating that, to the best of the affiant's knowledge, there have been no satellite or sub-system failures subsequent to the satellite's launch that would degrade the design performance to such a degree that a satellite transponder used to provide local service to any such designated market area is precluded from delivering a good quality satellite signal to at least 90 percent of the households in such designated market area based on the most recent census data released by the United States Census Bureau.

''(E) Any additional engineering, designated market area, or other information the Commission considers necessary to determine whether the Commission shall grant a certification under this section.

''(c) CERTIFICATION ISSUANCE.—

''(1) PUBLIC COMMENT.—The Commission shall provide 30 days for public comment on a request for certification under this section.

''(2) DEADLINE FOR DECISION.—The Commission shall grant or deny a request for certification within 90 days after the date on which such request is filed.

''(d) SUBSEQUENT AFFIRMATION.—An entity granted qualified carrier status pursuant to section 119(g) of title 17, United States Code, shall file an affidavit with the Commission 30 months after such status was granted stating that, to the best of the affiant's knowledge, it is in compliance with the requirements for a qualified carrier.

''(e) DEFINITIONS.—For the purposes of this section:

''(1) DESIGNATED MARKET AREA.—The term 'designated market area' has the meaning given such term in section 122(j)(2)(C) of title 17, United States Code.

''(2) GOOD QUALITY SATELLITE SIGNAL.—

''(A) IN GENERAL.—The term ''good quality satellite signal'' means—

''(i) a satellite signal whose power level as designed shall achieve reception and demodulation of the signal at an availability level of at least 99.7 percent using—

''(I) models of satellite antennas normally used by the satellite carrier's subscribers; and

''(II) the same calculation methodology used by the satellite carrier to determine predicted signal availability in the top 100 designated market areas; and

''(ii) taking into account whether a signal is in standard definition format or high definition format, compression methodology, modulation, error correction, power level, and utilization of advances in technology that do not circumvent the intent of this section to provide for non-discriminatory treatment with respect to any comparable television broadcast station signal, a video signal transmitted by a satellite carrier such that—

''(I) the satellite carrier treats all television broadcast stations' signals the same with respect to statistical multiplexer prioritization; and

''(II) the number of video signals in the relevant satellite transponder is not more than the then current greatest number of video signals carried on any equivalent transponder serving the top 100 designated market areas.

''(B) DETERMINATION.—For the purposes of subparagraph (A), the top 100 designated market areas shall be as determined by Nielsen Media Research and published in the Nielsen Station Index Directory and Nielsen Station Index United States Television Household Estimates or any successor publication as of the date of a satellite carrier's application for certification under this section.''.

SEC. 207. NONDISCRIMINATION IN CARRIAGE OF HIGH DEFINITION DIGITAL SIGNALS OF NONCOMMERCIAL EDUCATIONAL TELEVISION STATIONS.

(a) IN GENERAL.—Section 338(a) is amended by adding at the end the following new paragraph:

''(5) NONDISCRIMINATION IN CARRIAGE OF HIGH DEFINITION SIGNALS OF NONCOMMERCIAL EDUCATIONAL TELEVISION STATIONS.—

''(A) EXISTING CARRIAGE OF HIGH DEFINITION SIGNALS.—If, prior to the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, an eligible satellite carrier is providing, under section 122 of title 17, United States Code, any secondary transmissions in high definition to subscribers located within the local market of a television broadcast station of a primary transmission made by that station, then such satellite carrier shall carry the high-definition signals of qualified noncommercial educational television stations located within that local market in accordance with the following schedule:

''(i) By December 31, 2010, in at least 50 percent of the markets in which such satellite carrier provides such secondary transmissions in high definition.

''(ii) By December 31, 2011, in every market in which such satellite carrier provides such secondary transmissions in high definition.

''(B) NEW INITIATION OF SERVICE.—If, after the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, an eligible satellite carrier initiates the provision, under section 122 of title 17, United States Code, of any secondary transmissions in high definition to subscribers located within the local market of a television broadcast station of a primary transmission made by that station, the such satellite carrier shall carry the high-definition signals of all qualified noncommercial educational television stations located within that local market.''.

(b) DEFINITIONS.—Section 338(k) is amended—

(1) by redesignating paragraphs (2) through (8) as paragraphs (3) through (9), respectively;

(2) by inserting after paragraph (1) the following new paragraph:

''(2) ELIGIBLE SATELLITE CARRIER.—The term 'eligible satellite carrier' means any satellite carrier that is not a party to a carriage contract with a qualified noncommercial educational television station, or its representative, that is in force and effect as of the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009.'';

(3) by redesignating paragraphs (6) through (9) (as previously redesignated) as paragraphs (7) through (10), respectively; and

(4) by inserting after paragraph (5) (as so redesignated) the following new paragraph:

''(6) QUALIFIED NONCOMMERCIAL EDUCATIONAL TELEVISION STATION.—The term 'qualified noncommercial educational television station' has the meaning given such term in section 615(l)(1) of this Act.''.

SEC. 208. SAVINGS CLAUSE REGARDING USE OF NON-COMPULSORY LICENSES.

(a) IN GENERAL.—Nothing in this title, the Communications Act of 1934, or regulations promulgated by the Federal Communications Commission under this title or the Communications Act of 1934 shall be construed to prevent a multichannel video programming distributor from retransmitting a performance or display of a work pursuant to an authorization granted by the copyright owner or, if within the scope of its authorization, its licensee.

(b) LIMITATION.—Nothing in subsection (a) shall be construed to affect any obligation of a multichannel video programming distributor under section 325(b) of the Communications Act of 1934 to obtain the authority of a television broadcast station before retransmitting that station's signal.

SEC. 209. SAVINGS CLAUSE REGARDING DEFINITIONS.

Nothing in this title or the amendments made by this title shall be construed to affect—

(1) the meaning of the terms ''program related'' and ''primary video'' under the Communications Act of 1934; or

(2) the meaning of the term ''multicast'' in any regulations issued by the Federal Communications Commission.

TITLE III—REPORTS

SEC. 301. DEFINITION.

In this title, the term ''appropriate Congressional committees'' means the Committees on the Judiciary and on Commerce, Science, and Transportation of the Senate and the Committees on the Judiciary and on Energy and Commerce of the House of Representatives.

SEC. 302. REPORT ON MARKET BASED ALTERNATIVES TO STATUTORY LICENSING.

Not later than 1 year after the date of the enactment of this Act, and after consultation with the Federal Communications Commission, the Register of Copyrights shall submit to the appropriate Congressional committees a report containing—

(1) proposed mechanisms, methods, and recommendations on how to implement a phase-out of the statutory licensing requirements set forth in sections 111, 119, and 122 of title 17, United States Code, by making such sections inapplicable to the secondary transmission of a performance or display of a work embodied in a primary transmission of a broadcast station that is authorized to license the same secondary transmission directly with respect to all of the performances and displays embodied in such primary transmission;

(2) any recommendations for alternative means to implement a timely and effective phase-out of the statutory licensing requirements set forth in sections 111, 119, and 122 of title 17, United States Code; and

(3) any recommendations for legislative or administrative actions as may be appropriate to achieve such a phase-out.

SEC. 303. REPORT ON COMMUNICATIONS IMPLICATIONS OF STATUTORY LICENSING MODIFICATIONS.

(a) STUDY.—The Comptroller General shall conduct a study that analyzes and evaluates the changes to the carriage requirements currently imposed on multichannel video programming distributors under the Communications Act of 1934 (47 U.S.C. 151 et seq.) and the regulations promulgated by the Federal Communications Commission that would be required or beneficial to consumers, and such other matters as the Comptroller General deems appropriate, if Congress implemented a phase-out of the current statutory licensing requirements set forth under sections 111, 119, and 122 of title 17, United States Code. Among other things, the study shall consider the impact such a phase-out and related changes to carriage requirements would have on consumer prices and access to programming.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall report to the appropriate Congressional committees the results of the study, including any recommendations for legislative or administrative actions.

SEC. 304. REPORT ON IN-STATE BROADCAST PROGRAMMING.

Not later than 1 year after the date of enactment of this Act, the Federal Communications Commission shall submit to the appropriate Congressional committees a report containing an analysis of—

(1) the number of households in a State that receive local broadcast stations from a station of license that is located in a different State;

(2) the extent to which consumers have access to in-state broadcast programming; and

(3) whether there are alternatives to the use of designated market areas, as defined in section 122 of title 17, United States Code, to define local markets that would provide more consumers with in-state broadcast programming.

TITLE IV—SEVERABILITY

SEC. 401. SEVERABILITY.

If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of such provision or amendment to any person or circumstance shall not be affected thereby.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Michigan (Mr. CONYERS) and the gentleman from Texas (Mr. SMITH) each will control 20 minutes.

The Chair recognizes the gentleman from Michigan.

GENERAL LEAVE

Mr. CONYERS. Madam Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

Mr. CONYERS. I also further ask unanimous consent that the gentleman from Virginia (Mr. BOUCHER) be yielded 10 minutes of my time and that he be allowed to control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

Mr. CONYERS. I yield myself such time as I may consume.

Madam Speaker and Members, H.R. 3570 extends the compulsory copyright license for satellite television providers for another 5 years, as Congress has done in each of the last two other cycles that this measure has been reauthorized.

□ 1715

This is an important intellectual property law and will also make a number of critical updates and much-needed clarifications to the compulsory copyright licenses for both satellite and cable television. Passage of this legislation before the end of the year is crucial. We must pass this bill in both bodies by December 31. If we don't pass this bill, thousands upon thousands of satellite television subscribers will lose their signals.

In addition to simply reauthorizing the license, the bill ambitiously tackles several other issues for consumers, for content owners, and for cable and satellite companies as well. For example, this bill restores the section 119 license to DISH Satellite Network if they serve every market in the United States, even neglected rural markets. The bill also resolves the phantom signal problem that has caused instability and confusion for the cable and content industries, to the detriment of consumers.

In addition, the bill provides an audit right to content owners so they can be sure that they are being fairly compensated for the use of their intellectual property. It significantly increases penalties for copyright infringement under the licenses and updates the licenses to reflect the national digital television transition.

The Judiciary Committee marked this bill up in September and reported it with a unanimous vote of 34–0. Since the markup, we have worked with the Energy and Commerce Committee, which has jurisdiction over communications policy. The bill that we vote on today is a combined Judiciary and Commerce bill. Title I contains the Judiciary piece on copyright. Title II contains the Commerce piece on communications. The committees have done their best to respect each other's jurisdiction, and I thank the chairman of the committee for his cooperation.

Since the markup, we have made further improvements to the language. We've attempted to address some concerns expressed by members of the

committee. The changes include: Harmonizing the so-called ''grandfathering'' provisions in the bill with those in the Energy and Commerce bill to ensure that consumers who lawfully receive certain kinds of programming are not abruptly cut off because of changes in the law; providing a method for calculating the value of multicast programming schemes under the section 111 license; strengthening the protections for copyright owners in the qualified carrier provision, which provides an incentive for a satellite carrier to serve every market in the United States; increasing the effectiveness of the national emergency provisions; and authorizing a study of how the compulsory licenses may be phased out in favor of direct negotiation for copyrights over time without disrupting the television marketplace.

Title I also includes a savings clause to make absolutely clear that the changes we make and issues we address have no application to communications law unless specifically mentioned. The committee is amending the cable and satellite licenses to reflect the digital transition—something new—and multicasting, in particular, as it pertains to copyright law only. Nothing in this title should be used as a basis for conclusions concerning cable and satellite regulation in areas where Congress has not yet spoken.

Among the many Members who contributed to this progress, I would like to single out in particular my good friend from Virginia, RICK BOUCHER, who serves in the dual role as a senior member of the Judiciary Committee and the Chair of the Telecommunications Subcommittee. I also must thank LAMAR SMITH, the ranking member of the Judiciary Committee, for helping work to improve the bill in several ways. Of course the distinguished chairman of Energy and Commerce, Chairman HENRY WAXMAN, and Ranking Member BARTON for all their counsel and cooperation which made this legislation possible.

We've been working on these issues for more than a year now, and the result is a consensus bill among just about all of the industry stakeholders, including satellite and cable companies, studios, sports leagues, public television and several others. Most importantly, it's a bill that improves service to television consumers and fosters efficiency and competition between cable, satellite, and broadcasters. The satellite license expires in less than a month, December 31, and we must have this reauthorized without delay to avoid the immediate loss of service to tens of thousands of satellite consumers.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC, October 28, 2009.

Hon. JOHN CONYERS, Jr.,
Chairman, Committee on the Judiciary, House of Representatives, Washington, DC.

DEAR CHAIRMAN CONYERS: I write to you regarding H.R. 3570, the ''Satellite Home Viewer Update and Reauthorization Act of 2009.''

H.R. 3570 contains provisions that fall within the jurisdiction of the Committee on Homeland Security. I recognize and appreciate your desire to bring this legislation before the House in an expeditious manner and, accordingly, I will not seek a sequential referral of the bill. However, agreeing to waive consideration of this bill should not be construed as the Committee on Homeland Security waiving, altering, or otherwise affecting its jurisdiction over subject matters contained in the bill which fall within its Rule X jurisdiction.

Further, I request your support for the appointment of an appropriate number of Members of the Committee on Homeland Security to be named as conferees during any House-Senate conference convened on H.R. 3570 or similar legislation. I also ask that a copy of this letter and your response be included in the legislative report on H.R. 3570 and in the Congressional Record during floor consideration of this bill.

I look forward to working with you as we prepare to pass this important legislation.

Sincerely,

BENNIE G. THOMPSON,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC, October 28, 2009.

Hon. BENNIE G. THOMPSON,
Chairman, Committee on Homeland Security, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for your letter regarding your Committee's jurisdictional interest in H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009.

I appreciate your willingness to support expediting floor consideration of this important legislation today. I understand and agree that this is without prejudice to your Committee's jurisdictional interests in this or similar legislation in the future. In the event a House-Senate conference on this or similar legislation is convened, I would support your request for an appropriate number of conferees.

Per your request, I will include a copy of your letter and this response in the Committee report, as well as in the Congressional Record in the debate on the bill. Thank you for your cooperation as we work towards enactment of this legislation.

Sincerely,

JOHN CONYERS, Jr.,
Chairman.

I urge my colleagues to support this important legislation, and I reserve the balance of my time.

Mr. SMITH of Texas. Madam Speaker, I yield myself as much time as I may consume.

H.R. 3570, the Satellite Home Viewer Reauthorization Act of 2009, in my judgment, is the single most important copyright bill Congress will consider this year. The legislation combines two separate bills: H.R. 3570, which was introduced by Chairman CONYERS and reported by the Judiciary Committee on September 16, 2009, and H.R. 2994, which is the Energy and Commerce Committee's related measure that contains amendments to the Communications Act.

The combined bill extends the compulsory license in section 119 of the Copyright Act that authorizes satellite carriers to deliver distant network programming to subscribers. Far fewer consumers rely upon this license to receive network programming than in past years, but there still remain about 1 million households that will lose such programming if the license is not extended beyond the end of this year, which is when it is currently due to expire. To avoid this outcome, the bill extends the compulsory license an additional 5 years to December 31, 2014. My hope is that this will be the last time Congress needs to reauthorize what was originally envisioned to be a temporary license.

H.R. 3570 also contains a number of significant amendments to the cable license in section 111 of the Copyright Act governing the retransmission of both local and distant programming, and the local programming license in section 122 that governs the satellite retransmission of local-into-local programming. The most significant immediate change to the cable license is a negotiated resolution of the phantom signal liability issue that I appreciate the chairman including in this bill.

I commend Chairman CONYERS for his decision to expand this reauthorization beyond the narrow limits of the expiring section 119 provisions. While circumstances prevented us from being able to iron out all the wrinkles from these related licenses, I'm pleased we were able to make substantial improvements and address some of the most urgent concerns. Among the elements for which there was bipartisan support to include in this bill are provisions that, one, modernize a license to account for digital broadcasting; two, preserve the ability of consumers to continue to receive lifeline network programming; three, make clear that copyright owners are generally entitled to a royalty for each stream of multicast programming; and four, establish a new audit right to permit copyright owners to make sure they are being paid the royalties they are entitled to.

Madam Speaker, I have strong reservations about the decision to permit DISH Network to again benefit from section 119's distant signal license in light of its prior record of willful infringement. However, I share the goal of making sure more Americans can benefit from satellite delivery of local-into-local programs. I'm grateful for Chairman CONYERS' recognition of the seriousness of these concerns and his willingness to work with me and Chairman BERMAN to strengthen the deterrence and enforcement provisions in

the bill. The enhanced penalties we've included for any future violation, along with provisions that require the GAO to audit DISH for its compliance with the law and DISH to certify its compliance to the Federal District Court, reflects substantial improvements from previous versions of the bill. The incorporation of these provisions reflect a carefully negotiated and fair compromise.

Madam Speaker, I urge my colleagues to support H.R. 3570, the Satellite Home Viewer Reauthorization Act. When enacted, this bill will both preserve and expand the ability of Americans to view vital network and independent station programming without interruption.

Madam Speaker, again, I want to thank the chairman for working with us to come up with a good bipartisan product. And this bipartisan effort, by the way, has gone on since last February.

I would now like to recognize several staff members on both sides of the aisle who have contributed so much to the success of this legislation. Those staff members would include David Whitney, sitting to my left here on the House floor on our side; and on the majority's side it would be Stacey Dansky, the chief copyright counsel, and Elizabeth Kendall, counsel as well. I thank Chairman CONYERS again for his cooperative efforts in getting this House bill to the floor today.

I ask unanimous consent that the gentleman from Florida (Mr. STEARNS), a senior member of the Commerce Committee, be able to control the remainder of the time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. SMITH of Texas. With that, I will reserve the balance of the time.

Mr. CONYERS. Madam Speaker, I would like to insert into the RECORD at this point a more detailed description of the changes that have been made in the bill since it was reported.

EXPLANATION OF CHANGES TO SHVRA

INTRODUCTION

The Committee believes that the licenses in Sections 111 and 119 should be updated to accommodate the growing practice of multicast broadcasting, by which television stations transmit multiple streams of digital television programming over a single broadcast signal. While the Committee has endeavored to avoid including in the bill any provisions that would interfere with existing communications law and regulation, the Committee has been cognizant of the interplay between the copyright and the communications elements of the legislation and intends to confine its amendments to the copyright licenses only.

In addition to addressing issues raised by multicasting in the 111 and 119 licenses, this bill addresses important concerns raised by Members at markup.

The penalties for willful and large-scale infringement of the license have been increased, and some damages now go directly to the pool of copyright owners.

The qualified carrier provisions have also been clarified and strengthened. While nothing in the qualified carrier provisions reported by the Committee lessened the qualified carrier's obligation to comply with all aspects of the Section 119 license, the Committee recognizes that the royalty and household eligibility requirements of the Section 119 license should not be overshadowed by the qualified carrier's unique commitment to provide local-into-local service to all 210 markets. Therefore, the bill provides for at least one compliance examination and a certification requirement for the qualified carrier.

Finally, the bill responds to some Members' concerns about the continued necessity of these compulsory copyright licenses by providing for a study of policy alternatives that may enable Congress to phase out the licenses without unfairly altering the television market or diminishing the value of the copyrights involved.

I. SECTION 111 MULTICASTING

With the transition from analog to digital technology, questions have arisen as to how digital streams shall be treated for cable royalty purposes. The definitions in Section 111 have been amended to address the multiple digital streams that television stations are now able to transmit. The definition of ''primary transmission'' now includes both the primary stream and any multicast streams transmitted by a television station. The ''local service area'' definition has been amended to clarify that the primary stream of a television broadcast station and any multicast streams of that station have the same local service area. For example, if the FCC has determined that a television broadcast station is ''significantly viewed'' in a particular area, that area will be part of the local service area of all of the station's digital streams for purposes of section 111. This definition is relevant to the Copyright Act only, and is not intended to create any inference in favor or against carriage obligations for cable multicast streams, which are the exclusive jurisdiction of the Communications Act and the Federal Communications Commission.

The calculation of royalties under the cable license has been amended to value multicast signals. The ''distant signal equivalent'' definition now specifies that each non-simulcast primary and multicast stream carried outside of its local service area will be subject to a separate royalty payment calculation by cable operators and should be evaluated separately to determine its distant signal equivalent value assignment.

Section 111 allows cable systems to pay less than full DSE rates where FCC rules permit only a portion of a distant signal to be carried. This amendment gives the same treatment to multicast streams. The significantly viewed status of a primary stream under the FCC rules and regulations also applies to the multicast streams of the same television stations, to determine distant or local status for royalty purposes. However, the 3.75 percent ''market quota rate'' and the ''syndicated exclusivity'' surcharge royalty rates are only payable for retransmission of primary streams, and are not applicable to secondary transmission of multicast streams.

In order to clarify the different types of digital streams that may be offered by television stations, definitions for ''primary stream,'' and ''multicast stream'' have been slightly altered and a definition has been added for ''simulcast stream,'' in Section 111. A ''primary stream'' is the digital stream that a television station is entitled to demand be carried by cable systems located within the station's local service area under the FCC's rules in effect on July 1, 2009. A ''multicast stream'' is any digital stream transmitted by a television station other than the primary stream.

The Committee recognizes that some broadcasters may use their multicast streams to create ''simulcast'' streams—i.e., streams that duplicate the programming on the broadcaster's primary stream or on other multicast streams. For example, a broadcaster may transmit the same content on two streams, but one stream will be in high definition format and the other will be in standard definition. In such instances, a DSE value will be assigned only to one of the duplicating streams. The Copyright Office may, as multicasting evolves, determine whether there are other circumstances in which two streams should be considered duplicating.

The definitions of ''network station,'' ''independent station,'' and ''noncommercial station'' have all been expanded to include a television station's multicast streams as well as its primary stream. The ''network station'' definition incorporates the conditions under which a multicast stream may be deemed a network station for royalty purposes. Thus, to be considered a network station for royalty purposes, a multicast stream must transmit all or substantially all of the programming from an interconnected program service that (a) is owned and operated by one or more of the networks that supply nationwide programming for a substantial part of the typical broadcast day and (b) offers programming on a regular basis for 15 or more hours per week to at least 25 affiliated television station licensees located in at least 10 states. These revisions do not alter the statutory definition of ''network station'' as it applies to a primary stream.

DSE values are applied to individual multicast streams as of the date of enactment, except where a cable system was retransmitting a distant multicast stream prior to that date, in which case the assignment of a DSE value to that multicast stream shall commence on July 1, 2010. Separately, a multicast stream retransmitted by a cable system subject to an agreement requiring carriage of multicast streams that was entered into prior to July 1, 2009 will not be assigned a DSE value for royalty purposes until the first accounting period after the expiration of the agreement.

While cable operators that did not account for multicast streams in their royalty calculations prior to the effective date are not retroactively liable for royalties for such carriage, cable operators that did may not seek refunds or offsets of any royalties paid on account of such secondary transmissions.

The Committee does not intend that any of its audit provisions in this bill alter existing liability and related damages for copyright infringements.

II. SECTION 119 GRANDFATHERING

The Committee also believes that simply because Congress changes the law, law-abiding consumers should not be deprived of programming they have become accustomed to receiving without fair warning. In Section 119, where changes to the law that govern the treatment of multicast streams have the potential to render certain consumers ineligible for distant signals that consumers are currently receiving, grandfathering provisions have been added to facilitate a smooth transition to the changed compulsory license system.

Households classified as ''unserved'' with respect to a particular network station are the only households eligible to receive secondary transmissions of an affiliate of that network station under the Section 119 license. The advent of multicasting has introduced confusion about whether a ''multicast stream'' of a particular network renders a household served, which would force the satellite carrier to stop providing distant signal programming to the household for that network.

The bill harmonizes the preexisting grandfathering provisions with those in the Energy and Commerce bill to ensure a smooth transition to a new regime in which, in three years' time, any stream of local programming, primary or multicast, will render a household served. Specifically, the bill provides that households that subscribed to distant signals before the date of enactment who were lawfully receiving them can keep those distant signals until the subscriber elects to no longer receive those signals.

A household that requests a network's distant signal from a satellite carrier after enactment can receive such a signal if: (1) the household is in a market where the satellite carrier offers local service, but does not yet receive from the satellite carrier the primary stream of an affiliate of that network that originates within its local market (in which case the subscriber can keep the distant signal until he or she does receive such stream from the satellite carrier); or (2) the household is in a market where the satellite operator does not yet offer local service (in which case the subscriber can keep the distant signal until he or she decides to discontinue it).

III. INCREASED PROTECTIONS FOR COPYRIGHT OWNERS IN SECTION 119

The bill also responds to concerns expressed by Committee Members at the markup by increasing transparency and accountability by the qualified carrier concerning its obligations to copyright owners. A certification provision similar to the one passed by the Committee on Energy and Commerce has been added. It requires the satellite carrier to certify to the district court and the Copyright Office that it remains compliant with the license 30 months after the district court initially recognized the satellite company as a qualified carrier.

The bill provides for at least one Qualified Carrier Compliance Examination. This examination is not intended to be punitive. The Committee anticipates that the Comptroller General will take precautions to ensure that compliance with its examination does not burden the qualified carrier any more than is necessary to examine the qualified carrier's observance of the proper royalty calculation, payment and adherence to the license's standards for eligible households. Only if the Comptroller General, in consultation with the Register of Copyrights, determines that there is a substantial likelihood that a copyright owner could bring a successful infringement action will a second examination be initiated.

The report does not replace the judgment of the district court, which retains exclusive jurisdiction over the waiver of the injunction and assessment of damages against the qualified carrier.

The Committee has taken one other additional step to strengthen protections for content-owners. The Committee has increased the damages available for infringement of copyright by any satellite carrier who engages in a pattern or practice of wrongful provision of distant signals on a substantially national basis. Statutory damages of up to $2,500,000 are now available for each 3-month period of infringement. Furthermore, these vastly increased damages will be split between the plaintiff and the pool of copyright holders whose funds are distributed by the United States Copyright Office, to compensate copyright owners who may have been unaware of the infringement.

IV. STUDY OF ALTERNATIVES TO COMPULSORY LICENSES

Despite these improvements, the Committee is aware that the compulsory license is not a perfect system. It is, however, deeply entrenched in the current cable and satellite television industries, and cannot be eliminated at the present moment without causing serious disruption for both the industries and the consumers. The compulsory license expires at the end of the year and must be reauthorized, but we know that the television marketplace and broadcast technology will continue to evolve. This legislation provides for a study of whether the licenses can be eliminated in the future, and how the marketplace could and should transition away from the licenses.

Madam Speaker, I yield with pleasure to Chairman BOUCHER.

Mr. BOUCHER. Madam Speaker, I thank the gentleman from Michigan for yielding the customary 10 minutes to the Energy and Commerce Committee.

At this time, I would like to yield such time as he may consume to the gentleman from the State of California (Mr. WAXMAN), the chairman of the full Energy and Commerce Committee.

Mr. WAXMAN. Madam Speaker, I rise in support of H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009. I want to commend Mr. BOUCHER, the chairman of the Subcommittee on Communications, Technology, and the Internet as well as Subcommittee Ranking Member STEARNS for their hard work on this bill. Mr. BOUCHER has been working on these issues since the first satellite TV bill in 1988, and he and his staff have been a tremendous resource for all of us as this bill has moved forward. Of course I also want to thank and recognize Mr. BARTON and his staff for their work on this legislation. This has been a bipartisan effort from the start of the 111th Congress, and I appreciate the cooperative manner in which this legislation was processed.

This bill is an important step forward for consumers. The communication provisions of this bill update the Communications Act to take account of the transition to digital television. The bill makes changes to the existing rules on ''significantly viewed'' signals in an effort to promote competition between satellite and cable companies. It directs the FCC to study issues that directly impact consumers, and it establishes a regime that should bring for the first time satellite-delivered local television programming, so-called ''local-into-local'' service, to communities throughout the country that currently lack such service.

These can be arcane issues, but they determine the availability of satellite-delivered video programming to American households. It involves communications and copyright law, and we need, as technology evolves, to revisit the issues and strike the right policy balance.

The task of combining separate Energy and Commerce and Judiciary Committee bills into a single product was complex and time consuming, but the final product is a balanced, bipartisan measure. I would like to commend Chairman CONYERS, Ranking Member SMITH and Judiciary Committee staff for working cooperatively with the Energy and Commerce Committee to produce a final bill. I note that the bill before us incorporates the language of H.R. 3570 as well as H.R. 2994. H.R. 3570 was referred solely to the Committee on the Judiciary, while H.R. 2994 was referred solely to the Committee on Energy and Commerce. The members of both committees worked diligently on their respective bills to address issues within the jurisdiction of each committee, and both committees filed reports on their separate bills.

Accordingly, the legislative history of H.R. 3570 incorporates the legislative history of H.R. 2994. The Judiciary Committee's title of this bill concerns the use of compulsory copyright licenses by cable and satellite companies to retransmit broadcast television programming.

□ 1730

The reauthorization and refinement of these provisions will serve to promote competition for pay television services and to ensure that consumers can continue to benefit from this competition.

The Judiciary Committee wisely chose to address for the first time the existence of the so-called ''multicast'' signals and how these signals are being treated with respect to the compulsory copyright license. It is important to note, however, that the Judiciary Committee's treatment of multicast signals does not, and should not, have any bearing on the treatment of multicast signals in other regulatory or statutory contexts.

Simply put, the treatment of multicast in title I of this bill is limited in application to copyright law. It is imperative that the way multicast signals are treated under copyright law cannot be confused with the way multicast signals are treated under communications law. Similarly, it's important that the communications law provisions of this bill do not affect copyright law beyond what is explicitly intended by the act.

To address this concern, the legislation includes savings clauses that make clear that the melding of two complicated statutes should not lead to

changes in title 47 or title 17 beyond the scope of this reauthorization. These clauses are important provisions designed to avoid unintended consequences.

In sum, I believe we have before us a carefully crafted bill that strikes the right balance among an array of complicated legal and policy matters. The bill is good for consumers, and I urge my colleagues to vote to approve this legislation.

Mr. STEARNS. Madam Speaker, I yield myself such time as I may consume.

My colleagues, this bill is about a hundred pages, and the Judiciary Committee had probably the majority of this bill. We start at page 74 in title II, and the preponderance is in the Judiciary. But the bill is critical in the sense that this act itself is going to expire at the end of this month and we need to make sure that this passes.

This has been a great display of bipartisanship. You had two committees. The Judiciary Committee and the Energy and Commerce Committee had separate bills just like they have in the Senate. The Senate has a separate bill in their Commerce Committee and also in the Judiciary. But we've come together, and it's a tribute to Mr. BOUCHER and Mr. WAXMAN as well as Mr. BARTON that we came together here in the House of Representatives with a bipartisan bill, and we now have it on the floor. And we're hopeful that the Senate will do the same thing, because at this point, they haven't, and we might have to have an extension. I hope not. But I think it's been outlined pretty much, some of the aspects about it, so I'm going to concentrate in the areas that deal with telecommunications, a committee I serve as the ranking member.

The Communications Act provisions make clerical and substantive changes to reflect the end of analog broadcasting. That's a statement in itself with the new digital spectrum.

They also require an FCC report on whether the signal strength and antenna standards for distant signal eligibility should be modified in light of the DTV transition. They implement the deal DISH has struck with broadcasters to regain authority to provide distant signals if they offer local-into-local service in all 210 markets. They clarify that nothing in this act affects must-carry rights. They clarify that if a subscriber starts receiving from their satellite operator the network programming from a local station's multicast stream, the subscriber shall no longer receive a distant signal carrying that network's programming. They include language clarifying that restrictions on use of compulsory licenses do not limit private deals negotiated without compulsory licenses, such as to provide in-State programming to orphan counties. It requires an FCC report analyzing, one, the number of households that receive out-of-State signals; two, the extent to which consumers have access to in-State programming; and, three, whether there are alternatives to use of the existing Nielsen-defined markets.

Earlier, LAMAR SMITH, the gentleman from Texas, mentioned there are some things that have to be ironed out, and I think that's true.

While it still contains, in this bill, a provision we opposed in the committee during the markup that tries to twist DISH's arm into carrying public broadcasting stations in high-definition format, and I was the one that spoke against this, the additional views in the committee report reflect our concerns, and there is a chance that provision will become moot since, obviously, the parties are in negotiation, and we're hoping for a favorable negotiation so that will work itself out.

Madam Speaker, I reserve the balance of my time.

Mr. BOUCHER. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, in a collaborative process, the House Energy and Commerce and Judiciary Committees are presenting to the House this afternoon a renewal of the Satellite Home Viewer Act, provisions of which are scheduled to expire at the end of this year. The act enables the delivery by satellite of distant network signals to homes that cannot receive network programming from a local television station.

We're taking the opportunity of this reauthorization to achieve a long-held goal of having all 210 local television markets across the Nation uplinked by satellite for retransmission of those local stations back into the market of their origination. The goal is to ensure that satellite TV subscribers everywhere will be able to receive both national television programs and local TV stations that serve their area.

At the present time, there are 28 local television markets in rural areas in various places of the Nation that do not have local television signals delivered by either of the major satellite television carriers, and much of our effort this year has been directed toward finding a way to obtain satellite carriage of these 28 rural markets for local television signals.

Earlier this year, following extensive discussions with the company, I received a letter from EchoStar, a company commonly known in the trade as the DISH Network, agreeing to uplink for local retransmission all 210 local television markets upon certain conditions. One condition is that the company receive the ability in our legislation to import into the markets distant network signals in order to supply the missing networks in the markets that do not have a full complement of the networks represented by local affiliates. The bill that we're presenting today grants that permission if EchoStar, in fact, provides local TV service in all 210 television markets nationwide.

Another condition of the company's willingness to serve all 210 markets is that the law not impose new carriage obligations that the company would have to devote its satellite capacity in order to meet. While the bill does impose some new carriage obligations, I'm optimistic that they will not be so extreme as to prevent EchoStar from launching local TV service in all 210 local markets over the coming year.

Providing local TV service in the 28 currently unserved local markets will make local TV news, sports, weather, essential emergency information, and locally originated programs available in every part of the Nation, a goal that we're now very close to achieving. Serving the 28 now unserved local TV markets involves a major expenditure by EchoStar for ground-based facilities in each of the currently unserved markets and for the launch, in 2010, of a new satellite that itself will cost hundreds of millions of dollars.

I want to commend EchoStar for expressing a willingness to make these very substantial investments if we pass legislation that meets the conditions I have previously described, and I think our legislation does. I also commend television broadcasters and DirecTV, the other major satellite television provider, both of which groups played highly constructive roles as our negotiations proceeded. And I want to thank the gentleman from Michigan (Mr. STUPAK), a member of our Commerce Committee, for bringing to our attention in very forceful terms the need to serve all of the 28 currently unserved local television markets across our Nation.

The bill before us makes other changes needed to harmonize the satellite carriage licenses with the transition from analog to digital television broadcasting, and it will result in more high-definition carriage of public broadcasting television under the terms of an amendment that was offered by the gentlewoman from California (Ms. ESHOO) and adopted during Commerce Committee consideration of our bill.

I want to say thank you this afternoon to Chairman CONYERS and his excellent staff for the cooperation with my staff and with me as our two committees structured the bill that we present to the House this afternoon. And I want to say thank you to the gentleman from Texas (Mr. SMITH) and the gentleman from Florida (Mr. STEARNS) for the highly constructive and cooperative bipartisan role that they have played in helping us move this measure through our two committees.

Madam Speaker, I urge approval of the bill, and I reserve any time I may have remaining.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. STEARNS. Madam Speaker, I yield 3 minutes to the gentleman from Texas (Mr. BARTON), the distinguished ranking member of the Energy and Commerce Committee.

Mr. BARTON of Texas. I thank the gentleman from Florida for yielding.

Madam Speaker, I rise in support of the Satellite Home Viewer Update and Reauthorization Act of 2009. I want to thank the majority in both the Energy and Commerce Committee and the Judiciary Committee for working with the minority. This is one of those rare instances in this Congress when there has been bipartisan cooperation and the result is a bill that both sides can support.

The bill itself is an example of what Congress should be about. It is an authorization bill with a finite authorization—in this case, 5 years—that authorizes the transfer of satellite signals to home viewers who cannot get cable or over-the-air broadcast signals. The industry today is much different than it was 20 years ago when we first authorized the Satellite Home Viewer Act, and this bill reflects that. As we are transitioning to digital television and high-definition television, this bill takes those technical advances into consideration, which I think is a good thing.

There is one provision in the legislation that is nettlesome from my point of view. We have adopted a provision that I opposed in committee that forces the DISH Network to carry high-definition signals for public broadcast stations. I'm not opposed to public television being broadcast in high definition, but I don't think it's the end of the world if DISH chooses for right now not to carry those signals because they're engaged in an upgrade of their base and won't be able to do so in their business model until 2013. So congressional intervention in this bill in that case is something that I wish was not in the bill. There is a chance, however, that the parties will negotiate and this provision of the bill will become moot by the time the bill moves to the other body.

With that said, Madam Speaker, this is a good piece of legislation. I want to compliment Ranking Member STEARNS, who's worked very hard on it, and the staffs on both sides of the aisle for their hard work, and I would hope the House will pass this bill at the appropriate time.

Mr. CONYERS. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

□ 1745

Mr. STEARNS. Madam Speaker, it is my pleasure to yield as much time as she may consume to the gentlelady from Tennessee, MARSHA BLACKBURN.

Mrs. BLACKBURN. Madam Speaker, I do rise in support of SHVERA, as we call it. And for those individuals that live in rural areas like my Seventh District in Tennessee, fixing a short market problem, which we have heard discussed on this floor tonight, is much more than just a convenience or an ''I want to see TV'' issue. For us, it is an issue of health and security and public safety. And by working to expand the definition of the unserved customer, which we have done on a bipartisan basis in this bill, my constituents in rural west Tennessee counties like Hardin and Hardeman and Chester are now going to be able to get that distant satellite signal that we've discussed.

The reason it is important for us is because a couple of years ago, we had a devastating tornado that swept through west Tennessee and touched down in our district. Nearly three dozen Tennesseeans were killed and 150 people were seriously injured. Communities were paralyzed and had significant difficulty in receiving news alerts and communicating.

By fixing this short market, we will all rest a little better knowing that should we be faced with any other such disaster of this magnitude, that we will be better prepared and able to respond and to persevere.

I do want to take a moment to thank Chairman CONYERS, Chairman BOUCHER, Ranking Member BARTON, and Ranking Member STEARNS for all of their hard work in fixing this short market issue and helping to resolve this issue for my constituents in Tennessee.

As has been said, the bill's not perfect, and there is an area that has been mentioned mandating that a private company like DISH Network carry public broadcasting in high def. It really does go against free market principles. I do know that is going to continue to be worked on. We are looking forward to getting that issue resolved.

I thank the gentleman from Florida.

Mr. STEARNS. Madam Speaker, how much time do I have left?

The SPEAKER pro tempore. The gentleman from Florida has 7½ minutes.

Mr. STEARNS. I yield such time as she may consume to the gentlelady from Wyoming (Mrs. LUMMIS).

Mrs. LUMMIS. I would like to thank the chairman and ranking member of the Judiciary Committee for the inclusion of language from my bill on statewide public television. Passage of this legislation will remove the legal obstacles for satellite carriers to offer statewide public television in Wyoming and other States. I don't care whether it's in high def or not. I just want public television carried in Wyoming and other States, and that's been achieved. So thank you kindly.

I also thank the gentleman from Georgia (Mr. DEAL) who worked diligently to address the problem of local television market areas. Despite his good work, I rise today to express regret for the missed opportunity the passage of this bill represents.

The decision to put off for another 5 years any real reform to the system of designated market areas carries with it very negative consequences for the citizens of my State. Out of Wyoming's 23 counties, 16 do not have satellite access to Wyoming-based stations. Over half of all television households in Wyoming do not have access to local television.

For a rural State like Wyoming, satellite sometimes represents the only viable option to receiving television programming. The inability to receive local stations restricts access to local content and severely limits the reach of emergency notifications.

Emergency situations, like the butane tank truck that recently overturned on an icy highway during a blizzard, should serve as proof that the availability of local stations on satellite television is not just an entertainment issue. The DMA system may make sense for the densely populated areas in the East, but it has created an absurdity in the sparsely populated areas of the West. I am grateful for the inclusion of a study to find a better way to determine what the local market is.

But, Madam Speaker, people in Wyoming do not need a study to tell them that when their network TV station originates 400 miles away from a different State, they are not receiving the local content they need. For this reason, I cannot support passage of this bill despite its tremendous improvements.

Mr. JOHNSON of Georgia. Madam Speaker, I rise today in support of H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009. I strongly support this important piece of satellite television reauthorization legislation.

H.R. 3570 reauthorizes satellite operators' licenses to import distant network affiliate television signals to viewers who cannot receive a viewable signal from their local affiliate. This is important as it allows satellite and cable television providers to carry out-of-market television signals to households that cannot receive stations in their own local markets. This allows state public television networks to reach all their state's residents with important news and public affairs programming.

Alongside the chairman, I worked hard to get the phantom signal language included in the bill. I am proud of the final product and believe it is something about which all Americans can be proud.

Previously, due to flaws in existing law, broadcasters sometimes paid royalties to content producers even when programming was not actually delivered to subscribers. Royalties for the transmission of broadcast signals to cable systems were paid as if the entire cable system received the transmission, even if it was only received by some subscribers within

the cable system. This has been known as the phantom signal problem. The cost of this flaw was passed down to consumers. With the passage of this reauthorization, including my phantom signal language, the American people will no longer be forced to pay for programming they have not received.

I join the chairman in urging my colleagues to support this bill. As a result of this legislation, constituents in my district will not be forced to pay for satellite and cable programming they have not received and, as a result, save money in this economy.

Mr. SMITH of Nebraska. Madam Speaker, I rise today to oppose suspending the rules to pass H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act.

I understand this legislation must be reauthorized by December 31 to ensure satellite television viewers have continued access to local stations. In many rural areas—including large portions of my district—satellite television carriage of local stations is one of the only sources for up-to-the-minute news and weather. It is vital we maintain that link.

I am pleased this legislation addresses two issues of concern to my constituents. It includes language allowing satellite carriers to provide in-state public television signals to all viewers in the state, regardless of television market, DMA. This means the thirteen counties in my district served by the Denver DMA will have improved access to the quality programming of NET—Nebraska's statewide PBS station.

The bill also takes steps to encourage satellite carriers to carry all 210 DMAs. Currently, 31 DMAs, including the city of North Platte in my district, are not carried by either of the two major satellite carriers and another 76 are carried by only one of the two. These unserved and underserved markets are typically small, rural areas and are often in the greatest need of satellite carriage for distant viewers to receive their signals. I am pleased the bill takes steps to encourage their coverage rather than implementing strong new mandates on these private companies.

However, I must oppose passage of this legislation under suspension of the rules. It does not contain language to address the needs of consumers in out-of-state DMAs who wish to receive in-state broadcast programming over satellite. Under suspension of the rules, no member will have the opportunity to offer an amendment to address this issue.

Under this legislation the thirteen counties which would gain access to Nebraska public television would still be forced to watch local broadcast programming from the Denver DMA. This includes places such as Sheridan and Cherry Counties which are over 400 miles from Denver and have three closer and arguably more local markets unavailable to them on satellite—North Platte, Scottsbluff-Cheyenne, and even Rapid City, South Dakota.

With this in mind, I must oppose suspending the rules to pass this legislation today in hope that this bill can be brought back up under a rule with the opportunity to make these needed changes for my constituents.

Ms. ESHOO. Madam Speaker, I rise in support of H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009. This bill provides much-needed improvements to the current legal structure governing the transmission of satellite signals to American consumers. We've come a long way since the days where satellite companies were fledging businesses with small customer bases and large backyard dishes. Now this industry is robust and competitive and holds its own in the world of multi-video providers.

With this increased popularity comes an increased responsibility to those who subscribe to satellite services. I sponsored an amendment to the bill that was adopted in the Energy and Commerce Committee which underscores the importance of the rights of satellite customers.

My language will finally end DISH Network's discrimination against noncommercial High Definition signals. Many of you know these noncommercial stations as educational and Public Broadcast Stations. DISH has roughly 14 million subscribers and they all deserve access to Public Television's signals. DISH had been providing preferential treatment to high-paying networks for the transmission of programming, but denying equal carriage for a television service supported by tax dollars. DISH gets privileges under this bill and with those privileges comes the obligation to serve the public interest.

The premise of my language is simple.

It requires satellite carriers to provide their customers with local noncommercial HDTV transmissions when carrying other local broadcast HD signals.

It provides for carriage compliance for 50 percent of the stations by the end of 2010, with an extra year for the remainder, thus accelerating the FCC 2013 date.

It ensures that when new service is initiated, noncommercial stations get equal treatment.

And, it gives carriers one last opportunity to sign a carriage contract because anyone who has one, has a safe harbor from the language here.

Most importantly, this language locks the door and rips off the knob—it not only accelerates the carriage date, it precludes potential waivers of that date extending well into the future.

It's important to note that Direct TV offers HD channels of 106 local public television stations in their local markets. DISH is carrying HD in local commercial broadcasts in 152 markets covering 93 percent of U.S. households. But they only carry local public television HD broadcasts in Alaska and Hawaii—where they are legally obligated to do so.

Consumers in all states have the right to view publicly funded programming. My preference would have been that some time during the past three years of negotiations with PBS, DISH would have decided to serve the public interest and provide equal treatment for noncommercial stations. Unfortunately, that didn't happen. There's been adequate notice of a serious problem, but no action. I encourage DISH to continue negotiating with PBS to reach a viable compromise on this issue before this measure passes the Senate as well. Otherwise, there will be no additional flexibility—and DISH will be legally obligated to carry those HD signals.

Thank you, Madam Speaker. I look forward to final passage of the Satellite bill, and especially the anti-discriminatory section which is part of it.

Mr. KRATOVIL. Madam Speaker, I rise in support of H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009. This legislation reauthorizes the satellite compulsory license for carriage of distant network satellite affiliate TV station signals. If this bill does not become law before the end of the year, the distant network carriage license will expire and satellite subscribers would be left in the dark.

While I support the underlying legislation, I would like to draw attention to a provision that I believe could undermine our efforts to ensure rural residents have access to local programming. By redefining an "unserved household" to include those served by multicast networks, this legislation allows satellite broadcasters to continue to import distant, out-of-market signals into short markets when they are no longer necessary. I request that a letter signed by 18 bipartisan Members of the House of Representatives expressing concern over this definition of "unserved household," be inserted as an extraneous material.

WASHINGTON, DC,
December 2, 2009.

Hon. JOHN CONYERS, JR.,
Chairman, Committee on the Judiciary, House of Representatives, Washington, DC.

Hon. LAMAR SMITH,
Ranking Member, Committee on the Judiciary, House of Representatives, Washington, DC.

DEAR CHAIRMAN CONYERS AND RANKING MEMBER SMITH: We write today to express our concerns regarding the manner in which H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009, would diminish the availability of local programming available to satellite television subscribers.

Digital multicasting enables broadcasters to provide TV viewers with expanded options for free, local TV programming beyond the primary network affiliate channel. In pursuit of this promise, many broadcasters have already begun multicasting dedicated sports, ethnic, minority, weather, news, and hyper-local channels.

In various markets, including "short markets," i.e., television markets lacking a full complement of network affiliates, some stations have begun multicasting a local network affiliate other than the network affiliate carried on their primary channel. For example, television viewers in the Beaumont, TX market, which lacked a local NBC station, can now watch local NBC affiliate K–JAC as a multicast channel provided by a station that broadcasts the ABC affiliate KBMT on its primary channel. It is important to note that this multicast channel, like numerous similar network affiliates that are broadcast on multicast channels across the country, is a full-fledged network station providing viewers with a full slate of a network's programming to the same geographic area as the station's other digital channel that broadcasts ABC programming. There is no rational public policy reason to treat the two network channels differently under copyright law.

Unfortunately, H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009, enables DBS companies to impede and undermine multicast network affiliates. By re-defining a household capable of receiving a local network signal through the air as "unserved" if the signal is delivered via digital multicast technology, Sections 3(h)(1) and 3(h)(6) of H.R. 3570 together

allow DBS companies to import distant network affiliates that duplicate the programming of the local, multicast network affiliate. This provision will not only undermine existing multicast stations, but it will also give local stations far less incentive to multicast an additional local network affiliate in the future if large numbers of potential viewers are already receiving an affiliate of that network through a DBS provider. Thus, these provisions may deprive viewers of locally-oriented programming by undermining existing multicast arrangements and removing the incentive for local stations to continue to offer or roll out new multicast network affiliated channels.

While H.R. 3570 only provides satellite companies this ability for 3 years following enactment, after the recent economic downturn, the next three years will be critical to the development of new, innovative, free, over-the-air digital network broadcast services, including networks that contain programming developed for ethnic minorities. Sections 3(h)(1) and 3(h)(6) of H.R. 3570 should be changed to ensure that DBS companies cannot import a distant network signal that duplicates a local network affiliated multicast station.

Additionally, as twelve members of the House Judiciary Committee stated in the additional views that were filed in the report language that accompanied H.R. 3570, "the preference in section three of the bill may result in discouraging free over-the-air local broadcasters from affiliating with more than one network and developing a market-based solution to the 'missing network affiliate' problem. This would limit the number of free network programming options available to consumers and, in effect, require consumers to subscribe to pay television to receive network they might otherwise have been able to view for free."

We appreciate your attention to this critically important issue. As you continue to work on the reauthorization of the Satellite Home Viewer Extension and Reauthorization Act during a House-Senate conference committee, we encourage you to support the approach to protecting multicast channels that was adopted by the Senate Judiciary Committee.

Sincerely,

Frank Kratovil; Roy Blunt; Tom Cole; Alan Mollohan; Rodney Alexander; Michael McMahon; Brett Guthrie; Bob Filner; Thomas Rooney; Nick J. Rahall; Christopher Lee; Gregory Meeks; Blaine Luetkemeyer; Raúl Grijalva; Shelley Capito; Sam Farr.

Mr. STEARNS. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Michigan (Mr. CONYERS) that the House suspend the rules and pass the bill, H.R. 3570, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. CONYERS. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

COMMUNICATION FROM THE CHIEF ADMINISTRATIVE OFFICER OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Chief Administrative Officer of the House of Representatives:

OFFICE OF THE
CHIEF ADMINISTRATIVE OFFICER,
Washington, DC, December 1, 2009.

Hon. NANCY PELOSI,
Speaker, House of Representatives, Washington, DC.

DEAR MADAME SPEAKER: This is to notify you formally, pursuant to Rule VIII of the Rules of the House of Representatives, that I have been served with a subpoena for production of documents issued by the U.S. District Court for the District of Connecticut, in connection with a criminal matter now pending in the same court.

After consultation with the Office of the General Counsel, I have determined that compliance with the subpoena is consistent with the precedents and privileges of the House.

Sincerely,

DANIEL P. BEARD.

CONGRATULATING THE DETROIT CATHOLIC CENTRAL SHAMROCKS

(Mr. MCCOTTER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MCCOTTER. Madam Speaker, today I rise to recognize the Michigan Division 1 State High School Football champions, the Detroit Catholic Central Shamrocks. On November 27, 2009, the Shamrocks defeated a fine Sterling Heights Stevenson team 31–21.

The victory earned head coach Tom Mach his 10th State championship in his 34 seasons leading the Shamrocks. The team's hard work, mental toughness, and burning desire epitomizes what it means to be a Shamrock molded by the Basilian Fathers and their mission to teach young men goodness, discipline, and knowledge. Truly this accomplishment is shared by the entire CC family.

Madam Speaker, meeting the challenge with an undefeated record of 14–0, I ask my colleagues to join me in congratulating the Detroit Catholic Central Shamrocks upon winning their Michigan State football championship and for proving they are indeed men of Mary, Alma Mater, who inspires us evermore.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

THE WRONG DECISION ON AFGHANISTAN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Massachusetts (Mr. MCGOVERN) is recognized for 5 minutes.

Mr. MCGOVERN. Madam Speaker, first I want to commend President Obama for thinking long and hard about the course that he believes the United States should take in Afghanistan. That kind of deliberation is a welcome change from the previous administration. I also want to commend him for making it crystal clear that the United States of America condemns torture.

Unfortunately, on the issue of troop levels in Afghanistan, I believe the President has reached the wrong conclusion. Sending 30,000 more U.S. troops to Afghanistan will make it 30,000 times harder to extricate ourselves from this mess. If our fight is truly with al Qaeda, then we're in the wrong country. They have moved to Pakistan. Indeed, General Jones has told us that there are maybe less than 100 al Qaeda members in Afghanistan. With the troop increase announced by the President last night, we will have over 100,000 U.S. service men and women in Afghanistan. Do we really need 100,000 troops to go after less than a hundred al Qaeda?

President Karzai is corrupt and incompetent. He cheated in the most recent election. By most estimates, 30 percent of his votes was rigged. I don't want any more American service men or women to risk their lives for his corrupt government; and I am a little bit stunned, quite frankly, by the quick and inexplicable pivot by the administration from rightly denouncing Karzai's behavior to now embracing him as our dear friend. I think our support for Karzai actually discredits us with the Afghan people. We have seen that it is exceedingly difficult to train Afghan troops, many of whom are not only illiterate, but unable to add or subtract.

The cost of this escalation will be enormous, both in terms of blood and treasure. We will need to borrow billions and billions of additional dollars to pay for this policy.

Madam Speaker, at a time of great economic crisis here in the United States, I would suggest that rather than nation-building in Afghanistan, we should do a little more nation-building here at home.

It is important to note that the so-called timeline outlined by the President last night envisions the beginning of drawing down our troops in July of 2011—the beginning, not the end. Does anybody really believe that we will not be deeply ensnared in Afghanistan well beyond 2011?

Madam Speaker, I do not and I never will suggest that we abandon the Afghan people. They have suffered greatly over the last several decades. We must continue to support meaningful economic development and political assistance.

But finally, Madam Speaker, there is another important issue here, and that is congressional involvement. I know the President last night cited the resolution to authorize force in 2001 as providing the authority that he needs. I would argue that it was not Congress' intent in 2001 to authorize decades of nation-building in Afghanistan. We voted to go after the people who committed the horrible atrocities on September 11. I would urge that before a single additional troop is sent, that the United States Congress have the chance to fully debate his proposal and have an up-or-down vote.

Under the Bush administration, what usually happened is that additional troops were deployed and then later, once they were already in theater, the administration would submit a supplemental request. That is backwards. We should debate and vote on this critical issue before we send additional troops.

□ 1800

And, Madam Speaker, this is a big deal. This is a major escalation and Congress has a major role to play. I would urge my colleagues on both sides of the aisle to continue to ask the tough questions and to continue to play our constitutional role.

CLIMATEGATE

The SPEAKER pro tempore (Mr. GARAMENDI). Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

Mr. POE of Texas. Mr. Speaker, over the past several weeks, evidence has come to light of fraud and corruption in the global warming scientific community. Or, as it is now called, the climate change community.

These shady scientists have made claims of a global warming apocalypse and created fear in the world that we are all doomed because man is the enemy destroyer of planet Earth.

But now thousands of their emails were recently leaked to the public. These emails, written by scientists at the British University of East Anglia exposed fraud and corruption in their global warming claims. Now Climategate is being exposed. These snake oil salesmen have been caught in their lies to the world. These are the very scientists who formed the foundation for world global warming claims. American politicians, the United Nations, everyone claiming that the world is headed toward this global warming catastrophe based their views on this information.

In these emails, these scientists conspired to destroy their own email discussion of data that contradicts their global warming claims. They discussed discrediting members of the scientific community who disagree with them. They even wish some of these dissenting scientists were beaten. Now isn't that lovely when you have an opposition.

Phil Jones, the director of the climate research unit at the University of East Anglia in England wrote in his now-leaked emails of thwarting access to the data by those who doubt global warming. He talked about getting around British Freedom of Information requests. He didn't want other scientists to get his data because they could expose flaws and faults in his global warming claims.

But the bread and butter of these global warming claims comes from what these scientists say is ''consensus'' within the scientific community. Now we learn there is not a consensus about global climate change. The emails show numerous actions taken to silence the dissenting voices and withhold the actual information being used to make their questionable claims.

The British university says they are going to release all of their data now, but the scientists have already admitted that they destroyed much of that data. Obviously, they destroyed the data that shows their theory on climate change is a ruse. It is a fraud on the world. That doesn't look like sound science to me. It sounds like they have cooked the books. It sounds like they have picked out an outcome and are trying to fix the data to make it say what they want it to say. It sounds like a political agenda.

World economies depend on these claims that have clearly been manipulated. The U.N. global warming summit in Copenhagen that starts next Monday, December 7, is using this tainted information. The United Nations wants to exert more control over world energy and emissions, and the sovereignty of nations using information that is apparently now faulty. It is tainted with scandal, and it is deceitful.

How can the American people trust any of these claims when they have clearly been manipulated? Well, the American public can be fooled no longer by these pseudo scientists. One may ask why would these scientists skew the facts? Well, it is obvious. Governments all over the world give climate change individuals in the climate change crowd millions of dollars of money to study climate change. And if manmade climate change is a falsehood, these scientists may fear that their money will dry up.

The jury is still out on the global warming theory and the climate change myth. Before Congress passes any legislation based on this theory regarding manmade climate change, we ought to have an open, honest debate from real scientists who didn't manipulate the evidence to get an outcome-based conclusion. Further, the EPA should halt all carbon emission regulations of the energy community until we learn the facts about climate change. Honesty is a prerequisite for conclusions about climate change legislation. And now we learn that climate change is not a well settled scientific fact at all, whether the mad scientists at the University of Anglia like that fact or not.

And that's just the way it is.

HIV/AIDS PROGRAMS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Florida (Ms. ROS-LEHTINEN) is recognized for 5 minutes.

Ms. ROS-LEHTINEN. Mr. Speaker, yesterday on World AIDS Day, the administration announced its proposed 5-year strategy for the President's Emergency Plan for AIDS Relief, otherwise known as PEPFAR. The strategy is required by the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008. That is a mighty long name, but it does so much good. And it begins to shift PEPFAR from an emergency program to one focused on sustainability.

Mr. Speaker, the challenges in fighting HIV/AIDS are daunting, but not insurmountable. Over 33 million people worldwide are infected, an estimated 67 percent of whom live in Sub-Saharan Africa. Nearly 2.7 million people, including 430,000 children, were newly diagnosed with HIV last year. Over 14 million children have lost one or both parents to HIV/AIDS. AIDS is decimating an entire generation of the most productive members of society in developing countries, which will cause GDP to drop by more than 20 percent in the hardest-hit countries over the next decade.

Without effective prevention, treatment, and care efforts, the AIDS pandemic will continue to spread its mix of death, poverty, and despondency that is destabilizing governments and societies and undermining the security of entire regions.

But one need not travel to Africa or the Caribbean or Eastern Europe to witness the devastation of HIV/AIDS; we need only to look out the front door. In my home State of Florida, Mr. Speaker, an estimated 90,000 people are living with HIV/AIDS, making us third in the Nation in the number of AIDS cases.

My home county of Miami-Dade ranks second among large metropolitan areas for people living with AIDS with over 32,000 currently diagnosed. These individuals need our assistance. They are fighting this disease.

On October 21 of this year, with a bipartisan majority, we voted in Congress to reauthorize the Ryan White HIV/AIDS Treatment Extension Act. The Ryan White program has been the largest supplier of services for those living with HIV/AIDS in the United

States. In the United States, over 500,000 people a year benefit from the Ryan White program. Florida alone received over $209 million in funding with Ryan White funds in 2009, and has been able to assist countless low-income Americans living with HIV/AIDS.

Fully appreciative of the challenges here at home, I am proud to have supported PEPFAR since its inception. To date, it has proven to be a highly effective and results-oriented program. For example, more than half of the 4 million people receiving lifesaving drugs in low- and middle-income countries around the world are directly supported through PEPFAR. PEPFAR has supported care for more than 10 million people affected by HIV/AIDS, including more than 10 million orphans and vulnerable children. At least 240,000 babies have been born free of HIV/AIDS thanks to PEPFAR prevention of mother-to-child transmissions.

The achievements of our bilateral programs are truly remarkable. However, the record of our multilateral organizations is problematic. While we need more robust burden sharing—particularly as the World Health Organization has revised its guidelines and vastly expanded the pool of people who require access to treatment—significant revelations of corruption in the global fund programs are cause for great concern.

Mr. Speaker, we must work together to ensure accountability, transparency, and maximum effectiveness of multilateral programs that are receiving United States support. We must work to ensure that every dime that is dedicated to PEPFAR, including our contributions to the global fund, is used for its intended purposes and delivered in the most effective, transparent, and sustainable manner possible. We must ensure that those precious resources actually reach those who are in need, without being diverted to line the pockets of unaccountable international bureaucrats or corrupt regimes.

Lastly, Mr. Speaker, we must also preserve the conscience clause and promote behavior modification, particularly abstinence and fidelity, under the new strategy.

In closing, let us recommit ourselves to saving the future by helping to save lives inflicted with HIV/AIDS.

AMERICAN TROOPS IN AFGHANISTAN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. DOGGETT) is recognized for 5 minutes.

Mr. DOGGETT. Mr. Speaker, after the tragedy of 9/11, I voted for the resolution that authorized military action against those who attacked us, including sending our troops into Afghanistan. We sent a strong, unified message that we will never yield to terrorism. We have not just the right but the duty to keep America secure. I certainly agreed with taking out Osama bin Laden. It is outrageous that the Bush-Cheney-Rumsfeld administration failed to stop him, unnecessarily prolonged this conflict, strengthened our enemies as their attention and our resources were diverted to an ideologically driven invasion of Iraq.

Surely all Americans should respond affirmatively to President Obama's call last night for unity of purpose in keeping our families secure and overcoming all of those who would do us harm. I agree with so very much of what President Obama said, but not so much with what and how he said he would accomplish our shared goal.

It is true he had no really good and easy alternatives, and I applaud his deliberative effort. But the path to peace and security will not be found through a wider war. It is wholly unrealistic to expect that we can escalate our military forces in the harsh, faraway landscape of Afghanistan by another 40 percent, then deescalate and begin bringing them home all within a mere 18 months.

We have been fighting in Afghanistan on the installment plan. A few more troops, a few more months, and a whole lot more money—billions. There is no way that 2011 will mark the end of this war or even the beginning of the end. This is just a mirage. In 18 months the reasons may vary, but the next installment will be requested in what is already a deteriorating war that has lasted 8 years with the illusive end of the war always just over the horizon.

The better exit strategy is to have fewer troops who need to exit. We should honor the sacrifice of those who are courageously serving and put fewer of them into harm's way. It should not take 100,000 highly equipped and trained American troops to defeat less than 100 al Qaeda in Afghanistan, an estimate yesterday from the President's National Security Adviser.

Once again, we hear talk of a grand coalition, but make no mistake, it is Americans who are being asked to bear the overwhelming share of the burden. As these troops would arrive in Afghanistan, the Canadians, the Dutch, they have already announced they will be bringing their troops home at the same time our people get there.

□ 1815

The French and the Germans have said not one more troop. Spain may increase its total to 1,200. Iceland has two, Luxembourg has nine. Every bit of help counts certainly, but it's clear that the great amount of blood that will be spilt will, once again, be American, and the cost will be to the American taxpayer.

Now, United States Army doctrine, as written by General Petraeus, calls for one counterinsurgent for every 50 members of the population. In Afghanistan, with a population of 30 million, that would work out to about half a million additional troops, not 30,000. Whatever the exact number is, it is clear that to meet the military's own objectives, more installments are in order. All this effort to prop up a corrupt Karzai government that just stole over 1 million votes to keep itself in power as it attempts to control a fraction of the country of Afghanistan.

My fellow Americans, we must chart a better course. Congress has a constitutional responsibility to scrutinize this request carefully as well as how to pay for it, to find a better way to achieve our shared goals of protecting every American family. To do otherwise will leave us embroiled in an Afghanistan that can consume, as it has throughout human history, as many lives and as many dollars as we are willing to expend there. And such a painful, unending sacrifice may well make our families less, not more, secure.

THE QUAGMIRE OF AFGHANISTAN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. PAUL) is recognized for 5 minutes.

Mr. PAUL. Certainly, in the last 24 hours, we've had a lot of discussion about Afghanistan and whether or not we should send more troops. As a matter of fact, that debate has been going on for a long time. The whole debate about Afghanistan is something that makes me think that we are bogged down, considering the fact that it has been going on for 8 years.

This is not new for us. This is more or less the rule rather than the exception, and I believe this comes about because of the way we go to war. In the last 60-some years, we have never had a declaration of war, but we have been involved in plenty. We've been involved in Korea, Vietnam, the Persian Gulf, and the Iraq War, and now Afghanistan, and it looks like it's going to be Pakistan as well.

So I think the reason we get here is because we don't declare war and we slip into war, and then it becomes political. There are two sides. There is one side of the argument that says, Let's just come home. And the other side says, Fight it all out. And people say, No, you can't be an extremist on this. You have to have a balance. And the balance is chaotic. There's no way of measuring victory, and nobody wants to give up, claiming it would be humiliating to give up.

But just think of the tragedy of Vietnam, all those years and all those deaths and all that money spent. Eventually we left, and South Vietnam is now a unified country, but we still have troops in Korea, in Europe, and in Japan. And we are bankrupt. So some

day we are going to have to wake up and look at the type of foreign policy that the Founders advised us to have, and that is nonintervention: don't get involved in the internal affairs of other nations, have free and open trade and accept friendship with other countries who offer it, and that we shouldn't be the policemen of the world and we shouldn't be telling other people what to do. We cannot be the policemen of the world and pay for all those bills because we are literally bankrupt.

In thinking about the dilemma that we have, I think back, even back in the 1960s when I was an Air Force flight surgeon for 5 years, and that was the first time I heard the term ''quagmire.'' And thinking about that for many, many years, that's all I can think about right now is to evaluate what we have. There are a few phrases that have been around for a long time, and I believe they more or less describe what is happening here. Quagmire. Certainly that is what we are doing. We are digging a hole for ourselves. ''Perpetual war for perpetual peace.'' We have all heard that term, and it sounds like we are in perpetual war. ''War is the health of the state.'' We all know the government size and sacrifice of civil liberties always occurs much more so in the midst of a war.

A book was written many years ago by one of the most, if not the most decorated soldier we ever had, Smedley Butler. He wrote a book called ''War is a Racket.'' And I have come to this belief that war literally is a racket for the people who push these wars, whether it's the military industrial complex or the special interests and the various factions, but it's never, it's never for the people.

Today it is said that we're over there to protect our national security to go into Afghanistan. Well, it's down to 100 al Qaedas in Afghanistan, and, quite frankly, the Afghan Government had nothing to do—they said they harbored the al Qaeda, and that is true, but do you think those 19 guys needed to do pushups in Afghanistan to come over here and do what they did? The real planning wasn't in Afghanistan. It was in Spain. It was in Germany. Where was the real training? The real training was in Florida. The training was in Florida, and the FBI had evidence at the time that they were being trained, and it's totally ignored. And yet we are concentrating, we are still back to 9/11, fear of nuclear war. We have to go in, scare the people.

Yet what is the motivation for individuals to become radical against us, whether it's in the Taliban or al Qaeda? There is one single factor that is the most influential in motivating somebody to commit suicide terrorism against anybody or us, and that is occupation by a foreign nation. And now, where have we occupied? We have occupied Iraq and Afghanistan. We are bombing Pakistan. But not only the literal occupation, but also, we have this threat on Pakistan.

So I would say it's time for us to reassess ourselves and look at a noninterventionist foreign policy.

RECOGNIZING THE GENEROSITY OF ROSS PEROT'S GIFT TO THE U.S. ARMY COMMAND AND GENERAL STAFF COLLEGE FOUNDATION

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Kansas (Mr. MORAN) is recognized for 5 minutes.

Mr. MORAN of Kansas. Mr. Speaker, I rise this evening in the House of Representatives to recognize a remarkable gift that will enhance the professional education of our country's military officers and thereby improve the safety and security of every American.

In November, Mr. Ross Perot of Texas pledged $6.1 million to support two new initiatives at the U.S. Army Command and General Staff College located at Fort Leavenworth, Kansas. At a time when our country is demanding so much from those in uniform, this significant contribution will ensure that America's military leaders receive the best education and training to accomplish their missions around the world.

Mr. Perot's contribution followed a recent visit to Fort Leavenworth. He experienced firsthand the classroom instruction that U.S. officers and their interagency and international counterparts receive at the Army's Command and General Staff College, our country's oldest and largest military staff college. He also met with students and toured the Lewis and Clark Center, an impressive new building completed in 2007 to house the college.

Mr. Perot's gift will fund a new center for interagency cooperation and a new chair of ethics. As the conflicts in Iraq and Afghanistan make clear, cooperation between military and other agencies is an important component for our country's success. To address this need, the Col. Arthur D. Simons Center for Study of Interagency Cooperation will enhance the cooperation of interagency affairs. The second initiative to be created, the Gen. Hugh Shelton Chair in Ethics, will attract world-class academics and researchers to stress the importance of ethics and values in the military.

You may notice that rather than naming these new programs after himself, Mr. Perot chose to name them after others. Col. Arthur ''Bull'' Simons led the 1970 Son Tay raid to free prisoners of war in Vietnam, as well as a 1979 mission to rescue, from a prison in Tehran, two of Mr. Perot's employees. Retired Army Gen. Hugh Shelton served as Chairman of the Joint Chiefs of Staff and is a friend of Mr. Perot's. Mr. Perot selflessly named his initiatives after military members who have played an important role in his life and defended our country's honor. This gesture is a testament to Ross Perot's character and patriotism.

I commend Mr. Perot for his generous and continued support for our Armed Forces. I also want to commend retired Colonel Bob Ulin, who, as CEO of the Command and General Staff College Foundation, was instrumental in securing this tremendous pledge and growing the foundation generally. Since its inception in 2005 as a not-for-profit to support the college, the foundation has offered many programs and activities to promote excellence, including awards for students and faculty, support for conferences and lectures, and community outreach activities.

For 128 years, the Command and General Staff College at Fort Leavenworth, Kansas, has served as the ''intellectual heart of the Army,'' producing numerous world and military leaders. The next Marshall, Eisenhower, or Petraeus may very well be sitting in a classroom in Leavenworth, Kansas, today.

We are grateful to Ross Perot, an American patriot, for his support of our men and women who protect and defend our Nation by their service in the United States military, and we are grateful for Fort Leavenworth, Kansas.

SMALL BUSINESS IS AMERICA'S ECONOMIC ENGINE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia (Mr. BROUN) is recognized for 5 minutes.

Mr. BROUN of Georgia. Mr. Speaker, the economic engine that pulls along the economic train of prosperity in America is being derailed. America's entrepreneurs, America's small business men and women are this country's economic engine. They are the backbone of our economy. They create most of the new jobs here in America.

Mr. Speaker, they have waited long enough for the so-called stimulus to kick in. In fact, they have been waiting far too long. Mr. Speaker, where are the jobs? It's time for us to scrap this failed policy. It's time for Congress to stop wasting taxpayer time and money. It's time to give a real jolt to the economy and stop taking so much through high taxes and more debt.

Mr. Speaker, I introduced H.R. 4100, the JOBS Act, to do just that. My bill, the Jumpstarting Our Business Sector, or JOBS Act, is a commonsense and simple approach. It provides a 2-year moratorium on capital gains and dividends taxes, two taxes which directly inhibit or derail a business' ability to reinvest their revenue into creating now jobs. It reduces the two lowest tax brackets by 5 percent. It cuts the payroll tax rate and the self-employment

tax rate in half for 2 years. Additionally, it reduces the corporate tax rate by 10 percent for 2 years.

In fact, the United States already has the second highest corporate tax rate in the world. It's incredible that our economy has prospered for this long under such an extraordinary tax burden.

At this time of great economic turmoil, it's only logical to curtail this massive tax and allow our business sector to propel us back onto a stable economic footing.

Finally, just as important, my JOBS Act recoups any and all unspent stimulus dollars, putting them to work instead of towards waste.

Now is the time for a new way forward. For 11 months, the so-called stimulus has been tried and tested. Unfortunately, it has failed. But there is no reason to keep going down the same track and throwing taxpayers' money down a rat hole towards a failed plan. And there is certainly no reason to keep sending money into Georgia's imaginary congressional districts, double zero, 27, 86, or any others that the government has identified.

The American people demand something better than more government and more debt. They deserve more, something better than more unemployment insurance and COBRA extensions. We need to stop handing them dead fish and, instead, hand them a fishing pole.

□ 1830

Mr. Speaker, I've introduced H.R. 4100, the JOBS Act, to answer their call. And I urge my colleagues to lend their support by cosponsoring this important legislation and keeping that economic engine of small business on the right track to economic prosperity.

JOB CREATION IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Missouri (Mr. AKIN) is recognized for 60 minutes as the designee of the minority leader.

Mr. AKIN. Mr. Speaker, this evening our topic is going to be something that is of interest, I believe, to all Americans, the topic of jobs. In the past we've talked something about health care. In fact, we've talked about that for a number of months. But it seemed appropriate to me this evening to open our discussion on the subject of jobs. Everybody in America is concerned about the subject. It is one of those things that affects everyone. And something that is not as clear, and the solution to the jobs question is not as simple as it might appear on the surface. And certainly, we have some examples of politicians doing exactly the wrong thing. So I think it's important that we start and just analyze what it is that makes jobs and what are the enemies of job creation. I have listed about six of them here that are the most common things that are destructive to jobs.

The first would be a bad economy. That seems fairly self-evident. If the economy is not doing well, the thing that people tend to do is to say, well, things aren't going so well; I need to cut my overhead, and, therefore, we will cut some jobs. And so that is one thing that affects jobs is a slow or poor economy.

Another thing that's extremely disastrous and very much basically stops the creation of jobs and maybe even gets rid of existing jobs is taxation. That also is fairly self-evident. Let's just think for a minute. You're an owner of a small business and you have 100 people working for you. All of a sudden, you find out, you read in the paper, here we go, the politicians, one more time are going to be taxing and spending. They're going to increase your taxes and increase the taxes to your business. Well, that has the same net effect as a bad economy because if all of a sudden you're expecting a big tax increase that your company is going to have to pay or you're going to have to pay because you own the company, you're thinking, oh my goodness, I don't have as much money to work with as I thought I did. I'm going to have to figure out ways to tighten the belt. And when you tighten the belt, many times that means you get rid of either existing jobs by laying people off, or perhaps you were thinking of creating new jobs and you decide, I think I'll wait on that expansion and buying that new piece of equipment and adding the addition to the building and in adding those new jobs. And so tax increases are also enemies of jobs.

A third problem that can also affect jobs, and that is what sometimes people call liquidity; that is, the available supply of money. If you're a small businessman, one of the things that you need in order to keep your business going is some source of loans or money to work with. Most small businesses have loans from local banks, and they get those loans at a reasonable interest rate because many small businesses are very good and prompt payers. The bank trusts them. The bank knows that the small business is solvent, that they run a good operation, that they're doing good work in the community, so the bank is taking that risk and is loaning that money at a fairly reasonable rate of interest, so the small businessman has this money or this liquidity in order to start paying for things that he needs in his business.

Just to give an example, perhaps, of a farmer. A farmer has a nice piece of land and he decides he wants to raise some crops. But in order to do that, he needs a tractor. He doesn't have enough money to buy that tractor right off the bat with cash, and so he gets a loan from the bank to buy the tractor, and then he uses the tractor to grow crops and to produce a product which we call food. In the meantime, as he makes profit on selling his food, he makes payments to the bank to pay for his tractor. It's a simple example, but what is required for jobs and for small businesses to operate is liquidity. There has to be a supply of money that's available at a reasonable interest rate in order to facilitate the growth of businesses, particularly small businesses, and jobs. If there is not good liquidity, not a good source of money, then you're going to have a problem with jobs.

A fourth enemy of job creation is uncertainty. Again, put yourself in the shoes of that small businessman. You look out on the horizon and you see all kinds of things that you don't know what's going on, and you're worried about what's going on. You know as you look out at the horizon that there's talk that these taxes that used to be low are going to go up. There's talk about taxes on energy, talk about taxes, heavy taxes, on a new health care bill. There's the possibility of energy shortages; there's the possibility of anything that might be disruptive to your business. Well, that uncertainty is going to have the effect of saying, hey, before I stick my neck out and do something new, I think I'm going to just instead sit back a little bit and wait, because I don't want to be too far leveraged. I don't want to make too much of a commitment because I don't know what's going to happen. Everybody is buying ammunition and hoarding gold, and everybody's nervous and concerned. There's talk about this, that and the other. So when you get uncertain, uncertainty makes it hard for business people to want to add jobs, and it may reduce jobs. Businesses work well when they have a plan. They know that they're going to have so many orders for so many years, they know that they're going to build, they can plan out, buy their materials, get the equipment they need and get the manpower. And so, when you want to mess up job creation and business, all you do is introduce a lot of fear and uncertainty and you're guaranteed to be hurting jobs.

A fifth thing that is going to be harmful to job creation is a whole lot of regulations and red tape. If you're thinking about taking on some new project or something, and you see just mountains of red tape, regulations, and all kinds of legal fees and problems in front of you that the government has created, then you're going to be a little bit more reluctant to jump into that project. I'll give you an example. For instance, let's say you're a power company and you have a number of coal-fired power plants. You take a look at what's going on, and you take a look at the technology that's available and

you say, you know, I think that it would really make a lot of sense to build a nuclear plant because coal prices are going up. We know that nuclear is safe. We know it doesn't generate any CO_2, so that should make people that are very worried about global warming happy, and we think that it makes sense to put a nuclear power plant. But then you start to think and say, Wait a minute. What are the regulations? What are the red tape? And how does this work? And you start looking at the red tape and you find out, oh my goodness, we apply for a license, and after we get done building the plant, which is going to cost millions and millions of dollars, then the government will tell us whether or not we can operate it. Wait a minute. That doesn't make sense. Doesn't the government give you a permit to operate the plant first, then you put the millions in and run the plant because you got the permit? No, you've got to get a permit to begin with, but you don't ever get any for sure that you can run that plant until after you've built it. Well, that would be an example of red tape and regulations making it so, hey, I'm not going to make that decision, I'm not going to do the job of building some big plant and a more efficient way to generate electricity because of the fact that we've got all this red tape and regulations in the way.

And then I would suggest that there is a sixth thing that's a job killer, and that is the excessive spending on the part of the Federal Government. When the Federal Government spends a whole lot of money, it has the net effect of eventually costing businesses and the taxpayers all the money that they spent and all. And so that the idea of doing what's sometimes called stimulus or spending actually is an enemy to jobs. We're going to get into that a little bit further along this evening. But I thought it would be important to start by defining our terms. Jobs are important for all of us. That's what you need to pay your mortgage. That's what you need to pay the food bill for your wife and kids. Jobs are an important thing in America, and Americans are a lot happier when they've got something to work on anyway, a good project or some work to do and they have a sense of paying off the mortgage and working their way toward the dream of a more prosperous future. And so these are the enemies of jobs. I'm going to review them one more time.

First of all, a slow economy. Second of all, taxes. The third thing is not enough liquidity. That is money. Fourth, uncertainty or fear. Fifth, red tape and government regulations. And sixth, the idea of excessive Federal spending, because that comes back in the form of taxes and reducing liquidity.

I am joined this evening by a very good friend of mine, Congressman SCALISE, who has a very good sense of business and a good sense of humor and is always a great contributor to our little Wednesday evening discussions.

My good friend from Louisiana, please join us.

Mr. SCALISE. I want to thank my friend from Missouri. We have been having these discussions for I guess the past few Wednesdays for a few months now. I appreciate the gentleman for hosting this hour that's become a regular tradition, not only to talk about the things that are happening in the country, but really to focus in on the actions that have been taken here in this Congress by this Democratic leadership that have actually led us to the decline in jobs that we're facing today.

Of course, so many Americans remember now back in the beginning of this year when President Obama stood right there, right there on that well behind you, and talked about the need for a stimulus bill, a bill that spent $787 billion of money that we don't have, money that was borrowed from our children and grandchildren, and he said it had to happen so that we would stop unemployment from exceeding 8 percent.

Now, of course today, as we look at 10.2 percent unemployment, the American people are asking, Where are the jobs? And, of course, when the White House came out with this Web site, and the White House and the President bragged about the transparency, and, in fact, the President talked about the fact that the American people would be able to track every dollar, and even said that Vice President JOE BIDEN would be in charge of tracking the money, and the American people would be able to go to a Web site and see where that money from that stimulus bill is being spent and how it's creating all these jobs. Of course you and I opposed that bill because we knew it wouldn't create jobs. In fact, we knew it would help actually lead to more unemployment because it would add so much more money to our national debt, money that we couldn't afford to spend, and money that was going to hurt small businesses and in fact did hurt small businesses.

Mr. AKIN. If I could reclaim my time, I think that the points that you're making are very, very good. I just want to recap what you're saying. I had, just as we got started, talked about things that kill jobs. And one of the things that kills jobs is excessive government spending. The first thing that you came to, ironically, was this supposedly stimulus bill which the President and the Democrat leadership thought was going to improve the economy, or at least they said that. That was what they claimed. In fact, the claim was, as you and I recall, that if we did not pass this $787 billion unfunded supposedly stimulus bill, we might get unemployment as high as 8 percent. We've seen unemployment go well beyond 8 percent. They passed that stimulus bill, and now unemployment is 10.2 percent. So that suggests just what we're talking about, that excessive government spending is, instead of making the situation better, will make it worse. But we were promised, as you were saying, by the administration, by the Democrat President, that this was going to create some jobs; and so they created a whole Web site, didn't they?

Mr. SCALISE. Well, in fact, they created a Web site called recovery.gov, and this is where the President said people could go and find out and track every dollar that's being spent, and it's going to be fully transparent. I guess maybe the White House didn't think that people were actually going to take him up on his offer. But of course the American people did. As people started going to that Web site, we had uncovered this about 2 weeks ago. When you would go to the Web site, we found out, first of all those of us in Louisiana found out that we had about 45 congressional districts because they actually had a listing of how many jobs were created in Louisiana's 45th Congressional District. And, of course, they showed that more jobs were created from the stimulus bill in Louisiana's Eighth Congressional District than in the district I represent, the First Congressional District. The only problem with that is Louisiana only has seven congressional districts. And so many people in Louisiana were not only asking, where are the jobs, but where is this Eighth Congressional District?

Mr. AKIN. I just want to stop you because what you're saying, people are going to think that this is either a comedy or a fiction.

□ 1845

You're saying that we put millions of Federal dollars into creating a Web site to let people know where the jobs were being created by this supposedly stimulus bill, and whoever it was that was hired said that the jobs are going into an Eighth and a Ninth and a Tenth Congressional District in Louisiana, and you, being from Louisiana, know there's only seven districts. So you're saying the Federal Government hasn't figured out how many congressional districts there are in Louisiana. That's amazing.

Mr. SCALISE. Not only that—and maybe this would be a comedy if it was fiction. The problem is, this is not fiction. This is reality. This is what the White House actually had on their Web site that was supposedly showing the transparency and accountability for all the tax dollars that they said that they would display how that money was being used. And so we had actually inquired about this and our local newspaper, the Times Picayune of New Orleans, did a little digging of their own

and called the White House and said, How is it that you can have this Web site and you're showing districts that don't even exist, showing jobs created in places that don't exist? What is really going on here?

The first thing the White House said is, We're not certifying the accuracy of the information. That was the quote from the White House. The group that said they would be the most transparent administration in history, when finally tasked with showing the American people where billions of dollars of money that we don't have is being spent, their answer was, We're not certifying the accuracy of the information.

And then, if I can follow up, they actually went further and they said, Okay, wait. Hold on a second. Okay, let's say you're not certifying the information, but you're actually showing on your Web site districts—and this just isn't in Louisiana. We found this in Arizona and Kentucky. Probably Missouri.

Mr. AKIN. I heard Oklahoma had 99 districts.

Mr. SCALISE. They were showing districts that didn't exist all across the country, and they were bragging about the jobs that were created in those districts that didn't exist, those phantom districts. So they said, Well, how is it that you can show on your Web site a district that doesn't even exist? The answer from the White House—and that is riveting, because this is taxpayer money, this is money our children and grandchildren are going to have to pay back, money that you and I said should not have even been spent in the first place because it was money we don't have, and it wasn't going to create jobs—and they asked the White House to follow up, and they said, How is it that you can show information that's false on your Web site? The White House's answer was, Who knows, man, who really knows. That was the best they could come up with, and the American people deserve better.

Mr. AKIN. This is a million-dollar Web site created by the White House, the Obama administration. They come up with districts that don't exist in various States. And when asked—what was the quote again? This is brilliant. This is really academic. Who knows, man, who really knows. Hey, far out, dude. I mean, Woodstock lives.

What are we talking about here? They're talking about districts that don't exist, claiming that jobs have been created; and yet here we are on the floor, we're not necessarily wizards, but we know enough about small business that excessive Federal spending is an enemy to it. And so what is it that the Obama administration promised? I happen to have the promise. Instead of all these jobs and, Who knows man, who really knows, here's who really knows. This is what the forecast was going to be for the unemployment if we passed the stimulus bill, which we did. This was the Obama forecast without the stimulus bill. And what really happened?

Well, the red line is what's going on. This is unemployment after we spent $787 billion that we don't have, which really wasn't a stimulus bill. As you recall, the chief of staff for the President said, We want to use every crisis as a good opportunity to move our agenda. So their agenda in the supposedly stimulus bill was to basically get rid of all the Republican welfare reforms and add all kinds of money in all kinds of various bailouts and things, but there really wasn't even an FDR-type stimulus in this bill.

And we stood here on this floor—I think you were with me, what was it, 6 months ago—we said, This isn't going to create any jobs. Now here we are at 10.2 percent unemployment, and that number is conservative because if you've lost your job for more than a year, you're not even on the report any more, even though you may be doing a little part-time work or don't have a job at all. It doesn't count you. And even not counting those people, 10.2 percent unemployment. And so what's happened here is just exactly what we talked about.

I'd yield.

Mr. SCALISE. Some of the economic experts are actually saying that the true unemployment number right now is probably closer to 17 percent because there's so many Americans that just stopped looking for work because of the tough economic times. And so what we had pointed out back then in February, 10 months ago when they first brought this stimulus bill, we pointed out that you don't create jobs by growing the size of government. You don't create jobs by borrowing money from our children and grandchildren. You create jobs by helping small businesses enjoy a climate where they can actually go and create jobs. Because it's not government that creates jobs, it's small businesses out there.

The small businesses create about 70 percent of all the jobs in this country. They are our job creators. And what they've been saying and what American families have been saying is: Government, stop all of these policies that are literally shutting down companies and running jobs off to countries like China and India.

And so what we've had this year, we have seen this cap-and-trade energy tax. That's been one of their answers that literally would run millions of American jobs out of this country to other countries. Then they came back with—of course, they had the bailouts and then they had the stimulus bill and then they had the budget that doubled the national debt in 5 years.

And then after cap-and-trade they came with the health care bill, the government takeover of health care, which they're still putting as their top priority. Of course, President Obama is using that as his top priority when the American people are saying, We don't want a government takeover of health care; we want you to reform things that are broken. And we've presented legislation to actually fix the problems—to lower costs, to address preexisting conditions—the real problems American families are having with health care. But what American families don't want to see is the government take over all of health care and literally shift the hundred million more people onto a Medicare system that's already struggling to make ends meet. And senior citizens know that.

So what they're asking is: stop dealing with all of these policies that are actually running more jobs out of our country. Go and help create jobs in small businesses by lowering tax rates. And guess what's going to happen here on the House floor tomorrow? The Democrat leadership is actually bringing a bill to make permanent the death tax at a 45 percent tax rate. That's going to kill small businesses in this country. And that's their priority instead of creating jobs.

Mr. AKIN. If I could just ask you to yield back, everything you said is exactly spot on, and it is the solution to trying to deal with unemployment. But I think what I'd like to, if it's possible, just for a minute, get a little philosophical here and talk about the fact that when you take a look at the political parties, in general these are two different ideas about what you do when you've got problems with unemployment.

One of them was proposed by a little British economist by the name of Lord Keynes. He was accompanied in his mischief with a fellow by the name of Morgenthau, who was FDR's Secretary of the Treasury. That idea was called "stimulating the economy." The idea was that if the government will just spend enough money, it's going to create demand, and therefore the whole economy will run. It appeals to me as an engineer about just as much as the idea of reaching down, grabbing your bootstraps, and try to lift yourself so you can fly around the room. But the idea is that when you've got a bad economy, the government should spend money like mad and it'll "stimulate the economy." And so that was one theory.

Another theory that was developed—and that usually is the Democrat theory, although not entirely—the other theory is: get your foot off the spending and the taxing, leave enough money in the company and, particularly with small business owners, to allow them to invest. When they invest, they create jobs and you allow the free market and you allow Americans, in the ingenuity of Americans

and freedom, to motivate and to build a country bigger and stronger than it was before. And by doing that the economy gets stronger because individual citizens, not the government, are the ones that create the jobs.

And so that was another formula that was tried by, among others, by JFK. Also by Ronald Reagan and G.W. Bush. All got off the taxes, left more money in the pocket of the small businessman, and voila, the economy takes off like a rocket in all three instances.

The other example, I want to run back to it. You've got this guy Morgenthau and here it is 1939. Now we have turned a recession into the Great Depression. And Morgenthau comes before the Ways and Means Committee. This is something that happened long enough that people around here should know something about it. This was the buddy of little Lord Keynes. And this is what he says: we have tried spending money. We're spending more than we have ever spent before—and it does not work. And he goes on to say, After 8 years of the administration, we have just as much unemployment as when we started, and an enormous debt to boot. This is FDR's guy that was one of the original stimulus people.

So when I hear people say stimulus—this is the result of stimulus: it's unemployment. It turns a recession into a Great Depression. So what did we try in April or May of this last spring? We tried the same dumb idea. And guess what? We're getting the same lousy results. No big surprise.

So there are two ways to approach unemployment when you've got a problem in the economy. And the idea of spending a whole lot of money that you don't have, like $787 billion, it never worked for him. And all of these nice predictions that we saw show that it just hasn't worked the way the administration said that's where we're going to be.

Here's where we are. You see the trend of that line? That's not exactly a hopeful trend.

I'd yield to my friend.

Mr. SCALISE. I thank my friend from Missouri for pointing that out. And when you go back to those comments by Henry Morgenthau, the Treasury Secretary for FDR, the comments that he made in 1939, there's an old saying: history repeats itself. And the unfortunate part of that is we're standing at a very critical point in our Nation's history. We're at one of those crossroads. And are we actually going to be here in Congress and try to perpetuate the great legacy of America, and that is that every generation has inherited a better Nation than the one that was passed down to them by the previous generation.

And that's a great tradition our country has always enjoyed. And that tradition is at risk right now. It's at risk because of the spending and the borrowing that's being perpetuated by the liberals that are running Congress right now.

When you show that comment from FDR, it's very telling because when this administration came in, President Obama made a point everywhere he went, and he still talks about it today, saying he inherited the worst economy since the Great Depression. Well, first of all, if you go back and look at the Great Depression and the signs there, they were much worse than the signs he inherited. The signs he inherited weren't as bad as what Jimmy Carter created that ultimately led us to Ronald Reagan. When Jimmy Carter was President we had double-digit unemployment, we had double-digit interest rates, and double-digit inflation. In fact, they created a new term for it called ''stagflation.''

When President Obama came into office, we were less than 8 percent unemployment. So it was single digit. It was still a high number, but it was a single-digit number. We had very low inflation and very low interest rates. Right now, because of President Obama's policies, these policies like cap-and-trade, like the spending and the stimulus bill and the health care government takeover, they have led us now to double-digit unemployment; but what we're starting to see are the telltale signs also of creeping up interest rates and inflation because of the policies of President Obama.

So when he talks about this being the worst economy since the Great Depression, I think what he was trying to do was set up an event so that he knew his policies probably would create double-digit unemployment and double-digit inflation and double-digit interest rates, because history does repeat itself. So he tried to set the stage that he was walking into something worse than what he walked into, but he's created an economy that virtually is leading us back to the 1930s, when we did have the Great Depression, and it's because of his policies that are spending, taxing, and borrowing our country into oblivion.

I yield back.

Mr. AKIN. Just reclaiming my time, the fact is that history does not have to repeat itself. It repeats itself if people make the same dumb mistakes over and over again. That's when it repeats itself. What we're doing here is we're doing the same things over and over again that have not worked in the past. But it doesn't have to be that way.

I really thank my friend, Congressman SCALISE, for his perspective and for joining us. I'm also joined here on the floor by my good friend, Mr. THOMPSON of Pennsylvania. I'd like to yield time to the gentleman.

Mr. THOMPSON of Pennsylvania. I thank my good friend for yielding and for also taking the leadership on this very important debate. I think of all the things that are going on across this Nation—and there are no shortage of issues—the issue that cuts directly to the heart, the economic well-being of our citizens, are jobs. We know that we are in dire straits with jobs in this country, the first time in decades the unemployment rate has gone over double digits, at 10.2 percent.

□ 1900

Now looking back, I see my good friend has a chart there that talks about the stimulus and talks about the percentage of unemployed. I remember vividly sitting in this Chamber where we were talking about—and it was a mandate that we had to do something because unemployment was at 8 percent, and if we did nothing, perhaps it would go over 8.5 percent. What was done and what the Democratic Party did was to just spend, and I think misspend.

I believed in my heart back then that it was not the right thing to do, that, frankly, it would make matters worse, that it would drive up unemployment, because as people would lose confidence, those entrepreneurs, those people that are small business people, those folks who were willing to take that risk and work long days—sometimes without taking a salary themselves to create prosperity—weren't going to have the confidence to be able to do that.

Usually I like being right. But unfortunately, I'm sad to say that we were correct, that I was correct, when unemployment went to 10.2 percent.

Mr. AKIN. Just reclaiming my time, gentleman, you were here on the floor with me when we were talking about this very thing. It wasn't so many months ago. It isn't that we are great wizards of economics. It's just that we've learned something from history. The fact is is that the method and the approach of ''stimulating the economy'' or, effectively, tremendous levels of government spending and money that they don't have, does not help an economy that's ailing, and it's not going to help unemployment. We were here at this 8 percent unemployment, and we were told that, Hey, if you don't get this stimulus bill through, why, it's going to go above 8 percent. We passed the stimulus bill, and here we are at 10.2 percent. But that's not a coincidence.

Now of course the Obama administration would love to try to blame that on President Bush and everything. But what he has unfortunately not done is learned from—even if he didn't want to learn from a Republican, he could learn from a Democrat. He could go back to JFK. JFK was faced with this problem. He had a problem with unemployment. And what did he do? He did something that was not intuitive to Democrats. He actually lowered taxes. He did a tax reduction just the same way Ronald Reagan did.

And the effect of that tax reduction was to allow the small businessman to have more money to invest in their business. And guess what happens? When small businessmen have the liquidity and they have more money to invest in their business, they add a wing on the building, they add a new machine, a new process, a new invention, a new idea. And freedom works. What happens is, you create jobs, and the economy takes off.

Now here are some numbers that—to my good friend, Congressman THOMPSON from Pennsylvania, you weren't here at the time. But when I came in at the beginning of 2001, people don't realize—just because the Federal Government doesn't like to balance their budget—they don't like to realize how much these recessions and a bad economy hurts the Federal Government in terms of taxation, in terms of revenue.

And what was going on was, you know, the liberals were crying and moaning about how much money we spent on tax reduction, and Oh, we're giving the rich guys a deal, and you're reducing taxes, and that's going to cost the Federal Government all its revenue, because they calculated that if you lower taxes, then you're going to collect less revenue. That was the logic. It seems intuitive when you just look at it superficially. But what you found was—and this was an interesting number—as we reduce taxes, the businessmen, the owners of small businesses, then created more jobs because they had money to spend. They created more jobs, and the economy turns around. What happens is, we take in more revenue than we had before.

But let's just say that, even in the most pessimistic sense, what surprised me was this: If you added the cost of—supposedly the cost of the Bush tax cuts, and you added the cost of the wars in Iraq and Afghanistan together, that total dollar value was less than what we had lost by the recession and what the recession had cost the Federal Government in revenue. You see this, gentleman, in Pennsylvania—and we do in Missouri, all the other States around the Union, particularly that have balanced budget amendments—and that is, when the recession comes, boy, the States are hurting. They have to really scramble because their revenues drop dramatically when we enter a recession. But that's also true of the Federal Government. Our revenues drop tremendously.

So this formula of excessive government spending is the exact wrong thing to do. And what it does is, it turns a recession into a depression. That's why these charts are going the way they are. This should be a warning sign that what we should not be doing is a whole lot more taxing on small business, yet it seems that every time you turn around, here comes another tax. We've got to hit somebody, so why not tax?

Let's take a look at just one other thing, and this will be something I would like to get your impression on because Pennsylvania is a good industrial State. You've got a lot of jobs, a lot of good hardworking people there. It's kind of a theoretical question. But does the government really create jobs? You know, on the surface, it seems like if the government takes the money and hires somebody to build a building or something, it seems like they have created a job, because somebody's got to build the building, and they took some money, and they paid somebody, and the somebody did something.

So can the government really create jobs? What we find is that you've got to be careful. I just wanted you to talk about that a little bit, if you would like to, gentleman.

Mr. THOMPSON of Pennsylvania. I would, and I appreciate that opportunity. The government cannot create jobs. Unemployment is now 10.2 percent. I would admit that I'm sure within that, even despite the bad unemployment, there are jobs that are temporarily subsidized by the Federal Government, even some of the projects that I originally thought would be good stimulus infrastructure projects. Well, those are not sustainable jobs. Those jobs are only there as long as the government is subsidizing them. As soon as that subsidy goes away, as soon as the stimulus money is spent, those folks are laid off.

A job, as I define it, is a good family-sustaining job that is there, that grows, that not only grows but that is working in a business, mostly small businesses is my experience, that is creating other new jobs. So this really has been fiscally irresponsible in terms of the spending that has gone on. It hasn't gone on for the right reasons. I think you and I are both supporters of a better plan. Now this is going back to when we were debating the stimulus originally, and the Republican alternative we had recognized that the true economic engine of this country is small businesses.

Mr. AKIN. Right.

Mr. THOMPSON of Pennsylvania. And we had proposals that were put on the table to ask for a vote that would provide tax deductions of up to 20 percent for small businesses, benefits that went to businesses with 500 employees or less, which effectively employ a large majority of Americans throughout this Nation. They are economic engines that create prosperity, create new jobs and not jobs that will go away when government subsidies stop. These are jobs that are sustainable because they are based on real economics. They are employing people that are hardworking Americans, and most of these are small businesses owned by individuals who are willing to make the sacrifices, take the risks to go after that.

Now as I travel around my district right now, I've talked with a number of people that I consider my heroes in terms of small businessmen and -women, people who have started with nothing, but they're willing to work hard to take that risk, and they had that American dream.

Mr. AKIN. Put everything on the line.

Mr. THOMPSON of Pennsylvania. Absolutely. And year after year, these folks have been the ones that have gone out, and they've created new jobs every year by taking what they've invested, the return on their investment, and put it back into their small business. They reinvest there.

And you know what, I can't believe how many of them I'm talking with right now that are sitting on the sidelines because they're afraid of what's been going on in this country since January. They're afraid of the deficit spending they've seen. They're afraid of the regulations we've seen. These are small businessmen that—most of them pay their taxes as a limited liability corporation or an S corporation. So they pay their taxes on their businesses through their personal income tax. These are the folks that my friends on the Democratic side of the aisle have been piling on in terms of new taxes, more taxes, claiming these are the rich, and they can afford to pay more taxes. Well, actually what these are are the job creators, and when we pile on them, it forces them to sit on the sidelines.

Mr. AKIN. Just reclaiming my time, what you're talking about is the old proverb of killing the goose that lays a golden egg. Here is the thing that's a little bit tricky, because if you think about it, the government goes to hire somebody to build a highway. You say, Well, that's a good job. Somebody is building a highway. Well, it's true that for some period of time—and you put the emphasis on temporary—that job is there as long as we are taxing somebody to get the money in order to hire that guy. The way that economics works is that for every job, by taking taxpayers' money and creating a job with the government, what we do is we kill 2.2 jobs in the private sector.

So effectively, what you're doing is a very inefficient means of bleeding part of the sector that creates the real jobs and creating temporarily a government job. My son is in Afghanistan. We have places where the Federal Government hires people. They're legitimate jobs that need to be done, but all of those things are balanced on the back of the private sector. If you get too greedy and you start to squeeze the private sector enough, not only do you make it sick, you can kill it. And that's what was done during the Great Depression. They started taxing those small businesses so much and put so many regulations on them that they killed them, and they went out of business.

And that's what's starting to happen, and that's what frightens me terribly about the approach that we've got here. As I started this evening, I talked about what are the things that destroy jobs, and you just intuitively—you are talking about the people of Pennsylvania and about the businesspeople, you know, those courageous, quiet souls that go out and take the risks, not knowing whether they're going to end up sleeping under a park bench if their business goes out. They've put their whole life into it. They've invested in a new piece of equipment. And in the process, they create wealth and create jobs and stuff, those people.

Well, what do we do if you really want to hurt them? Well, what we do is everything we've been doing for the last year. First of all, it's this out-of-control Federal spending on all kinds of wasteful things. For instance, that stimulus bill had billions of dollars for community organizers like ACORN. We had money in that bill to produce that Web site that created congressional districts that don't even exist, claiming the jobs were created. That's a waste of money. The next thing, as you properly pointed out, is that you start taxing people, not only for the stimulus bill, but you tax them on energy.

So now this guy that's got a business, perhaps he uses a fair amount of energy, thinks, uh-oh, I'm going to have taxes on energy now. Then the issue that you properly pointed out is that you start creating this sense of fear and uncertainty. So now you've got red tape and more taxes and more taxes. The guy thinks, How in the world am I going to make a living with that? That's what's being done not just in Missouri and Pennsylvania, but it's being done to our economy because we're doing the wrong things. And it's not so complicated because other Presidents have shown the right way to go.

Let's just take a look at what we're doing, just hammering them fiscally. You started to list them off. First of all, there's the death tax, and there's dividends and capital gains. Those are taxes that were cut by Bush back in 2001 and '03 in order to get those small businessmen up and going. So those have been cut temporarily, and now that's going to expire, and what have the Democrats told us? I yield.

Mr. THOMPSON of Pennsylvania. I think this week, tomorrow we're going to be voting on the estate tax here.

Mr. AKIN. You mean the death tax.

Mr. THOMPSON of Pennsylvania. The death tax.

Mr. AKIN. Death is a taxable event, is the way they want it to be.

Mr. THOMPSON of Pennsylvania. It's not only a taxable event, but it's double taxation because all the money the government will be taxing has already been taxed at one time or another.

Mr. AKIN. So we'll get them coming and get them going. If they're dead, they don't complain as much.

Mr. THOMPSON of Pennsylvania. I think that's an excellent point, but that still doesn't make it right, and it's just absolutely wrong. I think the rate that we're looking at was 45 percent.

Mr. AKIN. Okay. So let's just run this logic. How logical is this if you want a decent economy? A guy is a farmer. Let's say he's got 200 acres of ground, maybe it's 2,000 acres of ground, and some tractors, and he dies. Now his son wanted to run the farm. So now when he dies, what does the son have to do?

Mr. THOMPSON of Pennsylvania. He's got to sell part of the farm because there is certainly no large fortune in farming sitting back there in liquid assets to be able to pay the death tax.

Mr. AKIN. So he has got to pay 45 percent of the value of the farm. If he's got 2,000 acres and a couple of tractors or whatever it is, he will have to sell almost half of that. Then it will get to the point where the farm is no longer selling half of what it makes it so that it doesn't really work. So what happens then?

Mr. THOMPSON of Pennsylvania. Well, I can't imagine. And today farming is such a challenge. We just had a hearing earlier today with one of the Agriculture subcommittees on the impact of the climate change on farmers. I was relating the plight of the average dairy farmer in my district. Dairy farming is a big industry. It's certainly an important industry to our Nation. Farms range in sizes, but the average size of a farm in my district is about 80 head of cow, 80 to 85. They tend to have enough acreage just to grow their own corn, to grow their own feed. Beyond that, that's the operation they run. And today on a dairy farm—and this is a Nationwide statistic—because of the problems we have with the pricing of milk, the fact that the Federal Government got involved in that decades ago, the average farmer loses $100 per cow per month.

Obviously, when, unfortunately, a dairy farmer passes away, there is no reserve sitting there to pay off the death tax. What are you going to sell from a dairy farm to pay that tax? Are you going to sell the cows? Well, you're not going to be a dairy farmer. Are you going to sell off the acreage? You're not going to be a dairy farmer. Are you going to sell the barn? You can't do that. You need the tractor. I think that just represents the plight of our farmers with that type of tax. There is nowhere to go.

Mr. AKIN. Reclaiming my time, it's interesting you mention that. I have a nephew that worked on a dairy farm in upper New York State. What you mentioned, 80 cow. The number I recall then was about 90 cows, 90 to 100 cows. It's kind of the standard lot size. It's about how much one man can kind of operate with his family.

So if you all of a sudden have to sell half of that, even if you could—say you could sell half the cows, half the farm, half the equipment, the problem is that half of it doesn't work. It no longer works. So if with every generation, you've got to cut the business in half, and give half to the Federal Government, how in the world are we going to have jobs and a strong economy? It's just nuts.

□ 1915

So, first off, we've got the death tax. We've got dividends capital gains. All of those are expiring and going back, which is going to have the exact opposite effect on the economy as what it had a couple years ago when we put it in place and it helped the economy get going.

Then on top of that, we've just spent $787 billion on that silly stimulus bill, $700 billion for the Wall Street bailout. And now we're talking about the biggest tax increase in the history of the country for global warming, an energy tax, along with tons of redtape that goes along with it, telling everybody in the country they've got to have an electrical outlet in their garage for their golf cart or whatever it is.

I mean, this is an awful lot of redtape, regulations, and taxes, all with the effect it's going to just kill those jobs. So there's a reason why that red line is going up, isn't there?

Mr. THOMPSON of Pennsylvania. If the gentleman would yield.

Mr. AKIN. I yield.

Mr. THOMPSON of Pennsylvania. Certainly, we cannot forget the taxes from the health care bill.

Mr. AKIN. Of course that's a couple of additional taxes on top of the small business men.

Mr. THOMPSON of Pennsylvania. Over $700 billion in taxes, much of that balanced on the backs of small businesses.

Mr. AKIN. So you're telling the small business man now we're going to tell you what kind of health insurance your employees need and you're going to have to pay for it, and if you don't do that, we're going to fine you and we're still going to tax you for it. And on top of that, that isn't quite enough to take out of your hide, we're also going to put an additional 5-something percent tax on top of any profits that you make in your business. So for sure you won't be able to invest that money back into your business because we're going to get that, too.

So on top of all of this, the redtape, the uncertainty, the lousy economy, tax after tax after tax, now we're going to hit them and tell them, by the way, any employee you've got, you're going to have to pay for their health care and

we're going to tax you heavily for that. What's that going to make a small business man do?

I yield.

Mr. THOMPSON of Pennsylvania. That's a great point.

There was a headline in The Wall Street Journal just yesterday that said ''Job Cuts Loom as Stimulus Fades,'' and I think that speaks to the original point that we've made that the stimulus is unsuccessful. It has failed.

I know the President is having a jobs summit tomorrow. I'm hoping, actually praying, that when he does that, that better minds prevail and he hears from people attending that summit the types of things that we've been talking about. And we have been talking about this since January because we know we've had this issue. We have been talking about things such as cutting taxes for small businesses, of reducing the burdens that we put on those job creators. I mean, those are the types of things that we should be doing in terms of economic stimulus. And I know that our friends, the Democratic colleagues, are going to be looking at a stimulus two here, and my concern, my big fear is it's going to another special interest, big spending bill that really isn't about creating jobs, but it will be in the name of jobs.

Mr. AKIN. Reclaiming my time, I appreciated your optimism. The President has declared that he's going to have a meeting to get together and talk about the economy and everything, but I happen to know something about the invitation list. I don't know who was invited, but I have a pretty good idea.

I know who was not invited. The U.S. Chamber of Commerce. They represent businesses and small business. They weren't invited. The National Federation of Independent Business. These are all over. I assume you have them in Pennsylvania.

Mr. THOMPSON of Pennsylvania. Oh, yes.

Mr. AKIN. I have them in Missouri. These are coalitions of lots and lots of small businesses. You think they were invited? No, they're not invited. Who is invited? All the people who got money under the first stimulus bill.

So, first of all, the whole idea of the stimulus bill is wrong economics. You're not going to get the economy going by spending more money. If getting the economy going by spending money were how you did it, holy smokes, our economy would be red hot and on fire. We've been spending money like there's no tomorrow. And the economy is not doing so well. Look at that unemployment line. Spending money is not the solution. Yet the idea of more stimulus, more stimulus, it's just nuts.

Who was it, Einstein, that said if you keep doing the same thing and expect a different result, it's insanity? We're getting close.

I yield.

Mr. THOMPSON of Pennsylvania. There's a two-part penalty to this. One is that we're spending all this money, but this is not even money that we have. This is deficit spending. This is spending that we have to reach out to creditors and to take out loans. And who is our number one creditor? Who's the number one entity that's lending us money? It's China. So it's not just spending; it's deficit spending.

The last time I remember a situation like this specifically was back at the tail end of the President Carter years, and my wife and I were young. We had just married. We were looking to purchase that first home. And we weren't making a whole lot of money, but it looked like, actually, as we looked around, that real estate wasn't particularly very expensive, and the reason for that was because of the inflation and stagflation that was going on at that point in time. So we actually applied for a first-time homeowner's loan from the State, and we thought we were in the money. We got that, and our interest rate was 14 percent.

Mr. AKIN. Fourteen percent.

Mr. THOMPSON of Pennsylvania. Fourteen percent. But that was a great interest rate, because at that point, the banks commercially were lending at 19 and 20 percent. But it was because of where we were in terms of high inflation and high unemployment, stagflation.

Mr. AKIN. Of course, the inflation is created by the Federal Government basically dumping more and more money into the money supply.

Mr. THOMPSON of Pennsylvania. Absolutely.

Mr. AKIN. I was just looking at a chart from 1960 up through this year, and you go along and it looks like a little saw tooth. It's running along. It's called M1, or the money supply, and last year we had a 10-times' increase in the government's release of that liquidity. Now, so far it hasn't turned into inflation yet, but every time that people have done that in the past, sooner or later it comes around to bite you as inflation.

We were just talking about spending. Here's kind of a chart of it. Here's the Wall Street bailout part two, and here's the stimulus bill, and then there's the SCHIP and then there's the appropriations bill. There's another bill. And then there are the other two that have not been passed yet, the cap-and-tax and the health care. To estimate that as a trillion is being generous.

I think it's helpful to compare a couple of things that are similar. As you recall, the Democrats were critical that Bush spent too much money. In fact, I was here some of those years. I voted against some things that the administration wanted because I thought it was too expensive. But let's take President Bush's biggest spending year. His biggest deficit was in 2008. That's when the Democrats ran the House here. That was about $450 billion or so, and that was 2008. If you took the $450 billion as a percent of our gross domestic product, that was about 3.3 percent.

This year they just calculated the numbers, and the spending is $1.4 trillion. That's three times more spending in the first year than President Bush's was in his worst year out of 8 years. Three times more. And it puts the level of debt that we have created not at 3.3 percent of GDP but at 9.9. So we've more than tripled that ratio. It's the highest it's been since World War II because of this, because we just can't seem to say no to spending. And that's not the formula to help with the jobs problem.

I yield.

Mr. THOMPSON of Pennsylvania. It's almost like our Democratic colleagues look at it as a candy store and that there's no end to it. It's an endless supply. And I suspect that at some point where—I know that we're probably coming up on the debt ceiling in terms of the amount of debt that we're able and allowed by law, by statute, to accumulate as a country. And I don't know that exact total, but I believe it's somewhere around $14 trillion, and the fact is that we are fast approaching that just after this past year.

I came here in January. Frankly, I think both parties were fiscally irresponsible in years past. I would be the first to admit that in terms of my party. And that's one of the reasons I was motivated to come, because if we were running a household, we would not be fiscally irresponsible. We'd live within our means. And the Federal Government has not done that under the leadership of either party in years past and certainly this year with my Democratic colleagues in control.

The fact is that this is not a candy store, and in terms of raising that debt ceiling, I think that's just providing a license for more and more deficit spending going forward into the future. And I would encourage all of my colleagues that we need to be bringing that debt down. We need to be working towards being debt free. That is fiscal responsibility. That is running this House the way we run our houses at home, and that is something that we need to restore. We have not had that for a very long time in this country, but I think that is something that we need to be committed to.

Mr. AKIN. You're absolutely right.

The reason that we're getting off the wrong track here is just because of this whole liberal Democrat concept of economics. They're trying to make two plus two equal five. They're trying to basically repeal the law of economics.

If you and I in our household, if we thought, oh, we're getting tight on money, we're starting to have economic hard times in our family, so let's

go out and just run up a huge credit card bill and that will somehow make it better, people would lock us up. They'd put us in little white suits and lock us away somewhere and say these people are crazy.

Mr. THOMPSON of Pennsylvania. And we did that. Unfortunately, that does happen in our Nation, and what happens is people experience bankruptcy. They ruin their lives by doing that.

Mr. AKIN. Right. Except in this case, when the Federal Government does it, we bankrupt the entire Nation.

Mr. THOMPSON of Pennsylvania. Correct.

Mr. AKIN. And one of the effects of the bankruptcy is unemployment, among other things, but it also is impoverishing everybody.

You cannot repeal the basic laws of supply and demand, and you cannot basically give away housing where people can't afford to pay for it without expecting to have consequences. Kind of going back to the beginning of things, that's what got us into this trouble not so many years ago.

Here's something I think a lot of people aren't aware of but we need to understand, how did we get into this problem? It was because of this idea that somehow we think that we are able to repeal the laws of economics.

This is September 11. It's not 2001. This is September 11, 2003. It's an article in The New York Times, not exactly a conservative source of information. And here is the author of the article, and it says: ''The Bush administration today recommended the most significant regulatory overhaul in the housing finance industry since the savings and loan crisis a decade ago.''

Let's get this straight. This is The New York Times. This is bad President Bush's saying that we need to have a significant regulatory overhaul in housing finance and the strongest thing since the savings and loan crisis.

''Under the plan disclosed at a congressional hearing today, a new agency would be created within the Treasury Department to assume supervision of Fannie Mae and Freddie Mac, the government-sponsored companies that are the two largest in the mortgage lending industry.''

So this is 2003, Bush sees irregularities in Freddie and Fannie in how they're managing the business. Why would there be irregularities? Because they were mandated and allowed to make loans to people who couldn't afford to pay the loans.

What's the Democrat response to what President Bush wanted to do? Well, what happened was he passed a bill in the House to do this. I was here. We voted for this bill. It went to the Senate. It was killed by the Democrats in the Senate.

What was the Democrat response in the House to Bush's saying we've got to get on this Freddie-Fannie problem or we're going to have an economic crisis on our hands? Well, with respect to Fannie and Freddie, I did not want the same kind of focus on safety and soundness that we have in——

The SPEAKER pro tempore. The gentleman's time has expired.

Mr. AKIN. Thank you, gentlemen, for joining me. It seems like the time has flown, and I look forward to our next evening.

□ 1930

THIRTY-SOMETHING WORKING GROUP

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Ohio (Mr. RYAN) is recognized for 60 minutes as the designee of the majority leader.

Mr. RYAN of Ohio. Mr. Speaker, we're happy again to kick off another edition of the 30-Something Working Group in which we will try to bring some facts and some analysis to the floor of the House of Representatives.

I can't help but get up after having to sit through what our friends on the other side were talking about a little bit. And it's interesting, Mr. Speaker, as we see some of our Republican friends have a very short memory as to what transpired here. And I have been fortunate enough to be here over the last 7 years and was able to watch President Bush with the Republican-controlled House, a Republican-controlled Senate, a Republican Supreme Court, many State legislatures and the State Governors' Mansions were controlled by the Republicans. In Ohio, I know that of course was the fact. Run up huge budget deficits, start wars, cut taxes for the top 1 percent, take their eye off Wall Street, ignore health care, continue to support and subsidize the oil economy, push globalization, not enforce our trade laws—all with a rubber stamp from the Republican Congress.

And then all of a sudden in 2008, 2009 the bottom falls out. Wall Street collapses. We see the stock market collapse, credit locks up. On and on and on. And our friends on the other side act like that just happened by happenstance.

And now, in order to try to address those issues, we have to make some very difficult decisions as a country and come together as a country. And we get people ignoring the previous 8 years, when anybody who is being realistic can see how we got here.

And all we want to do now is have a conversation about how we move forward and how we use this and see this as an opportunity to address some of the major structural changes that we have in the United States of America. And there are two major ones in our economy that have been like an albatross around the necks of small business people all over our country and big businesses all over our country, and that is health care and that is energy.

And so this Congress has stepped up to bat to address two of those major problems without a lick of help from the Republicans, not a lick of help. And at the end of the day, they're going to be on the wrong side of history, like they were for Social Security and Medicare and civil rights and a lot of the other major issues that really gave us things to be proud of in this country.

And so as we move forward with the House bill on health care—and now the Senate is opening up debate and having debate on the health care bill—we are trying to address the concerns of the American people.

And I want everyone, Mr. Speaker, to understand the issues that we have taken up here as a Democratic Congress. And this is all with the understanding that we know that the unemployment rate is too high, there are too many people out of work. There is a lot more work to be done.

But if you look at the previous 8 years prior to President Obama, you will see an administration that completely catered to Wall Street and Big Business in the United States of America, whether it was a trade agreement, whether it was immigration laws, whether it was health care, whether it was energy. You could bet your bottom dollar that President Bush was on the side of Big Insurance, Big Pharmaceutical, Big Oil, Big Agricultural, right down the line.

And when we came in as Democrats, we began to change that. And all you have to do—and they say you can judge someone by their enemies—the Democratic Party took on the Big Oil interests. The Democratic Party is taking on the insurance industry. The Democratic Party is the one party getting the banks out of the student loan business. And all of these sweetheart deals that were set over the last 8 years are on their way out the door. And President Obama got stuck with a heck of a mess, there is no question. A heck of a mess.

But in America, we have to live in reality. I know some people on the other side may not necessarily agree with that or like that, which is fine. But we are the majority party, and we have to deal with reality without illusions and deal with the facts that are at hand.

And here are the facts: if we do absolutely nothing with health care, the average family of four next year will have an $1,800 increase, $1,800. And then the following year it will be another $1,800, and the following year it will be another $1,800. That's reality. Everyone is agreeing on that

If we do nothing, human beings, American citizens in this country, will continue to get denied coverage by insurance companies because they have a

preexisting condition. That preexisting could be you were involved in a domestic violence situation; that preexisting condition could be infertility, or as we even heard, spousal infertility. You're denied. Diabetes. Cancer. That's if we do nothing. If we do nothing, just in my congressional district in northeast Ohio we will have 1,700 families go bankrupt next year because of health care costs—if we do nothing. And on and on and on right down the line. An inhumane, costly, expensive, inefficient health care system.

And so we chose to take on the big fight. We chose to make a human decision to say this problem needs to be fixed, it needs to be addressed, and we know it's politically risky but we know we're going to do it because there are too many people in the country, Mr. Speaker, who need us to act and not sit on the sidelines where it is safe.

It would have been nice, we could have just said, You know what? We're going to play it safe. We're not going to do anything that's going to upset anybody or get FOX News riled up or Rush Limbaugh or Clear Channel, the right wing talk radios. We're just going to play it safe. But at the end of the day, history would not be very good to us because they would have said, What did they do in Washington, D.C., when this decision, these hard decisions needed to be made 10 years ago?

And our kids and our grandkids would say, Jeez, Mom. Jeez, Dad, you were in Congress during the very difficult time. We needed some big decisions to be made. What did you do when you were there? And you can look proudly at your kids and say to them, I did nothing. I played it safe. I sat on my hands because I wanted to get reelected or I was afraid that Rush Limbaugh would make fun of me.

The reforms that are coming out of this House of Representatives—as I have said when I am back home in Youngstown, Ohio; in Niles, Ohio; in Warren, Ohio; in Ravenna; in Kent and Portage County; Akron—these reforms are for our people, our people who have struggled and fought and got zero wage increases over the last 30 years, who've got to haggle with the insurance company, get denied, get ignored while they're on their death bed, lose their job, lose their pension. That is wrong, Mr. Speaker. Wrong. And we're going to do something about it.

So let's just take what happens when health care reform passes. There will be some time until the exchange gets set up and, you know, whether there's a public option and what it looks like. That may take a couple of years. But immediately what happens is that no longer in America will you get denied coverage because of a preexisting condition. Never again. If you have a child, a son or daughter, who is under the age of 27 years old, they can stay on your health care insurance. So all of those young people in their early and mid-20s who can't get health insurance or can't afford health insurance can stay on their parents' health insurance. That gets implemented immediately.

If you have a health care catastrophe in your family—and being a Member of Congress, we get these calls, and we are out in the public and we meet these people at the fairs, at the festivals, at the bowling alley, at the bingo halls, at the civic events—there will be a cap on how much you can pay out of pocket per year on health care costs so that we can eliminate people in the United States of America going bankrupt because they had a health care catastrophe. And all of our friends on the other side of the aisle who talk about family values and everything else voted against that. Voted against it.

So when you look at the health care reform bill, it is a values issue. It is a family values issue that we need to address. And our budgets and our investments speak to that, speak to our values and what we care about and what we stand for.

And when you look at it, AARP's endorsed it, the American Medical Association's endorsed it, the Catholic Bishops had nothing but good things to say about it. And even the Business Roundtable, the top CEOs in the country, said that the health care reform bill in 2019 will save them $3,000 an employee, $3,000.

Now, you can argue with me, you can argue and call people ''liberal'' and ''socialist'' and pull out all of the names that our friends on the other side have been using for the last 60 or 70 years in their rebuttals to policy initiatives by the Democratic Party, but you can't argue with the Business Roundtable saying that it's going to save them $3,000 per employee.

And aren't we tired of getting calls from small business people telling us about all of the increases, all of the rate increases? And I just got a call the other day from a health care provider talking about this issue and another from a health care business person who said he just got in the mail a 50 percent increase for his business. He had one person out of a couple hundred get sick. Pushed the number up. Next thing you know, he goes from paying $600,000 a year to next year he is going to have to pay a million dollars a year. And he said, TIMMY, I may have to shut the doors. I may have to shut the doors. That's what we're trying to prevent.

How can we have any sustained long-term economic growth if we don't take care of the health care issue in this country? If we keep strangling our small business people? And I understand that there may be some small business people that maybe disagree with any extension of the role of government in any area. But there is nothing left to control the massive insurance industry in the United States of America unless we do what the people have always done when we needed to address a big problem in this country, and that is join together through our elected officials who we send to Washington to help us.

□ 1945

We need to ask them to get together and solve this problem, and that is what is happening. And we see the insurance industry and the extreme right wing of the Republican Party, the neoconservatives, continue to be offended. Nobody here wants to hurt anybody. Nobody here wants to destroy America. We are here to help, and we are here to address these problems collectively as a country.

We have people on the other side of the aisle, because Rush Limbaugh says they shouldn't, they won't even work with us. Getting rid of preexisting conditions, letting people be on their parents' insurance until they are 27, limiting how much out-of-pocket you can spend, making sure that they can't knock you off the rolls after you have insurance coverage, these are some basic things that we should all be able to agree upon. Mr. Speaker, we are doing it.

And the same issue happens with energy, to where we send in this country $750 billion a year in wealth out of our country through the gas stations that go to oil-producing countries: a $750 billion wealth transfer right out of our country. And a couple of years ago, Mr. Speaker, we spent about $115 billion out of the Defense Department escorting ExxonMobil and Big Oil ships in and out of the Persian Gulf. So if you do the math, the Persian Gulf oil that ends up in your gas tank should really be $1.50 more because of the subsidies that the American taxpayer has paid to provide the security of these ships going in and out of the Persian Gulf. Now in addition to that, subsidies for oil companies, tax credits and tax cuts to go and continue to drill, so completely subsidizing Big Oil and the oil economy.

And what Democrats have said is, how do we put together an energy policy that will take some of the $750 billion and instead of letting it go offshore and out of our country, how do we direct it back into the United States, and at the same time reduce CO_2 and at the same time resuscitate manufacturing in the United States of America through our windmills, through our solar panels, using natural gas that is here in the United States.

We don't have the kind of oil that some of these other countries do. And why do we prop up these dictators and these royal families who have no concern for our well-being, when we can use the need for energy and make it work for us and put together a system and a national policy that is pro-American.

There is not a bigger, more patriotic piece of legislation in the United States of America's House of Representatives right now than the energy bill that passed this House. What kind of national security plan is it for us to continue to send money that goes to these kingdoms that fund terrorist organizations that don't like us when we could be putting steel workers to work making the 400 tons of steel that go in the windmills or resuscitate manufacturing in the United States of America by making sure that our people manufacture the 8,000 component parts that go into a windmill. To me that makes a good deal of sense.

And both of these issues in the long term are jobs programs. Does anybody have a better idea, Mr. Speaker, on how to stimulate manufacturing in the United States? I can't think of one. We have tried to cut taxes on the top 1 percent and hope something trickles down, and that means they will invest back in America and will create jobs in the United States. That didn't work. It did not work. The Republicans had the House, the Senate, the White House. They implemented the whole George Bush economic policy, and it didn't work. And here we are today.

I know our friends like to be critical of the stimulus bill, but in January we lost 750,000 jobs. Now we are still losing a couple hundred thousand jobs a month, but it is not quite as bad. We are trending in the right direction, and we do need to put together a jobs program. We do need to invest in the transportation and put thousands and thousands of people to work. We need to do that. We need to make those investments. There is no question about it. And we need to get back to a moderate, balanced, prudent, wise, economic policy and tax policy here in the United States.

The old Keynesian economic theory that asked some of the wealthiest people in our country to pay a little more in the good times, cut taxes in the bad times and increase social spending to stimulate the economy and smooth out these rough edges, worked for a long time in this country. It led to the construction of a great middle class, balanced investments in education and transportation and roads and bridges. It is time for us to get back to that.

In the Mahoning Valley in the 17th Congressional District, we are putting together what is a very smart, balanced, economic policy locally where we are making the proper investments and laying the proper groundwork. What we are trying to do locally is to line up with where the national policy and the national trends are going. You had to be sleeping if you can't tell that the world is moving towards green technology, green energy. The hedge funds, the big money people are all moving in that direction. The scientists, the engineers, all moving in that direction. All of the research moving in that direction.

And so there is health care reform and what that will do for our local community, and there is energy. And so we have been fairly fortunate amidst all of the economic problems and the high unemployment, that we are seeing back home seeds that are beginning to sprout, and that once credit loosens up, we will see long-term economic growth.

But we need our national policies, Mr. Speaker, to shape us as a country and push our economy in the right direction. The big decisions that are being made here through the Obama administration are sound. I think we are making some smart long-term decisions, and it will pay off in the long run.

We see it in sports all of the time where you can start a game or start rebuilding your program, whether it is college football or basketball or the NBA or whatever the case may be, where you see a great coach start to implement the plan and you don't necessarily start winning all of the games right away. You saw it with Bill Walsh in San Francisco, and you see it with the Patriots and the Steelers. It doesn't always start off with the Super Bowl. And for the Browns, Mr. Speaker, it has been a rough road, but we are going to get past it. It has been a difficult time to have been a Cleveland Browns fan. But the bottom line here is we are in a rebuilding process. We are laying the groundwork. We are making the fundamental decisions necessary to allow for long-term economic growth.

When you look at health care and 30 million more people that are going to have health insurance, we are going to need docs, we are going to need nurses. There is going to be a total reinvigoration of health care information technology.

Just, for example, I was at the National College a few days ago in Youngstown, Ohio. They have programs primarily in health, health information technology and some business entrepreneur classes. The college opened up with 50 people. It now has 850 kids from Youngstown and Campbell and Struthers and Warren going to this school to learn health information technology.

Now here we have people, young and middle-aged, looking at where the economy is going and what they need to be doing. And so the huge investment in health information technology in the stimulus bill, the investment that we will be making in health care by making sure that everybody is covered and coordinating all of these different systems, is going to be an opportunity for many of these young kids who are doing what we asked them to do: Go to school and get educated and do the right thing, and you will be rewarded.

And so in 10 years, Mr. Speaker, in 2019, 2020, we will look back on these decisions that have been made in this Congress and we will see that we have eliminated a lot of human suffering because of what we have done with the health care system. We will see that we have reined in costs for the insurance companies, and that has allowed small businesses to reinvest back into their own companies and give pay increases to their workers as opposed to covering all of the health care increases. We will see people who believe that a compassionate government can exist to advocate on their behalf.

A lot of people say, I am afraid of the government. It is not the government you need to be afraid of; it is the big insurance company you need to be afraid of. It is the Big Oil companies you need to be afraid of. And we are taking them on. Ten years from now, it is going to be looked back upon as one of the turning points in our Nation's history, like Medicare and like civil rights, and like a lot of the great programs that have been established to help our people. Average Americans are getting represented in this government.

We will look back on our energy policies, and we will see that we have reduced our dependency on foreign oil. We have given people hope. We have reestablished America as an innovative leader in the world, and it will help with health care reform and lift up the middle class because we need to start making things again in the United States. We need to start making things again. And with windmills and wind turbines, these are things we can't ship in from China. We have to make them here. We are, and it is going to put middle class people back to work. So those two major issues are going to unleash the creativity needed, the American spirit needed, the American independence needed.

I am proud of what is happening here. I am proud of what is happening in the United States. I know it is difficult. I know it is tough. I know it is noisy, Mr. Speaker, but these things are happening for us in the United States. When it is all said and done and that parent goes to get health insurance, or some young person goes to get health insurance, and they call the insurance company, and they have diabetes or cancer, the insurance company cannot deny them.

□ 2000

Their parents are going to say, Did you know there was a day 5 years ago where you would have gotten denied coverage? And 20 or 30 years from now, our kids will say, You've got to be kidding me. That really happened in America? And we look back on the civil rights movement today. Our generation says, You've got to be kidding me. White people and black people

weren't allowed to drink out of the same water fountain?

That's how we're going to look back. Did we really, as a country, do that? And it is shameful that that happened in this country. Those are the same exact feelings and sentiments that we are going to have here in the United States years from now. And we will say, Did we really deny people health care? We really had people die because they couldn't afford health care when the treatment was available and the technology was available? We really let that happen?

This is a turning point in our country's history, and I'm proud to be a part of it.

HONORING THE GENEROSITY AND COMMUNITY SERVICE OF JERRY LONG

(Ms. FOXX asked and was given permission to address the House for 1 minute.)

Ms. FOXX. Mr. Speaker, I rise today to praise the generosity and community work of my friend, Jerry Long. Today, Jerry is being honored for his generous philanthropy back in North Carolina as the West Forsyth Family YMCA officially changes its name to the Jerry Long Family YMCA.

This honor comes to Jerry thanks to his tireless work as a community leader. He is someone who understands that making a positive difference in your community and helping your neighbors can start with the hard work and dedication of just one person.

His example of serving his community is inspiring, and this renaming is a much deserved honor. Congratulations to Jerry and his family, and thank you for your many years of giving back to Forsyth County and the communities there.

IMMIGRATION

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes.

Mr. KING of Iowa. Mr. Speaker, I'm privileged and honored to be recognized to address you here on the floor of the House of Representatives, and I appreciate the opportunity to, I think, help enlighten you and the Members that are listening in and anyone who might be observing this process that we have in the House of Representatives.

In this great deliberative body, there is a limited amount of time that we can debate here on the floor. And as things churn through, sometimes we don't come back and revisit subject matter, but I think it's necessary to establish the perspective that fits into the broader picture.

The perspective that I intend to address tonight is the perspective of immigration, and that debate has gone on in this country for a number of years. It was brought up by Pat Buchanan as a candidate for President back in the 1990s. He said he would hold congressional hearings on immigration if he were elected President of the United States. He did a lot to help galvanize this immigration debate and bring the issues that are important to this country to the forefront. And since that time, people like Tom Tancredo, and probably before that time, actually, came to this floor and raised the issue of immigration and the rule of law over and over again.

Eventually, the American people began to look at the circumstances of millions of people that are in the United States illegally, their impact on this economy, this society, and this culture.

As intense as this debate got in 2006 and 2007, it got so intense, Mr. Speaker, that as the Senate began to move on a comprehensive amnesty bill that was bipartisan in its nature, however weak it was in its rationale, it had the support of the President of the United States at that time, George W. Bush, and it had the support of leaders of the Democrat and the Republican Party in the United States Senate, as well as here in the House of Representatives, Mr. Speaker. And yet the American people rejected the idea of amnesty in any form, whether it be comprehensive amnesty that was proposed and then the nuances that they tried to bring through or whether it would just be blanket amnesty.

Well, here we are again, Mr. Speaker. Here we are again with a transformational issue that is slowly being brought forward before the American people, and I'm here to say, let's pay attention. My red flag is up, and I have watched the transition of issues that have unfolded since, actually for years, but intensively unfolded since the beginning of the Obama Presidency.

And these issues unfolded in this fashion, and perhaps I'll go back and revisit them in some more detail. But the American people did go to the polls a year ago last November and sustained majorities and actually expanded majorities for Democrats in the United States Senate and in here in the U.S. House of Representatives, and they elected a President who fit their mold as a party member, a Democrat, a very liberal Democrat. In fact, President Obama, in the short time that he served in the United States Senate, had the most liberal voting record out of all 100 U.S. Senators. So they elected, I think it's not even close to arguable, the people in the United States elected the most liberal President in the history of this country.

And while there wasn't a legitimate debate in the Presidential race that had to do with immigration, because neither candidate really wanted to touch the issue, they knew that they were at odds with the American people on immigration. JOHN MCCAIN knew that, and he didn't bring up the subject after the nomination, at least not in a substantial way. I couldn't say that it never happened. And Barack Obama knew the same thing and didn't bring immigration up in a substantial way during the Presidential campaign after the nominations.

And so this Nation went forward with discussions about national security, about economic development, discussions about energy, but not discussions about immigration. Here we are today, a year and a month after President Obama was elected, and we have seen these big issues come through this Congress. And here is the sequence of events, Mr. Speaker, that has taken place, and I invite anybody to challenge me on the facts of these, but it is this:

During the Bush administration, we had the beginning of the first call for TARP funding. That was the beginning request that began by my mental marker here, chronologically, September 19, 2008, when Secretary of the Treasury at the time, Henry Paulson, came to this Capitol and asked for $700 billion. All of it, of course, would be borrowed money. All of it would have to be paid back, and the interest on it, by the taxpayers and their children and their grandchildren, presuming we would be able to retire our national debt in that period of time. Or it might take more generations, Mr. Speaker. $700 billion in TARP, this Congress approved half of it then, and I believe that it was actually into October, the early part of October 2008, delayed the other half, the other $350 billion to be approved by a Congress to be elected later and signed into law by a President to be elected later. That began September 19, 2008. $700 billion in TARP funding, partly before that, mostly after that, became the sequence of events then.

As the described downward spiral and threat of economic crisis of global proportions came at us here in this Congress and it was spread around the globe, causing nation after nation to react in one fashion or another, we saw most of it under the hand of President Obama, the nationalization of three large investment banks, Fannie Mae, Freddie Mac, AIG, the large insurance company, General Motors, Chrysler, all of that swept through in a period of time of approximately 1 year. And at the tail end, framing the nationalization of those eight huge entities that represent about one-third of the private sector profits in the United States, framed on the other end of that nationalization effort on the part of the White House and those who supported that, was a $787 billion economic stimulus plan. All of this just raced us towards the nationalization of an economy, the socialization of our economy, Mr. Speaker.

The American people looked at that, and it went so fast that they didn't believe they had the expertise. They trusted Wall Street. They trusted Big Business in America, and they believed, as I did for a time in my adult life, that Wall Street was looking out for the foundations of free-enterprise capitalism so that over the long term they could continue to do business in a free-market environment to be able to buy, sell, trade, and make legitimate gain by creating real wealth that is rooted in the productivity increase of the American workers and the American economy. Well, it didn't turn out to be necessarily the case that clearly.

But while this was unfolding, $700 billion in TARP, the eight huge national entities of the private sector that were nationalized by the Federal Government, and the $787 billion economic stimulus plan, all of that came at the American people faster than they could react and faster than they could understand. And they were not simple enough in the foundational understanding of them that the American people could look at that, describe it in a bumper sticker and mobilize. It took too long to understand them. It took long to explain. It was harder for the American people to get caught up, and it was hard for Members of Congress in the same fashion to understand the nuances and the details with the level of confidence necessary to rise up and say, Hold it. That's it. We've got to stop. We cannot race down this path and leap off the abyss into the socialized economy. But that is where we have gone, Mr. Speaker.

The American people started to catch up when they saw cap-and-trade being pushed through this Congress. The cap-and-tax legislation that taxes every bit of energy in America and transfers wealth from one group of people in America to another group, they understood that. It came so fast they couldn't get mobilized very much.

Meanwhile, while this was going on, organizations across America were spontaneously growing up out of the prairie, out of the mountains, out of the western States and off the east coast. People that love this Constitution, love fiscal responsibility and free-market capitalism have risen up, and they have carried their flags into city after city, and they have jammed the capitals of the States, and they have jammed this United States Capital. And when you look out across that sea of people, you will see represented there, Mr. Speaker, American flags, one after another after another, patriotic Americans, any one of which I would expect to see at my own church picnic. And among those American flags, you will see yellow ''Don't tread on me'' flags. These are the Americans that will save us from the greed that is also political power greed as well as an economic greed in this country.

All of that has taken place. The American people have mobilized. By the end of July of 2009, this year, they had seen all of this come to pass, and they saw cap-and-trade, or cap-and-tax, pass off the floor of the House of Representatives and a hurry-up rush to judgment, a proposal and a model that cannot be sustained, debated, or argued in any logical fashion that has to do with economics, and neither can the science be defended, especially in light of the emails that have been dumped onto the Internet in the last week or two.

And we've seen at least one resignation, Phil Jones, one of the scientists promoting the climate change argument. The change actually went from the words ''global warming'' to the phrase ''climate change,'' because obviously they can't show the warming of the globe over the last decade in the fashion that they predicted at least.

All of this happened and we saw town hall meetings fill up all across America during the month of August and early September. Hundreds and hundreds of town hall meetings. Hundreds of thousands of Americans came up and filled those town hall meetings, and they filled up the public squares, and they stepped up and resisted the idea of a government-run health care system of socialized medicine in America.

Now the American people are starting to get some traction. They can see the pattern. They voted for change. They didn't know what the change was, Madam Speaker. And now they have a pretty good idea of that change that has been in store for us, and they reject it. It's why they filled up the Capital and filled up the town hall meetings.

But what we've seen so far is this intensity, this resistance to cap-and-tax, this resistance to a national health care act, the resistance that brought somewhere between 20,000 and 60,000 people here to this Capital to be outside this west side of the Capitol on the Thursday before the final vote. And some of those people that came here on Thursday got on a plane and flew back to their hometown, landed, and they saw that they had a request to come back to the Capital to do this again on Saturday, to do our very level best to dump out all of our energy to kill this socialized medicine bill.

□ 2015

That's the American people mobilized, Madam Speaker. The American people have been mobilized in every State in this union and they came to this city just a few weeks ago to resist socialized medicine. They came from every single State, including Alaska and Hawaii. And that mobilization of the American people that are determined to defend this country and the values that made this a great Nation is only a smaller part of the energy that's out there if this President, this majority and this Congress, this Pelosi majority and the Harry Reid majority down the hallway through the center of the Capitol in the United States Senate, if they decide they want to try to bring comprehensive amnesty to overhaul the immigration laws in the United States of America, rather than enforcing them, we've seen nothing yet so far this year to what we will see if they try to bring amnesty and force that down the throats of the American people.

The lines have been drawn. The American patriots have stepped up. They understand what's going on. This is about the rule of law. At the core of the argument on immigration is the rule of law. A Nation cannot be a Nation unless it defends the rule of law. And we have been so proud of the rule of law in America. When I went home over Thanksgiving vacation, I arrived home, actually it was very early on a Friday morning and I went to Sioux City. One of the things I did that day was to go to a naturalization ceremony at the Federal building in Sioux City. I have spoken to the naturalized groups there a number of times. There were 37 new Americans that took the oath of allegiance to the United States on that day. They were from 11 different countries that I counted, perhaps a couple of more. These are people that today are as much an American citizen as the residents of 1600 Pennsylvania Avenue, or the residents in my house. I welcome the legal immigrants that come into America, that follow the law, that come here, lawfully, to have access to this American dream, because when they do, they will build this dream for others. The vitality that we have gotten from every donor nation is the cream of the crop off of every donor civilization. It's one of the things about being an American that's unique. We're not just an appendage of Western Europe or the other countries that have contributed people to come to the United States and become Americans. We have a unique vitality, Madam Speaker. It's rooted in a lot of things. It's built upon the foundation of the pillars of American exceptionalism. Among them are free enterprise, capitalism and property rights and freedom of speech, religion, assembly and the press and the right to keep and bear arms; and also, the right to be judged by a jury of your peers.

And the rule of law, Madam Speaker. The rule of law says that if you are judged, and I said this to that group of newly naturalized Americans in Sioux City that day, some week and a half or so ago: If you come before a court of law in the United States of America, if you're the richest man in the world, you'll get the same level of justice that you get if you're the poorest man in America. If Bill Gates comes before that court, before the Federal court in Sioux City, Iowa, he'll be judged on the

same standard as the poorest person in that room that day, or the poorest person they could find off of the street, the same measure of justice. It's what we've pledged. It's one of those foundations of being an American, the same level of justice. Justice is blind. Equal justice before the law. That rule of law, that profound respect for the rule of law would be cast asunder if we grant amnesty to anyone, especially not 10 million or 20 million or more that have come into the United States illegally, demonstrated their lack of respect for our rule of law and, in many cases, demonstrated their contempt for the rule of law in America.

During the early part of July, I went down to the border, mostly in Arizona, and there I went into the border patrol station at Nogales. It's the busiest border patrol station in the country. It's part of that section of 2,000 miles of border from the coast of California all the way to Brownsville. There, as I watched what was happening, we went out and watched as some who were jumping the fence that exists there, it's not a good enough fence, but it's better than no fence. They couldn't control anything without it. And they monitor the fence. They picked up some illegals that had jumped the fence or otherwise broke into the United States. We also saw others on film that were picked up and they were brought to the center, the center at the border patrol station in Nogales. Good people work in there that do respect the rule of law.

If you watched the people that I'd seen arrested because of breaking our immigration law come waltzing into the border patrol station at Nogales, some of them just with a smirk on their face, Madam Speaker, some of them thought they had accomplished something again, that, well, so they got caught; they knew what was going to happen to them. I looked at that smirk, and that smirk on face after face, not every one of them and probably not even quite half of them, but the attitude of many of those who were picked up for unlawful entry into the United States was an attitude that allowed that smirk to be there, that they had tried to pull something off, so they got caught; and they knew what would happen to them. They knew that they would be released and released back to Mexico, and then they would have a chance in the next hour or the next day or the next week, whenever they decided to come back into the United States again. And they knew that they could keep trying over and over and over again until they finally got where they wanted to go.

Some of these questions come down to this. I posed this question, Madam Speaker. How often does one suppose that a unique individual is picked up at the border sneaking into the United States? We don't have to wonder; we don't have to ask the question because we have some data now that's more than a year old since we've been accumulating, fingerprinting and taking a digital photograph of each individual who is being processed for a voluntary return, or anyone who's been processed for violating our immigration laws, for that matter, those that are processed for voluntary return.

And so I asked the question, How many times do you meet a unique individual? What's the maximum? And we go back and look at the data. Anecdotally it goes to 37 or 38 times for one single individual that's been picked up and brought to the same station, printed, photographed; and then what happens? Oh, and by the way, Madam Speaker, the process is this: Border patrol picks them up, and when they're able to, let's say, interdict one or more individuals, then they call the contractor, a contractor who has a van and a couple of uniformed officers. The van is set up for security so they can haul inmates or those individuals in the van. The van comes, picks them up and two of these people that look like officers, I guess you'll say they are officers, but they're contractors, they load up the one or more illegals that have been interdicted by the border patrol, they take them up to the station where when they walk in, they already have their little plastic bag with their personal items in it. They sit down against the wall; they all get processed, fingerprinted, they get their pictures taken and then they put them in one of four different holding cells, and if they'll do a voluntary return, then they pick them up, it might be the same officers, it often is the same officers, that will take these illegals and haul them down to the border, turn the van sideways, open up the side door and they get out the side of the van and walk back into Mexico. The door gets closed on the van. This time I was watching, they squealed their tires as they turned around and went back to get another load.

The things that I saw in front of my eyes were not catch and release into the United States, but catch near the border and release at the border and direct them to go back to Mexico. No further questions asked. We just have your prints and we have your digital photographs. Anecdotal evidence says 37 to 38 times a unique individual—when I go back and look at the data, the data supports numbers that go up to 28 times that we process the same individual. That's part of the records.

What kind of a law enforcement, what kind of a rule of law would establish the law that says that it's illegal to come into the United States and violate our immigration laws, and then pick people up, run them through the process, and drop them back off at the border and just simply put them back in the condition they were in and very close to the place they were in before they broke the law and not at least have a limit? Voluntary return 28 times, no consequences?

So I asked those questions: What do you do when you have these numbers that run up, even a second time, even a first time? I'd say zero tolerance. Let's put the resources down there and have zero tolerance; punish everybody to the maximum extent of the law and see what kind of a deterrent effect we can establish. But that's not the case. And when they sometimes have moved people up the line for expedited removal and tried to get them a stiff sentence to punish them, at least in one case, the judge released the individual for time served.

What a demoralizing exercise to go to work every day, put on the uniform of the border patrol and go out and pick up individuals; you catch them and a contractor hauls them, they're processed through the station and hauled back to the border where they go back to Mexico to be caught again, around and around and around again, a never-ending circle, and we call that enforcement of immigration law.

But at least, Madam Speaker, we have immigration law. At least it's against the law to come into the United States in violation of the standards that we have; and at least we have penalties that we can impose against the people that do. But we're here in a Congress that looks like it has the will to start this idea again, this comprehensive amnesty argument again, that if people can get into the United States and they express that they want to stay here, that we should just say, We'll give you amnesty and we'll give you a path to citizenship because we don't have the will to enforce the law.

And this argument, this specious, baseless argument that's been made by this side of the aisle over and over again, and by some on this side of the aisle too, Madam Speaker, that somehow or another America can't get along without having immigrants, legal and otherwise, and actually they say especially illegal immigrants, to do the work that Americans won't do. What an offense to the people that are hardworking in America.

Americans are the majority of every single profession out there. And I mean Americans, legal workers in America, are the majority of every single profession out there with the exception of agriculture and farm workers. Everybody else is predominantly Americans. Yet they'll say there are jobs Americans won't do. Well, what jobs? Tell me what jobs?

JOHN MCCAIN said, well, Americans won't pick lettuce and offered $50 an hour. I'd have lost my whole construction crews. They'd have gone down there and picked lettuce for $50 an hour instead of haul dirt for the price we pay them, which isn't bad, by the way.

That argument that there are jobs that Americans won't do and those are jobs that must be done doesn't have a foundation. Americans will do these jobs over and over again. And if there's a job that Americans won't do, let me describe to you the most difficult job there is. The most dangerous, the dirtiest, the most stressful, the riskiest, hottest, dustiest, dirtiest, nastiest job to do is rooting terrorists out of places like Fallujah or Karbala or Ramadi, or Iraq, Afghanistan and the mountains in Afghanistan, for example. That's the most difficult job there is. It's the most dangerous. It's the dirtiest. You don't get to take a shower every day and sit down and take a coffee break when the bullets are flying or the IEDs are being detonated.

And what do we pay Americans to do that? The lowest ranking marines—a couple of years ago I checked the number—about $8.09 an hour, presuming it is a 40-hour week, and it's not. Can you look those people in the eye that are defending our safety and our security, Madam Speaker, and say to them, There are jobs Americans won't do? That marine, that soldier, he's going to look at you and wonder, well, what's dirtier or more dangerous, what's nastier than this job that I'm doing for the love of my country? For the love of my country and $8.09 an hour? And we have to take this insult that there's jobs that Americans won't do.

Americans do every job. I look at my family. I look at my neighbors. It's hard to come up with a job that we haven't done. That includes processing meat. I've done a fair amount of it myself. But if I look at the meat processing around my neighborhood, 25 years ago, at about that era of time, if you wanted to get a job in the packing plant around my neighborhood, you had to know somebody to get in. These weren't union jobs, but you had to know somebody to get a job like that because they paid well. The benefits were competitive with anyplace else. I watched people grow up and maneuver and position themselves to go through school and get out of school so they could get a job working on the line at the packing plant, just the way a lot of miners got in line to go down and mine some coal or steelworkers lined up at the mill and generation after generation went to work at the steel mill. These are proud jobs, and there's dignity in every kind of work that's necessary to be done.

□ 2030

But at the time, 25 or 30 years ago, you had to know somebody to get a job to work in the packing plant, and the job paid about the same as a school teacher made then. Today, that same job is usually held by someone whom we suspect is illegal, and it pays about half of what a teacher is making.

So what we've seen is we've seen an oversupply of labor that has poured into these jobs because people can go in and do these jobs without being particularly literate or particularly educated, but you can't do it without being particularly ambitious.

And so the young American that grew up that really only wanted to go and do his 40 or 45 hours a week and go work in the plant and punch the clock and come home and raise his kids and play ball and take them fishing and modestly pay for a modest house and give an opportunity for his children and focus his life on other things other than always career advancement, that opportunity is nearly gone in America today because we have an oversupply of labor that's willing to work cheap and they can compete in these jobs because it doesn't take a long period of education to do some of the work out there where the wages have gone down.

The highest levels of unemployment that we have in America are in the lower-skilled jobs. That's to the detriment of the American worker. And, Madam Speaker, there are people out there today that are going to work in these jobs that are legal. They're legal immigrants or else they're natural-born Americans. And when they step up to the line, whether it's at the steel mill or whether it's the packing plant or food processing or whatever it might be, and if you look to their right and they see someone whom they suspect is illegal, and may well know that they are, and they look to their left and they see another person that they suspect is illegal, or know that they are, they need to understand that on their right and left likely are jobs that Americans would be doing if those positions weren't taken by those who broke into this country or those who overstayed their visas, Madam Speaker.

Here we are with the President of the United States tomorrow having his jobs summit at the White House. And there you will see a collection of Keynesian economists, the kind of brains that brought about all these things that I've talked about, from TARP funding to the nationalization of the investment banks and AIG and Fannie Mae and Freddie Mac and General Motors and Chrysler and $787 billion and an economic stimulus plan; the kind of brains that decided we should tax all the energy consumed in America and tell America that we're going to create green jobs; the kind of people that can't draw a distinction between the private sector and the public sector; people that don't understand that it's the private sector that produces all of the new wealth that's necessary—in fact, all of the wealth that's necessary to make this society work—and that out of that wealth that comes from the private sector is skimmed the funding that goes into the government machinery. It has been so convoluted over the last generation or so that economists can go through a college education and go off and get their master's and really not have much exposure to where the new wealth comes from.

I need to make this point, Madam Speaker, that the American people need to understand there's a distinction between the private sector—the productive sector of the economy—and the public sector of the economy—the parasitic sector of the economy, the sector of the economy that comes from government that taxes production and punishes production and regulates production until it defeats the very spirit of the entrepreneurs that start the companies that create the jobs.

And these companies that come from the entrepreneurs, they aren't just based on some esoteric dream like we seem to be getting out of the White House economists that we will hear about tomorrow. The idea that we have out there, I can't draw a distinction very much between what is going on between the years of Larry Summers, for example, or someone who may believe that they can always keep pushing the system further ahead. We have heard of those people.

Madam Speaker, my news to the White House is this American economy is not just simply a large magic chain letter that you can stimulate some people to make another investment and send out another dozen letters in the chain and they would get theirs out of the next group of suckers. That's what a chain letter does. That's what a government-driven economy does. It always has to find another group of suckers. And the suckers today are becoming the ones that are producing some wealth in the private sector.

Now where does wealth come from? It comes from the production of goods and services, first, that are essential to the survival of mankind and, second, to the production of goods and services that improve the productivity of those goods and services that are essential to the survival of mankind.

So if it's food, clothing and shelter, the things that we must have if we're going to live, if you produce those things, you're at the foundation of the new wealth. If you produce those things that make us more efficient in producing those essentials for life, you're at the second level of the economy. The third level is the disposable income that comes that's in excess to the necessities that are required to replace your capital investment and the necessities that are required to continue the production of the necessities of life. And so that's the disposable income. That's the income we use to add those things to our quality of life that allow us to go to Disney World, to go on vacation, travel around. Those things that, when we buy nice things and sit them on the shelf, make us feel good. They're not essential. They're nice, but we can get along without them.

So those are the levels of the economy and all new wealth comes from the land or out of Mother Earth. And whether you want to mine some gold or some platinum or whether you want to raise some corn or soybeans or cotton or peanuts, all of these things add to our ability to provide for the survival of mankind and the production efficiency of mankind. And when we do that well enough, we've got disposable income and the Federal Government and other political subdivisions come in and skim the cream off that production out of the private sector that I've just described.

And then you have people like those who have been appointed by the President, hired by the President, and the President himself, who sit back, get this thoughtful look on their face, and they think, Let me see, if I could borrow a few hundred billion dollars from the Chinese and promise to pay interest on that few hundred billion dollars, then I could drop this money in and I could do a few hundred billion dollars' worth of patronage—patronage jobs that will call for more political loyalty and the government jobs that are temporarily created by the taxation and the borrowing that takes place.

Never mind about 4 years from now or 8 years or a decade or two or a generation from now. We'll just borrow that money now and drop this into the economy and give this big, giant economic chain letter a spin. That's what's been going on, but it has gone into over-drive in the last year. And while this is going on, we have this immigration policy that's becoming more and more errant in its philosophy and its results.

I've talked about the lack of will to enforce immigration law just by illustrating what we're doing. We're doing catch-and-return as opposed to catch-and-release. We're just returning them to the border and releasing them there. So catch-return-release is a better way to describe what is going on with immigration law in the United States. We have a Secretary of the Department of Homeland Security that has essentially said, I'm not going to go out and do raids on employers, even if I know there might be thousands there that are working there illegally. She's essentially said that she just wants to go in and find the employers that are violating the law by hiring illegals.

Now, I think we should do that; but I think when we encounter people that are in this country illegally, whether they're working or whether they aren't, we have an obligation when we encounter people unlawfully present in the United States to take them back and put them where they're lawfully present. All we're doing is putting people back into the condition they were in before they broke the law. Deporting someone who's violated immigration law in the United States is the equivalent of catching—let's just say you catch a bank robber and he's got the money and you say, Hold it, you're going to have to give up the money and I'm going to take you outside the door of the bank and turn you lose again. That's the equivalent of deportation.

Any nation that doesn't have the will to put people back in the condition they were and the location they were in before they broke the law on immigration cannot sustain any kind of enforcement whatsoever. It's predicated on the ability to return them to where they came and keep them out. That's why. Not only do we need to use all levels of law enforcement; we need the 287(g) program to be refurbished again to what it was before it was distorted by the Secretary of Homeland Security for the purposes, I believe, of jerking the 287(g) local law enforcement cooperation memorandum of understanding rug out from underneath Sheriff Joe Arpaio down in Maricopa County. It was one of the strong motivations that took place.

We have to have, in a Nation with a rule of law, we have got to have cooperation at all levels of government with all laws. We cannot have local law enforcement take a position that they don't have the authority to enforce immigration law. Of course they do. The Attorney General should know that. There's an Attorney General's opinion that supports it; a previous Attorney General actually under Ashcroft. There are several Federal court cases that support the authority and the jurisdiction of local law enforcement to enforce Federal immigration law.

And I could drop those all into the RECORD here tonight, Madam Speaker. They are a matter of fact here in America, no matter how they have tried to distort this, because the open borders people don't want to enforce immigration law. They want to see a greater number of people come into the United States, and they want to empower themselves politically with the masses of those that are here illegally.

But they're running up against a little problem, Madam Speaker. This problem is the growing problem of unemployment in America: the pressure on our economy—the pressure on our economy that's watching us lose, over the last month, 190,000 jobs. We lost 190,000 jobs last month that were eliminated by the downward spiral of our economy. During the same period of time our Federal Government saw fit to approve permanent work permits—those are green cards—for legal immigrants of 75,000 per month.

Now, if you look at these numbers, these numbers work like this: there are approximately, according to the Pew Hispanic Center, 8 million illegals working in the United States. I think the number is greater than that. These numbers can be verified, I believe, by solid analysis. It's not under that unless the suppression of the economy has reduced that number marginally over the last few months, and it may have actually dropped as far as 7 million. But their number is 8 million.

The second number is 75,000. We issued in October of this year, the Federal Government, 75,000 working permits for immigrants; 75,000 new illegal immigrant workers in just one month. Seventy-five thousand. That's an actual rate of 900,000 new working legals in the United States of America while we're losing 190,000 jobs a month. This works out to be, on an annual basis—and I'm just extrapolating over the last month because we don't know what the future is going to bring, Madam Speaker—but I extrapolate this. We lost 190,000 jobs last month. That's 2,280,000 jobs lost at that rate. Those jobs gone, disappeared. But at the same rate, 900,000 jobs taken up by legal immigrants, not to count the illegal immigrants that are there.

So we had a net annual loss of jobs of about 1.1 million, 380,000 net loss of jobs as a result of the 900,000 green cards. We have 8 million—perhaps as low as 7—but 8 million illegal workers in America. You add that to the number, and you have a pressure on this economy that is just an awesome thing to think that we have a President of the United States that declared that his stimulus plan was going to, Madam Speaker, he said—and I'm almost embarrassed to repeat this—save or create 3.5 million jobs by September of 2010. I believe that's the date that he gave in that. Save or create 3.5 million jobs by September, 2010, if we just put another $787 billion into the economy, which some of that happened. All of it was approved and authorized in one fashion or another. However it was used is another story.

□ 2045

So a government, led by the White House, that was going to save or create 3.5 million jobs now has to admit that, according to the CBO, you can't determine what number of jobs have been created, let alone what jobs have been saved. And I always knew that those were pretty slippery words. It's hard to pin down a definition when you say ''save or create.'' But on that day—in fact, that moment—when I heard the language from the President that he was going to save or create 3.5 million jobs with the $787 billion, my instantaneous response was, as long as there are 3.5 million jobs left in America, they will be the jobs the President points to and says, See, those are the jobs that I saved with the $787 billion stimulus plan.

That's how this language works. If you're going to create jobs, you should be able to quantify how you're going to do that, and you should lay out the cost per job to create them. If you're going to save jobs, how do you invest

money in saving a job? I suppose you could go to a company and say, Listen, we're going to buy up all of this product that you're producing because you have got a 1,000 jobs here, and part of the money that we're contributing to buy this product we wouldn't buy otherwise is going to save these 1,000 jobs that you have. It is pretty hard to measure.

So the Federal Government didn't really do much analysis. They just set up this Web site. This Web site, Madam Speaker, is recovery.gov/transparency/statesummaries, and the list goes on. Well, I didn't look at all 50 States. I went as far as Iowa before I actually learned all I needed to know at this point. This is the Web site. Not only does it create jobs that certainly don't exist, but it also creates congressional districts that don't exist. Just for the State of Iowa, on this Web site, recovery.gov/transparency, for the jobs that were created in western Iowa, alleged by the White House's Web site, they spent $862,498 per job created. Now, get that, $862,498 jobs per job created in western Iowa, created a lot of these jobs in nonexistent congressional districts.

We have five congressional districts in Iowa. Some of these jobs were alleged to have been created. These are the district numbers. Seventh, Eighth, 16th, 17th, 19th, 24th, and 31st Iowa Congressional Districts, jobs created at the cost of $862,498, and that leaves off the double-aught district of the State of Iowa. That's zero-zero. That's double goose egg. That's nonexistent, if you could put nonexistent there without a decimal point and carry it out to infinity. There they spent $114,000 to create five nonexistent jobs.

This is what's going on with these Keynesian economics on steroids while they're propping up immigration, while we have Americans that need jobs, want jobs, line up for jobs. While this is going on, we have this kind of fuzzy math accounting and a complete misunderstanding of where wealth comes from, a complete misunderstanding of the foundation of our economy. And I know John Maynard Keynes had some ideas, and I know he has got followers, and I know FDR was one of them. But Keynes was also the guy who said back in the 1930s, I can solve all of your unemployment in America. Just take me to an abandoned coal mine, and I will go out and drill a bunch of holes out there, and I will bury American cash in there, and then I will fill that coal mine up with garbage—this was before the EPA was created, by the way, Madam Speaker—and turn the entrepreneurs loose to go dig the money up out of the holes that were drilled in the bottom of the coal mine that was filled with garbage.

That was Keynes' idea, and I know he was sounding facetious, but, giving a little bit for his sense of humor and for his sense of accuracy, because we have spent a lot of money in this country, dug holes and filled them back up figuratively without putting the money in it, just put money in the hole.

Do Americans want jobs? Absolutely they do, Madam Speaker. And here's what's taking place: Day labor centers are now seeing natural born Americans, United States citizens, line up at the day labor centers right next to illegals, competing for jobs that illegals were supposedly doing that Americans wouldn't do. Here is an article in my hand, USA Today, December 1—that's yesterday—titled ''Unemployed U.S.-born workers seek day-labor jobs.'' It quotes a professor at the University of California-Los Angeles, Abel Valenzuela, Jr.—he is a professor of urban planning. To quote him, he says this:

''You had many, many unemployed construction workers who found themselves without any permanent or stable work. Some of them have gone on to seek employment by standing on street corners alongside immigrant workers.'' That's the professor at the University of California-Los Angeles. It goes on to say, ''Contractors and homeowners describe the jobs and negotiate pay on the spot,'' just like illegals have, for too long in this country. There are stories and narratives that come from Tucson, Arlington, Virginia, Los Angeles. Los Angeles, it says that ''Citizens are replacing''—citizens, Madam Speaker—''Citizens are replacing immigrant day laborers who had trouble finding work and returned to their home countries. These are people who used to have permanent positions. It's happening everywhere.''

That's the article from USA Today. Jobs Americans won't do? Americans are lined up to get jobs in day labor gatherings right alongside groups of illegals who have, some of them, decided to go back home because of the lack of opportunity here. The unemployment rate is 10.2 percent. Seven to eight million working illegals, as I said. That's about 15.7 million unemployed, and Madam Speaker, if you add to the list of that 15.7 million legitimate workers in America who are unemployed and, by definition, are looking for a job, there is another 5.5 million or more who have exhausted their unemployment benefits who don't quite fit the definition that are looking for a job.

There are more than 20 million Americans that want a job today. The American workforce, of 154.4 million of our total workforce, there are over 70 million Americans of working age who are not working. Over 70 million. We could tap into a workforce of more than 70 million people of working age that are just simply not working because the wages don't pay enough, the benefits don't pay enough. Maybe they're independently wealthy. Maybe they're in between jobs, but they're all hirable if you make a good enough offer.

These are Americans that will work. There are 70 million nonworking Americans of working age, 7 million to 8 million working illegals, and they tell us that they are jobs Americans won't do, and we won't possibly run our economy unless we have these millions of illegal workers that are here, but they want to give them amnesty and legalize them?

All we have to do, Madam Speaker, is hire 1 out of 10 of the Americans who are of working age and not in the workforce, put them into those jobs, and we could easily replace—by hiring 10 percent of the nonworking Americans of working age, we could replace every illegal in America, according to these numbers, that are produced by the Pew foundation. If it's double that, like I think it is, then we hire 20 percent, 2 out of 10 of Americans. We're looking at more than 20 million Americans that are looking for work. I think this is an easy solution for us. And by the way, we are wiping out 900,000 jobs a year because of legal immigration, green cards that we're granting at the rate of 75,000 per month. That number I believe is 780,000 so far this year.

''Federal records show that before the recession began, the Federal Government issued 830,000 green cards in the previous year. Last year, during the first year of the recession, the government granted 875,000 new green cards, and we're at the pace to go to 900,000 or more this year.'' There were 900,000 jobs granted to people who were—at the time the card was advanced—not Americans, while Americans are lined up 20 million deep. We're wiping out almost 1 million jobs a year because of the legal immigration, and we know that there are 7 million to 8 million or more jobs that are taken by illegals, and we know that if we enforce the job—if we enforce a law for every illegal that's removed from a job, it opens up a job slot for an American to step into.

Madam Speaker, any sane nation would go after this enforcement. They would adjust their immigration policy to reduce the legal immigration because of the recession that we are in. Here is what's going on in this chart, Madam Speaker. The workforce enforcement free-fall—what we've seen happen is, the unemployment has gone up 58 percent overall. At the same time that's happened, here is the enforcement that has gone down. Department of Homeland Security administrative arrests are down 68 percent; criminal arrests are down 60 percent; criminal indictments are down 58 percent, almost reflecting the same; criminal convictions are down 63 percent. This whole level is down roughly 60 percent or a little bit more in the enforcement

of our immigration laws, while unemployment is up almost the same thing, almost 60 percent.

What nation that needs a sound economic policy would go down this path of reducing its enforcement of immigration law while it watched unemployment go up to 10.2 percent and rising to 15.7 million by definition unemployed, more than 20 million altogether, and still we grant green cards at the rate of 900,000 a year. And every one of them supplants—if they go to work, they supplant a job an American would be doing otherwise while we tolerate, I'll say, tens of millions of illegals in America who come here and—yes, I know everybody has a dream, but everybody can't live in the United States of America. That is the bottom line. We can't help the world if we sink the lifeboat. That's what will happen.

I'm for a tighter labor supply, Madam Speaker. I'm for the kind of labor supply that will allow that person who grows up in this country or comes legally to this country to go to work and earn a living and be able to claim a salary and benefits package that they can live on, that they can raise a family on. And yes, today it takes two workers in a family to make this happen. Mom and dad to raise the kids, working together and making ends meet as best they can.

But that's not really possible today for the lower-educated Americans. Their dreams have been taken away by illegal immigration. And somewhere, somewhere in America thousands of times over, over Thanksgiving and coming up for Christmas, there will be a brother and a sister, or a brother and a brother, siblings sitting around the table, and they'll say grace and ask the blessings on their turkey, and they'll start to talk as they eat, and somebody will be unemployed. And their brother or sister will have a job, and they'll understand that there are people who are in the United States illegally that are filling those slots that they could have, and this discussion, which becomes a nationwide discussion, the rejection of amnesty starts to swell.

As the subject is brought forward here before this Congress—if it is—you will see the American people rise up, and their rejection of amnesty that we saw in 2006 and '07 will be child's play compared to the anger of the American people who now see themselves unemployed, 20 million or more, watching them being replaced by legal immigrants at the rate of almost 1 million a year and watching 8 million, or maybe twice as many, illegals working in America, taking jobs that Americans will do.

In fact, taking jobs, according to the USA Today article that I referenced, that Americans are standing in line to do right next to people that—if I needed to come and hand out the work permits, they would be compelled to deport many of these workers. This Nation does not have a logical and coherent enforcement of immigration law.

One of the things we need to do for a tool to enforce, Madam Speaker, is to pass my New IDEA Act. The acronym is this: The New Illegal Deduction Elimination Act. It brings the IRS into this so that the IRS—it clarifies to the IRS that wages and benefits are not deductible for income tax purposes. It allows the IRS to do the audit and deny the business expense of wages and benefits paid to illegals, which takes—when the interest and the penalty and the tax liability that accrues from that decision at a 34 percent rate, will take your $10 an hour illegal up to $16 an hour.

Employers will understand that they would rather go with the legal worker at $13 or $14 an hour than the illegal that could cost them $16 an hour, and we have the IRS into this. They love enforcing their work. I know that. So we bring the IRS into the mix, and they would be required under the New IDEA Act to cooperate with the Social Security Administration and the Department of Homeland Security. We can shut down this jobs magnet. We can control this border. We can reestablish the rule of law in America. We can reinvigorate this economy, and we can produce a tight enough labor supply that the wages and benefits paid to our workers, whatever their education level is—if they're willing to work, they need to be able to sustain themselves in this society.

We're moving away from it today. We can move this back. We can refurbish the middle class in America. That's one of our charges during this time. It's one of our opportunities during this time, Madam Speaker. And I urge that you and everyone in this Congress bring special attention to the preservation of the rule of law which is more important than our economy is today in this country.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. LARSEN of Washington (at the request of Mr. HOYER) for after 1:30 p.m. today.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. MCGOVERN) to revise and extend their remarks and include extraneous material:)

Ms. LEE of California, for 5 minutes, today.

Mr. MCGOVERN, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. DOGGETT, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. GRAYSON, for 5 minutes, today.

(The following Members (at the request of Mr. POE of Texas) to revise and extend their remarks and include extraneous material:)

Mr. POE of Texas, for 5 minutes, December 8 and 9.

Ms. ROS-LEHTINEN, for 5 minutes, today and December 3.

Mr. JONES, for 5 minutes, December 8 and 9.

Mr. BURTON of Indiana, for 5 minutes, today, December 3 and 4.

Mr. MORAN of Kansas, for 5 minutes, today, December 3, 4, 7, 8 and 9

Mr. BROUN of Georgia, for 5 minutes, today.

Ms. FOXX, for 5 minutes, today.

SENATE ENROLLED BILL SIGNED

The Speaker announced her signature to enrolled bills of the Senate of the following titles:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1860. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

ADJOURNMENT

Mr. KING. Madam Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 p.m.), the House adjourned until tomorrow, Thursday, December 3, 2009, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of Rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

4777. A letter from the Regulatory Analyst, Department of Agriculture, transmitting the Department's final rule — Scales; Accurate Weights, Repairs, Adjustments or Replacements After Inspection (RIN: 0580-AB09) received October 22, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4778. A letter from the Acting Farm Bill Coordinator, Department of Agriculture, transmitting the Department's final rule — Grassland Reserve Program (RIN: 0578-AA53) received November 18, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4779. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's final rule — Pyriproxyfen; Pesticide Tolerances [EPA-HQ-OPP-2009-0018; FRL-8795-3] received October 21, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4780. A letter from the Under Secretary, Department of Defense, transmitting a letter to report the Antideficiency Act violation,

Air Force case number 07-07, pursuant to 31 U.S.C. 1351; to the Committee on Appropriations.

4781. A letter from the Chief Judge, Chair, Joint Committee on Judicial Administration, District of Columbia Courts, transmitting a report of a violation of the Antideficiency Act by the District of Columbia Courts, pursuant to 31 U.S.C. 1517(b); to the Committee on Appropriations.

4782. A letter from the Under Secretary, Department of Defense, transmitting the Department's quarterly report entitled, ''Acceptance of contributions for defense programs, projects, and activities; Defense Cooperation Account'', for the period ending September 30, 2009, pursuant to 10 U.S.C. 2608; to the Committee on Armed Services.

4783. A letter from the Assistant Secretary, Department of Defense, transmitting the Department's annual report for fiscal year 2008 on the quality of health care furnished under the health care programs of the Department of Defense; to the Committee on Armed Services.

4784. A letter from the Assistant Secretary, Department of the Navy, Department of Defense, transmitting notice of the completion of a public-private competition for identification card and administrative functions; to the Committee on Armed Services.

4785. A letter from the Director, Defense Procurement and Acquisition Policy, Department of Defense, transmitting the Department's final rule — Defense Federal Acquisition Regulation Supplement; World Trade Organization Government Procurement Agreement Designated Country [DFARS Case 2009-D010] received November 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Armed Services.

4786. A letter from the Assistant to the Board, Board of Governors of the Federal Reserve System, transmitting the Reserve's ''Major'' final rule — Electronic Fund Transfers [Regulation E; Docket No.: R-1343] received November 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

4787. A letter from the Chairman and President, Export-Import Bank, transmitting a report on transaction involving U.S. exports to Ireland pursuant to Section 2(b)(3) of the Export-Import Bank Act of 1945, as amended; to the Committee on Financial Services.

4788. A letter from the Secretary, Department of Health and Human Services, transmitting the twenty-ninth annual report on the implementation of the Age Discrimination Act of 1975 by departments and agencies which administer programs of Federal financial assistance, pursuant to 42 U.S.C. 6106a(b); to the Committee on Education and Labor.

4789. A letter from the Assistant General Counsel for Regulatory Services, Department of Education, transmitting the Department's ''Major'' final rule — Race to the Top Fund [Docket ID: ED-2009-OESE-0006] (RIN: 1810-AB07) received November 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

4790. A letter from the Secretary, Department of Education, transmitting the Department's final rule — Institutions and Lender Requirements Relating to Education Loans, Student Assistance General Provisions, Federal Perkins Loan Program, Federal Family Education Loan Progam, and William D. Ford Federal Direct Loan Program [Docket ID.: ED-2009-OPE-0003] (RIN: 1840-AC95) received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

4791. A letter from the Secretary, Department of Health and Human Services, transmitting the Department's report entitled, ''Report to Congress on the Social and Economic Conditions of Native Americans: Fiscal Years 2003 and 2004'', pursuant to Section 811A of the Native American Programs Act of 1974; to the Committee on Education and Labor.

4792. A letter from the Assistant Secretary, Employee Benefits Security Administration, Department of Labor, transmitting the Department's ''Major'' final rule — Interim final Rules Prohibiting Discrimination Based on Genetic Information In Health Insurance Coverage and Group Health Plans (RIN: 1210-AB27) received October 7, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and Labor.

4793. A letter from the Assistant General Counsel for Legislation and Regulatory Law, Department of Energy, transmitting the Department's final rule — Energy Conservation Program: Repeal of Test Procedures for Televisions [Docket No.: EERE-2009-BT-TP-0020] (RIN: 1904-AC09) received October 21, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4794. A letter from the Secretary, Department of Health and Human Services, transmitting a report entitled ''Performance Evaluation of Accreditation Bodies under the Mammography Quality Standards Act of 1992 as amended by the Mammography Quality Standards Reauthorization Acts of 1998 and 2004'' covering the year 2008; to the Committee on Energy and Commerce.

4795. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Requirements and Procedures for Consumer Assistance To Recycle and Save Program [Docket No.: NHTSA-2009-0120] (RIN: 2127-AK61) received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

4796. A letter from the Acting Deputy Administrator, National Highway Traffic Safety Administration, Department of Transportation, transmitting a report entitled ''A National Plan for Migrating to IP-Enabled 9-1-1 Systems''; to the Committee on Energy and Commerce.

4797. A letter from the Director, Regulatory Management Division, Environmental Protection Agency, transmitting the Agency's Uniform Resource Locators (URLs) for documents recently issued related to regulatory programs; to the Committee on Energy and Commerce.

4798. A letter from the Assistant Legal Advisor for Treaty Affairs, Department of State, transmitting a report prepared by the Department of State concerning international agreements other than treaties entered into by the United States to be transmitted to the Congress within the sixty-day period specified in the Case-Zablocki Act, pursuant to 1 U.S.C. 112b(b); to the Committee on Foreign Affairs.

4799. A letter from the Secretary, Department of the Treasury, transmitting a six-month periodic report on the national emergency with respect to Iran that was declared in Executive Order 12170 of November 14, 1979, pursuant to 50 U.S.C. 1703(c); to the Committee on Foreign Affairs.

4800. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting a report concerning methods employed by the Government of Cuba to comply with the United States-Cuba September 1994 ''Joint Communique'' and the treatment by the Government of Cuba of persons returned to Cuba in accordance with the United States-Cuba May 1995 ''Joint Statement'', together known as the Migration Accords, pursuant to Public Law 105-277, section 2245; to the Committee on Foreign Affairs.

4801. A letter from the Special Inspector General for Afghanistan Reconstruction, transmitting the October 2009 Quarterly Report on reconstruction efforts in Afghanistan, pursuant to Public Law 110-181; to the Committee on Foreign Affairs.

4802. A letter from the General Counsel, Department of Housing and Urban Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

4803. A letter from the General Counsel, Federal Retirement Thrift Investment Board, transmitting the Board's final rule — Uniformed Services Accounts; Death Benefits; Court Orders and Legal Processes Affecting Thrift Savings Plan Accounts; Thrift Savings Plan received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

4804. A letter from the Chairman, Merit Systems Protection Board, transmitting the Board's report entitled ''Addressing Poor Performers and the Law''; to the Committee on Oversight and Government Reform.

4805. A letter from the Director, Office of Management and Budget, transmitting a report entitled, ''Statistical Programs of the United States Government: Fiscal Year 2010'', pursuant to 44 U.S.C. 3504(e)(2); to the Committee on Oversight and Government Reform.

4806. A letter from the Acting President, Overseas Private Investment Corporation, transmitting the Annual Report on Audit and Investigative Activities for Fiscal Year 2009, pursuant to 5 U.S.C. app. (Insp. Gen. Act), section 5(b); to the Committee on Oversight and Government Reform.

4807. A letter from the Director, Fish and Wildlife Service, Department of the Interior, transmitting the 2007 annual report on reasonably identifiable expenditures for the conservation of endangered or threatened species by Federal and State agencies, pursuant to 16 U.S.C. 1544; to the Committee on Natural Resources.

4808. A letter from the Assistant Attorney General, Department of Justice, transmitting a copy of a report required by Section 202(a)(1)(C) of Pub. L. 107-273, the ''21st Century Department of Justice Appropriations Authorization Act'', related to certain settlements and injunctive relief, pursuant to 28 U.S.C. 530D Public Law 107-273, section 202; to the Committee on the Judiciary.

4809. A letter from the Program Analyst, Department of Transporation, transmitting the Department's final rule — Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments [Docket No.: 30695; Amdt. No. 3347] received November 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4810. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments [Docket No.: 30690 Amdt. No. 3312] received November 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4811. A letter from the Assistant Chief Counsel, Department of Transportation, transmitting the Department's final rule — Hazardous Materials: Chemical Oxygen Generators [Docket No.: PHMSA-2009-0238 (HM-224G)] (RIN: 2137-AE49) received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4812. A letter from the Paralegal Specialist, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Construcciones Aeronauticas, S.A. (CASA), Model C-212-CB,C-212-CC, C-212-CD, and C-212-CE Airplanes [Docket No.: FAA-2009-0611; Directorate Identifier 2008-NM-165-AD; Amendment 39-16033; AD 2009-20-10] (RIN: 2120-AA64) received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4813. A letter from the Paralegal Specialist, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Chuathbaluk, AK [Docket No.: FAA-2009-0231; Airspace Docket No. 09-AAL-6] received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4814. A letter from the Paralegal Specialist, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce plc (RR) RB211-535E4 Series Turbofan Engines [Docket No.: FAA-2009-0057; Directorate Identifier 85-ANE-25-AD; Amendment 39-16037; AD 2009-20-14] (RIN: 2120-AA54) received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4815. A letter from the Paralegal Specialist, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 737-300 and 737-400 Series Airplanes[Docket No.: FAA-2009-0429; Directorate Identifier 2007-NM-059-AD; Amendment 39-16038; AD 2009-21-01] (RIN: 2120-AA64) received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4816. A letter from the Paralegal Specialist, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Eastsound, WA [Docket No.: FAA-2009-0554; Airspace Docket No. 09-ANM-8] received October 20, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4817. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments [Docket No.: 30693; Amdt. No. 3345] received November 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4818. A letter from the Assistant CC for General Law, Department of Transportation, transmitting the Department's final rule — Pipeline Safety: Incorporation by Reference Update: American Petroleum Institute (API) Standards 5L and 1104 [Docket No.: PHMSA-2008-0334.] (RIN: 2137-AE42) received November 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4819. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Federal Motor Vehicle Safety Standards; Air Brake Systems [Docket No.: NHTSA-2009-0151] (RIN: 2127-AK44) received November 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4820. A letter from the Administrator, General Services Administration, transmitting informational copies of lease prospectuses that support the General Services Administration's Fiscal Year 2010 Capital Investment and Leasing Program; to the Committee on Transportation and Infrastructure.

4821. A letter from the Secretary, Department of Labor, transmitting the Department's report entitled, ''2008 Findings on the Worst Forms of Child Labor'', pursuant to 19 U.S.C. 2464; to the Committee on Ways and Means.

4822. A letter from the Branch Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Cost-of-Living Adjustments for 2010 to certain items as required (Rev. Proc. 2009-50) received October 21, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4823. A letter from the Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Guidance for Expatriates Under Section 877A [Notice 2009-85] received October 21, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4824. A letter from the Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Guidance under Section 2053 Regarding Post-Death Events [TD 9468] (RIN: 1545-BC56) received October 21, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4825. A letter from the Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Tax-free sales of articles for use by the purchaser as supplies for vessels or aircraft (Rev. Rul. 2009-34) received October 21, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4826. A letter from the Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property (Rev. Rul. 2009-35) received October 21, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4827. A letter from the Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Withholding on Wages of Nonresident Alien Employees Performing Services Within the United States [Notice 2009-91] received November 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4828. A letter from the Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Effective Date of Regulations Under Sec. 411(b)(5)(B)(i); Relief Under Sec. 411(d)(6); and Notice to Pension Plan Participants received November 13, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

4829. A letter from the Director, Office of National Drug Control Policy, Excutive Office of the President, transmitting the office's acceptance of recommendations of the report entitled ''Firearms Trafficking: U.S. Efforts to Combat Arms Trafficking to Mexico Face Planning and Coordination Challenges''; jointly to the Committees on Foreign Affairs and the Judiciary.

4830. A letter from the Secretary, Department of Health and Human Services, transmitting a report entitled ''Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities''; jointly to the Committees on the Judiciary and Education and Labor.

4831. A letter from the Office Manager, Department of Health and Human Services, transmitting the Department's final rule — Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans (RIN: 0938-AP37) received October 7, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); jointly to the Committees on Ways and Means and Energy and Commerce.

4832. A letter from the Administrator, FEMA, transmitting the Department's report on the Preliminary Damage Assessment information on FEMA-1857-DR for the State of New York; jointly to the Committees on Transportation and Infrastructure, Appropriations, and Homeland Security.

4833. A letter from the Administrator, FEMA, transmitting the Department's report on the denial of appeal for disaster assistance for the State of Oklahoma; jointly to the Committees on Transportation and Infrastructure, Appropriations, and Homeland Security.

4834. A letter from the Administrator, FEMA, transmitting the Department's report on the Preliminary Damage Assessment information on FEMA-1856-DR for the State of Tennessee; jointly to the Committees on Transportation and Infrastructure, Appropriations, and Homeland Security.

4835. A letter from the Administrator, FEMA, transmitting the Department's report on the denial of appeal for assistance for the State of Pennsylvania; jointly to the Committees on Transportation and Infrastructure, Appropriations, and Homeland Security.

4836. A letter from the Chairman, U.S.-China Economic and Security Review Commission, transmitting a report entitled ''Capability of the People's Republic of China to Conduct Cyber Warfare and Computer Network Exploitation''; jointly to the Committees on Ways and Means, Armed Services, and Foreign Affairs.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. WAXMAN: Committee on Energy and Commerce. H.R. 515. A bill to prohibit the importation of certain low-level radioactive waste into the United States; with an amendment (Rept. 111–348 Pt. 1). Referred to the Committee of the Whole House on the State of the Union and ordered to be printed.

Mr. WAXMAN: Committee on Energy and Commerce. H.R. 2994. A bill to reauthorize the Satellite Home Viewer Extension and Reauthorization Act of 2004, and for other purposes; with an amendment (Rept. 111–349). Referred to the Committee of the Whole House on the State of the Union.

Mr. POLIS: Committee on Rules. House Resolution 941. Resolution providing for consideration of the bill (H.R. 4154) to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than

would benefit from repeal, to retain the estate tax with a $3,500,000 exemption, and for other purposes (Rept. 111–350). Referred to the House Calendar.

DISCHARGE OF COMMITTEE

Pursuant to clause 2 of rule XIII the Committee on Ways and Means discharged from further consideration. H.R. 515 referred to the Committee of the Whole House on the State of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. RANGEL (for himself and Mr. CAMP):

H.R. 4169. A bill to amend the Internal Revenue Code of 1986 to make technical corrections, and for other purposes; to the Committee on Ways and Means.

By Mr. HODES:

H.R. 4170. A bill to amend the Emergency Economic Stabilization Act of 2008 to strike the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program after 2009, and for other purposes; to the Committee on Financial Services, and in addition to the Committees on the Budget, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. TEAGUE (for himself, Ms. MARKEY of Colorado, Ms. KOSMAS, Mr. KISSELL, and Mrs. HALVORSON):

H.R. 4171. A bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program, and for other purposes; to the Committee on Financial Services, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CARTER (for himself, Mr. WESTMORELAND, and Mr. BURGESS):

H.R. 4172. A bill to provide the same penalty rate for taxpayers who voluntarily disclose unreported income from offshore accounts as was afforded Timothy Geithner with respect to his failure to pay self-employment taxes with respect to his compensation from the International Monetary Fund; to the Committee on Ways and Means.

By Mr. FRANK of Massachusetts:

H.R. 4173. A bill to provide for financial regulatory reform, to protect consumers and investors, to enhance Federal understanding of insurance issues, to regulate the over-the-counter derivatives markets, and for other purposes; to the Committee on Financial Services, and in addition to the Committees on Agriculture, Energy and Commerce, the Judiciary, Rules, the Budget, Oversight and Government Reform, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. NYE:

H.R. 4174. A bill to amend the Internal Revenue Code of 1986 to provide relief with respect to estate and gift taxes, small businesses, and government contractors; to the Committee on Ways and Means.

By Mr. BOUCHER (for himself, Mr. AKIN, Mr. CARNAHAN, Mr. GRAVES, Mr. BOREN, Mr. SULLIVAN, Mr. ISRAEL, Mr. WILSON of South Carolina, and Mr. CARTER):

H.R. 4175. A bill to protect consumers from discriminatory State taxes on motor vehicle rentals; to the Committee on the Judiciary.

By Mr. ABERCROMBIE:

H.R. 4176. A bill to amend the Military Construction Authorization Act for Fiscal Year 2010 to authorize construction of an Aegis Ashore Test Facility at Pacific Missile Range Facility, Hawaii; to the Committee on Armed Services.

By Mr. BERRY (for himself and Mr. CHILDERS):

H.R. 4177. A bill to provide emergency disaster assistance to certain agricultural producers that suffered losses during 2009, to provide emergency disaster assistance to certain livestock producers that suffered losses during 2008 or 2009, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Appropriations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CLEAVER (for himself, Mr. FRANK of Massachusetts, Mr. MOORE of Kansas, Mr. PAUL, Mr. WATT, Mr. MARCHANT, Mr. MCCOTTER, Mrs. CAPITO, and Mr. BACHUS):

H.R. 4178. A bill to amend the Federal Deposit Insurance Act to provide for deposit restricted qualified tuition programs, and for other purposes; to the Committee on Financial Services.

By Mr. CONYERS (for himself, Mr. JOHNSON of Georgia, Ms. LEE of California, and Mr. MASSA):

H.R. 4179. A bill to amend the Internal Revenue Code of 1986 to keep Americans working by creating a refundable work-sharing tax credit that stimulates demand in the private sector labor market and provides employers with an alternative to layoffs; to the Committee on Ways and Means.

By Mr. HASTINGS of Florida (for himself, Mr. MORAN of Virginia, Mrs. CAPPS, Ms. BERKLEY, Ms. NORTON, Mr. STARK, Ms. WATSON, Ms. EDWARDS of Maryland, Mr. GRIJALVA, Mr. GRAYSON, Ms. CHU, Mr. MEEKS of New York, Mr. CUMMINGS, Mr. HALL of New York, Mr. ACKERMAN, Ms. SPEIER, Ms. LORETTA SANCHEZ of California, Mr. ELLISON, Mr. DINGELL, Mr. BLUMENAUER, Ms. WOOLSEY, Ms. KILPATRICK of Michigan, Ms. CLARKE, Ms. PINGREE of Maine, Ms. HIRONO, Mr. FILNER, Mr. ABERCROMBIE, and Mr. WALZ):

H.R. 4180. A bill to amend title 10, United States Code, to include the disclosure of sexual orientation by a member of the Armed Forces to a Member of Congress as a lawful and protected communication and to prohibit retaliatory personnel actions against members of the Armed Forces who make such a disclosure in a Congressional hearing or who testify, for or against, the policy concerning homosexuality in the Armed Forces; to the Committee on Armed Services.

By Mr. HINOJOSA:

H.R. 4181. A bill to provide grants to States to improve high schools and raise graduation rates while ensuring rigorous standards, to develop and implement effective school models for struggling students and dropouts, and to improve State policies to raise graduation rates, and for other purposes; to the Committee on Education and Labor.

By Mrs. LOWEY:

H.R. 4182. A bill to amend the Homeland Security Act of 2002 to limit the number of Urban Area Security Initiative grants awarded and to clarify the risk assessment formula to be used when making such grants, and for other purposes; to the Committee on Homeland Security.

By Mr. MCDERMOTT (for himself, Mr. NADLER of New York, Mr. CONYERS, Mr. SIRES, Mr. ACKERMAN, Ms. SCHAKOWSKY, Ms. HIRONO, Mr. LEWIS of Georgia, Mr. CAPUANO, Ms. DELAURO, Mr. MICHAUD, Ms. WOOLSEY, Mr. GRIJALVA, Mr. KILDEE, Mr. LEVIN, Mr. CARDOZA, Ms. BERKLEY, Mr. ELLISON, Mr. DEFAZIO, Ms. PINGREE of Maine, Mr. LANGEVIN, and Ms. MCCOLLUM):

H.R. 4183. A bill to amend the Assistance for Unemployed Workers and Struggling Families Act and the Supplemental Appropriations Act, 2008 to provide for the temporary extension of programs providing unemployment benefits, and for other purposes; to the Committee on Ways and Means.

By Mr. POMEROY:

H.R. 4184. A bill to amend the Internal Revenue Code of 1986 to make permanent the qualified tuition deduction; to the Committee on Ways and Means.

By Mr. POMEROY:

H.R. 4185. A bill to amend the Social Security Act and the Internal Revenue Code of 1986 to exempt certain employment as a member of a local governing board, commission, or committee from Social Security tax coverage; to the Committee on Ways and Means.

By Mr. POMEROY (for himself, Mr. HERGER, Ms. HERSETH SANDLIN, and Mr. BRALEY of Iowa):

H.R. 4186. A bill to amend the Internal Revenue Code of 1986 to extend for 2 years the treatment of certain farming business machinery and equipment as 5-year property for purposes of depreciation; to the Committee on Ways and Means.

By Mr. SARBANES (for himself, Mr. CUMMINGS, Mr. VAN HOLLEN, Mr. RUPPERSBERGER, Mr. BARTLETT, Mr. HOYER, Mr. KRATOVIL, Mr. CASTLE, Ms. EDWARDS of Maryland, Mr. CONNOLLY of Virginia, Ms. NORTON, Mr. SCOTT of Virginia, Mr. MORAN of Virginia, and Mr. HOLDEN):

H.R. 4187. A bill to amend the Water Resources Development Act of 1996 to make modifications to the Chesapeake Bay environmental restoration and protection program; to the Committee on Transportation and Infrastructure.

By Mr. SESTAK (for himself, Mr. PALLONE, and Mr. GRIJALVA):

H.R. 4188. A bill to authorize appropriations for brownfields site assessment and cleanup, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. MATHESON (for himself, Mr. ALTMIRE, Mr. ARCURI, Mr. BACA, Mr. BAIRD, Mr. BARROW, Ms. BEAN, Mr. BISHOP of Utah, Mr. BOREN, Mr. BOSWELL, Mr. BOUCHER, Mr. BOYD, Mr. CHAFFETZ, Mr. CHANDLER, Mr. CHILDERS, Mr. CONAWAY, Mr. COOPER, Mr. COSTA, Mr. CUELLAR, Mr. DAVIS of Tennessee, Mr. DAVIS of Alabama, Mr. DINGELL, Mr. DONNELLY of Indiana, Mr. DOYLE, Mr. ELLSWORTH, Mr. ETHERIDGE, Mr. GONZALEZ, Mr. GORDON of Tennessee, Mr. GRIFFITH, Ms. HERSETH SANDLIN, Mr. HILL, Mr.

HODES, Mr. HOLDEN, Mr. INSLEE, Mr. ISRAEL, Mr. KIND, Mr. KRATOVIL, Mr. LARSEN of Washington, Mr. LARSON of Connecticut, Mr. MELANCON, Mr. MICHAUD, Mr. MINNICK, Mr. MITCHELL, Mr. MOORE of Kansas, Mr. PATRICK J. MURPHY of Pennsylvania, Mr. MURPHY of New York, Mr. NYE, Mr. ROSS, Mr. SALAZAR, Mr. SCHIFF, Mr. SCOTT of Georgia, Mr. SHULER, Mr. SMITH of Washington, Mr. SPACE, Mr. TANNER, and Mr. UPTON):

H. Res. 942. A resolution commending the Real Salt Lake soccer club for winning the 2009 Major League Soccer Cup; to the Committee on Oversight and Government Reform.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 43: Mr. TIM MURPHY of Pennsylvania, Mr. THORNBERRY, Mr. REHBERG, and Mr. ACKERMAN.
H.R. 223: Ms. CHU.
H.R. 233: Ms. BEAN.
H.R. 305: Mr. POLIS of Colorado.
H.R. 432: Mr. COSTA.
H.R. 470: Mr. SOUDER.
H.R. 482: Mr. HINCHEY.
H.R. 537: Mr. GERLACH.
H.R. 571: Ms. WOOLSEY.
H.R. 606: Ms. WATSON.
H.R. 646: Mr. JOHNSON of Georgia.
H.R. 690: Mr. ADLER of New Jersey.
H.R. 699: Mr. MORAN of Virginia.
H.R. 725: Mr. BACA.
H.R. 734: Ms. RICHARDSON.
H.R. 739: Ms. SLAUGHTER.
H.R. 768: Mr. LUJÁN.
H.R. 847: Mr. MARKEY of Massachusetts.
H.R. 916: Ms. BALDWIN and Mrs. CAPPS.
H.R. 930: Mr. MORAN of Virginia.
H.R. 960: Mr. PIERLUISI and Mr. CONNOLLY of Virginia.
H.R. 1045: Mr. PIERLUISI and Mr. CONNOLLY of Virginia.
H.R. 1204: Mr. SPRATT.
H.R. 1215: Ms. WATSON.
H.R. 1230: Mr. CLEAVER.
H.R. 1236: Ms. SLAUGHTER.
H.R. 1318: Mr. MCMAHON.
H.R. 1362: Mr. FRANK of Massachusetts.
H.R. 1403: Mr. PERRIELLO and Mr. PITTS.
H.R. 1585: Mr. MORAN of Virginia and Ms. FUDGE.
H.R. 1623: Mr. MCCOTTER and Mr. MARCHANT.
H.R. 1628: Mr. BILBRAY.
H.R. 1792: Mr. TERRY.
H.R. 1869: Ms. BERKLEY, Mr. WALZ, Ms. TSONGAS, Ms. GIFFORDS, and Mr. LEWIS of Georgia.
H.R. 1880: Mr. CARNAHAN.
H.R. 1974: Mr. SCOTT of Virginia and Mr. WOLF.
H.R. 2006: Mr. BISHOP of Georgia, Mr. DEFAZIO, and Ms. EDDIE BERNICE JOHNSON of Texas.
H.R. 2068: Mr. WOLF.
H.R. 2074: Mr. NADLER of New York, Mr. JOHNSON of Georgia, Mr. HONDA, Mr. SIRES, Mr. SCHIFF, Ms. MCCOLLUM, Mr. TONKO, Mr. BRALEY of Iowa, Mr. GRIJALVA, Mr. MASSA, Mr. DAVIS of Illinois, Ms. CORRINE BROWN of Florida, Ms. PINGREE of Maine, and Mr. PASTOR of Arizona.
H.R. 2103: Ms. SLAUGHTER.
H.R. 2112: Mr. CAPUANO.
H.R. 2138: Mr. COHEN.
H.R. 2156: Mr. YOUNG of Alaska.
H.R. 2239: Mr. BERMAN.
H.R. 2243: Mrs. LOWEY.
H.R. 2246: Mr. HINOJOSA.
H.R. 2254: Mr. ADLER of New Jersey, Mr. HOLDEN, Mr. INSLEE, Mr. BUCHANAN, Mrs. NAPOLITANO, and Ms. CHU.
H.R. 2276: Mr. KENNEDY.
H.R. 2339: Mr. FRANK of Massachusetts.
H.R. 2377: Mr. PRICE of North Carolina and Mr. CASTLE.
H.R. 2405: Mr. SCHOCK.
H.R. 2425: Mr. PETERSON.
H.R. 2460: Ms. CHU.
H.R. 2476: Mr. MCKEON.
H.R. 2478: Mr. BACA and Mrs. BLACKBURN.
H.R. 2480: Ms. DELAURO, Mr. LANGEVIN, Ms. ESHOO, Ms. ROYBAL-ALLARD, Mr. HIGGINS, and Mr. HARE.
H.R. 2492: Mr. SCHIFF.
H.R. 2531: Mr. JACKSON of Illinois, Ms. JACKSON-LEE of Texas, and Mr. ROTHMAN of New Jersey.
H.R. 2565: Mr. CASSIDY.
H.R. 2573: Mr. TEAGUE, Mr. BISHOP of New York, and Mr. HOLT.
H.R. 2575: Ms. KILROY.
H.R. 2766: Mr. PALLONE, Mr. TOWNS, Mr. ACKERMAN, Mr. SERRANO, Mr. WEINER, and Mr. HONDA.
H.R. 2807: Mr. POLIS of Colorado.
H.R. 2817: Mr. OBERSTAR.
H.R. 2850: Mr. MCDERMOTT.
H.R. 2852: Ms. DEGETTE.
H.R. 2866: Mr. POLIS of Colorado.
H.R. 2906: Mr. CARNAHAN, Ms. TITUS, and Ms. DELAURO.
H.R. 2941: Mr. GONZALEZ.
H.R. 3020: Mr. TEAGUE.
H.R. 3025: Mr. BLUMENAUER.
H.R. 3077: Mr. GUTIERREZ, Mr. STARK, and Ms. HIRONO.
H.R. 3093: Mr. PETERSON.
H.R. 3099: Ms. SHEA-PORTER.
H.R. 3101: Mr. ROTHMAN of New Jersey, Mr. PETERSON, Ms. MCCOLLUM, and Mr. CLEAVER.
H.R. 3105: Mr. ROHRABACHER.
H.R. 3153: Mr. KAGEN.
H.R. 3185: Mr. FRANK of Massachusetts.
H.R. 3227: Mr. MCDERMOTT.
H.R. 3259: Mr. DICKS, Mr. GALLEGLY, and Mr. PASTOR of Arizona.
H.R. 3287: Ms. BALDWIN.
H.R. 3308: Mr. TURNER.
H.R. 3359: Mr. MCNERNEY and Ms. ZOE LOFGREN of California.
H.R. 3381: Mr. POLIS of Colorado.
H.R. 3407: Mr. TIM MURPHY of Pennsylvania.
H.R. 3421: Mr. LEWIS of Georgia, Ms. HIRONO, and Ms. KILPATRICK of Michigan.
H.R. 3455: Mr. THOMPSON of Mississippi.
H.R. 3457: Mr. HILL.
H.R. 3458: Mr. FRANK of Massachusetts and Ms. EDWARDS of Maryland.
H.R. 3464: Mr. SNYDER and Mr. SCHOCK.
H.R. 3474: Mr. KILDEE, Ms. LEE of California, Mr. KENNEDY, Mr. PAYNE, Mr. MOORE of Kansas, Ms. SCHAKOWSKY, and Mr. HASTINGS of Florida.
H.R. 3477: Mr. MANZULLO.
H.R. 3524: Mr. REHBERG, Mr. ELLSWORTH, and Mr. GRIFFITH.
H.R. 3554: Mr. MCNERNEY.
H.R. 3564: Mr. SERRANO.
H.R. 3578: Mr. DELAHUNT, Mr. GORDON of Tennessee, and Ms. SHEA-PORTER.
H.R. 3646: Mr. MCNERNEY.
H.R. 3654: Mr. GENE GREEN of Texas and Mr. FALEOMAVAEGA.
H.R. 3656: Mr. WOLF.
H.R. 3668: Mr. PETERSON, Mr. ROE of Tennessee, and Mr. TEAGUE.
H.R. 3671: Mr. JACKSON of Illinois.
H.R. 3691: Mr. MANZULLO.
H.R. 3692: Ms. TITUS.
H.R. 3695: Mrs. MALONEY, Mr. MCCOTTER, Mr. HINCHEY, and Ms. NORTON.
H.R. 3705: Mr. GRAYSON, Ms. CASTOR of Florida, Ms. WATSON, Mr. WELCH, Mr. CARNAHAN, and Mr. STARK.
H.R. 3712: Mr. PRICE of North Carolina and Mr. LANCE.
H.R. 3745: Ms. WOOLSEY.
H.R. 3758: Mr. MANZULLO, Mr. MOORE of Kansas, Mr. SOUDER, Mr. WILSON of South Carolina, Mr. LOEBSACK, Mr. ALEXANDER, Mr. ROGERS of Michigan, and Mr. MORAN of Kansas.
H.R. 3905: Mr. SPACE, Ms. TITUS, Mrs. HALVORSON, Mr. PUTNAM, Mr. MINNICK, Mr. RUPPERSBERGER, and Mr. TERRY.
H.R. 3926: Mr. SNYDER.
H.R. 3930: Mr. DELAHUNT.
H.R. 3942: Mr. BOOZMAN.
H.R. 3957: Mr. JOHNSON of Georgia, Mr. GRIJALVA, Mr. CUMMINGS, and Ms. SHEA-PORTER.
H.R. 3986: Mr. STARK and Mr. GRIJALVA.
H.R. 4000: Mr. DAVIS of Illinois.
H.R. 4053: Ms. FUDGE.
H.R. 4058: Mr. MCNERNEY.
H.R. 4067: Mr. THORNBERRY, Ms. MARKEY of Colorado, and Ms. KOSMAS.
H.R. 4085: Mr. KILDEE, Mr. EHLERS, and Mrs. MILLER of Michigan.
H.R. 4092: Ms. JACKSON-LEE of Texas, Ms. NORTON, Ms. CLARKE, and Mr. JACKSON of Illinois.
H.R. 4099: Mr. CARNAHAN.
H.R. 4100: Mr. AUSTRIA, Mr. HARPER, Mr. PITTS, Mr. LATTA, Mrs. SCHMIDT, Ms. FALLIN, Mr. AKIN, Mr. BILBRAY, Mr. CULBERSON, and Mr. WITTMAN.
H.R. 4103: Mr. BOOZMAN.
H.R. 4114: Ms. WOOLSEY.
H.R. 4116: Ms. BORDALLO, Ms. SCHAKOWSKY, Mr. PAYNE, Ms. DELAURO, Mr. GRIJALVA, Mr. INSLEE, Ms. HIRONO, Mr. CAO, Mr. MCGOVERN, Mr. MOORE of Kansas, and Ms. BERKLEY.
H.R. 4117: Mr. CARNEY.
H.R. 4120: Mr. SOUDER.
H.R. 4127: Mr. KLINE of Minnesota.
H.R. 4131: Mr. MASSA, Ms. JACKSON-LEE of Texas, and Mrs. CAPPS.
H.R. 4135: Mr. BISHOP of New York and Mr. CARSON of Indiana.
H.R. 4140: Mr. SERRANO.
H.R. 4148: Mr. FATTAH and Ms. DELAURO.
H.R. 4154: Mr. ETHERIDGE, Mr. MICHAUD, Mr. COOPER, Mr. BERRY, Mr. MELANCON, Mr. MOORE of Kansas, Mr. HILL, Ms. HERSETH SANDLIN, Mr. BOSWELL, Mrs. DAHLKEMPER, and Mr. TANNER.
H.R. 4160: Mr. MORAN of Virginia and Mr. POLIS of Colorado.
H.R. 4161: Mr. MORAN of Virginia and Mr. POLIS of Colorado.
H.R. 4163: Mr. MCGOVERN.
H.R. 4168: Mr. DREIER, Mr. GRIJALVA, and Mr. LUJÁN.
H.J. Res. 50: Mr. MORAN of Kansas.
H.J. Res. 61: Ms. SLAUGHTER.
H. Con. Res. 16: Mr. SHULER.
H. Con. Res. 169: Mr. AUSTRIA.
H. Con. Res. 193: Mr. CONAWAY, Mr. SMITH of Texas, Ms. GRANGER, Ms. MARKEY of Colorado, Mr. OLSON, and Mr. CULBERSON.
H. Con. Res. 197: Mr. SCALISE.
H. Res. 35: Mr. BOSWELL, Mr. BERRY, Mr. MOORE of Kansas, Mr. TAYLOR, Mr. LOEBSACK, Mr. EDWARDS of Texas, Mr. ROYCE, Mr. MELANCON, Mr. BOREN, and Mr. LIPINSKI.
H. Res. 55: Mr. BLUNT.
H. Res. 588: Mr. WEINER.
H. Res. 615: Mr. WOLF and Mr. PUTNAM.
H. Res. 704: Mr. PITTS, Ms. ROYBAL-ALLARD, Ms. WATERS, Mr. GORDON of Tennessee, Mr. PAYNE, Mr. DREIER, Mr. GOHMERT, Mr. PENCE, Mr. LEWIS of California,

Mr. OLVER, Mr. PLATTS, Mr. ALEXANDER, Mr. COOPER, Mr. CONAWAY, Mr. CARTER, Mr. YOUNG of Florida, and Mr. WAXMAN.

H. Res. 771: Mr. NADLER of New York.

H. Res. 776: Mr. FOSTER, Mr. MOORE of Kansas, Mr. SCOTT of Georgia, Mr. CARNAHAN, Ms. HERSETH SANDLIN, and Mr. MATHESON.

H. Res. 779: Ms. JENKINS, Mr. KIRK, and Mr. ROSKAM.

H. Res. 812: Mr. CONAWAY, Mr. COURTNEY, Mr. FLEMING, Mr. FRANKS of Arizona, Mr. ELLSWORTH, Mr. KIRK, Mr. WITTMAN, Mr. ANDREWS, Mr. PLATTS, Mr. THORNBERRY, Mr. GARRETT of New Jersey, Mr. BRIGHT, Mr. LINDER, Mrs. MILLER of Michigan, Mr. HALL of Texas, Mr. CAO, Mr. MCKEON, Mr. BUCHANAN, Mrs. BACHMANN, Mr. POSEY, Mr. CALVERT, Mr. THOMPSON of Pennsylvania, and Mr. KING of New York.

H. Res. 852: Mr. LUCAS, Mr. BOOZMAN, Mr. MILLER of Florida, Mr. SOUDER, Mr. FLEMING, Mr. GOHMERT, Mr. KINGSTON, Mr. CARTER, Mr. NEUGEBAUER, Mr. SHIMKUS, Mr. MANZULLO, Mrs. LUMMIS, Mr. TURNER, Mr. CASSIDY, Mr. COBLE, and Mrs. MCMORRIS RODGERS.

H. Res. 862: Ms. BEAN, Mr. KIRK, Mr. SCHOCK, Mr. EHLERS, and Mr. BLUMENAUER.

H. Res. 888: Mr. KIRK, Mr. SMITH of New Jersey, and Mr. LOBIONDO.

H. Res. 901: Ms. SCHAKOWSKY, Mr. CARSON of Indiana, Mr. CONYERS, and Mr. QUIGLEY.

H. Res. 902: Mr. PRICE of North Carolina.

H. Res. 911: Ms. GINNY BROWN-WAITE of Florida, Mr. OLSON, Mr. SMITH of Nebraska, Mr. BARTON of Texas, Mr. BARTLETT, Mr. PETRI, Mr. WALDEN, Mr. GERLACH, Mr. LATOURETTE, Mr. SOUDER, and Mrs. EMERSON.

H. Res. 915: Mr. VISCLOSKY.

H. Res. 934: Mr. KAGEN.

CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, OR LIMITED TARIFF BENEFITS

Under clause 9 of rule XXI, lists or statements on congressional earmarks, limited tax benefits, or limited tariff benefits were submitted as follows:

OFFERED BY MR. RANGEL

H.R. 4154, the Permanent Estate Tax Relief for Families, Farmers and Small Businesses Act, does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:

H. Res. 648: Mr. WILSON of South Carolina and Mr. POE of Texas.

SENATE—*Wednesday, December 2, 2009*

The Senate met at 9:30 a.m. and was called to order by the Honorable TOM UDALL, a Senator from the State of New Mexico.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Eternal God, thank You for the gift of this day. Help us to use it for Your glory. Guide our lawmakers to labor with diligence for the good of our Nation. Deliver them from bitterness, frustration, and futility as they lift their eyes to You, their ever-present help for life's difficulties. Lord, save them from the futile repetition of old errors and the restoration of old evils. May they live such exemplary lives that people who see their good works will glorify You. Use the Members of this body to increase opportunities for more abundant life to people everywhere. Help our lawmakers to be aware of Your nearness and to recognize Your voice as You lead them to Your desired destination. We pray in Your sacred Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable TOM UDALL led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 2, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable TOM UDALL, a Senator from the State of New Mexico, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. UDALL thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health care reform legislation. It will be for debate only until 11:30 a.m., with alternating blocks of time. The first 30 minutes will be under the control of the Republicans; the majority will control the next 30 minutes.

The Senate will recess from 11:30 a.m. until 12:30 p.m. today. Following the recess, the Senate will resume consideration of the health care legislation. I am hopeful we can have some votes this afternoon. We have been unable to work that out with the minority and so we will see what the afternoon brings.

HEALTH CARE REFORM

Mr. REID. Mr. President, this historic health care reform bill before us is strong, and it is a strong head start in the right direction toward urgently needed change. But similar to nearly every bill to come before the Senate, it stands to benefit from the constructive input of all Senators. This good bill will be even better when this body debates it, refines it, and improves it.

I am pleased we have begun the amendment process. I hope we will soon be able to begin voting on those amendments—the ones drafted and sponsored by both Republicans and Democrats. But as we delve into the details and give the individual parts of this bill the considerable thought and attention they deserve, let's not forget the big picture.

So as we begin the third day of debate on this bill, let's remember what it does: First, we are making it more affordable for every American to live a healthy life. Second, we are doing it in a way that is fiscally responsible and in a way that will help our economy recover.

This bill does not add a dime to the deficit—quite the opposite. In fact, we will cut it by $130 billion in the first 10 years and as much as $¾ trillion in the next 10 years. We do this by keeping costs down. This critical piece of legislation will cost less than $85 billion a year over the next decade—well under President Obama's goal. It will make sure every American can afford quality health care. We will make sure that more than 30 million Americans who don't have health care today will soon have it. It will not only protect Medicare, but it will make it stronger. In short, this legislation saves lives, saves money, and saves Medicare.

The Congressional Budget Office and respected economists outside Washington have studied it, and they agree. The bill will do what we set out to do at the beginning of this Congress: It will lower costs and increase value so all Americans can afford quality health care, not just a few.

The experts have crunched the numbers, and they have come back with positive reviews. It will help parents afford to take care of their children and help bosses provide coverage for their workers. It creates more choices and more competition in the health care market. It will protect everyone against insurance company abuses, and for all the changes, in areas where our health care system does work, it keeps it the way it is.

I am very happy with the way Democratic Senators have stood for these principles and those who have defended them against hollow attacks from the other side. One after another, Republicans have come to the floor with disingenuous claims.

For example, they have talked about health care premiums, overlooking the fact that those costs will go down for the vast majority of Americans—in fact, 93 percent. They have talked about the deficit, ignoring the fact that health care reform will do more to lower the deficit than any other measure has in years—remember, over 20 years, almost $¾ trillion. They have tried to scare seniors, saying you are going to die soon, as an example, closing their eyes to the fact that we strengthen Medicare and cut waste, fraud, and abuse from the program. They have tried to scare women, closing their ears to the fact that we will make it easier than ever for women to get the preventive screenings they need, and that is a gross understatement. They claim to speak for the American people but neglect to mention that, for the last year, a majority of the Americans have consistently said it is more important than ever to nurse our health care system back to health.

What is the most consistent Republican attack on this bill? They carefully count the number of pages in this legislation but completely discount the number of people it helps. Can anyone think of a more superficial way to measure the worth of a bill than how many pages it is printed on? As far as I can tell, the only threat that poses is more paper cuts, perhaps.

Those who want to keep the broken system the way it is throw everything they can at the wall, but nothing has stuck. Incredibly, my distinguished counterpart, the Republican leader, last week, called the health care crisis

manufactured, in spite of the fact that 750,000 people filed for bankruptcy last year—70 percent of them because of health care costs. In one sense, my Republican counterpart is right—it was manufactured. This health care crisis has been manufactured by the greedy insurance companies that raise families' rates on a whim and deny health care to the sick.

Remember, the health care industry is exempt from the antitrust laws. They can conspire to fix prices with no civil or criminal penalties. No other business is like that, except baseball. This crisis was manufactured by leaders who enabled them, who empowered them, and who sat idly by while the problem grew worse and worse, until it finally collapsed into a crisis.

My Republican friends have been so busy coming up with distortions that they have forgotten to come up with solutions. They seem more concerned with scaring the American people than helping them. This barrage of baseless accusations underscores how desperate some are to distract the American people from the real debate and from the fact they have no vision for fixing our health care system, which is broken.

Yes, correcting the record has taken a long time. That is OK. We will continue to do so as long as necessary. Democrats are more than willing to defend this good bill. After all, it is not hard to do. As Mark Twain, a great Nevadan, said: ''If you tell the truth, you don't have to remember anything.''

I wish to note that I especially appreciate the assistant leader, my friend of decades, Senator DURBIN, for his brilliant statements on the floor during the last several weeks on this health care issue. I so admire his spunk, his intelligence, and his ability to deliver a message.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Mikulski amendment No. 2791 (to amendment No. 2786), to clarify provisions relating to first-dollar coverage for preventive services for women.

McCain motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 11:30 will be equally divided with alternating blocks of time, with Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KYL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. KYL. Mr. President, to continue our debate on the McCain amendment to ensure Medicare benefits for our seniors are not cut, as would happen under this legislation, I wanted to talk a little bit about the commitments we have made to our seniors and what exactly would happen under the legislation that is before us.

As we all know, seniors have paid into the Medicare Program, and that is with the expectation that they will get the benefits that have been promised to them. The question is, Why would we, at this point, reduce the benefits that have been promised to them, especially if the purpose is not to enhance the financial viability of Medicare, which everyone knows is going broke but, rather, to use that money to establish a new entitlement program?

Let me break down the list of cuts seniors would face under this legislation: $137.5 billion would be cut from hospitals that treat seniors, $120 billion from the Medicare Advantage plan. By the way, that Medicare Advantage plan serves almost 40 percent of the Arizona seniors on Medicare. It cuts $14.6 billion from nursing homes, $42.1 billion from home health care, and $7.7 billion from hospice care. These are deep cuts, and you cannot avoid jeopardizing the health care seniors now have under Medicare by making these deep cuts. That is why the Chief Actuary at the Centers for Medicare and Medicaid Services—we use the initials CMS—believes these cuts would cause some providers to end their participation in Medicare, which, of course, would further threaten seniors' access to care. There would not be as many providers to whom they could go for their services.

Our friends on the other side of the aisle say part of this is an intention to eliminate waste, fraud, and abuse. Of course, we have known for many years that there is waste, fraud, and abuse in Medicare, but actually doing something about the problem and recognizing it are two different things. If it were easy to wring hundreds of billions of dollars of savings from Medicare by just pointing to waste, fraud, and abuse, we would have done it a long time ago. Certainly the President would, during his first year in office, want to do that, given the fact we are spending a lot of money and he is trying to find sources of revenue for the various spending programs he has proposed. If it were that easy to do, it would have been done before now.

Moreover, Medicare faces a $38 trillion, 75-year unfunded liability. That is almost incomprehensible. Most of us believe that whatever savings we could achieve in Medicare, to the extent you could eliminate waste, fraud, and abuse, for example, you should do that to help make Medicare solvent.

Next I want to talk about what seniors are telling us. They believe, according to public opinion surveys—and I have talked to enough of them to know this is true—that these Medicare cuts are going to jeopardize their health care. They are troubled in particular by this $120 billion proposed cut to Medicare Advantage. It has been called the crown jewel of Medicare. It is the private insurance addition to Medicare in which many are able to participate in programs they would never have been able to afford otherwise. It gives them this choice to supplement Medicare to provide all kinds of benefits such as dental, vision, hearing, physical fitness programs, and other things, as I said, that they could not get otherwise. One in four of the beneficiaries in Arizona, as I said, signs up for this program—more than 329,000 seniors. They like the low deductibles and copayments in Medicare Advantage.

But the Congressional Budget Office has bad news for the seniors who like this program and who like the extra benefits they have under Medicare Advantage because, as the Congressional Budget Office notes, it would cut benefits on average by 64 percent over the next 10 years, from an actuarial value of $135 to $49 a month. Think about that. The actuarial value of the benefits the average Medicare Advantage participant has is worth $135 a month today. It would be cut in this bill to $49 a month. That is a 64-percent cut, according to the Congressional Budget Office. When we say we are not cutting benefits seniors currently receive, that is not true. This legislation would do that.

I have been sharing letters from constituents who have expressed concerns to me. Let me share three more letters today.

One recently arrived from Joseph and Mary-Lou Dopak of Sun City West, in Arizona, of course. They wrote as follows:

The plan to reduce our coverage and take $120 billion from Medicare Advantage is a

slap in the face to all seniors. The Medicare Advantage plan works because Medicare funds are given to a private insurance company to administer the plan.

We do not want our Medicare Advantage plan robbed to fund a government-operated comprehensive health insurance plan. Commonsense tells us that will not work.

The President should be fixing what ails the current health care system, instead of putting everyone into a government-operated health care plan.

For our President to pick on Medicare Advantage is totally unfair to those of us upon whose shoulders this country has been built.

A constituent from Tucson, AZ, wrote a rather short and direct letter, and so it is easy to quote here.

I am a senior citizen age 83. If I lose my Medicare Advantage coverage, I'll also lose my primary care physician of 18 years because he does not accept Medicare Direct. Senator KYL, do not let them take away my Medicare Advantage.

I get these letters every day. I have not yet had a constituent come up to me and say: Please, would you take away the Medicare Advantage Program, it is not right. Everybody has said, of course: Please preserve this important program.

Finally, a constituent from Phoenix, AZ, who suffers from multiple sclerosis, describes what it means to her.

I am a 57-year-old woman with multiple sclerosis, currently on Social Security Disability. I make under $14,000 a year and have been on the Secure Horizons Medicare Advantage plan for a long time now. . . .

I realize it is hard for Congress to understand, but we need to keep our Medicare Advantage plans in order to have [quality] health care at a price we can afford.

We need you to help protect Medicare Advantage plans for the seniors in your State. We are the ones you need to fight for and we should not have to choose between going to a doctor and getting our medication and having food on the table and a place to live. Please do your part to protect our Medicare Advantage plans and keep prices within our reach.

As I said, these are the kinds of letters we get all the time. It is hard for these folks to understand, first of all, why, having paid into the plan and having taken advantage of what is a good supplement to the basic Medicare, that would be taken away from them. I think it is even harder for them to fathom that the reason it is being done is to pay for a new program rather than to keep Medicare itself solvent.

I tell folks like this that I will continue to fight for her and I will continue to try to protect this program because we believe it is essential. It is why I support the McCain amendment to commit the bill back to committee. It only has to be there a day. We are not talking about a further delay here. But it addresses both of the key issues of cuts and savings. If the McCain amendment passes, it would send the bill back to the Finance Committee with instructions to remove the Medicare cuts from the bill. That is all it does. But, second, those savings would be applied to Medicare rather than to fund a new government program. Those savings could therefore address the waste, fraud, and abuse problem that has been identified by everyone. It can be used to strengthen the Medicare trust fund rather than to fund a new health care entitlement program.

We believe the first thing we should do to see whether we can actually fix this bill—I have been quoted as saying that I don't think we can fix this bill. By that, I mean, with all due respect to my colleagues on the other side of the aisle, I don't think they want to make the changes I think would be necessary for the American people to begin to support this kind of legislation. Seniors are overwhelmingly opposed to the Medicare cuts. That is a fact. If my colleagues on the other side of the aisle are not willing to support the McCain amendment or something like it, I don't know how we could then say we can fix this bill. So I hope my colleagues will use this process we have to actually make amendments to the bill and not simply have a political discussion.

Republicans have pointed out that there are better ways to reform the health care problems we have today than to do it on the backs of seniors. We put forth a bounty of ideas. Let me just recoup some of them.

We think we could start and we could save a great deal of money by medical malpractice reform. That would bring down costs. We could allow Americans to buy lower cost insurance policies across State lines. That alone would unleash a wave of competition for patients' business. We could allow small businesses to band together to get the same purchasing power big businesses have. These ideas have essentially been ignored by the majority. Instead, we have this big government takeover of health care at a huge cost and significant reduction in quality and benefits to the American people. We don't think this is the way to go.

Certainly, on behalf of my senior citizen constituents and others who are on Medicare Programs, I am going to continue to fight for them, as my colleague John McCain is, and therefore urge my colleagues to support his amendment to eliminate the Medicare cuts under this bill.

The ACTING PRESIDENT pro tempore. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I rise to speak in favor of the McCain motion, and I do it from the perspective of a representative of the State of Kansas.

We have a number of senior citizens and hospitals that are Medicare-dependent. We have a number of providers for whom a majority of their practice is Medicare reimbursement. They are scared to death of these cuts, and the cuts are well documented—$500 billion in Medicare cuts, and for the 43 million senior citizens on a program that is already projected to go insolvent by 2017, specific cuts of $135 billion from hospitals, $120 billion from 11 million seniors in Medicare Advantage, nearly $15 billion from nursing homes, nearly $40 billion from home health agencies, and then—a cruel gesture, it seems to me—nearly $8 billion from hospice, where people are getting their final care for cancer and diseases that are killing them—$8 billion cut from hospice.

What that does in a State such as mine and in many rural hospitals, it cuts the legs out from under them. They are not going to have the money they need to operate. They are going to do everything they can to continue to operate—and they will, probably. What they will try to do is tax their local citizenry, raise property taxes, in all probability, to make up for the Medicare cuts because they are going to have a hospital there and they are going to do everything they can to keep a hospital there.

But what a terrible gesture on our part here, to take money that has been going into Medicare—and people have been paying into Medicare—and then steal it for a new program that is not going to get everybody covered on top of that and from a program that is already set to go insolvent by 2017. It is like writing a big fat check on an overdrawn bank account to start something new, to buy a new motorcycle. That doesn't make sense to people. Then it seems cruel and unusual to the senior citizens that you are taking $500 billion and really gutting a lot of their care programs on a program that doesn't work.

I met earlier, within the last several days, with the Kansas Association of Anesthesiologists. They are looking at these things and saying: This is really going to hurt us and our ability to provide services and care. I talked with other individuals who look at this, and they say: Wait a minute, you are going to change everything to try to get a few more people covered and you are going to gut a Medicare program that is not paying the bills now, that a number of private insurance plans are helping to subsidize Medicare and Medicaid, and you are going to cut the reimbursements that are not making things work yet? It makes no sense to individuals that this would take place.

I get called by a number of individuals across the State of Kansas saying they are very scared of this bill and what it is going to do to their health care. I do telephone townhall meetings, as a number of individuals across this body do, and the individuals there whom you get on a random phone calling basis are scared and mad about this bill and the prospects of what it does to their health care. I get it from individuals. I get it from mail.

I was in a meeting in Kansas the week of Thanksgiving, and I polled the audience—it was an audience that was mostly over the age of 65—how many were in favor of the overall bill? There were about 200-some people there, and 10 were in favor. How many opposed? Everybody else, with a few saying they don't have an opinion. But it was 90 percent, 95 percent opposed to this bill, and it is because they look at it and they see what it is going to do to them, and they don't see it providing the care that is being promised—and adding, on top of that, to the deficit.

One of two things is going to happen on these Medicare cuts, because we have seen, in the past, efforts to control the spending in Medicare passed by this body and then each year those cuts to try to restrain the spending on Medicare being restored.

One of two things is going to happen. Either these cuts in Medicare are going to take place, and it is going to cripple the program and particularly hurt it in a number of rural areas across the country and in my State, or these cuts will never take place in Medicare and it is going to add to a ballooning deficit and debt that is taking place right now. Either choice is an irresponsible choice for this body to do. It is irresponsible for us to do for this country. Most people look at it and say: I want to get more people covered, and I want to bend down the cost curve. But let's do that on an incremental basis.

Senator KYL spoke about incremental changes that can take place, whether it is tort reform, allowing bigger pooling on health insurance, whether it is starting more community-based clinics, one that I look at as something that has worked in my State to get more people covered at an earlier phase in their health care needs. All of those are incremental, low cost, and, in some cases, ones that actually do bend down the cost curve and that can help, not a gargantuan $2.5 trillion program that takes $500 billion out of Medicare that is already headed toward insolvency in less than a decade. The bill doesn't make sense to individuals.

Then to do it on top of a time period when the President, 10 days ago, comes back from China, meeting with our bankers, as most people look at it, and the bankers lecturing us on why are we spending more money which we don't have, going further and further into debt, which we should not do at this point in time, being lectured by the Chinese when we ought to be talking to them about what they are doing about human rights and currency. We are being lectured about fiscal irresponsibility, and it is because of bills such as this. If we just stop and slow down and listen to seniors and others across this country, there is a commonsense middle ground that we can go to, that doesn't cost anything along the nature of this, doesn't change health care for most people but addresses the narrow problem of getting the cost curve down, of getting more people covered. This bill with these cuts in Medicare cripples many of my providers in the State of Kansas and will make them raise property taxes to keep the hospitals open, to try to provide doctors in the community—a lot of the hospitals are going to close and a lot of providers will stop providing Medicare—or, in all probability, these cuts will never happen, and it will be added to the debt and deficit, completely irresponsible toward our kids.

I urge my colleagues to vote for the McCain motion that makes sense, that is what the citizenry wants to do: send these cuts in Medicare back to communities and pull out of this bill.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. CORKER. Mr. President, how much time remains on our side?

The ACTING PRESIDENT pro tempore. There is 7 minutes 6 seconds.

Mr. CORKER. I thank the Chair.

Mr. President, I am glad to be on the floor of the Senate with the distinguished Senators from Kansas and Connecticut and Montana. We have obviously before us one of the most important issues we will deal with in this body.

I have had over 40 townhall-like meetings since the beginning of August. I can say without hesitation that I have never used those meetings to try to focus on some of the hot-button issues that divide us. On not one occasion have I tried to do that. I have tried to focus on the fundamentals of this health care bill. Way back when, when I began meeting with the distinguished chairman of the Finance Committee—I greatly appreciated his desire to meet with me—and realized that Medicare may be a place where money will be taken to leverage a new entitlement, I began expressing my concerns about that.

Later, I sent a letter to Majority Leader REID, signed by 36 Senators, talking about the fact that if Medicare moneys were used to leverage a new entitlement, we could not support that effort.

The reason I say this is, this is the same exact thing I have been saying about this bill from day one, before it was ever constructed. I am very dismayed that we find ourselves here in December debating a bill that does exactly that.

When I first came to this body, there was a lot of concern about the solvency of Medicare. Everyone here knows the trustees have stated that in 2017 Medicare will be absolutely insolvent. Two Senators from opposite sides of the aisle have tried to create legislation that would put in place a commission, eight Republicans and eight Democrats, to actually solve that issue. We realize we do not have the resources in Medicare to actually deal with the liabilities we have with seniors.

The fact that we are taking $464 billion in savings out of Medicare to leverage a new entitlement, to me, is totally irresponsible. It is the same thing I have been saying from day one. I am dismayed that we would consider kicking the can down the road, making sure that people of the generation of the many people who are helping us on the floor today will be saddled with huge amounts of cost that they will not be able to deal with in a responsible manner. I am discouraged.

The fact is, the other piece of this that is extremely troubling is that we all know we have the issue of SDR, the doc fix, which is a colloquial term to describe the fact that in any year after this bill passes, physicians across the country will be receiving a 23-percent cut for serving Medicare recipients. Medicare recipients understand what that means. It means they will have less physicians to deal with the needs they will have at that time. This bill, instead of dealing with that issue, deals with it for one year. What that means is there is about $250 billion worth of expenses that are not being dealt with with this Medicare savings.

Let me go walk it one more time. We have a program that is insolvent. We have a program that cannot meet the needs of those people who have paid into it for years and many of us continue to pay into. This program is insolvent, and we are going to take moneys out of this program, $464 billion—something that most Americans cannot do, something that does not pass the commonsense test in Tennessee, and my guess is doesn't pass the commonsense test in most States—we are going to take $464 billion out of this program, this entitlement which is underfunded and insolvent, and we will leverage it to create a new entitlement for Americans. Yet we are not going to deal with the issue of the doc fix, which is a $250 billion issue. We are going to kick the can down the road. We are going to cause physicians around the country next year to, if this bill passes—if not, certainly they will be dealing with that this year—but we are going to cause physicians around the country another year to be concerned about these huge cuts, not deal with it in this bill, and possibly end up with a $250 billion obligation that could have been dealt with during this health care reform that now is not met, that is going to create additional fiscal burdens to this country and certainly great distress to seniors and physicians who care for them.

I tried to stick with the basic fundamental building blocks of this bill. I don't think anybody in this body has ever heard me focus on some of the more emotional issues. The fact that

we would use Medicare moneys to create a new entitlement, the fact that we would have an unfunded mandate to States through Medicaid of $25 billion, to me, is problematic; the fact that premiums are going to increase, whether it is the CBO number of 10 to 13 percent or the Oliver Wyman number in my State which says 60 percent, the fact that private premiums are going to go up and the fact that we are using 6 years' worth of costs and 10 years' worth of revenues—I don't know how we have gotten caught up in this debate in such a manner that we are ignoring basic fundamentals that I don't think any of us on our own accord would consider supporting.

The fact is, I am afraid this, again, has become nothing but a political victory for the President.

What I hope we will do is step back and do some things in a bipartisan way that will stand the test of time. I ran on health care reform. I would like to see us do responsible health care reform. The basic fundamentals of this bill do not meet that test.

I see my time has expired. I thank the Chair and the Senators on the other side of the aisle who have worked hard to put this bill together. I hope they will step back away from these flawed fundamentals, and I hope in some form or fashion we will put together a bill that will stand the test of time.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, how much time do we have?

The ACTING PRESIDENT pro tempore. The Senator has 30 minutes.

Mr. DODD. Mr. President, let me first talk about the Medicare issue, because this has been the subject of sort of round-and-round debate, back and forth over the last couple of days. It is important to share, again, as emphatically as I know how what is being done with regard to Medicare. The whole idea is to strengthen Medicare, to put it on a sounder footing, to extend its solvency from 8 years by an additional 5 years, which we do under this bill, making it a stronger, more reliable source of health care for older Americans.

In fact, the finest and largest organization representing older Americans, which doesn't lightly endorse proposals without examining them thoroughly—hardly a partisan group given the fact of where they have been on these issues—has put out, once again, in the last 24 hours, a statement laying out the facts of what is included in the bill drafted by the Finance Committee principally in this area of Medicare.

Let me recite, if I may, the facts as they identify them. Fact No. 1, none of the health care reform proposals being considered by Congress would cut Medicare benefits or increase out-of-pocket costs for Medicare services. That is not from the Democratic National Committee. It is not from the HELP Committee or the Finance Committee. This is from AARP saying: None of the proposals in this bill cut Medicare benefits or cut Medicare services.

Fact No. 2, the health care reform bill drafted by the Finance Committee will lower prescription drug costs for people in the Medicare Part D coverage gap, or the so-called doughnut hole with which many seniors are familiar.

We are going to cut the cost of prescription drugs. Again, this is not from some partisan group announcing what is in the bill. This is from an objective, nonpartisan analysis of the bill that is before us.

Fact No. 3, health care reform will protect seniors' access to their doctors and reduce the cost of preventive services so patients stay healthier. Again, that is critical.

I presume others understand this; it is so axiomatic you wonder why you have to explain it. It is better to catch a problem before it becomes a major problem. Through mammograms, colonoscopies, obviously examinations and screenings, you can discover that an individual has a problem and, if caught early enough, can address it. As many of my colleagues know because it became rather public, I went through cancer surgery in August. It was discovered that I had an elevated PSA test, indicating I had prostate cancer. That screening let me know that I had a growing problem that I had to deal with. So I went through a variety of discussions on what best to do, what was the best way to handle all of this and decided that surgery made the most sense.

The cost of that surgery is expensive. It is not cheap—$5,000, $6,000, $7,000, $8,000 to do it. If I had not discovered I had prostate cancer and it had grown, I could have become 1 of the 30,000 men a year in this country who die from it, or if I had waited longer for it to be full-blown cancer, I am told it could have easily cost $250,000. So by catching this early and getting the needed treatment, I was not only able to stay alive and stay healthier, with two young daughters aged 4 and 8—and looking forward to the day I may dance at their weddings—but also there were the savings because it did not grow into a problem that would require massive expenditures to deal with it.

Our bill deals with that. We provide for the first time ever that seniors and other Americans have access to prevention and screening tests that would allow them to discover problems they have early on. That is according to AARP. That is what we drafted in this legislation. It is a major benefit.

I listened to our colleague from North Carolina yesterday, Senator HAGAN, talk about nurses in a hospital in her State of North Carolina who were not getting mammograms early, not because they did not want them but because, of course, the out-of-pocket expenses for them are so high they could not afford to do it and pay rent and put food on the table and take care of their families.

That hospital in North Carolina decided they were no longer going to require their nurses to pay those high out-of-pocket expenses and they eliminated that. As a result, every nurse—or almost every nurse—in that hospital got those mammograms early on and, of course, could identify problems before they became larger issues for them to grapple with.

That is what this bill of ours does. That is a major achievement—a major achievement. So the suggestion is, we ought to roll back and commit this bill. But that would eliminate the kind of investments we make in reducing the cost of prescription drugs or providing the kinds of benefits so people can get screenings and treat problems while they are still small.

As a Senator, I have a health care plan that allows me to do that. I am 1 of 8 million people in this country who are Federal employees. We all get to do that. Why should a Senator's battle with cancer be more important than someone else's in this country? Why shouldn't every American male over the age of 50 be able to be screened to determine whether they might have prostate cancer?

That is what we are talking about. That is what we are achieving in this bill. The idea that the status quo is OK is wrong. It is not OK. To say we ought to throw the bill back into committee, again—we all know what the meaning of that is, of course. It will mean an end to this legislation. Those are the facts.

Fact No. 4, if you will: Rather than weaken Medicare, the health care reform will strengthen the financial status of the Medicare Program. That is from AARP. That is not some partisan conclusion.

I say, respectfully, to our colleagues, and having been through this at great length over the summer, filling in for our friend whom we have now lost, Senator Kennedy, we went through long debates and discussions early on, a lot of bipartisan discussions. As I pointed out earlier, as to the bill that came out of the Health, Education, Labor, and Pensions Committee in the Senate, we conducted the longest markup in the history of that committee, going back decades, in order to listen to each other and to try to provide a bipartisan bill.

In many ways, that bill is a bipartisan bill. It did not get bipartisan votes, unfortunately, coming out of committee. But the substance of the legislation includes the ideas and

thoughts of our colleagues across the political spectrum, and it is important the public know that during the debate.

This is not a bill that was rushed through, jammed through. My colleague from Montana, Senator BAUCUS, spent weeks and weeks—months—with Democrats and Republicans gathered around the table late into the evenings talking about how we can shape this bill on a bipartisan basis. I attended many of those meetings in his office. No one can accuse the Senator from Montana of not reaching out to the other side to be a part of this solution. He went beyond the extra mile to achieve that, and he was flatly turned down, regretfully, in that effort. But that should not be a reason why we do not try to move forward.

I am still hoping we can get bipartisan support for the bill before it is concluded, but we will only get there if we work at it, and this is where we are working at it: on the floor of the Senate, and this debate is an opportunity to come forward and make constructive suggestions—not sending the bill back to committee, in effect, killing the legislation. That is the effect of what would happen if the McCain amendment were adopted.

Rather than engage in this kind of debate back and forth, where the Republicans say Medicare gets cut and the Democrats say, no, it does not, I wished to share with my colleagues this morning what nonpartisan, outside groups say about this bill. Listen to those who have made an analysis of this bill who do not wear a partisan hat, who do not have a political label attached to their names but are viewing every syllable, every punctuation mark in the bill to determine what it does for people. The most important, significant organization that represents the interests of the elderly in this country has analyzed this bill and has said to America: This is a good bill. This bill strengthens Medicare, provides benefits, and reduces costs.

That is what we have tried to achieve over these many months. So let's move on. If you want to cut this bill, if you want to change all this, then offer an amendment and let's vote on it, up or down, and move forward. I urge my colleagues to support this legislation and reject the McCain amendment because I think his proposal would do great damage to the effort we have achieved so far.

With that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I noted that the other side, in the last couple, 3 days, has tried to make the case that seniors' Medicare benefits are in jeopardy because ''this legislation cuts Medicare.'' I have heard that statement over and over and over and over again. In fact, the last speaker on the other side made that same point.

I am confounded, I am very surprised, when I hear those statements. Why am I very surprised? Because it is totally, patently false. It is false. It is untrue. There are no benefits cut here, none. One could say that with the private plans, the Medicare Advantage plans, which are vastly overpaid—the nonpartisan MedPAC organization states they are vastly overpaid by about 14 percent—one could say those private plans—it is not Medicare; those private plans, Medicare Advantage; those are not Medicare plans, those are private plans, private insurance plans—they may be overprescribing some nonguaranteed benefits for beneficiaries, things such as eyeglasses or something like that, which might be cut back. That is true. But none of the guaranteed benefits—the basic benefits under Medicare that every senior knows about when he or she goes to the doctor; and it is care under Medicare—is reduced. None. Nothing is cut.

In fact, this legislation adds benefits to seniors. For example, it virtually fills up this thing we call the doughnut hole. That is the portion of prescription drug payments that seniors otherwise would have to pay. But we say $500 of that is going to be paid for, and the rest of it is going to be paid for at least for 1 more year. So that is an additional benefit. Then all the screening provisions that are in this bill, that is an additional benefit. There are many other benefits that are added onto the ordinary benefits seniors have.

So it is not true—it is not true—that the basic guaranteed benefits under Medicare are cut. None of the guaranteed benefits under Medicare are cut—none. So it is totally untrue. It is false when people make the claim that ''Medicare is being cut.''

They are being very clever, the people who are making those claims. What they are saying when they say Medicare will be cut—they want you to think they mean benefits will be cut—but deep in their mind, what they are holding back in their mind—well, when pressed, they will agree, well, it is the Medicare providers, it is the hospitals, it is the medical equipment manufacturers, it is the pharmaceutical industry. That is being cut. That is ''Medicare'' that is being cut and, therefore, that will hurt seniors. That is kind of the way they get around it.

Well, the fact is, the way you preserve the solvency of the trust fund is to make sure there are not so many payments, frankly, by Uncle Sam going to pay for all the doctors and hospitals and so forth so the solvency of the trust fund is extended. Right now this legislation extends the solvency of the Medicare trust fund. If this legislation were not to pass, the Medicare trust fund would probably go insolvent in about the year 2017. But this legislation extends the solvency of the trust fund for at least 5 more years to 2022.

So I wish to make it very clear that this legislation we are considering does not cut Medicare benefits. In fact, the hospitals and docs, I would say, are going to find at least a 5-percent increase in growth over the next 10 years in payments to them under the Medicare Program—growth. I have a chart which I showed yesterday on the floor. It showed, for each of the various years, it is a 5-percent increase in growth for all those industries. They are being cut 1.5 percent, but that is from a 6.5-percent growth, to net down to a 5-percent growth for each of the years.

You ask analysts on Wall Street how hospitals are doing. They are doing great under this legislation. You ask analysts on Wall Street how the pharmaceutical industry is doing. They are doing great under this legislation. You ask any analyst about other industries—home health care, hospice care, you name it—they are all doing OK. Wall Street analysts say they are doing fine.

Why are they doing fine? Why, objectively, are they doing fine? Why do the CEOs of these organizations not grumble too much? Because they know what they may lose in a little bit of a reduction in their payments—they will still get big, hefty payments—they will make up in volume because so many more people will have health insurance. They know that. They are going to make a lot of money. So they are OK.

So it is not true that Medicare is going to go broke under this legislation. First of all, there is no reduction in benefits. That is very clear. Senator DODD read a letter from AARP making that very clear. Also, the reductions are not reductions in provider payments; they are reductions in the rate of growth of provider payments, and they are going to do fine. Providers do not care that much because they are making it on volume because everybody is going to have health insurance. They have quite a bit—a 5-percent growth rate anyway. So it is not true—it is not true—that Medicare is in jeopardy because of this legislation. It is not true that benefits are going to be cut. In fact, just the opposite is true. This legislation strengthens benefits, increases benefits, extends the length of the Medicare trust fund to a future date further down the road, so it stays solvent for many years than otherwise is the case.

This legislation helps seniors. It helps seniors, contrary to what you are hearing on the other side that it hurts seniors. If you just look at the facts, not the rhetoric—not the rhetoric but just look at the facts, look at the facts and look at who the supporters of this legislation are and objective groups and what they say about this legislation—you cannot help but be compelled

to the conclusion that this legislation is not only good for seniors, it is very good for seniors.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, with the apologies to my good friends from Montana and Connecticut, I was unavoidably detained at the opening and would like to now, on my leader time, give my opening remarks.

The ACTING PRESIDENT pro tempore. The Senator has the floor.

AFGHANISTAN

Mr. MCCONNELL. Mr. President, the challenges of the ongoing war in Afghanistan are immense, but Americans believe in the mission. They trust the advice of our commanders in the field to see that mission through.

So I support the President's decision to follow the advice of General Petraeus and General McChrystal in ordering the same kind of surge in Afghanistan that helped turn the tide in Iraq.

These additional forces will support a counterinsurgency strategy that will enable us to begin the difficult work of reversing the momentum of the Taliban and keeping it from power.

The President is right to follow the advice of the generals in increasing troops, and he is also right to focus on increasing the ability of the Afghan security forces so they can protect the people.

By doing both, he has made it possible for our forces to create the right conditions for Afghanistan—the right conditions for them to defend themselves, create a responsible government, and remain an ally in the war on terror.

Although our forces are in Afghanistan to defend our security interests, the people of Afghanistan must assume a greater burden in the future. The President's plan recognizes that.

Once we achieve our objectives—an Afghanistan that can defend itself, govern itself, control its borders, and remain an ally in the war on terror—then we can reasonably discuss withdrawal, a withdrawal based on conditions, not arbitrary timelines.

But, for now, we owe it to the American people, to those who died on 9/11, and to the many brave Americans who have already died on distant battlefields in this long and difficult struggle, to make sure Afghanistan never again serves as a sanctuary for al-Qaida. We owe it to the men and women who are now deployed or who will soon be deployed to provide every resource they need to prevail.

HEALTH CARE REFORM

With every passing day, the American people become more and more perplexed about the Democratic plan for health care, and they like it less and less.

Americans thought reform meant lowering costs. This bill actually raises costs. Americans thought reform meant helping the economy. This bill actually makes it worse. Americans thought reform meant strengthening Medicare. This bill raids it to create a new government program that will have the same problems that Medicare does. Americans wanted reform. What they are getting is the opposite—more spending, more debt, more burdens on families and businesses already struggling to get by.

One of the biggest sources of money to pay for this experiment is Medicare. This bill cuts Medicare Advantage by $120 billion. It cuts hospitals by $135 billion. It cuts home health care by $42 billion. It cuts nursing homes by $15 billion. It cuts hospice by $8 billion.

Reform shouldn't come at the expense of seniors. The McCain amendment guarantees it wouldn't. The McCain amendment would send this bill back to the Finance Committee with instructions to remove the language that cuts Medicare. The McCain amendment also says any funds generated from rooting out waste, fraud, and abuse should be used to strengthen Medicare, not to create an entirely new government program.

A vote in favor of the McCain amendment is a vote to protect Medicare. Let me say that again. A vote in favor of the McCain amendment is a vote to protect Medicare. A vote against the McCain amendment is a vote to raid this vital program in order to create another one for an entirely new group of Americans. So a vote against the McCain amendment is a vote to take money out of Medicare to create a program for an entirely different set of Americans. A vote against the McCain amendment is a vote against our seniors, and it is a vote against real health care reform.

Mr. President, I yield the floor.

Mr. DODD. Mr. President, how much time remains?

The ACTING PRESIDENT pro tempore. There is 13½ minutes.

Mr. DODD. I yield myself 5 minutes, if I may. I want to go back, if I can. I wish to put up these charts. Again, I say this respectfully, because I genuinely believe that people across the spectrum want to see some reform of the health care system. The question is whether the proposal that has been laid before us by the Finance Committee and the HELP Committee achieves reform and whether the ideas we bring to the table are actually going to achieve lower costs, provide greater access, and improve the quality of health care. We believe very firmly and strongly that it does.

There are outside observers of this process who have no political agenda whatsoever other than to make determinations as to whether the goals we have sought in this legislation achieve the desired results. It is the conclusion of the major organizations that make these determinations that, in fact, we have done exactly what we said we had set out to do.

But I wish to point out, because I think it is important when I hear the arguments from our friends on the other side about their deep concerns about Medicare, it is very important they understand that over the last number of years, we have seen quite the opposite reaction when it comes to the Medicare Program in our Nation. Going back to 1995, when our friends took control of both this body and the other body, the then-Speaker of the House Newt Gingrich announced to the world that basically he was prepared to let Medicare ''wither on the vine.'' That is not ancient history. That is not 1965 when the Medicare Program was adopted; that is merely 14 years ago when the other party, for the first time in 40 years, became the dominant party here in Congress. One of the first statements from the leadership of that party was to let this program ''wither on the vine.'' Again, that is one person, the Speaker, the leader of the revolution that produced the results electorally in 1994. But I think it is important as a backdrop. When we hear the debate about Medicare, it is important to have some history about where the parties have been on this issue, generally speaking. So in 1995 we begin with that as a backdrop.

In 1997, 2 years later, it happened again. In 1997, proposed Medicare cuts in the Republican Balanced Budget Act of that year were twice as much as the savings we are talking about in this bill. They proposed a 12.4-percent reduction in Medicare benefits in 1997. Of course, the last budget submitted by President Bush last year—again, reflective of where things stand, and this is a year ago, not 14 years ago, and not 1997, but 2009—the Bush administration in its submission of this budget proposed a $481 billion reduction in Medicare benefits. That was not in the context of a health reform bill; that was in the context of a budget proposal.

Here we are talking about savings by reducing costs for hospitals and other providers as a way of strengthening Medicare, providing more benefits to the beneficiaries themselves through things such as prescription drugs as well as screenings and early prevention efforts which are included in our bill. Those things have been identified, of course, by AARP and the National Committee to Preserve Social Security and Medicare. They have analyzed our proposals and have suggested we do just that. We strengthen Medicare and we preserve those benefits. Our bill saves $380 billion in order to strengthen the Medicare proposal. It improves the quality of health care for seniors as part of our comprehensive reform. In fact, Senator COBURN's Patient Choice

Act actually imposes $40 billion more in cuts to Medicare Advantage than our bill does.

I find it somewhat intriguing that those who are arguing for the Coburn proposal as an alternative and simultaneously suggesting we ought not to do anything to Medicare Advantage have not read the Coburn bill, because he cuts $40 billion more out of Medicare Advantage than we did in our legislation as proposed.

In conclusion, let me quote from the National Committee to Preserve Social Security and Medicare—again, not a partisan organization. Their sole mission is to see to it that Social Security and Medicare will be there for the people it was intended to support. Let me quote exactly from a letter sent to every Senator yesterday from the committee:

> Not a single penny of the savings in the Senate bill—

the bill now before us—

> will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings included in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits, and it will extend the solvency of the Medicare trust fund by 5 years. To us, this is a win-win for seniors and the Medicare program.

So we can hear all of the partisan debate back and forth as to what this bill does, but if you are interested in what those organizations say, whose sole mission is to analyze whether beneficiaries are going to be advantaged or disadvantaged by what is being proposed here, they categorically, unequivocally, suggest that the McCain amendment does just the opposite of what our bill does. It would roll the clock back, damage seniors terribly by reducing or eliminating the provisions we have included in our bill, and they strongly support what the Finance Committee wrote in its bill that is now presented to all of us here as a way to strengthen and preserve the Medicare Program.

I say to my colleagues and to others, you can listen to this partisan debate back and forth as to whether you want to believe the Democrats or believe the Republicans, but I would suggest if you are not clear who to believe in this, listen to the organizations whose job it is to protect this program, with whom we have worked very closely to determine that we would not in any way reduce those guaranteed benefits that Senator BAUCUS addressed in his remarks. That is what we do. That is why this bill is a good bill and deserving of our support. I urge our colleagues to reject the McCain amendment.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, the Republican leader a few moments ago said this bill raises costs. With all due respect to my good friend from Kentucky, that statement is false.

Just this week, the nonpartisan Congressional Budget Office, the organization that analyzes legislation—and both sides, both bodies depend on it; it is a very professional outfit, I might add—said our bill would reduce premiums, not increase but reduce premiums for 93 percent of Americans. And for all Americans, it would make sure that better quality insurance is available.

Let me state that a little bit differently. The Congressional Budget Office said that for 93 percent of Americans, premiums would be reduced. It is true that for 7 percent that is not the case. Those are Americans whose incomes are too high to qualify for subsidies; that is, the tax credits, buying insurance in exchange. But those 7 percent would get a lot better insurance, a lot higher quality insurance than they get today because of the insurance market reforms that are in this legislation. The provisions prevent insurance companies from denying coverage based on preexisting conditions, health status, the committee market rating provisions, no rescissions, et cetera. So for all Americans, it is true that this legislation will provide better quality insurance comparing apples with apples. There is a reduction for 93 percent of Americans. The other 7 percent would be in the individual market and they would have a lot higher quality insurance. So if the quality is much higher, it would exceed the increase in premiums. They would be getting a better deal than they would otherwise be getting.

CBO looked at this for the year 2016. They didn't look at it for other years, but at least that is the case for 2016: a reduction, not an increase but a reduction. In fact, for many in the nongroup market, those who individually buy insurance, they would find their premiums would be reduced about 40 or 50 percent. About 60 percent of those in the nongroup market are finding their insurance premiums would be reduced. I don't have the exact figure in front of me, but it is in the neighborhood of a 40- or 50-percent reduction in premiums. That is due to tax credits. Again, CBO says those tax credits would cover nearly two-thirds of premiums. So I guess I was a little conservative. It is a little more than 40 or 50 percent. It would cover two-thirds of premiums.

CBO said those getting these tax credits would pay for roughly 56 percent to 59 percent lower premiums than they would without our bill. Those are real savings. That is with respect to the premiums.

What about out-of-pocket costs? This legislation has absolute limits on out-of-pocket costs. Today insurance companies can sell you a policy, you pay certain premiums, but there is no limit on the out-of-pocket costs you might have to pay. Your deductible is so high, for example. This legislation puts an absolute limit so no policy can be sold that allows you to have out-of-pocket costs above a certain amount. I think it is $6,000 for an individual, and it might be double that for a family. But there is a limit. So this bill does not, as stated by the minority leader, raise costs. In fact, it reduces costs.

In addition, there are many people who say, Oh, gosh, this is a $1 trillion bill. Some people even say it is a $2.5 trillion bill. Senators on the other side of the aisle make those statements and they say this to try to scare us.

I will be honest with you. I don't know if they believe it. They like saying it because it is a nice, good scare tactic. I say I am not sure they believe it. I wonder if they believe it, because when you read the legislation, it is deficit neutral. It does not add to the deficit.

We have a budget resolution. Under that budget resolution, health care legislation for the next 10 years has to be deficit neutral. It cannot add one thin dime to the deficit. So I am a little curious when people talk about a $1 trillion bill. In fact, it reduces the deficit by $130 billion over a 10-year period. That is what the Congressional Budget Office says, the professional nonpartisan budget office.

In the second 10 years, the CBO says our bill reduces the deficit by a one-quarter of 1 percent of the gross domestic product. That is roughly $½ trillion. In the second 10 years, this legislation reduces the deficit by $½ trillion. That is a reduction in the deficit.

I don't know why these people are saying on the other side that this is a trillion-dollar bill. One said—and I will not mention his name—the other day that this is a $2.5 trillion bill. That is not true. It is just not true because it is paid for. It would only be fair for them to say it is paid for. I think it is fair to get both sides of the story, not just one side. It does cost $1 trillion over 10 years, but it is more than paid for over 10 years. Those who say $2.5 trillion—they start at 2014 up to 2020, and say that is why it costs so much. It is paid for during those years, too.

Let me make it very clear this bill doesn't raise costs. In fact, it lowers costs, and the CBO says so. It doesn't add to the Federal deficit. In fact, it reduces the Federal deficit. I urge everyone to look at the facts closely whenever we hear statements made by anybody, including me. I urge people to listen to the words and read between the lines and see what is really going on. Like my father used to say: Don't believe everything you read and only half of what you hear. Take everything with a few grains of salt.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Tennessee is recognized.

Mr. ALEXANDER. Mr. President, I agree with the Senator. That is why we have 22 minutes on the Republican side to clear up some misconceptions.

The Democratic health care bill does cost $2.5 trillion over 10 years when it is fully implemented. If I may say so, it is arrogant to think the American people couldn't figure out the difference between the first 10 years, when the bill wasn't implemented in 4 of those years, and they would like to know that it costs $2.5 trillion.

Mr. BAUCUS. Will the Senator yield for a question?

Mr. ALEXANDER. If it is on your time.

Mr. BAUCUS. Is it paid for?

Mr. ALEXANDER. The Senator is right. It is paid for by cutting grandma's Medicare. It is paid for by cutting grandma's Medicare by $465 billion over a 10-year period of time, and about $500 billion in taxes——

Mr. BAUCUS. That is a second question I would love to debate with the Senator. But on the first question only, the Senator admits it is paid for?

Mr. ALEXANDER. No. I admit it costs $2.5 trillion, and the attempt to pay for it is through Medicare cuts, tax increases, and increases to the deficit by not including the physician reimbursement in the health care bill.

Mr. BAUCUS. One more question. I think we all know the House has taken action on physician reimbursement, and the Senate will also do so before we adjourn. That is the so-called doc fix. That is a separate issue. That will be paid for. Putting the doctor issue aside, health care reform—and I say that because we take up the doc fix virtually every year. We don't take up health care reform every year. That is an entirely separate proposition, separate legislative endeavor.

If the Senator will bear with me and take the doc fix off the table for a second—we can address that later—health care reform—to use a 10-year number, or when you start in 2010 or in 2014, wherever you are starting—either there is $1 trillion or $2.5 trillion, depending where you start, not getting into how it is paid for. Is it paid for and therefore it is not deficit; am I not correct?

Mr. ALEXANDER. I will concede to the Senator from Montana that the attempt of the Democrats to pay for this $2.5 trillion bill consists of Medicare cuts, tax increases, and additions to the deficit by not including the physician reimbursement, which is an essential part of any 10-year health care plan. There may be other problems, but those are the three things I know about.

Mr. BAUCUS. One more question on my time. Is it true there are no cuts in guaranteed beneficiary payments—none whatsoever—in this legislation—in guaranteed benefits?

Mr. ALEXANDER. I would say no to that, Mr. President, because the Director of the Congressional Budget Office made it clear there would be specific cuts in benefits for those who have Medicare Advantage, which is about one out of four seniors.

Mr. BAUCUS. Is it true those provisions are not guaranteed provisions? I am talking about guaranteed benefits that seniors expect to get when they go to the doctor, fee for service, expected benefits, under ordinary Medicare, not benefits that a private plan may pay in addition.

Mr. ALEXANDER. Mr. President, it is clear there are $465 billion in cuts in Medicare. The Chair and the Senator from Montana and the Senator from Connecticut have all agreed that is a big part of how the bill is supposedly paid for. It is specific enough to say that $135 billion comes from hospitals; $120 billion from Medicare Advantage, which 11 million seniors have; nearly $15 billion from nursing homes; $40 billion from home health agencies; $8 billion from hospices.

The Director of the CBO testified that provisions like that would result in specific cuts to benefits for Medicare Advantage. He said that fully half of the benefits currently provided to seniors under Medicare Advantage would disappear. The changes would reduce the extra benefits, such as dental, vision, and hearing coverage, that currently are made available to beneficiaries.

Mr. BAUCUS. One more question. Does the Senator agree this legislation will extend the solvency of the Medicare trust fund for 5 years, and failure to pass this would mean the solvency of the Medicare trust fund would not be extended for 5 years?

Mr. ALEXANDER. I wholeheartedly disagree with that. The Medicare trustees have said that between 2015 and 2017 Medicare will be approaching insolvency. They have asked that we take urgent action. The urgent action recommended by the Democratic majority is that we take $465 billion out of the Medicare Program over 10 years and spend it on a new entitlement.

It is hard for me to understand how that can make Medicare more solvent, when you take money out of grandma's Medicare and spend it on someone else.

Mr. MCCAIN. Will the Senator yield?

Mr. ALEXANDER. Yes.

Mr. MCCAIN. Isn't it, shall we say, Enron accounting when you have a proposal that, as soon as the bill becomes law, you begin to raise taxes and cut benefits, and then you wait 4 years before any of the benefits are then extended to the beneficiaries? That, on its face, is a remarkable piece of legislation. My experience, which has only been 20-some years, is that we haven't passed legislation that says we are going to collect taxes on it for 4 years, and then we are going to give you whatever benefits that may accrue from this legislation. Again, there has been no time in history where we have taken money from an already failing system to create a new entitlement program.

Mr. BAUCUS. Which colleague is the Senator asking that?

Mr. MCCAIN. I believe the Senator from Tennessee has the floor.

Mr. BAUCUS. He does.

Mr. MCCAIN. I was addressing the person who has the floor, which I am sure the Senator from Montana should understand by now.

Mr. ALEXANDER. I say to the Senator from Arizona that he is exactly right. Another way to describe it, the Senator from Kansas said it was like writing a big check on an overdrawn bank account and buying a big new car. Maybe another way, if I may respond to the Senator from Arizona—I ask unanimous consent that Republican Senators, on our time, be allowed to engage in a colloquy.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BAUCUS. May I ask the Senator another question?

Mr. ALEXANDER. I would like to finish responding to Senator MCCAIN, if I might.

Mr. BAUCUS. Then I have a question on the same subject.

Mr. ALEXANDER. I hope the Parliamentarian is keeping track of the Republican time. I am enjoying the questioning, and I thank the Senator for his question. One of the things—in fact, a great compliment has been paid to the Senator from Arizona. It is rare that a Senator can have something he said actually begin to break through the fog.

Dana Milbank, a columnist for the Washington Post, wrote a column about it being all about grandma and wondering why we never mention grandpa. Maybe Mr. Milbank hasn't seen the movie ''My Big Fat Greek Wedding,'' where the man said, ''I'm the head of the house,'' and the woman said, ''I'm the neck, because I can turn the head any way I want.''

We are talking about grandma because she can help persuade grandpa. If we take $465 billion out of Medicare over 10 years, grandma and grandpa and those who are younger and looking forward to Medicare will be affected.

If I may say to the Senator from Arizona—and I see the Senator from Oklahoma and the Senator from Nebraska—it wasn't long ago, in response to the question—in fact, in 2005, when we sought to restrain the growth of Medicare by $10 billion over 5 years, and this is what they said—remember, they are ''restraining'' the growth of Medicare by $465 billion and spending it on a new program, and Republicans were, at that time, trying to save $10 billion over 5 years.

''An immoral document,'' said Senator REID and Senator DODD. The Senator from Connecticut said that funding for Medicare would be cut. Senator

ROCKEFELLER: ''A moral disaster of monumental proportion.'' Senator BOXER, in the same way, compared it to Katrina. Senator KERRY said we are ''passing the costs on to seniors.'' Senator LEVIN said people are ''going to be hurt by this bill.'' ''Irresponsible and cruel,'' said Senator KOHL. Senator REED and Senator Hillary Clinton also made similar comments.

That was for $10 billion of restraining the growth of Medicare to spend it on the existing program. Yet this proposal by the Democrats would take $465 billion and spend it on a new program.

Mr. MCCAIN. Isn't it true—and the Senator from Montana is on the Senate floor and wants to enter into this. Maybe he can respond to his comments of 14 years ago. We weren't trying to create a new entitlement program, which is the object of the Senator's bill. We were just trying to enact some savings in the Medicare system.

What did Senator BAUCUS say? He said:

> And above all, we must not use Medicare as a piggy bank.

What are we using the $483 billion in cuts in Medicare for?

Then he said:

> That is disgraceful. Perhaps some changes lie ahead. But if they do, they should be made for the single purpose of keeping Medicare services for senior citizens and people with disabilities.

Isn't it true that now that we are taking $483 billion out of a failing system the Medicare trustees say is going to go bankrupt, and the Senator from Montana, 14 years ago, said:

> Seniors could easily be forced to give up their doctor, as doctors begin to refuse Medicare patients and hospitals—especially rural hospitals—close.

Isn't that the effect of taking $483 billion in cuts in Medicare? Then the Senator from Montana went on to say:

> Equivalent to blowing up the house and erecting a pup tent where it used to be.

Instead of blowing up a pup tent, I would say what they are doing is like a hydrogen bomb. Finally, Senator BAUCUS said:

> Staggering. The leadership now proposes something like $250 billion in Medicare cuts. It is staggering. It is a reduction of nearly a quarter in Medicare services by the year 2002.

All of us here learn about the issues. Apparently, the Senator from Montana didn't learn much, because he was deeply concerned 14 years ago about a very small savings in Medicare. Now he wants to spend $2.5 trillion and taking $483 billion out of Medicare to create a new entitlement system.

Mr. BAUCUS. Might I respond to the Senator?

Mr. ALEXANDER. Mr. President, I am happy to see a debate actually break out on the Senate floor on this issue.

Mr. BAUCUS. Here is your opportunity; here is your chance.

Mr. ALEXANDER. As long as it is on Democratic time.

Mr. BAUCUS. It is on both sides. We have even time.

Mr. ALEXANDER. I mean whatever time the Senator uses should be on Democratic time.

Mr. BAUCUS. Yes. The basic question, obviously, is how to protect Medicare benefits. I think most of us would say how do we protect Medicare benefits and extend the solvency of the Medicare trust fund. I think we would all agree that excessive payments to providers would cause insolvency of the trust funds to come earlier rather than later. We all agree with that proposition.

The next question is, What would excessive payments to providers be? Do providers get paid excessively? I think that is an honest question we should ask ourselves in a way to help extend the solvency of the Medicare trust fund. In fact, in 1995, many Senators, especially on the other side of the aisle, did say just that, that we have to cut Medicare in order to save benefits. That was made by many Senators. I have them right in front of me, if anybody wants to hear them. I am not going to go through all of that, but it is the truth. That is exactly what we are doing in this bill. We are trying to help extend the solvency of the Medicare trust fund by cutting down on excessive provider payments from the Medicare trust fund.

How do we decide whether payments are excessive? That is the basic question here. All we can do is just give it our best shot, make our best judgment. I think it makes sense to look at the recommendations by outside independent groups, what they think. One is MedPAC, the Medicare Payment Advisory Commission. That is an outside group, as we all know, that advises Congress on Medicare payments. As Members of Congress, we are not totally competent to know exactly what dollars should go to which industry group. We have too many other obligations to think about. As Senators, we must be responsible to do the best we can. MedPAC has said these groups have been overpaid. And Wall Street analysts tend to agree. In fact, MedPAC said, with respect to Medicare Advantage, that they have been overpaid—I forget the exact amount but much less than the $118 billion reduction in this bill.

In fact, I totaled up and looked at the projected growth rate of providers—hospitals, nursing homes, home health, hospice, PhRMA, you name it—and on average their growth rate over the next decade is going to be 6½ percent. That is the growth rate of providers. We decided to trim that a little bit by 1.5 percent. So it is 5 percent. It is a 5-percent growth rate in an attempt to try to find the right levels of reimbursement to providers, which will also help extend the solvency of the Medicare trust fund.

When we talk to providers, they basically agree with those cuts. They basically agree. Why do they basically agree? They basically agree because they know that with much more coverage, with many more people having health insurance, they could spread out their business. They may lose a little on margin, but they can pick it up on volume. That is exactly what their business plan is under this bill.

Wall Street analysts say—I quote them—these industries are doing great, they are doing well under this bill. They are not getting hurt. So we do achieve a win-win—I don't like that phrase, by the way, but I will use it here—where the solvency of the trust fund is being extended and where reimbursement rates to providers are fair—not being hurt; it is fair. And that is why they want this bill, by and large.

Most groups tend to want this bill enacted because they know it is good for the country, it is good for the seniors, and it is good for them too.

Mr. MCCAIN. Mr. President, may I just mention again, $70 billion in fraud, abuse, and waste, and Senator COBURN, the doctor, can tell you, that is nowhere in this bill. The fact is, maybe some of the providers have been bought off, jawboned, or had their arms twisted or given a good deal, like PhRMA has. Recipients have not. Medicare recipients know you cannot cut $483 billion without ultimately affecting their benefits, and that is a fact.

Again, conspicuous by its absence, I say to the Senator from Montana, totally conspicuous by its absence is any meaningful malpractice reform, which has been proven in the State of Texas and other States to reduce costs and to increase the supply of physicians and caregivers. There is nothing in this bill that is meaningful about medical malpractice reform.

I had a townhall meeting with doctors in my State, and everyone stood up and said: I practice defensive medicine because I fear being sued.

If you are really serious, I say to the Senator from Montana, if you are really serious about this, medical malpractice should be a key and integral part of it. Even the CBO costed it out at about $54 billion a year. When you count in all the defensive medicine, it could be as much as $200 billion over 10 years. That is conspicuous by its absence. I think it brings into question the dedication of really reducing health care costs across America.

Mr. ALEXANDER. Mr. President, we have enjoyed our discussion with the distinguished chairman of the Finance Committee and thank him for his questions.

Senator COBURN, who is a physician—the Senator from Montana talked about doctors being overpaid. He talked about——

Mr. BAUCUS. No, no, no, I did not. With all due respect, I did not say that.

Mr. ALEXANDER. Didn't I hear the words ''providers overpaid''?

Mr. BAUCUS. I talked about hospitals. I did not talk about doctors overpaid. If I may say to my friend from Tennessee, this legislation pays more to primary care doctors, a 10-percent increase in Medicare reimbursement for each of the next 5 years. I did not say ''doctors.''

Mr. ALEXANDER. I must have misunderstood. Normally when we talk about providers, we talk about hospitals and physicians.

We have a physician on the Senate floor, the Senator from Oklahoma. I wonder if he, having heard this debate, might want to comment. I might say, isn't it true that the McCain motion, which we have on the floor, would send this back to the Finance Committee and say: If there are savings, let's spend it on Medicare to actually strengthen it?

Mr. COBURN. Mr. President, I thank the Senator. The first comment I have is about relying on what Wall Street analysts say today. They have about this much credibility in this country today. Look at the economic situation we find ourselves in because of what Wall Street analysts have said. That is the first point I would make.

The second point is that the majority whip yesterday said we should cut Medicare Advantage because of the 14 percent. Senator DODD just recently went after the Patients' Choice Act because we actually make it be competitively bid without any reduction in benefits. Your bill, for every Medicare Advantage, cuts 50 percent of the benefits out. It cuts the benefits.

The difference is—and I agree with the majority whip—we do need to have the savings in Medicare Advantage, but the way you get that is through competitively bidding it while at the same time maintaining the requirements for the benefits that are offered. There is a big difference in those two. Ours ends up being pure savings to save Medicare. The savings in this bill are to create a new entitlement.

The other point I wish to make is, if you are a senior out there listening and if you are going to be subject to the new increase in Medicare tax, for the first time in history, we are going to take the Medicare tax and not use it for Medicare, we are going to use it for something else under this bill. This one-half of 1 percent is now going to be consumed in something outside of Medicare. So no longer do we have a Medicare tax for the Medicare trust fund. We have a Medicare tax that funds the Medicare trust fund plus other programs.

I say to my colleagues, I think we want a lot of the same things. How we go about it—the Senator from Montana recognized the fact that we are going to increase payments to primary care physicians. Ask yourself the question why only 1 in 50 doctors last year who graduated from medical school is going into primary care. Why do you think that is? Could it be that the government that is setting the payment rates created a maldistribution in remuneration to primary care physicians; therefore, they choose to go where they can make 200 percent more over their lifetime by spending 1 additional year in residency rather than doing primary care?

What this bill does, and what the Senator from Arizona is trying to do by sending this bill back, is to refocus it on the fact that Medicare money ought to be used for Medicare. If, in fact, we are going to slow the growth of Medicare, can we do that without cutting benefits? To slow the growth in this bill for 11 million Americans who now have Medicare Advantage will diminish their benefits. That is out of the $120 billion that is going to come.

You cannot tell a senior who is in a rural area today, who is on the economic lower rungs of the ladder, who uses Medicare Advantage to equalize their care with somebody who can afford a Medicare supplemental policy, you cannot tell them this is not going to decrease their benefits and their care, because it is. And in the bill, it actually states that it is going to decrease their benefits.

Mr. McCAIN. Will the Senator yield? Very briefly, the Senator from Montana talked about the support the bill gets. AARP makes more money from Medigap plans they sell to seniors. AARP should be opposing the bill, but other groups such as 60 Plus are educating seniors.

The AMA endorsement of the bill—shocking. The bill puts the government in charge, but AMA cut a deal to get their Medicare payments addressed by increasing the deficit by $250 billion.

Mr. COBURN. Mr. President, will the Senator yield for a minute?

Mr. McCAIN. PhRMA—my God, if there ever was an obscene alliance made that will harm seniors because it has the administration against drug reimportation from Canada and competition for treatment of Medicare patients.

So now we understand a little bit better why these special interest groups, 500-some of them, have visited the White House in recent months, according to White House logs.

Mr. COBURN. The Senator would probably be interested to know—and, I know, my colleagues on the other side—that the American Medical Association now represents less than 10 percent of the actively practicing physicians in this country. The physicians as a whole in this country are adamantly opposed to this bill. The reason they are opposed to this bill is because you are inserting the government between them and their patient. That is why they are opposed to this bill.

So you have the endorsement of the AMA which represents less than 10 percent of the practicing doctors—actively practicing doctors—in this country because not only will it increase payments, but CPT code revenue is protected. That is the revenue AMA gathers from the payment system that continues to be fostered in this bill, which is their main source of revenue.

Mr. McCAIN. May I ask my colleague's indulgence for just a moment because, as you know, the majority leader seems to appear more and more frantic as he, perhaps, is reading the same polls we are that more and more Americans, when they figure out this legislation, are becoming more and more opposed to it.

Yesterday, the majority leader came out and directly addressed me, saying:

This man talks about earmarks, but his amendment is one big earmark to the insurance industry. And in addition to that, the sponsor of the amendment—

Talking about me—

during his Presidential campaign talked about cutting these moneys.

Mr. President, I hate, I say to my colleagues, to take a trip back down memory lane, but at the time—of course, this was echoed by a DNC spokesperson, who then echoed it throughout the blogosphere and left-wing liberal blogs. The fact is, on October 20, FactCheck.org says:

He accuses McCain of proposing to cut benefits. Not true.

This is from FactCheck.

In a TV ad and in speeches, Obama is making bogus claims that McCain plans to cut $880 billion from Medicare spending and to reduce benefits.

A TV spot says—

A very well-funded campaign, I might add—

McCain's plan requires ''cuts in benefits, eligibility, or both.''

Obama said in a speech that McCain plans ''cuts'' that would force seniors to ''pay more for your drugs, receive fewer services, and get lower quality care.''

A second ad claims that McCain's plan would bring about a 22 percent cut in benefits.

FactCheck.org says:

These claims are false, and based on a single newspaper report that says no such thing. McCain's policy director states unequivocally that no benefit cuts are envisioned.

Mr. President, I ask unanimous consent to have printed in the RECORD the entire FactCheck.org article.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

OBAMA'S FALSE MEDICARE CLAIM

SUMMARY

In a TV ad and in speeches, Obama is making bogus claims that McCain plans to cut $880 billion from Medicare spending and to reduce benefits.

A TV spot says McCain's plan requires ''cuts in benefits, eligibility or both.''

Obama said in a speech that McCain plans ''cuts'' that would force seniors to ''pay more for your drugs, receive fewer services, and get lower quality care.''

Update, Oct. 21: A second Obama ad claims that McCain's plan would bring about a 22 percent cut in benefits, ''higher premiums and co-pays,'' and more expensive prescription drugs.

These claims are false, and based on a single newspaper report that says no such thing. McCain's policy director states unequivocally that no benefit cuts are envisioned. McCain does propose substantial ''savings'' through such means as cutting fraud, increased use of information technology in medicine and better handling of expensive chronic diseases. Obama himself proposes some of the same cost-saving measures. We're skeptical that either candidate can deliver the savings they promise, but that's no basis for Obama to accuse McCain of planning huge benefit cuts and more expensive prescription drugs, and claims that both nursing home care and a patient's choice of doctor could be affected.

ANALYSIS

As the narrator says that McCain's plan ''means a 22 percent cut in benefits,'' the ad displays a footnote citing an Oct. 6 Wall Street Journal story as its authority.

But, in fact, the Journal story makes no mention of any 22 percent reduction, or any reduction at all. To the contrary, the story's only mention of what might happen to benefits is a quote from McCain adviser Douglas Holtz-Eakin promising to maintain ''the benefit package that has been promised.'' The story quotes him as saying ''savings'' would come from eliminating Medicare fraud and by reforming payment policies to lower the overall cost of care.

The fact is that McCain has never proposed to cut Medicare benefits, or Medicaid benefits either. Obama's claim is based on a false reading of a single Wall Street Journal story, amplified by a one-sided, partisan analysis that piles speculation atop misinterpretation. The Journal story in turn was based on an interview with McCain adviser Holtz-Eakin. He said flatly in a conference call with reporters after the ad was released, ''No service is being reduced. Every beneficiary will in the future receive exactly the benefits that they have been promised from the beginning.''

TWISTING FACTS TO SCARE SENIORS

Here's how Democrats cooked up their bogus $882 billion claim.

On Oct. 6, the Journal ran a story saying that McCain planned to pay for his health care plan ''in part'' through reduced Medicare and Medicaid spending, quoting Holtz-Eakin as its authority. The Journal characterizes these reductions as both ''cuts'' and ''savings.'' Importantly, Holtz-Eakin did not say that any benefits would be cut, and the one direct quote from him in the article makes clear that he's talking about economies:

Wall Street Journal, Oct. 6: Mr. Holtz-Eakin said the Medicare and Medicaid changes would improve the programs and eliminate fraud, but he didn't detail where the cuts would come from. ''It's about giving them the benefit package that has been promised to them by law at lower cost,'' he said.

Holtz-Eakin complains that the Journal story was ''a terrible characterization'' of McCain's intentions, but even so it clearly quoted him as saying McCain planned on ''giving [Medicare and Medicaid beneficiaries] the benefit package that has been promised.''

Nevertheless, a Democratic-leaning group quickly twisted his quotes into a report with a headline stating that the McCain plan ''requires deep benefit and eligibility cuts in Medicare and Medicaid''—the opposite of what the Journal quoted Holtz-Eakin as saying. The report was issued by the Center for American Progress Action Fund, headed by John D. Podesta, former chief of staff to Democratic President Bill Clinton. The report's authors are a former Clinton administration official, a former aid to Democratic Sen. Bob Kerrey and a former aid to Democratic Sen. Barbara Mikulski.

The first sentence said—quite incorrectly—that McCain ''disclosed this week that he would cut $1.3 trillion from Medicare and Medicaid to pay for his health care plan.'' McCain said no such thing, and neither did Holtz-Eakin. The Journal reporter cited a $1.3 trillion estimate of the amount McCain would need to produce, over 10 years, to make his health care plan ''budget neutral,'' as he promises to do. The estimate comes not from McCain, but from the Urban-Brookings Tax Policy Center. McCain and Holtz-Eakin haven't disputed that figure, but they haven't endorsed it either.

Nevertheless, the report assumes McCain would divide $1.3 trillion in ''cuts'' proportionately between the two programs, and comes up with this: ''The McCain plan will cut $882 billion from the Medicare program, roughly 13 percent of Medicare's projected spending over a 10-year period.'' And with such a cut, the report concludes, Medicare spending ''will not keep pace with inflation and enrollment growth—thereby requiring cuts in benefits, eligibility, or both.''

The Obama campaign began the Medicare assault with a 30-second TV ad released Oct. 17, which it said would run ''across the country in key states.''

ANNOUNCER. John McCain's health care plan . . . first we learned he's going to tax health care benefits to pay for part of it.

Now the Wall Street Journal reports John McCain would pay for the rest of his health care plan ''with major reductions to Medicare and Medicaid.''

Eight hundred and eighty-two billion from Medicare alone. ''Requiring cuts in benefits, eligibility, or both.''

John McCain . . . Taxing Health Benefits . . . Cutting Medicare. We Can't Afford John McCain.

OBAMA. I'm Barack Obama and I approved this message.

The ad quotes the Wall Street Journal as saying McCain would pay for his health care plan with ''major reductions to Medicare and Medicaid,'' which the ad says would total $882 billion from Medicare alone, ''requiring cuts in benefits, eligibility, or both.''

Obama elaborated on the theme Oct. 18 in a stump speech in St. Louis, Mo., claiming flatly that seniors would face major medical hardships under McCain:

Obama, Oct. 18: But it turns out, Senator McCain would pay for part of his plan by making drastic cuts in Medicare—$882 billion worth. Under his plan, if you count on Medicare, you would have fewer places to get care, and less freedom to choose your doctors. You'll pay more for your drugs, receive fewer services, and get lower quality care.

Update, Oct. 21: A second and even more misleading Obama ad begins: ''How will your golden years turn out?'' It states flatly that McCain's plan would mean a 22 percent cut in benefits, higher premiums, higher co-pays, . . .

Mr. McCAIN. Mr. President, I hope the Senator from Nevada will stop making false claims—repeating the false claims that were in attack ads on me throughout the campaign, funded by tens of millions of dollars, about my positions on health care in America which the fact checkers found to be totally false.

As the narrator says that McCain's plan ''means a 22 percent cut in benefits,'' the ad displays a footnote citing an Oct. 6 Wall Street Journal story as its authority.

FactCheck:

But, in fact, the Journal story makes no mention of any 22 percent reduction, or any reduction at all.

I hope, among other things, in his, may I describe, frustration, that the Senate majority leader would at least not repeat false accusations about what I wanted to do in the Presidential campaign. It is unfortunate.

And I hope that maybe, instead of attacking David Broder, instead of attacking me, instead of attacking others who are in support of this amendment, maybe we could have a more meaningful discussion about the facts surrounding this legislation.

Mr. DODD. Mr. President, may I inquire how much time remains on both sides?

The PRESIDING OFFICER. Thirty seconds remains for the minority.

Mr. DODD. The minority has 30 seconds.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. JOHANNS. Mr. President, I will speak very quickly, since we have 30 seconds.

Reality does set in. We have looked at the impact of these cuts on our nursing home beds in Nebraska. We have about 14,000 beds dedicated to Medicare. This will be a loss of $663 per bed. That affects real people.

I thank the Chair.

The PRESIDING OFFICER. The minority's time has expired.

Mr. DODD. Mr. President, I yield 2 minutes of our time to the Senator from Nebraska.

Mr. JOHANNS. I thank the Senator. That is very kind of you, and I appreciate that.

Maybe it comes from my time as Governor, maybe it comes from my time as mayor, but somehow, some way, you have to live with the legislation that is passed, whether it is by the Federal Government, whether it is at the State level or whatever. You can bounce this back and forth all day, but the reality is these are real cuts and they involve real programs that involve real people in our States. You can describe them any way you want, you can call them excessive payments, you can do this, that, or the next thing. You can say: Well, we are giving this our best shot, but the difficulty is

this is a high-risk venture. We will be impacting in my State, for example—and every Senator could stand up and give this same speech—but this will impact the most vulnerable population in our Nation—people who are in a nursing home and who are the Medicare beneficiaries.

As I said in my short statement, there are 14,061 nursing home beds across our State that are dedicated to Medicare patients. We are working overtime to try to understand what this legislation does to real people. The number we have come up with, working with our nursing home industry, is that if this legislation is passed, each bed is impacted by a loss of $663.

I will sum up my comments by reading something that was sent to me by someone who works in the nursing home industry. Here is what this person says:

For the first time in my career, I am honestly questioning how much longer I can continue. To constantly be up against regulation and funding, when all you want to do is make a difference in someone's life, is exhausting.

This is a high-risk venture. This shouldn't be about taking our best shot, this should be about getting this legislation right.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, let me, if I can, address a couple of points. First of all, I made this point yesterday, but it deserves being made again because the suggestion somehow that this bill doesn't provide any benefits to anyone until the year 2014 is untrue. I could spend the next 40 minutes describing the various things our bill does immediately. Upon the enactment of this legislation, there are tax breaks immediately for small businesses to be able to reduce the cost of health care in a market where small businesses pay, on average, 18 percent more for health care premiums than other businesses do. As pointed out by the CBO, under our bill you are actually seeing premium cost reductions in the small business market, as well as the individual market and the large-group market.

Right away our legislation closes a good part of that doughnut hole, which is an immediate benefit to the cost of prescription drugs for the elderly. That doesn't happen 4 or 5 years from now, but immediately.

We provide immediate screening and prevention services for Americans. As I mentioned earlier, that is not only the humane thing to do, it is also a great cost saver. If you can detect an early problem and deal with it, the cost savings are monumental, and we all know that.

Under our health care plans as Senators—where we get 23 different options every year to choose from—we have that benefit. I am a beneficiary of that benefit, having identified a health care problem early through screening. That was not only beneficial to me personally, because I am going to be alive for a longer period of time than otherwise, but it saved thousands of dollars in long-term medical costs that would have occurred if I had not identified the problem. Those are simple things that are included in our bill that happen immediately.

You can't be dropped by your health care carrier, as you are today. Today, you can be dropped for no cause—for no reason whatsoever. That is stopped immediately on the adoption of this legislation.

So when I heard my good friend from Arizona saying there are no benefits in this bill for 4 or 5 years, that is not true. And again, a simple reading of the legislation would identify any number—I have here a long list—of benefits that will happen immediately.

The issue Senator BAUCUS has raised over and over again is the issue of guaranteed benefits under Medicare. Guaranteed benefits. Let me challenge my colleagues to identify a single guaranteed benefit under Medicare that is cut by the bill before us. There is not a single benefit under the guaranteed program that is in any way disadvantaged or reduced as a result of this legislation. What is cut are private health care plans under the Medicare Advantage Program. The reason why we are doing this is Medicare Advantage overpayments cost every senior more money. A typical elderly couple pays $90 more per year in Part B premiums to pay for the Medicare Advantage overpayments, even if they are not enrolled in these plans. That is $90, on average, for every couple, and they get none of the benefits from it. Fully 78 percent of beneficiaries are forced to pay higher premiums for non-Medicare extra benefits they will never see.

Again, I understand some people would like to have these additional benefits. I understand that. They are not guaranteed Medicare benefits. These are benefits that are provided for under Medicare Advantage. But 78 percent of our elderly are paying higher premiums so a smaller percentage of people can get those benefits. Why should 78 percent of the elderly in this country pay a higher premium for a smaller percentage of people under private health care plans?

What Senator BAUCUS and the Finance Committee tried to do is to reduce those costs. Those are not guaranteed Medicare benefits. There is no guaranteed Medicare benefit that is cut under this bill, and I defy any Member of this body to find one guaranteed benefit that is reduced under this plan.

Mr. BURR. Will the Senator yield for a question?

Mr. DODD. I will be happy to yield to my friend.

Mr. BURR. I would ask the distinguished Senator from Connecticut if we empower the independent Medicare advisory board to come up with $23.4 billion in cuts under Medicare? Can the Senator from Connecticut assure me that the independent Medicare advisory board would not find a benefit that they would suggest cutting?

Mr. DODD. Absolutely. That is not allowed under this. You cannot cut guaranteed benefits. Going back and looking at providers—

Mr. BURR. If the Senator will yield for an additional question: Is this board empowered to find $23.4 billion worth of cuts?

Mr. DODD. Not under guaranteed benefits. That is very clear.

Mr. BURR. Will the Senator show me that language?

Mr. DODD. The board is prohibited, forbidden, from proposing changes that would take benefits away from seniors or increase their costs. The board cannot ration care, raise taxes on Part B premiums, or change Medicare benefits eligibility or cost-sharing standards.

It couldn't be more clear. They are absolutely prohibited from doing that. And that is the point we have been trying to make here. Frankly, as we know, there are hospitals that will tell you themselves, in many cases, as a provider, there are cost savings there. I am told—and again my colleagues know more about these details than I do—that it is not uncommon for an elderly person to leave a hospital and, on average, be given four prescription drugs to take. I am told as well that within a month or so that elderly person is not following their prescriptions very well—either they live alone, or for one reason or another they do not follow their prescriptions—and they end up being readmitted. There is a very high readmission rate in hospitals, thus raising the cost for hospitalization.

Our bill makes significant efforts to try to reduce the problem of hospital readmissions, which, again, raises costs tremendously. That is where the savings are coming from here, by taking steps to try and reduce the readmission rate to the hospitals. That is a cost savings that is not denying a benefit to the elderly. It is trying to save money and save lives. That is what we are trying to achieve here.

But, again, I challenge any Member to come up and identify a single guaranteed benefit under Medicare that is cut in this bill. There are none. And 78 percent of our elderly should not be required to pay additional premiums to take care of a handful of other people out there. I understand why they want some of these benefits, and they shouldn't be denied them, if they want to pay for them, but don't charge the other Medicare beneficiaries for the benefit they never get.

Mr. DURBIN. Will the Senator yield for a question?

Mr. DODD. I would be happy to yield to my colleague.

Mr. DURBIN. It is interesting to me that under the McCain amendment, the first line in the amendment—the motion to commit—relates to Medicare Advantage. I used to work for an old fellow in Illinois politics named Cecil Partee, and Cecil said: For every issue in politics, there is a good reason and a real reason. We hear a lot of good reasons on the floor for this McCain amendment and the future of Medicare. The real reason is on the first line of Senator MCCAIN's motion to commit. He says: Send this back to committee and don't touch Medicare Advantage.

I want to ask the Senator from Connecticut about Medicare Advantage, because some of the things I have read around the country about Medicare Advantage tell me this plan, run by private health insurance companies, costs more than basic Medicare. These companies promised us, when they got involved, they would show us how to run a health insurance plan. They would show us how to provide Medicare benefits and they would save us money. Some have. But by and large, if I am not mistaken, isn't the verdict in—a 14-percent increase in cost for Medicare benefits under this Medicare Advantage?

Mr. DODD. My colleague from Illinois is absolutely correct, it is 14 percent. In some States it is 50 percent more.

Mr. DURBIN. When we talk about saving over $100 billion in the Medicare Program over the 10 years, part of it is by saying to those private health insurance companies that are overcharging Medicare recipients, the party is over. The subsidy is over. We are going to make sure that every American who qualifies for Medicare gets the basic benefits, but we will not allow these private health insurance companies to get a subsidy from the Federal Government at the expense of Medicare and its recipients.

Mr. DODD. And then charging the other 78 percent of Medicare recipients to raise their premiums. That is the outrage of all this.

Mr. DURBIN. So the motive behind the McCain amendment is less about saving Medicare and more about saving a private health insurance program called Medicare Advantage.

Mr. DODD. And talk about misbranding, calling something Medicare Advantage. It is neither Medicare nor an advantage. Quite the opposite, in fact.

You are accurate in your numbers, by the way, because I want people to know, as much as we respect the Senator from Illinois and his math, the numbers he identifies of $100 billion this program is costing us, comes from the Congressional Budget Office. We didn't make up these numbers. That is the cost savings by modifying Medicare Advantage that has cost us so much and deprived the overwhelming majority of our elderly the benefits they end up paying for. So I appreciate very much the Senator's question.

Mr. BAUCUS. If the Senator will yield for another question, might I ask my friend if it isn't also true that in the June MedPAC report it states that Medicare Advantage overpayments cost taxpayers an extra $12 billion?

Mr. DODD. That is correct. And again, that is MedPAC.

Mr. BAUCUS. Well, that is right, that is MedPAC. I think the point the Senator from Illinois is making needs to be underlined two or three or four times here—and the Senator from Connecticut has made it too—and that is there is a huge distinction between Medicare and these private insurance plans.

Mr. DODD. I think too many of our fellow citizens hear the word Medicare Advantage and assume that is the Medicare Program, and it is not.

Mr. BAUCUS. It is not. It is a private plan.

What Medicare Advantage is overpaid—that is what these insurance companies are overpaid, and a lot of that goes back to the Part D drug bill and so forth—do those overpayments necessarily mean better benefits for persons who signed up for those plans?

Mr. DODD. No. In fact, there is no evidence that overpayments to plans leads to better health care. That is again according to MedPAC.

Mr. BAUCUS. If that is true, why might that be the case, just so people understand?

Mr. DODD. Because insurers, not seniors or the Medicare Program, determine how these overpayments are used. And too often they are used to line the pockets of insurers, to increase their profits and not to provide benefits.

Mr. BAUCUS. Does Medicare decide what the benefits will be for those folks?

Mr. DODD. No, it is the private carriers that decide that.

Mr. BAUCUS. The private insurance carriers.

Mr. DODD. Yes, they are the ones that set the rates and determine where the profits go. That is why it is such a misnomer to call this Medicare Advantage, because it is neither Medicare nor an advantage.

The PRESIDING OFFICER. The time has expired.

Mr. DODD. Mr. President, I ask unanimous consent for 2 additional minutes.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. Reserving the right to object, I will ask for 2 additional minutes for my side.

Mr. DODD. Well, I gave 2 minutes to my friends earlier.

Mr. COBURN. How about 1?

Mr. DODD. OK, 1. Well, make that 2. If he wants 2 additional minutes, I have no problem giving my colleague 2 additional minutes.

Mr. BAUCUS. You already said it, but I think it is worth repeating——

The PRESIDING OFFICER. Without objection, the request is agreed to.

Mr. BAUCUS. Most seniors, as they pay Part B premiums under fee for service, don't get any benefit whatsoever?

Mr. DODD. That is correct. None whatsoever. In fact, all they do get is higher premiums.

Mr. BAUCUS. That is right. Higher premiums.

Mr. DODD. Higher premiums. And 78 percent, almost 80 percent are paying more for a program from which they never get any benefit.

Mr. BAUCUS. The figure I saw—I guess it is $90 a year they pay extra and get no benefit from it.

Mr. DODD. So vote for the McCain amendment and you do exactly what Senator DURBIN is suggesting: Preserve Medicare Advantage, and under Medicare Advantage 78 percent of our elderly pay more premiums, never get any benefits, and the private carriers get to pocket the difference. That is a great vote around here. That is great health care reform.

Mr. DURBIN. I say to the Senator from Connecticut, could we characterize this as an earmark in the Medicare Advantage Program?

Mr. DODD. It is two ears, not even one ear. I give it two ears.

Mr. BROWN. I say to Senator DODD, we remember 10 years ago when the insurance companies came to the government and said we can do something that later became Medicare Advantage, and we can do it less expensively. They said we can do it for 5 percent less than the cost of Medicare and the government unfortunately made the agreement with them to sign up to do that. Then what happened in the last 10 years is, the insurance lobbyists came here and lobbied the Bush administration and lobbied the Congress and got bigger payments. It is a subsidy for the insurance companies, but you and Senator BAUCUS and Senator DURBIN said it is not Medicare, it is private insurance, privatized form of Medicare that serves the insurance companies very well, is that correct, but doesn't serve the seniors in this country?

Mr. DODD. I will sit here all day waiting for someone to identify a single benefit guaranteed under the Medicare Program that is cut in our bill. They are all talking about Medicare Advantage, not Medicare. There are no guaranteed benefits cut under this bill nor can those benefits be cut. Our legislation bans and prohibits any cuts in guaranteed benefits.

The PRESIDING OFFICER (Mr. CASEY). The Senator from Oklahoma is recognized.

Mr. COBURN. One of the questions and one of the promises was: If you

have what you have now and you like it, you can keep it. What is happening under this bill for 11 million seniors on Medicare Advantage, that is not going to happen. If they like it, they are not going to be able to keep what they have. You can't deny that. That is the truth.

Medicare Advantage needs to be reformed. There is no question about it. I agree. As the Senator alluded to, in the Patients Choice Act we actually save $160 billion in the Patients' Choice Act, but we don't diminish any of the benefits, and we do that because CMS failed to competitively bid it, because when it was written—and I understand who wrote it—when it was written we didn't make them competitively bid it. You could get the same savings, actually get more savings and not reduce benefits in any amount, if you competitively bid that product. But we have decided we are not going to do that.

The second point I make with my colleagues is the vast majority of people on Medicare Advantage are on the lower bottom economically. They can't afford an AARP supplemental bill. They can't afford to pay an extra $150 or $200 a month. So what happens most of the time with Medicare Advantage is we bring people up to what everybody else in Medicare gets because most people can afford—84 percent of the people in this country can afford to buy a Medicare supplemental policy because Medicare doesn't cover everything.

Your idea to try to save money, I agree with. But cutting the benefits I do not agree with. You are right, Senator DODD, the basic guaranteed benefits have to be supplied to Medicare Advantage and then the things above that which you get from the supplemental policy, what you can afford to buy, is what these people get. And what you are taking away from poorest of our elderly is the ability to have the same care that people get who can afford to buy a supplemental policy. That is the difference.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. COBURN. I appreciate my chairman for his courtesy in yielding the time.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 12:30 p.m.

Thereupon, the Senate, at 11:35 a.m., recessed until 12:30 p.m. and reassembled when called to order by the Presiding Officer (Mrs. HAGAN).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—Continued

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, on Monday the Congressional Budget Office sent a letter to the Senator from Indiana, Mr. BAYH, that provides a very comprehensive analysis of what health insurance premiums will look like as a result of this 2,074-page bill before us, introduced by Senator REID. Listening to that discussion, I am starting to wonder if anyone actually read the letter. I hear a lot of people saying this letter proves that premiums will go down under the Reid bill, even though that is not what the letter says. I am here to tell my colleagues what the letter really says.

The letter makes it very clear that premiums will increase on average by 10 to 13 percent for people buying coverage in the individual market. Since it seems to fly by everybody what this letter actually said about increasing premiums, I brought down a chart to show everyone in case they missed it.

The letter from the CBO says very clearly that for the individual market, premiums are going to go up 10 to 13 percent. My colleagues keep saying premiums are going to go down, conveniently forgetting, then, to mention this 10- to 13-percent increase. They prefer to talk about the 57 percent of Americans in the individual market who are getting subsidies. It is true that government is spending $500 billion in hard-earned taxpayer money to cover up the fact that this bill drives up premiums faster than current law. So we might as well repeat it: Premiums will go up faster under this bill.

Supporters of this bill are covering this increase in cost how? By handing out subsidies. If you are one of the 14 million who doesn't happen to get a subsidy, you are out of luck. You are stuck with a plan that is 10 to 13 percent more expensive and also, simultaneous with it, an unprecedented new Federal law that mandates that you purchase insurance. If you don't purchase insurance, you are going to pay a penalty to the IRS every time you file your income tax. Some may say this is just the individual market. It only accounts for a small portion of the total market. If you are comfortable with 14 million people paying more under this bill than they would under current law, let's look at the employer-based market.

The Congressional Budget Office analysis says this bill maintains the status quo in the small group and large group insurance market. Is that something to be celebrating? Are expectations so low at this point that my friends on the other side of the aisle are celebrating that this bill will increase premiums for some and maintain the status quo for everyone else? I am being generous in using the phrase ''status quo'' because this bill actually makes things worse for millions of people. This bill is so bad that my friends on the other side of the aisle are trying to convince the American people that this is just more of the same, when that doesn't happen to be the case.

Whatever happened to bending the growth curve? If that is too Washingtonese for people, the goal around here of a bill at one time was to make sure the inflation in insurance didn't continue to go up so much that it would go the other way.

Then what about the President's promise that everyone would save $2,500? According to the Congressional Budget Office, almost every small business will pay between 1 percent more to 2 percent less for health insurance. That means, of course, that compared to what businesses would have paid under current law, this bill will either raise premiums 1 percent or decrease them a whopping 2 percent. It doesn't sound like this bill is providing any real relief or, for sure, not providing $2,500 savings for every American, as President Obama repeatedly pledged during the campaign. Larger businesses will pay the same or up to 3 percent less for health insurance. Once again, that doesn't sound like relief; it sounds like more of the same.

In fact, the Congressional Budget Office has confirmed that between now and 2016, premiums will continue to grow at twice the rate of inflation. I thought Congress was considering health reform to put an end to unsustainable premium increases.

So this bill cuts Medicare by $500 billion, raises taxes by $500 billion, restructures 17 percent of our economy, and spends $2.5 trillion. Yet some of my colleagues on the other side of the aisle are celebrating that they have achieved the status quo when, in fact, the situation will be worse. I always thought the status quo was unacceptable. I thought businesses could not afford the status quo. I thought the status quo was killing American businesses, killing jobs, and making this country less competitive. But Member after Member keeps coming down to the floor to celebrate spending $2.5 trillion on the status quo. We could have done that for free. Am I missing something? Did people really read the same letter I did from the CBO?

When President Obama visited Minneapolis in September, he didn't sound as though he was celebrating maintaining the status quo. On the contrary, I have a chart with one of his quotes:

> I will not accept the status quo. Not this time. Not now. . . .

Some Members seem to disagree. Some Members are celebrating that they are making things worse for millions of Americans and maintaining the status quo for everyone else.

Here is what Vice President BIDEN said:

> The status quo is simply unacceptable. Let me say that again—the status quo is simply unacceptable. Rising costs are crushing us.

That doesn't sound like a call for more of the same. Once again, Members on the other side of the aisle seem

quite comfortable investing $2.5 trillion in more of the same. That is taxpayer dollars we are talking about.

If I asked most Iowans how they would feel about government spending $2.5 trillion and premiums would still increase as fast or faster, they would say that was a pretty bad investment. Well, I will not argue with what our constituents would say on that point. I agree with them.

This Congressional Budget Office letter tells me that we are debating a pretty bad investment. Our constituents want lower costs. That is their main concern. But this bill fails to address that concern because it raises premiums. Despite offering new ideas throughout the committee process and on the floor of the Senate, Republicans are being accused of supporting the status quo. CBO has spoken, and it is pretty clear that my colleagues are not only OK with the status quo, they are OK with making things worse: higher taxes, higher premiums, increased deficit, less Medicare. They are celebrating that they spent $2.5 trillion to raise premiums for 14 million people, not bending the growth curve of inflation in health care, and not cutting costs. Don't take my word for it. Read the letter. Read the letter from the Congressional Budget Office. I have copies I will pass out if anybody wants them. I have this chart that demonstrates that point.

I also wish to take a few minutes at this time to correct some inaccurate comments made earlier by some of my colleagues. When we are talking about 17 percent of the economy and something that touches the lives of every single American, I want to make sure we have an honest and accurate debate. This morning I heard at least three Members on the other side of the aisle say that Medicare Advantage is not part of Medicare. This is totally false.

But don't take my word for it. I would like to have Members turn to page 50 of the handbook,''Medicare and You.'' Presumably it has the date of 2010 on it. It is sent out every year. In fact, I think I have two copies of this in my household. If anybody wants to save paper and not waste taxpayer money, they can get on the Internet and tell them only to send one to their house next year. I have done that.

This book says, for those who say Medicare Advantage is not part of Medicare:

> A Medicare Advantage plan is another health coverage choice that you may have as part of Medicare.

I repeat, despite what Members were saying earlier, the ''Medicare and You'' handbook says very clearly: Medicare Advantage Plans are part of Medicare. So if you are cutting Medicare Advantage benefits, you are, in fact, cutting Medicare benefits.

Next, I hear a lot of Members talking about guaranteed benefits versus statutory benefits. I can't speak for my other 99 colleagues, but the seniors in Iowa who have come to rely upon the free flu shots, eyeglasses, and dental care that Medicare Advantage provides don't care if they are guaranteed or if they are statutory. Seniors in Iowa just want to know they will still have these benefits after health reform is passed.

The Senator from Connecticut challenged any Member to come down to the Senate floor and point out where this bill will cut benefits. He even read a section from page 1,004 of this 2,074-page bill that talks about how the Medicare Commission cannot cut benefits or ration care. I have read page 1,004. What Senator DODD failed to mention is that this section only refers to Parts A and B of Medicare. It fails to provide any protection to Medicare Part D, the prescription drug benefit, or the Medicare Advantage Program that covers 11 million seniors.

Are we now going to start hearing that Medicare Part D is not part of Medicare either? In fact, on page 1,005, it specifically says the Medicare Commission can ''[i]nclude recommendations to reduce Medicare payments under parts C and D.''

I have asked CBO, and they have confirmed this authority could result in higher premiums and less benefits to seniors. In fact, this is what Congressional Budget Office Director Elmendorf said, and we have that on a chart for you to see the quote I am going to read: ''A reduction in subsidies to [Part D] would raise the cost to beneficiaries.''

Lastly, I wish to raise an issue about access to care. I keep hearing my friends on the other side of the aisle talk about how these cuts will not affect seniors. They say they are just overpayments to providers. Well, in my opinion, if you cannot find a doctor or if you cannot find a home health provider or a hospice provider to deliver care, then that tends to be a very big problem. I would even consider that a cut in benefits or hurting access to care.

But, once again, do not take my word for it. In talking about similar cuts to Medicare in the House bill, the Office of the Actuary at the Centers for Medicare & Medicaid Services said providers that rely on Medicare might end their participation, ''[p]ossibly jeopardizing access to care for beneficiaries.''

So let's be accurate and let's be honest. Medicare Advantage is part of Medicare, and this bill cuts benefits seniors have come to rely upon. The Medicare Commission absolutely has authority to cut benefits and to raise premiums, and this bill will jeopardize that access to care.

Those are all facts. They are not my facts but facts taken directly from the language of this 2,074-page bill and from reports of the Congressional Budget Office and the Office of the Actuary at the Centers for Medicare & Medicaid Services.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, it seems I am following the Senator from Iowa every day. I, first, wish to acknowledge my friendship and respect for him. But the Medicare Advantage Program, which the Republican side is trying to protect, is a program which is private health insurance.

The largest political opponent to health care reform in America is the private health insurance industry. We estimate they have spent $23 million so far lobbying to defeat this bill because they are doing very well under the current system. They are very profitable companies, and they realize, if they face competition, limitations on the way they do business, it will cut into their bottom line and their profits, and, naturally, are fighting the bill.

The amendment before us, the motion to commit by Senator MCCAIN—the first thing it does is to protect the Medicare Advantage Program. That is a private health insurance program that was created with the promise that it would be cheaper than traditional government-run Medicare. In some cases, they have offered a cheaper policy. But, overall, these private health insurance companies are charging the Medicare Program 14 percent more than the actual cost of the government-run system.

The promise that the private sector could do it more cheaply and better turned out not to be true. So we are paying a subsidy in profits—extra profits—to private health insurance companies. The McCain amendment, which has been supported by Senator GRASSLEY and others who have come to the floor, is an effort to stop us from eliminating this subsidy.

What is this subsidy worth? This subsidy to private health insurance companies will cost the Medicare Program $170 billion over the next 10 years—no small amount. We believe that money is better spent on extending benefits to Medicare beneficiaries, not in providing additional profits to already profitable private health insurance companies.

Yes, Medicare Advantage policies are offering Medicare benefits, but they are charging more for it than the government. So it did not turn out to be a bargain. It turned out to be a loss to the Medicare Program. They did not do what they promised to do. We want to hold them accountable. The McCain amendment wants to let them off the hook and basically say: Private health insurance companies, keep drawing that money out of Medicare. We are not going to hold you accountable.

That earmark of the Medicare Advantage Program, that decision by

Congress to give them a special privilege in selling this health insurance, is too darn expensive for senior citizens and people who rely on Medicare. That is why we are opposing the McCain amendment.

I might add, this is the third day of the debate on health care reform in America. We have yet to vote on a single amendment because the Republicans refuse to allow us to bring an amendment to the floor for a vote. How can you have an honest debate about a bill of this seriousness and magnitude if you cannot bring a measure to a vote on the floor?

Those who follow the Senate know it is a peculiar institution and its rules protect minorities, and individual Senators can object to a vote. The Republican Senators have objected to a vote, even on the McCain amendment, which I believe was filed on Monday, and here we are on Wednesday. We have talked about it. We know what is in it. We should vote on it. But the Republicans do not want to vote on it. They want to drag this out in the hopes that our desire to go home for Christmas means we will walk away from health care reform.

Well, if a few of the Republican Senators could have just left the Democratic caucus, they would know better. We are determined to bring this bill to a vote. We are determined to bring real health care reform to this country. We know what is at stake.

The current health care system in America is not affordable for most Americans. Health insurance premiums have gone up dramatically in cost. Individuals cannot afford to buy a policy. Businesses are dropping coverage of their employees. We know the costs are unsustainable.

Unless we start bringing those costs down, this great health care system is going to collapse. We need to preserve the things that are good in this system and fix those that are broken. Affordability is the first thing we need to address. The second thing we need to address, quite obviously, is to make sure every American has the right, as a consumer, to get coverage when they need it.

How many times have you heard the story of people who pay their health insurance premiums their whole lives, then somebody gets sick in their house—a new baby, a child, your wife, your husband—a big medical bill is coming, you go to the health insurance company, and you are in for a battle. They will not pay it. They say: Oh, we took a look at your application you filed a few years ago. You failed to disclose that you had acne when you were an adolescent. Am I making that up? No. That is an actual case. Because you did not disclose that you had acne as an adolescent, you failed to disclose a preexisting condition, so we have no obligation to pay for anything. If this sounds farfetched, believe me, it is an actual case—and there are many others like it.

Private insurance companies have spent a fortune hiring an army of people, sitting in front of computer screens, talking to the people who are paying the premiums, and above their computers is a sign that says: ‘‘Just Say No.’’ They say no consistently because every time they say no, their profits go up. But it leaves individuals and families in a terrible situation—denied coverage because of a preexisting condition; denied coverage because they could not carry their health insurance policy with them after they lost their job; denied coverage because of a cap in the amount of money the policy would pay; rescinded, where they walk away from an insurance policy because of some objection they have, legal objection; or how about one of your kids who turned age 24, no longer covered by your family health plan, now out on their own, maybe fresh from college, and has no job and no health insurance.

This bill addresses those issues. This bill eliminates the concern people will have over a preexisting condition. It takes away the power of the health insurance companies to say no. It finally creates a situation, which we have waited for for a long time. America is the only civilized, industrialized country in the world where a person can die for lack of health insurance. It does not happen anywhere else—only in America. Madam President, 45,000 people a year die for lack of health insurance.

Who are these people? Let me give you an example, one person whom I met. Her name is Judie, and she works in a motel in southern Illinois. She is 60 years old, a delightful, happy woman. She is the one who takes the dishes at the end of this little breakfast they offer at the motel. She could not be happier and nicer. She is 60 years old, with diabetes. She never had health insurance in her life—never. She goes to work every day, works 30 hours a week, and makes about $12,000 a year. She does not have health insurance, but she does have diabetes. She said to me: If I had health insurance, I would go to the doctor. I have had some lumps that have concerned me for a little while here, but I can't afford it, Senator.

That is an example of a person who does not have the benefit of health insurance. This bill we are talking about—this bill we are going to produce for everyone to read on the Internet; it is already there; it has been there for 10 days already; it will continue to be there—this bill makes sure that 94 percent of the people in America have health insurance coverage. That is an alltime high for the United States of America.

I might also say, despite the criticisms—and they are entitled to be critical on the Republican side of the aisle—they have yet to answer the most basic criticism I have offered. Where is your bill? Where is the Republican health care reform bill? They cannot answer that question because it does not exist. They have had a year to explore their ideas and develop them, but they have failed. They cannot produce a bill. They are for the current system, as it exists, that is unsustainable, unaffordable, leaving too many Americans vulnerable to health insurance companies that say no and too many Americans without health insurance.

I wish to address one particular issue that seems to come up all the time, and it is the issue of medical malpractice. I know my Republican colleagues are going to bring up that issue. Senator MCCAIN has, many others have as well. President Obama recently recognized this as an issue of concern. Our bill will as well. We are going to explore, encourage, and fund State efforts to find ways to reduce medical malpractice premiums and to reduce, even more importantly, the incidence of medical errors.

Medical malpractice reform proposals are based in States. The Federal Government does not have a medical malpractice law, not in general terms. It does for specific programs such as Indian health care, for example, or federally qualified clinics. But when it comes to the general practice of medicine, that is governed by State laws, and the States decide when you can sue, what you can sue for, and the procedures you have to follow.

In almost every State there has been a system that has developed over the years to handle these cases. States regularly change and update their laws. The States try to strike a balance to protect patients, preserve their hospitals and doctors and other medical providers, ensure that those who are injured have a chance for compensation, and manage the cost of their system.

At least twenty-eight States, as of last year, have decided to impose caps on noneconomic damages in medical malpractice cases. A long time ago, before I came to Congress, I used to be a practicing lawyer in Springfield, IL, and I handled medical malpractice cases. So I do not profess to be an expert, nor even have current knowledge of medical malpractice, but I did in a previous life have some experience. I defended doctors, when they were sued, for a number of years on behalf of insurance companies, and I represented plaintiffs who were victims of medical negligence. So I have been on both sides of the table. I have been in the courtroom. I have gone through the process.

Here is what it comes down to. If you are a victim of medical malpractice, medical negligence, the jury can give

you an award, which usually includes a number of possibilities: pay your medical bills, pay for any lost wages, pay for any additional expenses that may be associated with the court case, and pay for pain and suffering. Those are the basic elements that are involved in a medical malpractice lawsuit.

The pain and suffering part of it—it is pain, suffering, loss of a spouse or child, loss of fertility, scars, and disfigurement—is an area where many States have said: We want to limit the amount you can recover for pain and suffering, what they call noneconomic losses. It is not medical bills. It is not lost wages. So my State, for example, has a limitation of $500,000 on noneconomic damages in a medical malpractice case, recently enacted by our general assembly. In the State of Texas, it is $250,000. Those are so-called caps, limitations on the amount of money a jury can award for pain and suffering, when they find, in fact, you were a victim of medical negligence.

Some States have decided to establish caps on pain and suffering, how much you can recover; others have not. The reason many imposed caps was because they wanted to bring down the cost of medical malpractice insurance for doctors and hospitals. Well, a number of States have done that. At least twenty-eight States have done that, and we have been able to step back and take a look: How did it work? If you put a cap, a limitation, on recovery for pain and suffering, noneconomic loss, does that mean there will be lower malpractice premiums for doctors? In some cases, yes; in some cases, no.

Minnesota is an interesting example. Minnesota does not have caps on damages. Yet it has some of the lowest malpractice premiums in America. Twenty-five States, including Minnesota, use a certificate of merit system which means before you can file a lawsuit you need a medical professional to sign an affidavit that you have a legitimate claim before you even get into the court. That is in Minnesota, it is in Illinois, and a number of other States to stop so-called frivolous lawsuits.

Some States such as Vermont have low malpractice premiums and don't have any malpractice reforms. It is hard to track cause and effect here between tort reform, malpractice changes, and the actual premiums charged physicians.

There are ways Congress can help States build on what already works for each State. Senator BAUCUS, who is here on the floor and who is chairman of the Senate Finance Committee, has worked with Senator ENZI to create incentives for State programs to look for innovative ways to reduce malpractice premiums and the incidence of medical negligence. I think that is a good idea and I hope it will ultimately be included in this bill.

One of the major considerations when it comes to malpractice reform is making sure we focus on real facts. One myth we hear over and over again is about frivolous lawsuits flooding the courts. I have heard many colleagues come to the floor and call it "jackpot justice," frivolous lawsuits, fly-by-night lawyers filing medical malpractice lawsuits. I am sure there is anecdotal evidence for each and every statement, but when you look at the record, you find that malpractice claims and lawsuit payouts are actually decreasing in America.

In 2008, according to the Kaiser Family Foundation, there were 11,025 paid medical malpractice claims against physicians nationwide. One year in America, the total number of medical malpractice claims paid, according to the Kaiser Family Foundation, was 11,025. There are 990,000 doctors in America, so roughly 1 percent of doctors is being charged with malpractice and paying each year. This is a decrease from 2007 where the number was 11,478. So the number of malpractice claims has gone down. The number of paid claims for every 1,000 physicians has decreased from 25.2 in 1991 to 11.1 in 2008. That is a little over 1 percent of doctors actually paying malpractice claims.

Not only is the number of claims decreasing, but the amount they are paying to victims is decreasing as well. The National Association of Insurance Commissioners—not a group that is biased one way or the other when it comes to plaintiffs or defendants—said in 2003, malpractice claim payouts peaked at $8.46 billion. In 2008 that number had been cut in half. In 5 years it went down from $8.4 billion to $4 billion. So rather than a flood of frivolous lawsuits, fewer lawsuits are being filed and dramatically less money is being paid out.

Incidentally, the New York Times in a summary of research in September of this year found that only 2 to 3 percent of medical negligence incidents actually lead to malpractice claims. So it is not credible to argue that we have this flood of malpractice cases—they are going down—or this flood of payouts for malpractice in America. It has been cut in half in 5 years.

A third key consideration in this debate is cost. One of the main goals of pursuing health care reform is to try to reduce the cost to the system and we want to try to do that in a way that won't compromise the quality of care. There has been a lot of talk about the Congressional Budget Office report that was ordered up by Senator HATCH on October 9. The Congressional Budget Office for years said they could not put a pricetag on medical malpractice reform in terms of savings to the system, but on October 9 they reported to Senator HATCH that they could. Senator HATCH asked them what would be the impact on our health care system if we had a Texas-style cap, which is $250,000 for pain and suffering—I see the Senator from Texas on the floor and I hope I am quoting the Texas law correctly. He was a former Texas supreme court justice. Am I close?

Mr. CORNYN. Close.

Mr. DURBIN. Close. That is all I will get from the Senator from Texas, close. But the fact is that Senator HATCH said to the CBO, what if we had the Texas-style cap on every State in the Union, what would be the net result? They came back and said there would be a savings of over $50 billion over the next 10 years. They said 40 percent of the savings would come from lower medical liability premiums, 60 percent through reduced utilization of health care services.

I don't question the Congressional Budget Office reaching that conclusion. They worked hard to come up with their figures. But there are other ways to reach results they want to achieve of lowering medical liability premiums and saving overall health care expenditures rather than adopting Federal damage caps. Keep in mind, these caps on what you can recover are for people who have been judged by a jury of their peers to have been victims. These are not people who have said I think I was hurt. We are talking about people who have a right to recovery in a lawsuit who are being told even though you were hurt, and somebody did something wrong, we are going to limit how much you can be paid when it comes to these noneconomic losses.

The CBO analysis that Senator HATCH received went on to say:

> Because medical malpractice laws exist to allow patients to sue for damages that result from negligent health care, imposing limits on that right might be expected to have a negative impact on health outcomes.

They cited one study which found that a 10-percent reduction in costs related to medical malpractice liability would increase the Nation's overall death rate by .2 percent. By calculation that means that if the Hatch proposal were applied nationwide, according to the CBO—and this is a cited study—4,853 more Americans would be killed each year by medical malpractice—or more than 48,000 Americans over a 10-year period of time that the CBO examines. So if you accept their projection on the savings for medical malpractice reform asked for by Senator HATCH, you cannot escape the fact that they say yes, you will save money, but more Americans will die because there will be more malpractice.

Let's look at the savings that can be achieved through reduced malpractice insurance premiums. The CBO said a $250,000 Federal damage cap would reduce overall malpractice premiums by about 10 percent and would reduce overall health care spending by .2 percent. Do we need a federally mandated

cap to achieve that? Malpractice insurance premiums are already going down. According to the Medical Liability Monitor's comprehensive survey of premiums in the areas of internal medicine, general surgery and OB/GYN: ''The most recent three years have shown a leveling and now a reduction in the overall average rate change'' for medical malpractice premiums. There was a time in the early 2000s where malpractice premiums were going up 20 percent a year, in 2003, 2004, and 9 percent in 2005. Since then they have gone down each year by less than 1 percent in 2006, by .4 percent—I am sorry, .4 percent increase in 2007, but a 4.3 percent decrease in 2008. That is without any Federal cap on damages.

Let's also consider the issue of defensive medicine. Many people claim that doctors do things such as order tests to cover themselves because they are afraid of being sued. I agree that there are undoubtedly some doctors who think that way. There was a famous article printed in the New Yorker where a surgeon from Boston, Dr. Gawande, who went to McAllen, TX—you probably saw this, Senator CORNYN—and he wanted to know in this article why in McAllen, TX, they were paying more for Medicare patients than any other place in the United States. So he visited with doctors and surgeons and hospital administrators to ask them why. What is peculiar about that city and its elderly people? He sat down with the doctors, and the first doctor said, Well, it is defensive medicine. We are doing all of these extra tests and extra costs to Medicare to cover ourselves, to protect ourselves. The doctor sitting next to him said, Oh, come on. With the Texas law, nobody is filing malpractice lawsuits around here. We are doing these extra procedures because it is a fee-for-service system. You are paid more when you do more. So at least in this case there was a dispute as to whether this was truly defensive medicine or overbilling.

Dr. Carolyn Clancy, the director for the Agency of Healthcare Research and Quality in the Department of HHS, has called medical errors a national problem of epidemic proportions. According to that agency, the rate of adverse events has risen about 1 percent in each of the past 6 years. The Institute of Medicine estimated in 1999 that up to 98,000 people died in America due to preventable medical errors. These medical errors cost a lot. A 2003 study published in the Journal of the American Medical Association found the medical errors in U.S. hospitals in the year 2000—just 1 year—led to approximately 32,600 deaths, 2.4 million extra days of patient hospitalization, and an additional cost of $9.3 billion.

I wish to also say a word about the medical malpractice insurers. Remember, insurance companies and organized baseball are the only two businesses in America exempt from the antitrust laws. What it means is that insurance companies can literally legally sit down and collude and conspire when it comes to the prices they charge, and they do. They have official organizations—one used to be known as the Insurance Services Offices—that would sit down to make sure every insurance company knew what the other insurance company was charging, and they could literally work out the premiums, how much they charge.

The same thing was true in market allocation. Insurance companies, unlike any other business in America, can pick and choose where they will do business: Company X, you take St. Louis; company Y, you take Chicago; company Z, you get Columbus, OH. They can do it legally.

So the obvious question is: If this is not on the square in terms of real competition from health insurance companies, are these companies, in fact, paying out the kind of money they should?

Let me see if I can find a chart here. My staff was kind enough to bring these out. Well, I can't. They are great charts, but I can't find the one I am looking for at this moment.

According to the information of the National Association of Insurance Commissioners, in 2008, medical malpractice insurers charged $11.4 billion in premiums, but only paid out $4.1 billion in losses. In other words, they took in $7 billion more than they paid out in losses. That is a loss ratio of 36 percent, which means they are basically collecting $3 for every $1 they pay out—pretty close. How does that compare to the rest of the insurance industry? Well, it turns out that private automobile liability insurance had a loss ratio of 66 percent, a payout of $2 out of every $3; homeowners, 72 percent, workers comp insurance, 65 percent. These medical malpractice insurance companies are holding back premiums and not paying them out. It reached a point in my State where our insurance commissioner ordered that they declare a dividend and pay back some of the premiums they had collected from doctors and hospitals when it came to malpractice insurance.

But rather than get lost in statistics, as important as they are, I think it is important that we also talk about the real life stories that are involved in medical malpractice. I hear these terms such as ''frivolous lawsuits'' and ''jackpot justice'' and people taking advantage of the system, but let's not forget the real life stories that lie behind medical malpractice. Let me show my colleagues a picture here of a couple. This is Molly Akers of New Lenox, IL, a lovely young lady, with her husband. Molly Akers had a swelling in her breast and went to her doctor who performed a biopsy that showed she had breast cancer. Molly had several mammograms which found no evidence of a tumor, but the doctors decided that despite the mammograms, she must have a rare form of breast cancer. They recommended a mastectomy, removing Molly Akers' right breast. After the operation, the doctor called her into the office and said that on further review, she never actually had breast cancer. The radiologist had made a mistake. He reviewed her slides and accidentally switched Molly's slides with someone else. Molly was permanently disfigured by an unnecessary surgery. She said afterwards:

> I never thought something like this could happen to me, but I know now that medical malpractice can ruin your life.

By the way, that other woman whose slides were switched with Molly's was told she was cancer free. What a horrific medical error that turned out to be.

This next picture is of Glenn Steinberg of Chicago. He went into surgery for the removal of a tumor in his abdomen. Ten days after the surgery, while still in the hospital, Glenn was having severe gastrointestinal problems. The doctors x-rayed his abdomen where the original surgery took place, and they found a 4-inch metal retractor from the surgery lodged against his intestine. A second surgery was performed to remove the metal piece, during which Glenn's lungs aspirated, and he died later that night.

Glenn's wife, Mary Steinberg, lost her husband. She said:

> Not a day goes by that I don't miss Glenn's companionship and the joy he brought to our household. Because of gross negligence, he was not here to support me when my son went off to serve our country in Iraq.

In this photo is a group of kids, including Martin Hartnett of Chicago. When Martin's mom Donna arrived at the hospital to deliver, her labor wasn't progressing. Her doctor broke her water and found out that it was abnormal.

Rather than considering a C-section, Donna's doctor started to administer a drug to induce contractions. Six hours later, she still hadn't delivered, but her son's fetal monitoring system began indicating that he was in severe respiratory distress. The doctor finally decided it was time to perform an emergency C-section, but it was another hour before Donna was taken into the operating room.

During that time, the doctor failed to administer oxygen or take immediate steps to help Martin breathe. After he was born, Martin was in the intensive care unit for 3 weeks. Later, Donna learned that Martin had substantial brain damage and cerebral palsy—a direct result of the doctor's failure to respond to indications of serious oxygen deprivation and delivery in a timely manner.

Donna's doctor told her not to have any more children because there was a serious problem with her DNA, which

could result in similar disabilities in any of her future kids. Since then, Donna has given birth to three perfectly healthy sons.

Donna sued the doctor responsible for Martin's delivery and received a settlement. She is thankful she has money from the settlement to help cover the costs associated with Martin's care that aren't covered by health insurance, such as the wheelchair-accessible van that she bought for $50,000 and the $100,000 she spent making changes to her home so her son can get around the house in a wheelchair.

What would Donna have done without the money from that settlement? It is a scary thought because Martin is going to require a lifetime of care. When we put caps on recoveries and say there is an absolute limit to how much someone who has created a problem has to pay out, we have to think about it in terms of real-life stories, such as Martin's. Martin will live for a long time, and he is going to need help. Somebody needs to be responsible for that. The person who caused this should be responsible for it. That is pretty basic justice in America.

When you establish an artificial cap on noneconomic losses for pain and suffering, then you are saying there is a limit to how much can be paid. I recall the case of a woman in Chicago who went into a prominent hospital—one that I have a great deal of respect for—to have a mole removed from her face—a very simple mole removal. They gave her a general anesthesia. In the course of that anesthesia, they gave her oxygen. The oxygen tank—in the administration of it—caught fire, literally burning off her face. She went through repeated reconstructive surgeries. I have met her. There was scarring and, as you can imagine, a lot of pain. Was $250,000 too much money for that, for what she went through? Her life will never be the same. That is the kind of disfigurement covered by noneconomic losses that would be limited by medical malpractice caps.

There are better ways to do this. We can, in fact, reduce the cost of medical malpractice insurance. We can, in fact, reduce medical errors. We should not do it at the expense of innocent victims—people who went in, with all the trust in the world, to doctors and hospitals and had unfortunate and tragic results.

Every time I get up to speak on this subject I always make a point of saying—and I will today—how much I respect the medical profession in America. There isn't one of us in this Chamber, or anyone watching this, who can't point to men and women in the practice of medicine who are true heroes in their everyday lives, who sacrifice greatly to become doctors, and who work night and day to get the best results for their patients. They richly deserve not only our praise but our respect.

But there are those who make mistakes—serious mistakes. There are innocent victims who end up with their lives changed or lost because of it. We cannot forget them in the course of this debate. This is about more than dollars and cents. It is about justice in this country. I urge my colleagues, when the issue of medical malpractice comes before us, to remember the doctors but not to forget the victims and their families.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Madam President, while our colleague from Illinois is still on the Senate floor, I always enjoy listening to him. He is one of the most effective advocates, and he is an outstanding lawyer. He and I frequently disagree, but I always enjoy listening to his arguments. That isn't what I came to talk about, but I am glad I happened to be here when he talked about the successful effort we have had in Texas, through medical liability reform laws, to make medical liability insurance more affordable for physicians and, as a consequence, increase the number of doctors who have moved to our State, including rural areas, which has increased the public's access to good, quality health care. We have seen, in 100 counties, where they didn't even have an OB–GYN, or obstetrician—a doctor who delivers babies—after medical liability reform, that has changed dramatically, along with a number of other high-risk specialties that have moved to these counties where they were previously afraid to go for risk of litigation and what that might mean to their future and career.

This is an important topic. We will talk about it more. I appreciate the Senator raising the issue. We have a different view about it. If we can save $54 billion and still allow each of these people who were harmed by medical negligence to recover—which, in fact, they would be under the Texas cap on noneconomic damages—each of these individuals would be able to recover their lost wages, their medical bills, and they would be able to receive large amounts of money for pain and suffering—I am sure not enough to compensate them for what they have been through. But no one should understand that these individuals would somehow be precluded or that the courthouse doors would be shut to people who are victims of medical negligence.

There needs to be some reasonable limitations that will help, in the end, make health care more accessible, which is what we are talking about.

I want to focus briefly on the cuts to Medicare in this new, huge piece of legislation we are considering. Of course, we are told by the CBO that as a result of Medicare cuts and the huge number of tax increases this bill is ''paid for.'' In other words, assuming the assumptions that the CBO took into account, which span for a 10-year budget window and are almost never true in the end—but if you take it on faith that we are going to raise taxes by $½ trillion and cut Medicare by $½ trillion, they say this is a budget-neutral bill—notwithstanding the fact that it spends $2.5 trillion over 10 years—basically, what we are saying to America's seniors, those already vested in the Medicare Program, is that we are going to take $464 billion that would go into the Medicare Program and we are going to use it to create a new government entitlement program.

Our record of fiscal responsibility, when it comes to entitlement programs, is lousy, to say the least. We know Medicare, Social Security, which is another entitlement program, and Medicaid have run up tens of trillions of dollars in unfunded liabilities. Most of them are riddled with fraud, waste, and abuse.

The question I have, and I think many have, is why in the world would you take money out of the Medicare Program that is scheduled to go insolvent in 2017, that has tens of millions of dollars in unfunded liabilities—why would you take $½ trillion out of Medicare to create yet another entitlement program that, no doubt, will have many of the problems we see now under our current entitlement programs? It just doesn't make sense, if you are guided by the facts.

Of course, our colleagues on the floor have said: We can cut $465 billion out of Medicare and, you know what, Medicare beneficiaries would not feel a thing.

Well, I don't think that is possible when you cut $135 billion in hospital payments, when you cut $120 billion out of Medicare Advantage on which 11 million seniors depend, on which they depend for their health care, or when you cut $15 billion from payments to nursing homes, another $40 billion in home health care. I think one of the most effective ways of delivering low-cost health care is in people's homes. You cut $40 billion from that, and you cut $8 billion from hospice, which is where people go during their final days in their terminal illness.

Some of my colleagues claim these cuts would not hurt patients, but many people, including me, disagree. As a matter of fact, to quote President Obama's own Medicare actuary, he said providers might end their participation in the program. In other words, as in Medicare now, in my State, 58 percent of doctors will see a new Medicare patient because reimbursements—payments to providers—are so low, which means that 42 percent will not see a new Medicare patient.

In Travis County, Austin, TX, the last figures showed that only 17 percent of physicians in Travis County will see a new Medicare patient because reimbursement rates are so low.

Yet we are going to take money from Medicare to create a new entitlement program. There is no question in my mind that providers—in the words of the Medicare actuary—might be hedging their bets. I think he is hedging his bets. He also said many will end their participation in the program and thus jeopardize access to care for beneficiaries.

We have heard some of the debate earlier about when our side of the aisle made proposals to fix some of the problems with the Medicare Program—not to create a new entitlement program—by taking this amount of money, $464 billion, from it. When we tried to fix it earlier, some colleagues, including the majority leader, called those cuts immoral and cruel. To quote President Obama on the campaign trail, he was one of those who criticized Senator MCCAIN for some of the proposals he made to try to fix the broken Medicare Program.

As we have heard from a Texas Hospital Association, the Medicare cuts to hospitals simply will not work because—and this is another sort of accounting trick that in Washington, DC, and in Congress people think we can get away with and fool the American people about what is actually happening. People are a lot smarter than I think Members of Congress sometimes give them credit for. Under the Senate bill, the expanded coverage doesn't start until 2014. But the hospital cuts begin immediately.

I have talked about the broken Medicare Program and, frankly, I think a lot of people would rather see us fix Medicare and Medicaid before we create yet another huge entitlement program that is riddled with fraud, that is on a fiscally unsustainable path, and one that, frankly, promises coverage but ultimately denies access to care because of unrealistically low payments to providers. We are going to make that worse if this bill passes, not better.

Well, this bill also includes something else that I think the public needs to be very aware of. It uses not only budget gimmicks so that our friends who support this bill can say that it extends the life of the Medicare trust fund for a few years, the problem is it doesn't solve the fundamental imminent bankruptcy of Medicare. That is one of the reasons the bill sponsored by the distinguished majority leader creates a new, unaccountable, unelectable board of bureaucrats to make further cuts to Medicare Programs.

After the Reid bill pillages Medicare for $½ trillion, as I said, to pay for a new entitlement, it creates a board of unelected, unaccountable bureaucrats, the so-called Medicare advisory board, which sounds pretty innocuous, but they have been given tremendous power—to meet budget targets—another $23 billion in the first years alone.

If Congress doesn't substitute those cuts with other cuts to providers or benefits, the board's Medicare cuts would go into effect automatically. That would mean Medicare patients, physicians, hospitals, and everyone else who depends on Medicare would have no say in what happens to personal medical decisions because they would just be cut and shut down by this unelected, appointed board.

The government-charted boards of experts we have in existence today are not always right. We may remember the Medicare Payment Advisory Commission, so-called MedPAC, which was created by Congress in 1997, has recommended more than $200 billion in cost cuts in the last year alone that Congress has not seen fit to order. In other words, this MedPAC board makes recommendations, and Congress is then left with the option in its wisdom to act to make those cuts. Congress has said no to the tune of $200 billion in the last year alone.

Then there is another relatively notorious board of experts—unaccountable, faceless, nameless bureaucrats—that we have learned a little bit about in the last few days: the U.S. Preventive Services Task Force. They are supposed to recommend preventive services but just recently said that women under the age of 50 do not need a mammogram to screen for breast cancer. Respected organizations, such as the American Cancer Society and the Komen Advocacy Alliance, disagree based on their own rigorous review of the latest medical evidence.

As the father of two daughters, I can tell you, I do not want my wife or my daughters restricted in their access to diagnostic tests that may save their lives if their doctor recommends, in his or her best medical judgment, that they get those tests. Yet what we will have in the future, if the medical advisory board is passed, is an unelected, unaccountable board of bureaucrats that can make cuts, based on expert advice, which will ultimately limit access to diagnostic tests, including tests such as mammograms, which became very controversial. The Secretary of Health and Human Services came out immediately and said: We will never allow that to go into effect.

Not even the Secretary of Health and Human Services, under this provision, could reverse the decision of this unelected, unaccounted board which may well—I would say probably will in some cases—limit a person's access to diagnostic tests and procedures that could save their life even though their personal physician, in consultation with that patient, may say: This is what you need. When you give that power to the government, not only to render expert advice but then to decide whether to pay or not to pay for a procedure, then the government—namely, some bureaucrat in Washington, DC—is going to make the decisions based on a cost-benefit analysis.

OK, on a cost analysis, we can afford, according to the decision of the U.S. Preventive Services Task Force, to lose women to breast cancer—women between the age of 40 and 49—because we don't think they need a mammogram. And on a cost-benefit analysis, they may say: Tough luck. But that is not where we should go with this legislation.

Many health care providers are concerned about the Medicare Payment Advisory Commission. According to a letter from 20 medical speciality groups, they said:

> We are writing today to reiterate our serious concerns with several provisions that were included in the health care reform bill . . . and to let you know that if these concerns are not adequately addressed when the health care reform package is brought to the Senate floor, we will have no other choice but to oppose the bill.

Included in those concerns was the ''establishment of an Independent Medicare Commission whose recommendations could become law without congressional action . . . ''

According to a letter from the American Medical Association today:

> AMA policy specifically opposes any provision that would empower an independent commission to mandate payment cuts for physicians. . . . Further, the provision does not apply equally to all health care stakeholders, and for the first four years significant portions of the Medicare program would be walled off for savings . . .

This is an example of another trade association that basically decided to cut a deal with the administration behind closed doors, and they have been prevented from some of these cuts under this Medicare Commission while physicians have not been accorded similar treatment, and they do not think it is fair. They think it is unfair, and I agree with them.

This letter goes on to say:

> In addition, Medicare spending targets must reflect appropriate increases in volume that may be a result of policy changes, innovations that improve care, greater longevity, and unanticipated spending for such things as influenza pandemics. These are critical issues with the potential for significant adverse consequences for the program, which must be properly addressed through a transparent process that allows for notice and comment.

Sounds to me as if the American Medical Association thinks this is a lousy idea, and I agree with them.

Artificial budget targets that the Medicare advisory board would have to meet leave virtually no room for medical innovation. It is unbelievable what medical science in America and across the world has done to increase people's quality of life—their longevity as a result of heart disease, for example. People who would have died in the seventies are today living healthy because they are taking prescription medications to keep their cholesterol in

check, and they have access to innovative surgical procedures, such as stents and other things that can not only improve their quality of life but their longevity as well.

If we have the Medicare advisory board saying: We are not going to pay for some of these things, it will crush medical innovation and have a direct impact on quality of life and longevity. What if we find a cure for Alzheimer's in 2020, but because this board says: It is too expensive, we are not going to pay for it, you are out of luck. What if there are things we cannot anticipate today, which we know there will be because who ever heard of the H1N1 virus or swine flu just a year ago?

Some of my colleagues have said an ''independent board,'' such as the Medicare advisory board, would insulate health care payment decisions from politics. But the very charter of the Medicare advisory board was the result of a deal cut behind closed doors with the White House, a political deal, and it has a lot of reasons why, as we can tell, I don't think it is going to work well.

According to Congress Daily:

> Hospitals would be exempt from the [board's] ax, according to the committee staff and hospital representatives, because they already negotiated a cost-cutting agreement with [the chairman of the Finance Committee] and the White House. ''It's something that we worked out with the committee, which considered our sacrifices,'' said Richard Coorsh, spokesman for the Federation of American Hospitals. A committee aide and a spokeswoman for the American Hospital Association reiterated that hospitals received a pass—

They were protected from 4 years of cuts—

> based on the $155 billion cost-cutting deal already in place.

Is that the kind of politics we want to encourage behind closed doors—deals cut to protect one sector of the health care industry and sacrifice another while denying people access to health care? That is the kind of politics I would think we would want to avoid.

The truth is, the Reid bill gives more control over personal health decisions to Washington, DC, where politics will always play a role in determining winners and losers when the government is in control because people are going to come to see their Members of Congress and say: Will you help us? We are your constituents. And Members of Congress are always going to try to be responsive, if they can, within the bounds of ethics to their constituents.

This needs to be not a process that is dictated by politics but on the merits and on the basis of preserving the sacred doctor-patient relationship. If we really want to insulate health care from politics, we need to give more control to patients—to patients, to families, to mothers and fathers, sons and daughters—to make health care decisions in consultation with their physician, not nameless, faceless, unaccountable bureaucrats.

I filed an amendment to completely strike the Medicare advisory board from the Reid bill. I urge my colleagues to support it at the appropriate time. The Medicare advisory board empowers bureaucrats to make personal medical decisions instead of patients, whose power to determine their own future, in consultation with their doctor, we ought to be preserving.

The Medicare advisory board is an attempt to justify the $½ trillion pillaging of Medicare from America's seniors to create a new entitlement program. We should fix Medicare's nearly $38 trillion in unfunded liabilities, not steal from a program that is already scheduled to go insolvent in 2017.

At a time of insolvent entitlement programs, record budget deficits, and unsustainable national debt, this country simply cannot afford a $2.5 trillion spending binge on an ill-conceived Washington health care takeover.

I yield the floor.

Mr. GREGG addressed the Chair.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, it is the tradition in this body that a person seeking recognition gets recognized, is it not?

The PRESIDING OFFICER. It is, and I say the Senator from California was here earlier.

Mrs. FEINSTEIN. If I might, Madam President, my understanding was we alternate, go from side to side. I have been sitting here waiting.

Mr. GREGG. Madam President, I believe I have the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, I ask unanimous consent that at the conclusion of remarks of the Senator from California, I be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from California.

AMENDMENT NO. 2791

Mrs. FEINSTEIN. Madam President, I admire the Senator's gentility. I thank him very much.

I rise to say a few words on behalf of the Mikulski amendment, but before I do, I wish to make a generic statement.

Those of us who are women have essentially had to fight for virtually everything we have received. When this Nation was founded, women could not inherit property and women could not receive a higher education. In fact, for over half this Nation's life, women could not vote. It was not until 1920, after perseverance and demonstrating, that women achieved the right to vote. Women could not serve in battle in the military, and today we now have the first female general. So it has all been a fight.

Senator MIKULSKI and Senator BOXER in the House in the 1980s carried this fight. Those of us in the 1990s who came here added to it. You, Madam President, have added to it in your remarks earlier. The battle is over whether women have adequate prevention services provided by this bill. I thank Senator MIKULSKI and Senator BOXER for their leadership and for their perseverance and their willingness to discuss the importance of preventive health care for women. Also, I thank Senator SHAHEEN, Senator MURRAY, and Senator GILLIBRAND, joined by Senators HARKIN, CARDIN, DODD, and others, for coming to the floor and helping women with this battle.

The fact is, women have different health needs than men, and these needs often generate additional costs. Women of childbearing age spend 68 percent more in out-of-pocket health care costs than men. Most people don't know that, but it is actually true. So we believe all women—all women—should have access to the same affordable preventive health care services as women who serve in Congress, no question. The amendment offered by Senator MIKULSKI—and she is a champion for us—will ensure that is, in fact, the case. It will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include mammograms, Pap smears, family planning, screenings to detect postpartum depression, and other annual women's health screenings. In other words, the amendment increases access to the basic services that are a part of every woman's health care needs at some point in her life.

Let me address one point because there is a side-by-side amendment submitted by the Senator from Alaska. Nothing in our bill would address abortion coverage. Abortion has never been defined as a preventive service. The amendment could expand access to family planning services—the type of care women need to avoid abortions in the first place.

As I mentioned, the Senator from Alaska has offered an alternative version of this proposal. But regardless of the merits or problems with her proposal, it remains a kind of budget buster. According to the CBO, the amendment would cost $30.6 billion over 10 years. Adopting this amendment would require us to spend some of the surplus raised by the CLASS Act or some of the budget surpluses in the bill. The underlying bill, as written, reduces the budget deficit by $130 billion in the first 10 years and as much as $650 billion in the second 10 years. This is a very important thing, in my view, and we need to maintain these savings. The Mikulski amendment would do that. It costs $940 million over 10 years as opposed to the $24 billion to $30 billion in the Murkowski amendment.

The Mikulski amendment is, I believe, the best way to expand access to preventive care for women, while keeping this bill fiscally responsible.

We often like to think of the United States as a world leader in health care, with the best and the most efficient system. But the facts actually do not bear this out. The United States spends more per capita on health care than other industrialized nations but in fact has worse results. According to the Commonwealth Fund, the United States ranks No. 15 in avoidable mortality. That means avoidable death. This analysis measures how many people in each country survive a potentially fatal yet treatable medical condition. The United States lags behind France, Japan, Spain, Sweden, Italy, Australia, Canada, and several other nations.

According to the World Health Organization, the United States ranks No. 24 in the world in healthy life expectancy. This term measures how many years a person can expect to live at full health—robust health. The United States again trails Japan, Australia, France, Sweden, and many other countries.

These statistics show we are not spending our health care resources wisely. The system is failing to identify and treat people with conditions early on that can be controlled. Part of the answer, without question, is expanding coverage. Too many Americans cannot afford basic health care because they lack basic health insurance. But another piece of the puzzle is ensuring this coverage provides affordable access to preventive care—the ability to be screened early—and that is what the Mikulski amendment will accomplish.

Women need preventive care—screenings and tests—so that potentially serious or fatal illnesses can be found early and treated effectively. We all know individuals who have benefitted from this type of care—a mammogram that suddenly identifies an early cancer before it has spread or before it has metastasized; a Pap smear that finds precancerous cells that can be removed before they progress to cancer and cause serious health problems; cholesterol testing or a blood pressure reading that suggests a person might have cardiovascular disease which can be controlled with medication or lifestyle changes. This is how health care should work—a problem found early and addressed early. The Mikulski amendment will give women more access to this type of preventive care.

Statistics about life expectancy and avoidable mortality can make it easy to forget that we are talking about real patients and real people who die too young because they lack access to health care. Physicians for Reproductive Choice and Health shared the following story, which comes from Dr. William Leininger in California, and here is what he says:

In my last year of residency, I cared for a mother of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband's insurance, but it was an abusive relationship and she lost her health insurance when they divorced. For the next 5 years, she had no health insurance and never received followup care, which would have revealed that her cancer had returned. She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread. She had two children from her previous marriage, and her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn't gain custody of her children after her death. She succeeded. She was 28 years old when she died.

Cases like these explain why the United States trails behind much of the industrialized world in life expectancy. For this woman, divorce meant the loss of her health coverage, which meant she could not afford followup care to address her cancer—a type of cancer that is often curable if found early. And that is where prevention comes in. So this tragic story illustrates the need to improve our system so women can still afford health insurance after they divorce or lose their jobs. And it shows why health reform must adequately cover all the preventive services women need to stay healthy.

The Mikulski amendment is a fight—I am surprised, but it is a fight—but it will help expand access to preventive care while keeping the bill fiscally responsible. To me, it is a no-brainer. If you can prevent illness, you should. In and of itself it will end up being a cost savings. So I have a very difficult time understanding why the other side of the aisle won't accept a measure that is more fiscally responsible by far than their measure, will do the job, and will give women preventive care and begin to change that statistic which shows that, among other nations, we do so badly.

I thank the Presiding Officer for coming to the floor and speaking out on this, and I hope there are enough people in this body who recognize that virtually everything women have gotten in history has been the product of a fight, and this is one of those.

I yield the floor.

The PRESIDING OFFICER (Mr. CARDIN). The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that the next Republican speaker be the Senator from Louisiana, Senator VITTER.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GREGG. Mr. President, at this point I rise to speak generally about the bill and specifically about this Medicare proposal—the proposal in the bill and the motion that has been offered by Senator MCCAIN, which I think is an excellent idea.

Let's start with the size of this bill. It is unusual that we would be considering a bill of this size and not have had more time to take a look at it, but the bill itself—and I am glad that the chairman of the Finance Committee has essentially agreed with this earlier today—costs $2.5 trillion when it is fully implemented—$2.5 trillion. When my budget staff took a look at this bill—and we only had a brief time to do it, obviously, last week—and came up with that number, people on the other side of the aisle said, regrettably: No, that is a bogus number. The number is $840 billion, it is not a $2.5 trillion bill. However, it is $2.5 trillion when it is fully implemented. When the programmatic activity of this bill is under full steam, over a 10-year period, it will cost over $2.5 trillion. That is huge—huge.

In an earlier colloquy, I heard the chairman of the Finance Committee—who does such a good job as chairman—make the point: Well, it is fully paid for. It is fully paid for in each 10-year period. That is true, literally. I give him credit for that. But two questions are raised by that fact. The first is this: Why would you expand the Federal Government by $2.5 trillion when we can't afford the government we have?

The resources that are being used to pay for this, should they ever come to fruition, are resources which should probably be used to make Medicare solvent or more solvent or, alternatively, to reduce our debt and deficit situation, as we confront it as a nation. We know for a fact that every year for the next 10 years—even before this bill is put in place—we are going to run a $1 trillion deficit every year, because that is what President Obama has suggested. We know for a fact that our public debt is going to go from 35 percent of our gross national product up to 80 percent of our gross national product within the next 6 years without this bill being passed. We know we are in a position where we are headed down a road which is basically going to hand to our children a nation that is fiscally insolvent because of the amount of debt put on their back by our generation through spending and not paying for it.

So why would we increase the government now by another $2.5 trillion when we can't afford the government we have? That is the question I think we have to ask ourselves. Isn't there a better way to try to address the issue of health care reform without this massive expansion of a new entitlement—creating a brandnew entitlement which is going to cost such an extraordinary amount of money and dramatically expand Medicaid, which is where most of the spending comes from in this bill—a massive expansion of Medicaid and a massive new entitlement created that we don't have today?

This bill, when it is fully implemented, will take the size of the Federal Government from about 20 percent

of GDP or a little less—where it has historically been ever since the post-World War II period—up to about 24 or 25 percent of GDP. To accomplish that, and claim you are not going to increase the deficit, requires a real leap of faith. Because it means that to pay for this—and this is why the McCain motion is so important—you are going to have to reduce Medicare spending by $1 trillion, when this bill is fully implemented—$1 trillion over a 10-year window. In fact, during the period from 2010 to 2029, Medicare spending will be reduced in this bill by $3 trillion.

Those dollars will not be used to make Medicare more solvent. And we know we have serious problems with Medicare. Those dollars will be used to create a brandnew entitlement and to dramatically increase the size of government for people who do not pay into the hospital insurance fund; for people who have not paid Medicare taxes, for the most part but, rather, for a whole new population of people going under expanded Medicaid and people getting this new entitlement under the public plan. So if you are going to reduce Medicare spending in the first 10 years by $450 billion, and the second 10 years fully implemented—there is some overlap there, but fully implemented $1 trillion, and then over a 19-year period, the two decades, by $3 trillion, instead of using those monies—those seniors' dollars—to try to make Medicare more solvent, they are going to be used for the purposes of expanding and creating a new entitlement and expanding Medicaid.

This is hard to accept as either being fair to our senior population or being good policy from a fiscal standpoint. Why is that? Because if we look at the Medicare situation, we know Medicare as it is structured today has an unfunded liability of $55 trillion—$55 trillion. That means in the Medicare system we do not know how we are going to pay $55 trillion worth of benefits we know we are now obligated for.

The answer we get from the other side of the aisle is: Well, this $55 trillion number goes down, because this bill cuts Medicare and, therefore, the benefit structure reduces. But do the revenues, or the reduction in that, go toward the purpose of making Medicare more solvent? No. Those monies are taken and spent. Those monies are taken and used to create a larger government. They aren't used to reduce the deficit or to reduce the debt, all of which is being driven, in large part, by this $55 trillion worth of unfunded liability as we go forward. No, they are being used to create a brandnew entitlement which has nothing to do with seniors, and a brandnew entitlement which is going to be paid for, in large part, by seniors, or by a reduction in their benefit structure.

That makes very little sense, because essentially you are taking money out of the Medicare system and using it to expand the government, when in fact what we should be doing, if you are going to take money out of the Medicare system, is you should be using it to reduce the obligations of the government—the debt obligation—so the Medicare system becomes more affordable. That is not the goal here, however.

Then, of course, there is the practical aspect of this. We know these types of proposals are plug numbers to a great degree, because we know this Congress is not going to stand up to a $½ trillion cut in Medicare over the next 10 years and a $3 trillion cut in Medicare over the next 20 years. Why do we know that? I know it from personal experience. I was chairman of the Budget Committee the last time we tried to address the fact that we have an outyear liability in Medicare that is not affordable—this $55 trillion number. We know it is not affordable. We know we have to do something about it. So I suggested, when I was chairman of the Budget Committee, that we reduce Medicare spending, or its rate of growth—not actual spending, its rate of growth—by $10 billion over a 5-year period, less than 1 percent of Medicare spending. My suggestion was that we do that by requiring—primarily we get most of that money by requiring senior citizens who are wealthy to pay a reasonable proportion of their Part D premium and then take those moneys and basically try to make Medicare a little more solvent with it. We got no votes from the other side of the aisle—none, zero—on that proposal.

Now they come forward with a representation that they are going to reduce Medicare spending and benefits to seniors by $3 trillion over the next 20 years and $400-some-odd billion over the next 10 years, and they expect this to be taken seriously? Of course not. This is all going to end up being unpaid-for expenditures in expansion of these programs.

These brandnew entitlements that are being put in this bill and this expansion of other entitlements that do not deal with Medicare, by the way, are going to end up being in large part paid for by creating more debt and passing it on to our children. As I mentioned earlier, that is a fairly big problem for our kids. They are going to get a country, as it is today, that has about $70 trillion in unfunded liability just in the Medicare and Medicaid accounts, to say nothing of the other deficits we are running up around here. Now we are going to throw another huge amount on their backs.

Some percentage of this $2.5 trillion—probably a majority of it—will end up being added to the deficit and debt as we move out into the outyears even though it is represented that it is not going to be. The only way you can claim you are going to pay for this, of course, is with these Medicare cuts and these tax increases that are in this bill, and these fee increases. We are going to spend a little time on the tax increases and fee increases and the speciousness of those proposals, but right now we are focusing on Medicare.

In any event, what we have is a bill that takes government and explodes its size. We already have a government that is pretty big—20 percent of our economy. You are exploding it to 24 percent of our economy, and then you are saying you are going to pay for that by dramatically reducing Medicare spending? It does not make any philosophical sense, and it certainly does not pass the test of what happens around here politically.

In addition, there is the issue of how this bill got to a score in the first 10 years that made it look as if it was more fiscally responsible. I have heard people from the other side. Again, I respect the chairman of the Finance Committee for acknowledging that this bill, when fully implemented, is a $2.5 trillion bill. But a lot of folks are claiming this is just an $843 billion bill, that is all it is in the first 10 years, that is all it costs. There are so many major budget gimmicks in this bill that accomplish that score that Bernie Madoff would be embarrassed—embarrassed by what this bill does in the area of gamesmanship.

Let's start with the fact that it begins most of the fees, most of the taxes, and most of the Medicare cuts in the first year of the 10 years, but it does not begin the spending on the new program, the new entitlements, until the fourth and fifth year. So they are matching 4 and 5 years of spending against 10 years of income and Medicare cuts and claiming that therefore there is a balance.

Ironically, it is represented and rumored—and I admit this is a rumor—that originally they were going to start the spending in the third year under this bill. Of course, nobody knew what the bill was because it was written in private and nobody got to see it. But then they got a score from CBO that said it didn't work that way, so they simply moved the spending back a year and started it in the fourth year. They sent it back to CBO, and CBO said: If you take a year of spending out in the 10 years and you still have the 10 years of income from the taxes, fees, and cuts in Medicare, you get a better score. We will give you a better score. You will get closer to balance. It is a pretty outrageous little game of hide the pea under the shell.

This is probably the single biggest—in my experience, and I have been on the Budget Committee for quite a while—in my experience, it is the single biggest gaming of the budget system I have ever seen around here. But it is not the only one; there is something here called the CLASS Act.

Mr. HATCH. Will the Senator yield?

Mr. GREGG. I will be happy to yield to the Senator from Utah for purposes of a question.

Mr. HATCH. What is the current cost of our health care across the board in this country, without this bill?

Mr. GREGG. It is about 16 to 17 percent of our gross national product.

Mr. HATCH. That is $2.5 trillion?

Mr. GREGG. That is correct.

Mr. HATCH. The Senator is saying they are going to add, if you extrapolate it out over another 10 years, $2.5 trillion.

Mr. GREGG. It takes the spending from 16 to 17 percent to about 20 percent of GDP.

Mr. HATCH. If I understand my colleague correctly, he is saying, to reach this outlandish figure of $843 billion, literally they do not implement the program until 2014 and even beyond that to a degree, but they do implement the tax increases?

Mr. GREGG. The Senator from Utah, of course, being a senior member of the Finance Committee, is very familiar with those numbers, and that is absolutely correct.

Mr. HATCH. Is that one of the budget gimmicks my colleague is talking about?

Mr. GREGG. I think that is the biggest in the context of what it generates in the way of Pyrrhic, nonexistent savings because it basically says we are really not spending—because it doesn't fully implement the plan in the first year, it says we are not spending that much money. In fact, we know that when the plan is fully implemented, it is a $2.45 trillion not a $840 billion bill.

Mr. HATCH. Am I correct that the Democrats have said—and they seem to be unified on this bill—that literally this bill is budget neutral? But as I understand it, in order to get to the budget neutrality, they are socking it to a program that has about $38 trillion in unfunded liabilities called Medicare—to the tune of almost $500 billion or $½ trillion in order to pay for this? Am I correct on that? No. 2, who is going to lose out when they start taking $500 billion out of Medicare? And what are they going to do with that $500 billion? Are they going to put it into something else? Are they using this just as a budgetary gimmick? What is happening here? As the ranking member on the Budget Committee today, you really could help all of us understand this better.

Mr. BAUCUS. Will the Senator yield for a question?

Mr. GREGG. If I can first answer the question of the Senator from Utah, and then I will be happy to answer the chairman of the Finance Committee.

The Senator from Utah basically is correct in his assumption. Essentially, they are claiming an approximately $400-some-odd billion savings in Medicare over 10 years which they are then using to finance the spending in this bill over the last 5 years, 5 to 6 years of the 10-year window. In the end, after you fully implement this bill and you fully implement the Medicare cuts, it represents $3 trillion of Medicare reductions over a 20-year period.

Where does it come from? It comes from two different accounts, primarily. One is, just about anybody who is on Medicare Advantage today—about 25 percent of those people will probably completely lose their Medicare Advantage insurance, and it is 12,000 people in New Hampshire, so say 4,000 people.

Mr. HATCH. How many people on Medicare are on Medicare Advantage?

Mr. GREGG. I believe 11 million people.

Mr. HATCH. That will be what percentage of people on Medicare?

Mr. GREGG. About 25 percent of those people will lose their Medicare insurance under this proposal, mostly in rural areas. And second, because there is $160 billion of savings scored. You can't save that type of money in Medicare Advantage unless people don't get the Medicare Advantage advantage.

Second, it comes in significant reductions in provider payments. How do provider payments get paid for when they are cut, I ask the Senator from Utah. I suspect it is because less health care is provided.

Mr. HATCH. How does that affect the doctors?

Mr. GREGG. It certainly affects the hospitals, and it probably affects the doctors. I have heard the Senator from Montana say they are going to straighten out the doctor problem down the road, but that is another $250 billion of spending which we don't know where they are going to get the money from. But, yes, it would affect, in my opinion, all providers—doctors, hospitals, and other people who provide health care to seniors. You cannot take $450 billion out of the Medicare system and not affect people's Medicare.

Mr. HATCH. Am I wrong in saying Medicare is already headed toward insolvency and that it has up to almost $38 trillion in unfunded liability over the years for our young people to have to pay for?

Mr. GREGG. The Senator from Utah is correct again. The Medicare system is headed toward insolvency, and it goes cash-negative in 2013, I believe—maybe it is 2012—in the sense that it is paying out less than it takes in, and it has an unfunded liability that exceeds, actually, $38 trillion now. I think it is up around——

Mr. HATCH. Then how can our friends on the other side take $½ trillion out of Medicare, which is headed toward insolvency, to use for some programs they want to now institute anew?

Mr. GREGG. I think the Senator from Utah has asked one of the core questions about this bill. Why would you use Medicare savings, reductions in Medicare benefits, which will definitely affect recipients, for the purposes of creating a new program rather than for the purposes of making health care more solvent if you are going to do that in the first place? And are these savings ever going to really come about? One wonders about that also.

Mr. HATCH. I heard someone say today on the floor—I don't know who it was, I can't remember—that Medicare Advantage really isn't part of Medicare. Is that true?

Mr. GREGG. Actually, I would yield to the Senator from Utah on that issue—not the floor but yield on that question because I think the Senator from Utah was there when Medicare Advantage was drafted as a law.

Mr. HATCH. I was there in the Medicare modernization conference, along with the distinguished chairman of the committee, Senator BAUCUS, and others, when we did that because we were not getting health care to rural America. The Medicare+Choice plan didn't work. Doctors would not take patients. Hospitals could not pay; they could not take patients. There were all kinds of difficulties in rural America. So we did Medicare Advantage, and all of a sudden we were able to take care of those people. Yes, it costs a little more, but that is because we went into the rural areas to do it.

But this would basically decimate Medicare Advantage, wouldn't it, what is being proposed here? And that is part of Medicare.

Mr. GREGG. I believe it is a legal part of Medicare, Medicare Advantage.

Mr. HATCH. No question about it.

Mr. GREGG. And this would have a massively disruptive effect on people who get Medicare Advantage because you are going to reduce it—the scoring is there will be a reduction in Medicare Advantage payments of approximately $162 billion, I believe it is, and there is no way you are going to keep getting the advantages of Medicare Advantage if you have that type of reduction in payments.

Mr. HATCH. How can they take $½ trillion out of Medicare? That is not all Medicare Advantage. Medicare Advantage is only part of that, the deductions they will make there. But how can they do that and still run Medicare in a solvent, constructive, decent, and honorable fashion?

Mr. GREGG. If the Senator will allow me to respond, the problem here is we have rolled the Medicare issue into this major health reform bill—or the other side has—and they have used Medicare as a piggy bank for the purposes of trying to create a brandnew entitlement which has nothing to do with senior citizens. Yes, Medicare needs to be addressed. It needs to be reformed. The benefit structure probably has to be reformed. But we should not use those

dollars for the purposes of expanding the government with a brandnew entitlement. We should use those dollars to shore up Medicare so we don't have this massive insolvency.

Mr. HATCH. You mean they are not using this $500 billion to shore up Medicare and to help it during this period of possible insolvency with a $38 trillion unfunded liability? They are not using it for that purpose?

Mr. GREGG. That is correct.

Mr. HATCH. For what purpose are they using it?

Mr. GREGG. They are using to fund the underlying bill, and the underlying bill expands a variety of initiatives in the area of Medicaid and in the area of a brandnew entitlement for people who are uninsured to subsidize the government plan.

Mr. HATCH. You were going to talk about the CLASS Act.

Mr. GREGG. The CLASS Act is another classic gimmick of budgetary shenanigans which I would like to speak to, briefly. I know the Senator from Montana had a question or maybe he has gone past that point and we have answered all his questions. I can move on to the CLASS Act.

Mr. BAUCUS. I would like to hear you talk about the CLASS Act. I am no fan of the CLASS Act myself so why don't you proceed.

Mr. GREGG. I thank the Senator for his forthrightness on that. The CLASS Act needs to be explained. It is a great title. We come up with these wonderful ''motherhood of titles.'' We attach them to things and then suddenly they take on a persona that has no relationship to what they actually do. The CLASS Act is a long-term care insurance program which will be government run. It is another takeover of private sector activity by the Federal Government. But what is extraordinarily irresponsible in this bill is, we all know in long-term care insurance that you buy it when you are in your thirties and your forties. You probably don't buy it when you are in your twenties. You buy it in your thirties, forties, and fifties. You start paying in premiums then. But you don't take the benefits. The cost of those insurance products don't incur to the insurer until people actually go into the retirement home situation, which is in their late sixties and seventies, most likely eighties in our culture today, where many people are working well into their seventies. So there is a large period of people paying in, and then 30 or 40 years later, they start to take out.

What has happened in this bill, which is a classic Ponzi scheme—in fact, ironically, the chairman of the Budget Committee did call it a Ponzi scheme, the Senator from North Dakota, Mr. CONRAD—they are scoring these years when people are paying into this new program and, because the program doesn't exist, everybody who pays into it, starting with day one, the beneficiaries of that program aren't going to occur until probably 30 or 40 years later. They are taking all the money that is paid in when people are in their thirties, forties, fifties, and sixties as premiums. They are taking that money and they are scoring it as revenue under this bill and they are spending it on other programmatic initiatives for the purposes of claiming the bill is balanced. It adds up to about $212 billion over that 20-year period, 2010 to 2029.

OK. So you spend all the premium money. What happens when these people do go into the nursing home, do require long-term care when they become 75, 80, 90 years old? There is no money. It has been spent. It has been spent on something else, on a new entitlement, on expanding care to people under Medicaid, on whatever the bill has in it. So we are going to have this huge bill that is going to come due to our kids one more time. We already are sticking them with $12 trillion of debt right now, and we are going to raise the debt ceiling, sometime in the next month, to, I don't know what it is going to be, but I have heard rumors it may be as high as 13 more trillion. We know we have another $9 trillion of debt coming at us just by the budgets projected for the next 10 years. Now we are going to, 30 years from now, have this huge bill come in as the people who decided to buy into the CLASS Act suddenly go into the retirement home. There will not be any money there for them. It is gone. It will have been spent by a prior generation to make this bill balanced.

The CLASS Act has been described as a Ponzi scheme relative to its effect on the budget. It is using dollars which should be segregated and protected under an insurance program. If this were an insurance company, for example, they would actually have to invest those dollars in something that would be an asset which would be available to pay for the person when they go into the nursing home so they are actuarially sound. But that is not what happens under this bill. Under this bill, those dollars go out the door as soon as they come in for the purposes of representing that this bill is in fiscal balance. It is not. It is not in fiscal balance, obviously.

Even if you were to accept these incredible activities of budgetary gimmickry, the fundamental problem with this bill is it grows the government by $2.5 trillion, and we can't afford that when we already have a government that well exceeds our capacity to pay for it. Inevitably, we will pass on to these young pages, as they go into their earning careers and raise their families, a government that is so expensive, they will be unable to buy a home, send their kids to college or do the things they wish to do that give one a quality of life.

I have certainly taken more than my fair share of time at this point. The Senator from Louisiana was going to go next.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, it has been a very interesting discussion, listening to the Senator from New Hampshire. Several points. One, the underlying bill is clearly not a net increase in government spending on health care. The numbers are bandied about by those on the other side—$1 trillion, $2.5 trillion, et cetera. I do acknowledge and thank the Senator from New Hampshire for saying, yes, it is all paid for. He did say that. He did agree this is all paid for. So I just hope when other Senators on that side of the aisle start talking about this big cost, $1 trillion, $2 trillion, whatever, that they do admit it is paid for. The ranking member of the Senate Budget Committee flatly said: Yes, it is all paid for. I would hope other Members on that side of the aisle heed the statement of the Senator from New Hampshire, ranking member of the Senate Budget Committee, for saying it is all paid for.

But don't take my word for it or his word. It is what the CBO says. In fact, let me quote from a letter to Senator REID not too long ago:

> The CBO expects that during the decade following the 10-year budget window, the increases and decreases in Federal budgetary commitment to health care stemming from this legislation would roughly balance out so that there would be no significant change in that commitment.

That is, a commitment to health care, to government health care spending, no change basically. It is flat. Although it is a little better than flat because the subsequent CBO letter has said the underlying bill achieves about $130 billion in deficit reduction over 10 years and one-quarter of a percent of GDP reduction in the next 10 years. The Senator from New Hampshire talks about large deficits this country is facing. That is true. Frankly, all of us in the Senate have a responsibility to try to reduce that budget deficit as best and as reasonably as we possibly can. Bear in mind, this underlying health care bill helps reduce the budget deficit. Sometimes people on the other side like to suggest that $1 trillion over 10 years will add to the budget deficit. Again, we have definitely established it does not add to the budget deficit at all, not one thin dime.

In addition, we actually reduce the budget deficit through health care reform, through this underlying legislation. We all know the Medicare trust fund is in jeopardy, in part, because baby boomers are retiring more but also because health care costs are going up at such a rapid rate. That is health care costs for everybody. It is health care costs for me, for every Senator, for every senior, for businesses.

Let's not forget, we spend in America about 60 percent more per person on health care than the next most expensive country, about 50 to 60 percent more per person. The trend is going in the wrong direction. We are going to spend about $33 trillion in America on health care over the next 10 years. That is going to be somewhat evenly divided between public expenditures and private. Every other country in the world has figured out ways to limit the rate of growth of increase in health care spending. We haven't. We are the only industrialized country—in fact, developing country—that hasn't figured out how to get some handle on the rate of growth of increase in health care spending.

One could say: Gee, let's forget about it. Just let the present trend continue. We all bandy about different figures. One I am fond of at least remembering is the average health care insurance policy in America today costs about $13,000. If we do nothing over 8 years, it will be $30,000. That is a much higher rate of increase than income for Americans. It means the disparity between wages of the average American and what they are paying on health care will widen all the more if we do nothing. We have to do something. This legislation is a good-faith effort to begin to get a handle on the rate of growth of spending in this country.

The Senator from New Hampshire was being honest, frankly. Some on the other side are being not quite so honest. He is basically saying: Yes, it is true we are not cutting beneficiary cuts, although he talks about Medicare Advantage. Let me point out that there is nothing in this legislation that requires any reductions in any beneficiary cuts. In fact, guaranteed benefits under Medicare are expressly not to be cut under the express language of this bill. The portion we are talking about is Medicare Advantage. The fact is, there is nothing in this bill that requires any cuts at all in Medicare Advantage payments. Those Medicare Advantage payments are in addition to the guaranteed Medicare payments, such as gym memberships, things such as that which are not part of traditional Medicare.

Why do I say there is nothing in there that requires cuts for those extras? That is because the decision on what benefits or what extras Medicare Advantage plans have to give the guaranteed benefits, that is by law. But the decision as to what extras should go to their members is a decision based not upon us in the government, in Congress, not upon the HHS Secretary; it is based on the corporate officers of these companies. They are overpaid, Medicare Advantage plans, right now. Everybody knows they are overpaid. Even they, privately, will tell you they are overpaid. They are overpaid based upon legislation that Congress passed in 2003, the Medicare Part D, by setting these high benchmarks. They are overpaid. The MedPAC commission also said they are overpaid to the tune of about between 14 and 18 percent. So the reductions that are provided for in this bill, in Medicare Advantage plans, the effect of those reductions is up to the officers of those plans.

They could cut premiums people otherwise pay. They could cut benefits to help themselves, help their salaries. They could cut stockholders. They could cut administrative costs.

They can decide what they want to do. That is solely a decision of the executives of Medicare Advantage plans. Private insurance plans is what they are. They are private insurance plans, so there is nothing here that says the fringes, the extras, have to be cut at all. Those executives could keep those fringes and maybe have a little less return to their stockholders or maybe make some savings in their administrative costs, maybe not increase their salaries. There is nothing here that requires those fringes, those extras, to be cut, nothing whatsoever.

The Senator from New Hampshire says: Oh, it is about $400 billion to $500 billion of reduced payments to providers in this legislation. That is true. Well, let's look and see what the consequences of that are. First of all, that means the Medicare trust fund's solvency is extended. It is more flush with cash. I would think all Senators here would like to extend the life of the Medicare trust fund. A good way to do that is by what we are doing in this bill, saving about $450 billion over 10 years that otherwise would be paid to Medicare providers is not being paid, and those benefits inure to the trust fund.

There is no dispute—none whatsoever—that this legislation extends the life of the Medicare trust fund by another 5 years. That is because of those changes in the structure and also because there are no cuts in benefits. There are no cuts in benefits, I say to Senators. Although sometimes Senators on that side of the aisle like to either say or strongly imply there are cuts in benefits, there are no cuts in benefits. There are no cuts in the guaranteed benefits with the basic benefits, and there are no required cuts for the fringes or the extras because the officers can make that decision not to cut, if they want to. That is their choice, as I have explained a few minutes ago.

Let's look to see what the other side proposed not too many years ago back in 1997. They proposed cutting the Medicare benefit structure, cutting payments to providers, big time—big time. They proposed a 12.4-percent cut to providers back in 1997, when they were in charge. They did that in part to save the Medicare trust fund, to extend the life of the Medicare trust fund.

I have a hard time understanding why back then it was a good thing to do, which was about three times more of a cut—let's see, twice as heavy a cut to Medicare providers back then, in 1997, than it is today. Nobody over there has explained why it was the right thing to do back then but not the right thing to do today, when the goal is the same. The goal is the same; that is, to extend the solvency of the trust fund.

One could say—I think the Senator from New Hampshire did say—well, let's take those savings, which do extend the solvency of the trust fund, but not—he said—provide another program. I think he wants to use that to cut the deficit. That is what I think he wants to do.

That is a very basic, fundamental, values question I think this country should face; that is, do we want to set up a system where virtually all Americans have health insurance? We are the only industrialized country in the world that does not have a system where its citizens have health insurance—the only industrialized country in the world. It is a very basic question. I think we should ask ourselves as Americans: In every other industrialized country, health insurance, health care is a right. That is the starting point. In every other country that has a health care system, health care is a right—that everybody should have health care.

Of course, it is true, people are different. Some are tall, some are short. Some are very athletically endowed, some are not. Some are smart, some are not so smart. But health care does not care—that is a way to put it—whether you are dumb, smart, tall, skinny. It affects everybody; that is, diseases affect everybody, and everybody needs health care regardless of your station in life, regardless of your income, regardless of whether you are an egghead, you are brilliant, or an athlete. It makes no difference whatsoever. We are Americans.

I frankly believe other countries on that point have it right; that is, that they treat all their citizens basically equally because disease is indiscriminate—who is going to get disease—accidents are indiscriminate—who is going to get in an accident—and so forth. So we could take this $400 billion, $500 billion and reduce the deficit with it and forget any health insurance coverage. That would be an option. That is a legitimate question we could ask ourselves. I frankly think the better choice is to take that $400 billion, $500 billion, which does extend the solvency of the trust fund, and help set up a way, help set up a system so all Americans have health insurance. We do it in a way that reduces the budget deficit. We do it in a way that reduces the budget deficit in the first 10 years and also in the next 10 years.

I again repeat, if trimming the rate of growth of provider payments was OK back in 1997—that was twice as much as today back then to extend the solvency of the Medicare trust fund—why isn't it OK today to do half as much to extend the life of the trust fund, in this case for 5 more years, and at the same time help provide health insurance benefits for people who deserve it?

Let's not forget, hospitals want us to do this. They want everyone to have health insurance. Doctors want us to have a system where everybody has health insurance, whether it is Medicaid or it is private health insurance. All the providers want it. The pharmaceutical industry does, the home health industry does, the hospice industry does. The durable medical equipment manufacturers want it. They all want it because they know it is the right thing to do. They also know they are not going to get hurt.

I heard some reference here that some HHS actuary, commenting on the House bill, said, oh, gee, it might scare providers and whatnot, but we actually got subsequent information which showed that letter—that actuary admitted it is extremely variable, what he came up with. There are lots of factors he did not take into consideration. I also have statements from hospital administrators saying no way are they going to be allowed.

In fact, let's remind ourselves of this: It was not too many weeks ago, a couple months ago—remember that meeting—when all the health care providers and the insurance industry went to the White House? They were all over there. What did they pledge to President Obama to help get health care reform passed? That they would cut their reimbursements by $2 trillion over 10 years. They would cut. They agreed to cut their payments that Uncle Sam makes to them in the health care system by $2 trillion over 10 years. It was widely reported in the papers.

What did we do in this bill? We reduced the rate of increase in payments to providers, not by $2 trillion, not by $1 trillion, less than $½ trillion over that same 10-year period. So if they could commit back then to $2 trillion, you would think, my gosh, this is a quarter of that. That is not too bad and not going to hurt anybody, and providers are not going to be leaving.

I might add too, I have a letter from AARP to the majority leader dated today. It has been handed to me. In part it says:

> The legislation before the Senate properly focuses on provider reimbursement reforms. . . . Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

This is a letter today from the American Association of Retired People. I will re-read that portion. It is addressed to Senator REID:

> The legislation before the Senate properly focuses on provider reimbursement reforms. . . .

And, man, we need about a week or so to talk about all the reforms in this bill that are so important so we have a better health care system focusing more on quality than we currently do in the United States system. Again:

> Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

In the letter they also say:

> AARP believes that savings can be found in Medicare through smart, targeted changes aimed at improving health care delivery, eliminating waste and inefficiency, and aggressively weeding out fraud and abuse.

That is important. It is very important. I might add, too, that every person today who pays a Part B premium—every American today—every senior today who pays that quarter, that 25 percent of Part B today, pays also for the waste that is in the system today, especially under Part B. So if we get the waste out, we also will be able to reduce that Part B premium payment that seniors have to pay too. I think that is a good thing.

So the more you dig into this bill, the more you see the good features. I do not think all the good features have been pointed out in this bill. One of our jobs here is to point out what they are, so when this legislation passes—mark my words, this legislation is going to be enacted. It is going to be enacted, I will not say exactly when, but certainly, if not this month, it will be signed by the President either this month or next month—then Americans are going to start to see: Oh, gee, there is a lot in there that is good. I didn't know about that. That is good. I like that. It may not be perfect, but they started in the right direction. That is pretty good. They are going to like it.

I hear all these references to polls around here, and that is because of all the confusion, in part. But once it is passed and people look to see what is in it—they will look to see what is in it because that is the law. They are forced to look to see what is in it because that is the law.

I know some of my colleagues on the other side of the aisle may say: Yes, when they look to see what is in it, they will see how bad it is. I disagree. That is not my view. My view is, the more this legislation is subjected to the light of day, the disinfectant of sunshine, which shows what is in this bill, the more people are going to say: Hey, that was a good thing they did back then in December or January.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Mr. President, I rise to talk about a very important topic on the floor right now, along with the Medicare issue; that is, preventive screenings and services, particularly for women. I want to focus on a very specific and important example of that, which is breast cancer screening through mammography, and also through the practice of self-examination.

This is very timely because 2 weeks ago, a U.S. government-endorsed panel issued new recommendations on this topic, which I believe, along with tens of millions of Americans, is a major step in the wrong direction. I think we need to focus on this recent action and talk about this and fix it in the context of this health care reform debate.

What am I talking about? Well, on Tuesday, November 17—literally just a couple weeks ago—the U.S. Preventive Services Task Force, which is an official government-sanctioned body—a task force about preventive medicine—issued new recommendations regarding breast cancer screening for women, including the use of mammography.

These new recommendations they came out with a couple weeks ago are a big step backward, a big retrenchment in terms of what the current state of knowledge is and what their previous recommendations were. Their new recommendations, just out 2 weeks ago, do four things that take a big step back on breast cancer screening.

No. 1, for women between the ages of 40 and 49, rather than get a routine mammogram every 2 years to screen for breast cancer, the task force said: Forget about that. We do not recommend that anymore. We step back from that recommendation.

No. 2, for women aged 50 to 74, the previous recommendation was to get a routine mammogram to screen against breast cancer every year. The task force, 2 weeks ago, stepped back from that and said: No, every other year is probably good enough. So not every year: every other year.

No. 3, for women over the age of 75, the previous recommendation was to have routine screening at least every 2 years. The new recommendation from the task force steps back from that and says: No, we do not recommend routine screening over the age of 75.

And, No. 4, the task force 2 weeks ago said: We no longer recommend breast self-examination by women to detect lumps to get treatment early. We do not believe in that. We do not think the science is clear on that. We step back from that.

Those are four huge changes in their previous recommendations. Those are four huge, new recommendations completely at odds with what I believe is the clear consensus in the medical community and the treatment community.

When I first read about these new U.S. Preventive Services Task Force recommendations, around November 17, I had the immediate reaction I just enunciated, but I said: I am not an expert. I am not a doctor. I am not a medical expert. I want to hear from folks who are much closer to this crucial issue than me. So my wife and I convened a roundtable discussion in

Baton Rouge, LA. We had it on Monday, November 23. It was at the Mary Bird Perkins Cancer Center. They were very kind to host it. It was cohosted by Women's Hospital in Baton Rouge. We had a great roundtable discussion featuring a lot of different people, including oncologists, other MDs, other medical experts, and including, maybe most importantly, several breast cancer survivors who literally lived through this issue themselves. Those breast cancer survivors were all women who got breast cancer and had it detected relatively early, in their forties. So they are exactly the group of people these new recommendations would work against because the new recommendations say don't get regular mammography screening in your forties.

Again, I was interested in hearing from the real experts, both medical experts and the survivors, what they thought about it. I wasn't very surprised, quite frankly, when they all had exactly the same reaction I did to these new U.S. Preventive Service Task Force recommendations. Everybody to a person said this is a big step backward. This will make us move in the wrong direction. Increased screening, early detection is a leading reason we are winning increasingly the fight against breast cancer. It is a leading reason we are doing so much better in this fight.

In that one room at the Mary Bird Perkins Cancer Center, in a sense we had a snapshot through history and proof of the great gains we have made, including through early screening because, as I said, we had these survivors, all a supercause for celebration: Folks who had detected their cancer, most of them relatively early; all of them first got it and detected it either in their forties or some in their thirties. Unfortunately, in the same room, we had a life experience on the other end of the spectrum going back 40-plus years. That is my wife Wendy who lost her mother to breast cancer when she was 6 years old. One of the reasons is simple and straightforward and directly related to what we are talking about.

Back in the late 1960s when Wendy lost her mom to breast cancer there wasn't this same routine. There wasn't this emphasis on screening. There wasn't the recommendation for annual mammograms. There wasn't the educational push for self-examination. There wasn't that focus, and because of that, far more women, tragically, including Wendy's mother, died.

We have made huge progress since then. Again, the very life experiences in that one room in Baton Rouge proved that. The medical doctors and the oncologists, the other experts, as well as the breast cancer survivors, all made that point.

So I am standing on the Senate floor to urge us to take focused, specific action to legislatively repeal any impact of these new recommendations by the U.S. Preventive Services Task Force issued in November.

This topic is on the Senate floor. It is on the floor through the Mikulski amendment. There is probably going to be a Republican alternative to that Mikulski amendment. My concern is, in terms of everything on the floor now, none of it directly, specifically takes back the impact of those new recommendations. I think that is the first matter we should all come together on, 100 to nothing, on this topic.

We can have a broader debate. We can have differences about the best approach to prevention and screening. But the first concrete, focused thing we should do right now on the Senate floor today is come together, 100 to nothing, to legislatively overrule any impact of those new recommendations. That is, again, what I have been hearing from experts not just in Baton Rouge, not just in that one room, but across the country; experts in terms of oncologists, other medical doctors, leaders of the cancer associations across the country and, perhaps most importantly, breast cancer survivors. I daresay that is what every Member of this body has heard from their States since those new recommendations came out around November 17.

So, again, whatever we do in this broader debate, I have a very simple, basic, focused suggestion. Let's show the American people we can come together around something on which I believe we all agree.

There is an expression: It is mom and apple pie. Well, this should be considered mom and apple pie because it is literally about mom and our wives and our daughters and, obviously, half the population. So let's come together around this issue, and let's legislatively overrule any legal impact, any legal consequence of these new task force recommendations of the U.S. Preventive Service Task Force.

That is what my Vitter amendment, No. 2808, does. I had hoped the amendments on the Senate floor on this general topic would do that already. Unfortunately, the one that is pending now, at least the Mikulski amendment, does not do that. In fact, in some ways it points to the new recommendations of the task force and holds up those new recommendations. Our current law holds up the current recommendations. I think because the new recommendations they promulgated around November 17 are so egregious, such a bad idea, because the consensus around the country starting with experts and oncologists is so clear that we should negate any impact of them. So, again, my Vitter amendment No. 2808, which is currently filed as a second-degree amendment to the Mikulski amendment, would do that.

Let me be perfectly clear and read my text because it is very short:

For the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

So what it does is simple. It says we are erasing, we are canceling out, any effect of those new recommendations made by the task force in and around November 2009. We are saying that never happened because the consensus is so clear against it.

Again, I expected the Mikulski amendment to do that directly. It doesn't do that. It does other things about prevention, which is fine. We can debate those points. We can have a discussion about that. But I think we need to all come together to absolutely, categorically, specifically, legislatively take back, overrule these new recommendations.

I am certainly eager to work with everyone in this body starting with Senator MIKULSKI, starting with Senator MURKOWSKI, whom I believe may offer a Republican alternative to include this language. I hope this language, which seems to me is a no-brainer given the consensus on the topic, can be included in both of those amendments. It should be just accepted and included in the Mikulski amendment. It should be accepted and included in the Murkowski amendment. That would be my goal so that whatever happens on these votes, we come together in a unified way. Literally, it would in essence be 100 to nothing, to say: No, time out. These new recommendations of the U.S. Preventive Services Task Force from November of this year are a huge step backwards, a huge mistake. That is what the experts are saying. That is what oncologists are saying. That is what cancer specialists are saying. That is what leaders of cancer associations are saying. That is what, perhaps most importantly, breast cancer survivors are saying.

We can look at history in this country in the last several decades and happily point to real progress in this fight. One of the causes of that good news, that improvement since the late 1960s when my wife Wendy's mom passed away from breast cancer, clearly one of the underlying reasons, clearly one of the leading causes is dramatic improvement in this prevention and screening, using mammography, also educating about self-examination.

So, again, I have this second-degree amendment. My hope and my goal would be that this language, which should be noncontroversial, would be accepted on it, as well as any Republican alternative, and that whatever happens in terms of those votes, we come together and make crystal-clear that this task force of unelected bureaucrats—didn't include a single

oncologist, by the way—made a big mistake and we are going to make sure those new recommendations don't have any impact in terms of law, in terms of government programs, in terms of legal impact on insurance companies.

Again, I look forward to working with everyone on the floor, including Senator MIKULSKI, including Senator MURKOWSKI and others to pass this language. It should be a no-brainer. It is mom and apple pie. Let's pass it and at least in this focused way come together and do the right thing in direct reaction to something that just happened 2 weeks ago.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I certainly appreciate Senator VITTER's empathy for victims of breast cancer, for people who obviously should be tested for breast cancer, in many cases more frequently than they are. I am sorry about Wendy's mother's death from breast cancer.

I think, though, that Senator VITTER missed the larger point. While most of us in this Chamber disagree with the finding of that Bush-appointed commission—committee, commission, task force—I think the bigger question is that a whole lot of the status quo which Senator VITTER has defended, sort of ad hominem, the bigger question is under the status quo so many women aren't getting tested for breast cancer. It is estimated that 4,000 breast cancer deaths could be prevented just by increasing the percentage of women who receive breast cancer screening.

That is why the Mikulski amendment is so important. It is important because in this country today, if you take a group of 1,000 women who have breast cancer and who have insurance, and 1,000 women who have breast cancer who don't have insurance, those who don't have insurance are 40 percent more likely to die. So the issue is that committee—I think that commission made a mistake. We pretty much, most of us here, think that commission made a mistake. I am not sure why those people whom President Bush put on the commission made the decision they did. It should have been oncologists sitting; Senator VITTER is right about that.

The larger point is that women without insurance don't get tested, and women without insurance are 40 percent more likely to die of breast cancer than those with insurance. At the same time, as the Presiding Officer knows, in the State of Maryland, women typically pay more for their insurance than men do on the average.

So if we are going to do this right, it means we need insurance reform, which is what this legislation does. No more preexisting conditions, no more men and women who have their insurance canceled because they got too sick last year and had too many expenses and the insurance companies practiced rescission and they cut them off. No more if I have insurance and if I have a child born with a preexisting condition do I lose my insurance.

I come to the floor pretty much every day reading letters from people in Ohio—from Galion and Girard and Gallipolis and Lima, all over my State. Typically, people were pretty happy with their insurance if they had written me a year ago, these people. But today these people writing found out their insurance doesn't cover what they thought it did. They end up losing their insurance because of a preexisting condition. They can't get insurance because they once had breast cancer. They have had this discrimination against them because of gender or geography or disability. That is what is important about the bill and what is important about the Mikulski amendment.

That is why I would hope Senator VITTER, as he is pushing for assistance for women with breast cancer—I applaud him for that—would go deeper than just dismissing the recommendations of one government commission and that, in fact, he would advocate for better testing, more frequent testing for women who are not getting tested often enough today, and that the rates for women would be comparable to the rates for men. That is, again, why the Mikulski amendment is so important.

I will repeat: The health reform legislation as is will finally put an end to discrimination, discrimination that charges women significantly higher premiums because they have had children.

It is considered a preexisting condition by some insurance companies if a woman had a C-section because she might get pregnant again and she is going to have another C-section and that costs more. A woman with a C-section has a preexisting condition. A woman who has been—in some cases, with some insurance companies' policies—victimized by domestic violence has a preexisting condition because the boyfriend, the husband or whoever hit her the one time, the insurance companies would suggest, is going to do it again. So she has a preexisting condition. What kind of health care system is that?

That is why I suggest Senator VITTER support the Mikulski amendment and support this legislation. In fact, it will put rules on insurance policies so people will be treated in a different way than they have been in the past.

Let me talk, for a moment, specifically about the Mikulski amendment and why it is so important. It will ensure that women are able to access needed preventive care and screenings at no additional cost. One of the things, in spite of the McCain amendment—and I appreciated Senator BAUCUS's comments a minute ago about how ironic it is. I was in the House of Representatives for 14 years and in the Senate now for the last 3 or so. I have heard so many colleagues eviscerate Medicare. They have tried to cut Medicare, privatize it, and come at it from all different directions repeatedly over these last 15 years. Now they want to tell us they are the ones who want to protect Medicare. In fact, this legislation saves money and saves lives, and this legislation saves Medicare.

One of the things this legislation does for Medicare beneficiaries is it will begin to provide these preventive care screenings so seniors will pay no copay. It is not cutting Medicare and services, as my friends on the other side say—all those who are opposed to every part of the bill, most of whom have tried to slow this legislation down. We cannot even vote on the McCain amendment. We are ready to do it, but the Republicans don't seem to want to move forward on this legislation.

Let me go back to why the Mikulski amendment makes so much sense. All health care plans would cover comprehensive women's preventive care and screenings, requiring that recommended services be covered at no cost to women. We know that to get preventive screenings and care—if we make them at no cost, the chances of people getting them are significantly higher. More than half of women delay or avoid preventive care because of the costs. One in five women at age 50 has not received a mammogram in the past 2 years.

That isn't because the Commission, appointed by the former President Bush, made this decision; it is not because of their bureaucratic decision that Senator VITTER rails about, and many of us agree with; it is not because 1 in 5 women age 50 has not received a mammogram; it is that they don't have insurance, in most cases, and they cannot afford the mammogram.

In 2009, some 40,000 women will lose their lives to breast cancer; 4,000 breast cancer deaths, one-tenth of those could have been prevented by increasing these preventive screenings. These kinds of mammograms, this preventive care, and these doctor visits will be covered for free for women.

This amendment would broaden the comprehensive set of women's health services that health insurance companies must cover and pay for.

For instance, it would ensure that women of all ages are able to receive annual mammograms, covered by their insurer. It would encourage coverage of pregnancy and postpartum depression screenings, Pap smears, screenings for domestic violence, and annual women's health screenings. It makes so much sense. It would save the lives of

women, and it means women would suffer from a lot less illnesses. It will save money for the health care system because these illnesses will be detected much earlier, and women will get the kind of care they should. That is what this whole legislation is about and what the Mikulski amendment will add to.

This amendment will remove any and all financial barriers to preventive care so we can diagnose diseases and illnesses early—when we have the best chance at being able to save lives, obviously.

Understand again, this legislation and the Mikulski amendment are supported by the National Organization for Women, the National Partnership of Women and Families, the American Cancer Society Cancer Action Network, and all kinds of women's organizations. They understand this is the best thing for women in this country.

I hope the Senate can proceed to a vote on this amendment. I hope my Republican colleagues will not just talk about the bad decision of this Commission—and most of us think it was a bad decision—but actually do something about it, something substantive, and give women in this country a fairer shake from health care insurance companies and cover these preventive services and cancer screenings. It will make a big difference if we can move forward and expand preventive health care services to women.

I yield the floor.

The PRESIDING OFFICER (Mr. MERKLEY). The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I wish to pick up where Senator BROWN left off. I will describe one of my real patients, but I will not use her real name. I will call her ''Sheila.'' Sheila was 32 years old. She came in with a breast mass. I examined it and thought it was a cyst. I sent her to get an ultrasound, which confirmed a cyst. OK. We did a mammogram to make sure. The mammogram said it looks like a cyst. The standard of care for somebody with a cyst is to watch it expectantly, unless it is painful, because 99 percent of them are benign cysts. I had the good fortune to do a needle drainage on her cyst 3 days after she had her mammogram. There were highly malignant cells within the cyst. She has since died.

The reason I wanted to tell the story about Sheila is because what the Senator from Ohio, in supporting the Mikulski amendment, doesn't recognize is, we don't allow the Preventive Services Task Force to set the rules and guidelines. We do something worse: We let the Secretary of HHS set the guidelines.

The people who ought to be setting the guidelines are not the government; they are the professional societies that know the literature, know the standards of care, know the best practices; and, in fact, the Mikulski amendment doesn't mandate mammograms for women. It leaves it to HRSA, the Health Resources Services Administration, which has no guidelines on it today whatsoever.

So what you are saying with the Mikulski amendment is, we want the government to, once again, decide—all of us are rejecting what the Preventive Services Task Force has said, but instead we are going to shift and pivot and say we will let the HRSA decide what your care should be.

The other aspect of the Mikulski amendment I fully agree with. I don't think there ought to be a copay on any preventive services. I agree 100 percent. But the last place we ought to be making decisions about care and process and procedure is in a government agency that, No. 1, is going to look at cost as much as at preventive effectiveness.

If the truth be known, the Preventive Services Task Force, from a cost standpoint—as a practicing physician, I know how to read what they put out—from a cost standpoint, it is exactly right. From a clinical standpoint, they are exactly wrong, because if you happen to be under 50 and didn't have a screening mammogram and your cancer was missed, to you, they are 100 percent wrong. You see, the government cannot practice medicine effectively. What we are trying to do in this bill throughout is have the government practice medicine, whether it is the comparative effectiveness panel or the Medicare Payment Advisory Commission.

What we have asked is for the government to make decisions.

Let me tell you what that is. That is the government standing between me and my patient. It is denying me the ability to use my knowledge, my training, my 25 years of well-earned gray hair, and combine that with family history, social history, psychological history, where it might be important, and clinical science, and me putting my hand on a patient such as I did Sheila. Most physicians would never have stuck a needle in that cyst, and she would not have lived the 12 years that she lived. She would have lived 1 or 2 years. But she got 12 years of life because clinical judgment wasn't deferred or denied by a government agency.

There is a wonderful member of the British Parliament who happens to be a physician. When we were debating the issue of the comparative effectiveness panel, which will be applied to whatever HRSA or the Secretary does, I asked him: What about the national institute of comparative effectiveness in England? Here is what he said: As a physician, it ruins my relationship with my patient because no longer is my patient 100 percent my concern. Now my patient is 80 percent my concern and the government is 20 percent of my concern. So what I do is I take my eye off my patient 20 percent of the time to make sure I am complying with what the national institute of comparative effectiveness says—even if it is not in my patient's best interest.

When we pass a bill that is going to subterfuge or undermine the advocacy of physicians for their patients, the wonderful health care we have in this country will decline. There are a lot of other things about the bill I don't agree with. But the No. 1 thing, as a practicing physician, that I disagree with is the very fact—the thing I am most opposed to as a practicing physician—I like best practices. I use Vanderbilt in my practice. I like them. They make me more efficient and make me a better doctor. But they are not mandated for me when I see something that in my judgment and in the art of medicine I get to go the other way because I know what is best for my patient.

What we have in this bill is what we passed with the stimulus bill, the comparative effectiveness panel—which is utilized in this bill—and we have the Medicare Payment Advisory Commission saying you have to cut. Where do we cut? Whose breast cancer screening do we cut next year? When we have the Commission saying we have to, unless we act affirmatively in another way, we are dividing the loyalty of every physician in this country away from their patients. They are no longer a 100-percent advocate for their patients. This is a government-centered bill. It is not a patient-centered bill.

Going back to the Mikulski amendment and what will come with the Murkowski amendment, the Murkowski amendment is far better. It does everything Mikulski does but doesn't divide the loyalty or advocacy of the physician. Here is what it does. The Murkowski amendment says nobody steps between you and your doctor—nobody, not an insurance company, not Medicare or Medicaid. We use as a reference the professional societies in this country who do know best, whether it be for mammograms and the American College of Surgeons, the American College of OB/GYNs, the American College of Oncology, the American Academy of Internal Medicine or the American College of Physicians, which have come to a consensus in terms of what best practices are but don't mandate what will or will not be paid for when, in fact, the art of medicine is applied to save somebody's life, such as Sheila's.

For you see, if this bill passed, Sheila would have lived 2 years instead of 12. Ten years was really important to her family. She got to see the children I delivered for her grow up. One of them she got to see married.

If we decide the government is going to practice medicine, which is what

this bill does—the government steps between the patient and their caregiver, deciding in Washington what we will do—what you will have is good outcomes 80 percent of the time and disasters 20 percent of the time. That is not what we want.

I do not deny that there are plenty of problems in my profession in terms of not being as good as we should be, of not having our eye on the ball some of the time, of making mistakes some of the time. I do not deny that. But what I do embrace is most people who go into the field of medicine go in for exactly the right reason; that is, to help people. It is so ironic to me that we have a bill before us that limits and discourages and takes away the most altruistic of all efforts, which is to do 100 percent the best right thing for your patient.

The reason having HRSA or the Secretary set guidelines is bad is because most patients do not fit the textbook. Here is what the textbook says, but this patient has this condition, this history, and this finding that are different. What we have done in this bill is, multiple times, take the learned judgment of caregivers and say: You will bow to what the Federal Government says; you will bow to what HRSA says; you will bow to what the Secretary of HHS says. Seventy-five times in this bill, there are new programs created; 6,950 times in this bill are requirements for the Secretary to set up new rules and regulations. If you do not think that will put the government between you and your care, you have no understanding of health care in this country and you have no understanding of the problems we face today because of Medicare and Medicaid rules that interrupt and limit the ability for us to care in the best way for our patients.

I am for the prevention aspects of the Mikulski amendment. I think it is a great idea. As a matter of fact, it should not be just about women. It should be about screening for prostate cancer for men as well. It should be about treadmills for people with high cholesterol. It should be about true preventive measures. Why were they not included? Because what we have done under the Mikulski amendment is $892 million over 10 years. We want to do this for one group but we will not do it for the other.

If you think the government will not get in between, let me give three examples right now which violate Federal law today. The Center for Medicare and Medicaid Services today violates Federal law. They ration the following three things:

If, in fact, you are elderly and you have a complication with your colon and you are a high-risk patient to have a perforation if you were to have a colonoscopy—that is when we go in with a fiber optic light to look at the colon—Medicare denies the ability for you to have a CT automated, camera-centered, swallowed-pill colonoscopy, which is available. The technology is proven and is being used outside of Medicare. You cannot have a video colonoscopy by way of a remote-control camera. Why did CMS eliminate that? They eliminated it because it costs too much. So if you are 87 years old and you have a mass in your colon and you cannot have a regular colonoscopy, you cannot even buy this procedure; it is against the law because Medicare forbids it.

No. 2—and this has happened to me numerous times—women with severe osteoporosis—a loss of calcium in their bones at 50 years of age—diagnosed with a DEXA scan in a screening prevention so they do not get a collapsed vertebra or break a hip, you put them on a medicine. The medicines are expensive, there is no question, but they really do work. Some medicines work for some people; other medicines work for others. Once you do a DEXA scan, under Medicare rules, you cannot do another one for 2 years. So you cannot check to see if the medicine is working after 6 months, to see if you see an improvement in the calcification of a woman's bones, because Medicare said it is too expensive and we are doing too many of them. Rather than go after the fraud in DEXA scans, what they did was ration the care.

Here we have a woman and you have diagnosed her properly. You have started her on the medicine, but you have to wait 2 years. What happens during that period of time if you are given a medicine that is not working effectively? Because it did not work in her case, you have to wait 2 years and her osteoporosis advances and she falls and breaks her hip because Medicare said we were doing too many of them?

Take what CMS did to all the oncologists in this country. They said we are paying too much money for EPOGEN. EPOGEN is an acronym for erythropoietin, which is a chemical that is kicked out by your kidneys to cause you to make red blood cells. When you get chemotherapy for breast cancer or colon cancer, like I have had, sometimes that chemotherapy not only kills your cancer but it kills your blood cells. Because we were using too much EPOGEN, Medicare put out a rule rationing EPOGEN and said: Unless you have a hemoglobin of X amount, you cannot get a shot of EPOGEN, and by the way, you cannot take your own money and buy it either. The doctor will get fined if he gives it to you if you don't meet the guideline. What happens? For 80 percent of the patients, it worked fine. But for those patients who have other comorbid—other conditions, such as congestive heart failure or chronic obstructive pulmonary disease—emphysema—where significant drops in hemoglobin can cause organ failures in other parts of the body, there was no exception made by CMS for a physician to make a judgment and say: This rule should not apply here because this patient is going to end up in the hospital.

My oncologist told me a story of one of his patients who could not get EPOGEN. It ended up that their heart failure was exacerbated because they got anemic from the chemotherapy, ended up on a ventilator in ICU, and died. Why did they die? Because they got heart failure. Why did they get heart failure? Because they got too anemic. Why did they get too anemic? Because Medicare would not allow the doctors to give them the medicine.

What is wrong with the bill, what is wrong with the Mikulski amendment is we rely on government bureaucracies to make the decisions about care rather than the trained, learned, experienced, truly caring caregivers in this country to make those decisions. Instead of going after the fraud in Medicare, which is well in excess of $90 billion a year, we decided we will ration care.

The authors of this bill are going to say: No, that is not true. But when I offered amendments in committee to prohibit rationing of Medicare services—to prohibit it—it was voted down. Every person who voted for moving on this bill voted against the rationing. Why would they do that? Because ultimately the feeling is: We know better. Washington knows better. We know your patients better. We know how to practice medicine better. We are going to take ivory tower doctors who do not have real practices anymore, we are going to take retired researchers, and we are going to tell you how to practice. And we are going to save money by limiting what you can get.

The chairman of the Finance Committee has said we do not truly cut Medicare Advantage, that the services are not reduced. The chairman's own bill, on page 869, subtitle C, part C—I won't go through reading it—reduces Medicare Advantage payments. The differential from $135 to—I will read it to the chairman. The chairman is shaking his head. Let me read it to him. Let me also reference what CBO has said. I will be happy to yield to the chairman if he wants to talk now.

Mr. BAUCUS. As soon as I get the page number, I guess I would like to ask the Senator from Oklahoma a question.

Mr. COBURN. I will be happy to yield for a question.

Mr. BAUCUS. What page?

Mr. COBURN. Page 869, subtitle C, part C.

Mr. BAUCUS. I don't have it with me right now, but there are no required reductions in fringes or extras—

Mr. COBURN. No required reductions in what?

Mr. BAUCUS. Fringes, such as gym memberships, and extras such as that.

The bill basically provides that there be no reductions in guaranteed Medicare payments. There is a long list of what guaranteed Medicare payments are.

Even the Medicare Advantage companies, which are private companies with officers and they have stockholders—they have to report to their board of directors, and they have all these administrative costs, very huge admin costs. The reductions to Medicare Advantage—the application of reductions to Medicare Advantage plans are at the discretion of the officers. The officers can decide they are not going to cut the fringes; that is, the fringes and the extras that are beyond, in addition to the guaranteed Medicare benefits.

If an officer wants to, it is his discretion, I am assuming—

Mr. COBURN. Reclaiming my time, I ask unanimous consent to have printed in the RECORD CBO 11/21/2009, which shows an average from $135 down to $51 per month on the average Medicare Advantage beneficiary.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ESTIMATED EFFECTS OF THE MEDICARE ADVANTAGE (MA) PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON ENROLLMENT IN MA PLANS AND ON FEDERAL SUBSIDIES FOR ENROLLEES IN MA PLANS OF BENEFITS NOT COVERED BY MEDICARE

Under Current Law

	Enrollment in MA Plans (millions)		Average Subsidy of Extra Benefits Not Covered by Medicare (dollars per month)	
	2009	2019	2009	2019
All Areas–	10.6–	13.9–	87–	135
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector–	4.7–	6.9–	120–	172
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector–	5.9–	7.0–	61–	98

Under the Patient Protection and Affordable Care Act

	Reduction in enrollment in MA plans, 2019		Net reduction in Medicare spending 2010–2019 Billions of dollars	Average subsidy of extra benefits not covered by Medicare, 2019 Dollars per month
	Percent	Millions		
All Areas–	−18–	−2.6–	105–	49
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector–	−29–	−2.0	[a] −62	51
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector–	−9–	−0.6–	−43–	47——

[a] The estimate of a $105 billion net reduction in Medicare spending over the 2010–2019 period reflects a $118 billion reduction in Medicare payments that would be offset, in part, by a $13 billion reduction in Part B premium receipts.

Note: Under current law, extra benefits include health care services net covered by Medicare, such as vision care and dental care, and subsidies of beneficiaries' out-of-pocket costs for Part B or Part D premiums or cost sharing for Medicare-covered benefits. Under the Patient Protection and Affordable Care Act, extra benefits would include health care services not covered by Medicare and subsidies of beneficiaries' out-of-pocket costs for cost sharing for Medicare-covered benefits.

Mr. COBURN. The fact is, if you like what you have, you cannot keep it, for 2.6 million Americans. You can say that is not true. That is what CBO says. Here are their numbers. They sent the report to the chairman.

Mr. BAUCUS. Will the Senator yield?

Mr. COBURN. I will be happy to yield.

Mr. BAUCUS. It is true—first of all, we need to back up. Isn't it true that the MedPAC commission came to the conclusion that the Medicare Advantage plans are overpaid?

Mr. COBURN. Absolutely. I agree with the chairman.

Mr. BAUCUS. It is also true that it is their recommendation that the Medicare plans overpaid by the amount of 14 percent.

Mr. COBURN. I don't know the actual amount. I agree with the chairman that they are overpaid.

Mr. BAUCUS. That is true. They are overpaid.

Mr. COBURN. Yes.

Mr. BAUCUS. If they are overpaid, doesn't that necessarily mean there are reductions in payments attributable to each beneficiary by definition?

Mr. COBURN. I disagree with that.

Mr. BAUCUS. If they are overpaid—

Mr. COBURN. Here is what I would say. This morning, the claim made by the chairman and Senator DODD is that Medicare Advantage is not Medicare. Medicare Advantage is Medicare law. It was signed into law. It is a part of Medicare. The chairman would agree with that?

Mr. BAUCUS. Absolutely. In 2003, I made the mistake and agreed to give the Medicare Advantage plans way more money than they deserved. And as the Senator from Oklahoma has said, they are overpaid.

Mr. COBURN. I agree with the chairman. You won't hear that from me. How did we get there? How did we get there? How did we get there, to where they are overpaid? We have an organization called the Center for Medicare and Medicaid Services. They are the ones who let the contract, are they not? They, in fact, are. Twenty-five percent of the overpayment has to be rebated to CMS today; the Senator would agree with that? Seventy-five percent for extra benefits, 25 percent rebate. How did we get to where they are overpaid? Because we have a government-centered organization that is incompetent in terms of how they accomplished the implementation of that bill.

What was said by Senator DODD this morning—and I confronted him already on it, but it bears repeating—is that the Patients' Choice Act eliminates the dollars without eliminating the services because it mandates competitive bidding with no elimination in services for Medicare Advantage. So if you want to save money, competitively bid rather than go through eight pages of reductions year by year in the payments that go back to Medicare Advantage.

We have this complicated formula that nobody who listens to this debate would understand. I know the chairman understands it because he helped write it. But the fact is 2.6 million Americans, according to CBO, will see a significant change in their Medicare benefits. Medicare Advantage is Medicare Part C. We have had a kind of a differential made that it isn't really Medicare. It is Medicare. And 20 percent of the people in this country who are on Medicare are on Medicare Part C—Medicare Advantage—and they like it. And why do they like it? Because most of them don't have enough money to buy a supplemental Medicare policy to cover the costs that are associated with deductibles and copays and outliers. So I agree with the chairman that Medicare Advantage is overpaid, but I disagree with the way you are going about getting there.

I also disagree with taking any of the money that is now being spent on Medicare Part C and creating another program. I think all that money ought to be put back into the longevity of Medicare.

In case you don't understand how impactful that is, we now owe, in the next 75 years—actually, we don't owe it, because none of the Senators sitting here will be around. Our kids are going to get to pay back $44 trillion in money for Medicare we will have spent, that we allowed to grow, in fraud, close to $100 billion a year and then did nothing about it. This bill does essentially nothing about that $100 billion a year, or $1 trillion every 10 years. If we were

to eliminate that—which this bill does not—we would markedly extend the life and lower the debt that is going to come to our children.

That leads me to the other important aspect of the health care debate. We know when you take out the funny accounting—the Enron accounting—in this bill, and you match up revenues with expenses, you are talking about a $2.5 trillion bill. The chairman of the Finance Committee readily admits he has it paid for, and CBO says you have it paid for. But how does he pay for it? He pays for it with the 2.6 million people who like what they have today and who are going to lose what they have today. He pays for it by raising Medicare taxes. Then the Medicare taxes he raises he doesn't spend on Medicare, he spends that on a new entitlement program. Think about what we are doing. Is there a better way to accomplish what we are doing?

I thank the chairman for indulging me and allowing me to continue this long. I will wind up with a couple of statements and then share the floor with him.

You know, after practicing medicine for 25 years, I know we have a lot of problems in health care, and I appreciate the efforts of the chairman of the Finance Committee to try to find a solution for them. It is not a bipartisan solution, but it is a solution. And it is a solution that grows the government. It puts the government in charge of health care and creates blind bureaucracies that step between you and your doctor. That is one way of doing it. But wouldn't a better way be to do the following: Let's incentivize people to do the right thing, rather than building bureaucracies and mandating how they will do it. Wouldn't it be better to incentivize tort reform in the States? Wouldn't it be better to incentivize physicians based on outcomes? Wouldn't it be better to incentivize good behavior by medical supply companies, DME, drug companies, hospitals, physicians, through accountable care organizations, through transparency for both quality and price?

We don't have any of that in here. What we have is a government-centered bureaucracy that, according to CBO figures, will add 25,000 Federal employees to implement this program—25,000. If you call the Federal Government, how long does it take you now to get an answer? Yet we are going to add 25,000 employees just in health care. That is an extrapolation of the amount of agencies, dividing what CBO says per agency and per cost they will come up with. Wouldn't it be better to fix the things that are broken, rather than to try to fix all of health care?

I heard one of my colleagues today say on the floor, and I think it is true, that people in America are upset with us, and I think rightly so. I apologize to the American people for my arrogance. I apologize to the American people for the arrogance of this bill; the thinking that we got it right; that we can fix it in Washington; that we don't have to listen to the people out there; that we don't have to listen to the people who are actually experiencing the consequences of what we are going to do. I apologize for the arrogance of saying we can create a $2.5 trillion program and that we know best. Well, you know what, we don't know what is best.

As Senator ALEXANDER has said so many times, what needs to happen is we need to start over. We need to protect the best of American medicine. And what is the best? Well, if you get sick anywhere in the world, this is the best place in the world to get sick, whether you have insurance or not. If you have heart disease or atherosclerotic disease, this is the best place in the world. It costs too much, there is no question, but it is the best place. If you have cancer, you are one-third more likely to live and be cured of that cancer living in this country than anywhere else in the world—for any cancer. It just costs too much.

This bill doesn't address the true causes of the cost. What are the true causes of the cost? Well, No. 1, we know Medicare and Medicaid underpay and so we get a cost shift that is $1,700 per year per family in this country. So you get to pay three taxes in this country on health care: You pay your regular income tax, which goes to pay for Medicaid, and it also now starting to pay for Medicare as well; you have to pay 1.45 percent, plus your employer gets to pay 1.45 percent of every dollar you earn for Medicare; and then your health insurance costs $1,700 more per year because Medicaid and Medicare don't compensate for the actual cost of the care because of the government-centered role that is played in terms of the mandates, the rules, and regulations.

We have a tort system in this country that costs upward of $200 billion in waste a year, which is 8 percent of the cost. Ninety percent of all cases are settled with no wrong found at all on the part of caregivers, and of the remaining 10 percent only 3 percent find anything wrong. Of 97 percent of all the cases, only 10 percent go to trial, and 73 percent of that 10 percent are found in favor of the providers. So we spend all this money practicing defensive medicine and there is not one thing in this bill to fix that problem. That is 8 percent.

Take your health care premium, or your percentage of your health care premium, and apply 8 percent, and that is going down the drain because I am ordering tests you don't need but I need to protect myself in case somebody tries to extort money from me with a lawsuit that I know is going to get thrown out, but I have to have it there to prove it. And then we have inefficiencies.

Ultimately, what we need to do is to protect what is good, incentivize the correct behavior in what is wrong, and go after the fraud in health care with a vengeance—put doctors in jail, hospital administrators in jail. Don't slap them with a fine and ban them from Medicare. Put them in jail. The people who are stealing our grandkids' money, up to $100 billion a year, need to go to jail. We play pay and chase. We pay everybody and then we try to figure out whether they deserve to get paid. Nobody else does that, but the government does, and that is who we are getting ready to put in charge of another $2.5 trillion worth of health care?

One of the reasons health care is in trouble in this country is that 61 percent of all the health care is run through the government today. Look at TRICARE for our military, look at VA care, look at Indian health care, at SCHIP and Medicaid. There is an estimate of $15 billion a year in fraud in New York City alone on Medicaid. That is one estimate, per year, in one city on Medicaid. And then Medicare. And we are going to say those are running so good that we ought to move another $2.5 trillion, or 15 percent of health care, to where we are at 76 percent of all health care is run by the government? I reject that out of hand until we can demonstrate we are good at what we do.

What we ought to be doing is turning it back. The private sector isn't the answer to everything. I agree with that. I can't stand 80 percent of the insurance bureaucrats I deal with. But at least I have a fighting chance, because they will call me back when I need to do something for a patient. I never get a call back from Medicare. They do not call me back. The State doesn't call me back on Medicaid when I need to do something. So I go on and do it and find somebody else to pay for it. That is the kind of system we have today.

Think about the mothers in this country in a Medicaid system where 40 percent of the primary care doctors in this country won't see their children. That is Medicaid. That is realistic Medicaid today in our country. So they have a sick kid, but they can't get in to a doctor, even though they have insurance. They have Medicaid, but they can't get in. Why can't they get in? Because only 1 in 50 doctors last year who graduated from medical school goes into primary care. We have created an abrupt shortage in primary care. And, No. 2, the payment is not enough to pay for the overhead to see the child. So you have a weepy woman who is worried about her sick kid, and care is delayed if you can't get in. It doesn't matter if you have Medicaid if you can't be seen. So what happens? She goes to the emergency room. What happens in the emergency room? We spend

three or four times as much as we should, because that is an emergency department. The doctor has no knowledge of the child or the mother. He doesn't want to get sued, so we have a 40-percent defensive medicine cost in the emergency room.

The answer is not more government health care. The answer is creating the incentives for people to do the right thing. The only way we get things under control in health care in this country and the only way we create access for people in this country is to decrease the cost of health care. This bill doesn't decrease the cost of health care. If we want to make sure we do what is best for American medicine while we fix what is wrong, we will do it one significant part at a time. I can't imagine dealing with thousands, tens of thousands of more bureaucrats in health care, and I can't imagine the impact it is going to have between me and my patients. It is going to severely impact them. Do I want everybody in this country to have available care? Yes; 15 percent of my practice was gratis, for people who had no care, who had no money. That is true with a lot of physicians out there in this country. It is true with a lot of labs. It is true with a lot of hospitals. It is true with a lot of the providers in this country. They are caring people.

We are going to tie them up. We are going to put regulations and ropes around them. We are going to mandate rules and regulations, and we, in our arrogant wisdom, are going to tell Americans how they are going to get their health care. I certainly hope not. But I am not thinking about me. I am thinking about our kids and our grandkids.

I will end with one last comment. Thomson-Reuters, in a study put out October 9 of this year—it is a very well-respected firm—their estimate of the $2.4 trillion that we spend on health care per year in this country is that between $600 and $850 billion of it is pure waste. Defensive medicine costs and malpractice is between $250 billion to $325 billion by their estimate. Not one thing in this bill to address that—not one thing.

Fraud, there is between $125 and $175 billion per year—insignificant in this bill, $2 billion to $3 billion.

Administrative inefficiency, 17 percent—between $100 and $150 billion wasted on paperwork in health care every year.

Provider errors—that is me—between $75 and $100 billion; that is either wrong diagnosis or failure to treat appropriately. It is the smallest of all.

What are we doing? We are going to tell the providers—the hospitals, the medical device companies, the drug companies, the doctors, the radiologists, the labs, the physical therapists—we are going to tell them how to do it. That is not where the problem is.

My hope is that the American people will come to their senses and say: Wait a minute. Slow down. Stop. Fix the important things. Fix the worst thing first, the next thing second, the next thing third, the next thing fourth. The unintended consequences of this bill are going to be unbelievable. Nobody is smart enough to figure all this out—nobody. Nobody on my staff, nobody on the Finance Committee, nobody in Majority Leader REID's office can predict all the unintended consequences that are going to come about because of this bill.

The chairman has been awfully patient, and I see my colleague here to offer an amendment. With that, I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Oregon is recognized.

Mr. MERKLEY. Mr. President, I rise today to share a few thoughts about our health care proposal and also to address the amendment of my good friend from Maryland, Senator MIKULSKI. We have heard the word ''arrogant'' echo in this Chamber. ''The bill before us is arrogant.''

I come to it with a somewhat different perspective. For 10 years, as a representative of a working class neighborhood back in Oregon, as a State legislator, I have heard a lot of stories from America's working families—from the working families in my House district back home, a lot of stories regarding health care. There is a lot of concern that they can't afford health care. There is a lot of concern that their children do not have appropriate coverage. There is a lot of concern that their health care is tied to their job, and if they lose their job they are going to lose their health care.

There is a huge amount of stress for America's families who understand if you have health care you have to worry about losing it, and if you don't have it you have to worry about getting sick. That is why we are here today in this Chamber debating health care, because so many of us have heard from our constituents, so many of us know from our personal experience what a dysfunctional, broken health care system we have in America.

Sometimes, listening to this conversation on the Senate floor, you would think this is a rather complicated debate. But the heart of this bill is not that complicated. The heart of this bill is that every single American should have access to affordable, quality health care, and that we can take a model that has worked very well for the Federal employees of our Nation, a model that encourages competition, a model that says let's create a marketplace where every individual, every small business that currently struggles to get health care and has to pay a huge premium for health care—enable them to join a health care pool that will negotiate a good deal on their behalf.

I think every American who has tried to get health care on their own, every small business that is paying a 15- to 20-percent premium because they don't have the clout of a large business, understands if they could join with other businesses, if they could join with other individuals, they would get a lot better deal.

Americans understand if there is a large pool of citizens who are seeking health insurance that insurers are going to be attracted to market their goods. We have seen that in the Federal employees system, where insurers come and compete. It turns the tables. It takes the power away from the insurance companies and it gives the power to the American citizen because now the citizen is in charge. Now the citizen gets to choose between health care providers instead of having to search for anyone from whom they can possibly get a policy.

I do not find that it is arrogant to try to create a system in which individuals and small businesses get health care that is more affordable. I don't find that a bill that says we are going to invest in prevention is arrogant, that is smart. I don't find a bill that says we are going to create incentives to do disease management arrogant, so someone suffering from diabetes has the disease managed rather than ending up with an expensive amputation of their foot. That is intelligent, that is not arrogant.

I don't find that having a bill that says every single American is going to find affordable health care, and if they are too poor to afford it we will provide a subsidy to assist them, to get everyone in the door, that is not arrogant. That is saying we are all in this together as citizens and that health care is a fundamental factor in the quality of life. It is a fundamental factor in the pursuit of happiness. It is not arrogant to find for fundamental access to health care.

I rise specifically to address the amendment offered by my good friend from Maryland, Senator MIKULSKI. The legislation we are considering has many parts that make health care more affordable and available, that expand access; many parts to hold insurance companies accountable. But a big part of health care reform also deals with helping people avoid illness or injury in the first place. That is what Senator MIKULSKI's amendment does and why it is so important that it be included in this package.

Preventive screening saves lives. That is a fact. Early detection saves lives. That is a fact. Too many women forgo both because of the cost.

I want to share a story from a physician in Oregon. The physician is Dr. Linda Harris. I am going to quote her

story in full. It is not that long. She says:

I work one day a week at our county's public health department. There I met Sue, a 31-year-old woman who came in with pelvic pain and bleeding. She proved to have extremely aggressive cervical cancer that was stage IV when I diagnosed it.

She continues:

When Sue was 18 she had a tubal ligation after she gave birth to her only child. As a single mom she did not have the financial resources to have more children. She concentrated on raising her daughter. Sue always worked, sometimes 2 jobs at once, but never the kind of job that offered health insurance. But because she had a tubal ligation she did not qualify for our State's family planning expansion project that provides free annual exams, Pap smears and contraceptive services to many of our clients.

The doctor continues:

Cervical cancer is an entirely preventable disease. Pap smears almost always find it in its preinvasive form, but Sue never came in for a Pap smear or an annual exam. Her lack of affordable access to basic health care proved fatal. When Sue died of cervical cancer her daughter was 13.

That is the completion of the story that the doctor shared. Sue should not be viewed as a statistic in a broken health care system. But, instead, we should take her story to heart, about the importance of preventive services. Sue is one of 44,000 Americans who die each year because they lack insurance, according to a recent Harvard Medical School study.

Let me repeat that statistic because I think it is hard to get your hands around—44,000 Americans die each year because they lack insurance. I don't think it is arrogant to say we should build a health care system that gives every single American access to affordable, quality care so that 44,000 of our mothers and fathers, our sons and brothers, our daughters, our wives, our sisters—so that 44,000 of them do not die each year because they lack insurance.

Senator MIKULSKI's amendment will help keep this tragedy from happening to our families. To put it plainly, it will save lives. It does this by allowing the Health Resources and Services Administration to develop evidence-based guidelines to help bridge critical gaps in coverage and access to affordable preventive health services—the same approach the bill takes to address gaps in preventive services for children. This will guarantee women access to the kinds of screenings and tests that can prevent illnesses or stop them early.

As the American Cancer Society Cancer Action Network notes:

Transforming our broken ''sick care'' system depends on an increased emphasis on detection and early prevention, enabling us to find diseases when they are easier to survive and less expensive to treat.

That last point is also important. Treating illnesses also saves money. With so much emphasis on the cost of health care, we should all agree that it is common sense to include reforms that lower health care costs for all Americans.

I was noticing that her amendment has a long list of organizations stating how important this is—the National Organization for Women, the National Partnership for Women and Families, the Religious Coalition for Reproductive Choice, the American Cancer Society-Cancer Action Network, the National Family Planning and Reproductive Health Association.

I applaud Senator MIKULSKI for offering this amendment. I urge my colleagues to remember the 44,000 Americans who die every year because they do not have access to insurance, because they do not have access to preventive services, and vote to include this important reform.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. Mr. President, I ask unanimous consent I be permitted to engage in colloquy with my Republican colleagues on an amendment I will be discussing.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. MURKOWSKI. Mr. President, there has been a great deal of discussion this week certainly, and last week, with the announcement from the U.S. Preventive Services Task Force, the USPSTF, of their recommendations as they relate to mammograms and recommendation that women under the age of 50 do not need to be screened until they reach age 50, and then on attaining the age 50, every other year after that.

When these recommendations came out on November 16, it is fair to say they generated a level of controversy, a level of discussion and a level of confusion around the country by women from all walks of life. For many years now, women have operated under what we knew to be the standards, the protocols. If you had a history of breast cancer in your family, you took certain steps earlier, but the general recommendation was out there. Certainly, the guidelines we had been following, the assurances we were seeking as women were that we would be encouraged to engage in these screenings on an annual basis. They gave us all a level of confidence. When these new recommendations, these new guidelines came out just a couple weeks ago, I do think the level of confusion, the level of anxiety that was raised because of this announcement brought a focus to some of what we are talking about when we discuss health care reforms and should the government be involved in our health care.

I know I have received e-mails from friends, from relatives, girlfriends I haven't heard from in a while, talking with women, generally, about what do they think about this. I would hear story after story of the woman who discovered, at age 39, a lump, something that was off, something that was not right, and then the stories subsequent to that, the steps she took as an individual with her doctor. Again, the announcement that we now have these guidelines that this preventative screening task force has put in place and everything we thought we knew and understood about what we should be doing with our health has been unsettled brings us to the discussion today.

We have an amendment offered by the Senator from Maryland. I would like to offer a little bit later an amendment, but I would like to speak to the amendment now, if I may. I am proposing this as a side-by-side to the Mikulski amendment. This is designed to allow for an openness, a transparency on preventative services, not just mammograms. I don't want to limit it to only mammograms, because we know that preventive services in so many other aspects of our health are also equally key and also equally important. What I am looking to do with my amendment is to rely on the expertise, not of a government-appointed task force but to rely on the expertise of medical organizations and the experts, whether they are within the college of OB/GYNs or surgeons or oncologists, rely on them and their expertise to determine what services, what preventive services should be covered.

What we are seeking to do is allow for a level of information so an individual can select insurance coverage based on recommendations by these major professional medical organizations on preventative health services, whether it is mammography or for cervical cancer screening.

I think we learned from the announcement from the USPSTF, the Preventive Services Task Force, that when we have government engaging in the decisions as to our health care and what role they actually play, there is a great deal of concern and consternation. I have heard from many colleagues on both sides of the aisle: That task force was wrong. We think they have made a mistake in their recommendations.

What we are intending to do with this amendment is keep the government out of health care decision-making and allow the spotlight to be shown on the level of prevention coverage that patients will get under their health care plan, rather than relying on unelected individuals, basically individuals who are appointed by an administration to serve as part of this panel of 16, on the Preventive Services Task Force. My amendment specifies that all health plans must consult the recommendations and the guidelines of the professional medical organizations

in determining what prevention benefits should be covered by all health insurance plans.

I know at least those of us who are on the Federal employees health benefits have an opportunity to subscribe to the Blue Cross/Blue Shield plan. This is their booklet that is out for 2010. This is under their standard basic option plan. Turn to preventive care for adults that is covered. They provide, under this particular plan, for cancer diagnostic tests and screening procedures for colorectal cancer tests, for prostate cancer, cervical cancer, mammograms, ultrasound, abdominal aneurysm. There is a list we can look to.

What we don't see laid out in this booklet or any of the other pamphlets that outline given plans out there is, OK, for instance, the breast cancer test, is there an age restriction. I am told under Blue Cross there is not. But it doesn't indicate that there. What do the experts recommend? It is not clear from what we receive. So what my amendment would do, in part, is to allow for this information to be directly made available to patients, to individuals who are looking at the plans, to make a determination as to what they will select.

If you go to the Web sites of these professional medical organizations, for instance, the American Congress of Obstetricians and Gynecologists, they recommend that cervical cancer screening should begin at age 21 years, regardless of sexual history. Cervical cytology screening is recommended every 2 years for women between the ages of 21 and 29. The American Society of Clinical Oncology, as to the recommendations for mammography, urges all women beginning at age 40 to speak with their doctors about mammography, to understand the benefits and potential risks. By age 50, at the latest, they should be receiving mammograms. The American College of Surgeons, in their recommendations, recommend that women get a mammogram every year starting at age 40.

As an individual who is looking to make a determination as to what the experts are saying out there, what is being recommended, I would like to know that this information is made available to me to help me make these decisions. What our amendment would require is the plans would be required to provide this information directly to the individuals through the publications they produce on an annual basis. What we are talking about now is the doctors. It is the specialists who will be recommending what preventative services to cover, not those of us here in Washington, DC, in Congress, not the Secretary of Health and Social Services, who may or may not be a doctor or a medical professional, not a task force that has been appointed by an administration. We are trying to take the politics out of this and put it on the backs of the medical professionals who know and understand this. This is where I think we want to be putting the emphasis. This is where we want to be relying on the professionals, not the political folks.

Additionally, my amendment ensures that the Secretary of Health and Human Services shall not use any recommendations made by the U.S. Preventive Services Task Force to deny coverage of any items or services. This is the crux of so much of what we are discussing right now with these latest recommendations that came out by USPSTF. The big concern by both Republicans and Democrats and everyone is the insurance companies are going to be using these recommendations now to deny coverage to women under 50 or to a woman who is over 50, if she wants to have a mammogram every year; that she would only be allowed coverage for those mammograms every other year rather than on an annual basis. We want to take that away from the auspices, if you will, of the government. To suggest that we will deny coverage based on the recommendations of this government task force is not something I think most of us in this country are comfortable with.

We specify very clearly that the Secretary cannot use any recommendations from the USPSTF to deny coverage of any items or services. We also include in the amendment broad protections to prevent, again, the bureaucrats, the government folks at the Department of Health and Human Services, from denying care to patients based on the use of comparative effectiveness research.

Finally, we include a provision that ensures that the Secretary of Health and Human Services may not define or classify abortion or abortion services as preventative care or as preventative services.

This amendment is relatively straightforward. It relies, essentially, on the recommendation of practicing doctors, as opposed to the bureaucrats, to the politicians, to those in office. My amendment addresses the concern that the government will make coverage determinations for your health care decisions. What we are doing here, quite simply, is making it transparent, making clear that the preventive services recommended by the professional medical organizations are visible, are transparent. We require the insurance companies to disclose that information that is recommended and, again, recommended by the professionals.

This is a good compromise. It basically keeps the government out, and it keeps the doctors in. It requires the insurance companies to disclose the information to potential enrollees and allows for, again, a transparency that, to this point in time, has been lacking.

It has been suggested by at least one other Member on the floor earlier that my amendment would cost somewhere in the range of $30 billion. I would like to note for the record, we have not yet received a score on this. We fully believe it will be much less than has been suggested. When the statement was made, it was not with a full view of the amendment we have before us and is not consistent with that. I did wish to acknowledge that as we begin the discussion on my amendment.

Mr. ENZI. Mr. President, first, I wish to thank the Senator from Alaska for the tremendous work she has done on this issue and for the dozens of people she has talked to over the last couple days to try to come up with an amendment that would actually solve the problem everybody has been talking about.

I appreciate the Senator from Maryland recognizing this major flaw in the bill, and it is in the bill. The U.S. Preventive Services Task Force is in the bill. That is exactly the group that specified this new policy on mammograms that has upset people all across the country. It upset everybody so much that we have an amendment on the floor by the Senator from Maryland reacting to that and reacting to the fact that it is in the bill at the current time.

So I appreciate the Senator from Alaska coming up with a plan that actually is more comprehensive than the amendment from the Senator from Maryland because the Senator has had a little bit longer to work on it. I appreciate the words the Senator has in there that "you cannot deny." The Senator is on the Health, Education, Labor, and Pensions Committee with me, and I know we have worked on this issue in committee. I hoped this kind of a realization would have been made at that time. We had some amendments where you could not deny based on this or the comparative effectiveness or could not prohibit based on it. We know all those amendments failed, meaning there was probably some intention to deny or to prohibit based on these groups.

So I appreciate the Senator bringing up the fact that it is the caregivers who will have some say in this so Washington cannot come between you and your doctor. I wish the Senator would go into a little bit of some of her background from Alaska because the Senator and Alaska have been very involved in breast cancer for a long time, and people ought to be aware of the kind of services that are available out there and what the costs of those services are.

Ms. MURKOWSKI. I appreciate the question from my colleague from Wyoming. The Senator knows, coming from a rural State, that our health care costs are typically higher, and it is not just an issue of cost, but it is an issue of access, and particularly in my State, where most of our communities are not

connected by roads, it is very difficult to gain access to a provider. It is even more difficult to gain access, for instance, to mammography units.

I have been involved in this issue, in terms of women's health and cancer screening, for many decades now, primarily because my mother got started in it back when I was still in high school and saw a need to provide for breast cancer screening for women in rural areas, where they could not afford to fly into town, as we would call it, for the screenings. So she engaged in an effort—and continues to this day—to raise money for not only mobile mammography units but to figure out how we move those units from village to village.

Essentially, what they have been able to do, over the years, is you put that mobile mammography unit on the back of a barge and you take it up and down the river and you stop in every village and offer free screenings for women. You fly it into a village, where you are not on a river. We have been making this effort, again, for decades, working, chipping away slowly at the issue of breast cancer. We recognize it in our State. Particularly with our Alaska Native populations, we see higher levels of breast cancer than we would like. We are trying to reduce that.

But when these recommendations came out several weeks ago from the USPSTF, I will tell you, there was a buzz around my State amongst women about: Well, now what do I do? Where do I go? Do I need to go in for my screening? What should I do?

There is an article that was actually in the news just, I guess, a couple weeks ago, and it cites a comment from a doctor. Her comment was, the new recommendations were confusing patients who usually come in for their annual screenings. She said: My schedulers have called to schedule patients to come in for their followup mammogram, and they have been told: Well, I don't have to do that now. This government group says I don't have to do that.

Mr. President and my colleague from Wyoming, maybe some do not. But what about those who are at risk? These are the ones whom I think we are continuing to hear from who say: Please, add some clarity to this.

Mr. ENZI. Mr. President, I know there is not any word that probably turns a family upside down as much as the word ''cancer,'' and it does not matter which form of cancer it is. It is just drastic because we do not know all the implications of it. Maybe someday we will. Maybe someday we will know how people get it, and we will be able to cure it with a vaccine. But, so far, what we have are some mechanisms for putting it into remission.

One of the reasons I know how upsetting that is and how it turns the world upside down is, 3½, 3¾ years ago my wife was diagnosed with colon cancer. She had screenings, but she listened to her body. She said: Something is the matter here. She kept going to doctors. So even if they do not recommend the screenings, if your body is saying something is the matter, pursue it until you are either convinced nothing is the matter or a doctor finds what is the matter. That is the advice she gives to everybody. These are things that need to be between the patient and the doctor.

Now that she is in remission, one of the things the doctor recommended was that she take Celebrex. That is something normally for arthritic pain, but what they found was in some patients that will keep polyps from growing that will turn into cancer in the colon, and we definitely do not want that to recur again. So she is taking that. But it is a constant fight with making sure that is an approved medication and that it can be done and that it will be paid for.

If that were just a task force recommendation—first of all, since she had the screening, they would say she does not have a problem and, later, she would die from it. But she was able to listen to her body, get the treatment she needed, and now is continuing to get the treatment without a task force saying: No, 99 percent of the people do not need that. Her doctor and she are able to determine what she needs.

On other screenings, once you have cancer, there are other times you need to have MRIs, other kinds of tests run. That, again, has to be up to the doctor and the patient to determine how often those are needed. Again, I know from talking to a number of people whom I know—not just ladies either—who have had cancer, once you have had cancer and you are in remission, you would actually prefer to have your screening a little bit earlier for the mental reassurance you get with it.

Again, from talking to people—and we have talked to more now because we are trying to give some reassurances to them when this terrible word comes up—when they go to the doctor, one of the first things that happens is they weigh in, they take your blood pressure. When you are waiting for a decision on how the blood test you got turned out or the MRI you got turned out or whatever it was, that blood pressure goes through the roof. Quite frequently, you cannot leave the doctor's office until you have—you went there for the information, so, of course, you stay for the information, but they will not let you leave until they do the blood pressure test again, to make sure it goes down below the critical stage. That is how much impact this has on people.

So I am glad the Senator did something that goes a little bit further, covers a few more things, and makes sure people have access to their doctor, to the tests they need, and not to be relying on some government bureaucracy to say: Well, in 99 percent of the cases or 85 percent of the cases—who knows how far down they will take it, depending on what the costs are. We do not want that to happen.

I think the Senator's amendment allows patients to get these preventive benefits and stops government bureaucrats and outside experts from ever blocking patients' access to those types of services.

I appreciate the Senator from Maryland who put up an amendment. I do not think it meets that standard. They still rely on government experts called the U.S. Preventive Services Task Force to decide what preventive benefits should be covered under private health insurance. This is the same Preventive Services Task Force that made this decision that women under the age of 50 should not receive annual mammograms.

In fact, I think I even remember in there that they were not necessarily recommending self-examination. Most people I know who are very young discovered it with self-examination. I certainly would not want them to quit doing that because there is a recommendation from somebody who does not understand them or their body.

Patients do want to receive preventive screenings. Sometimes they are a little reluctant to do it because nobody wants the possibility of hearing that word given to them.

Americans should be able to get screened for high blood pressure and diabetes when a doctor recommends they get these tests. I think the Senator and I agree they should be able to get colonoscopies, prostate exams, and mammograms, so they can prevent deadly cancers from progressing to the point where they are no longer curable. Many of these diseases are preventable or curable or can be put into remission if they are discovered early enough.

I think we agree with Senator MIKULSKI's goal that all Americans should be able to get preventive benefits, but we disagree that her amendment achieves that stated goal. Her amendment does not ensure access to mammograms for women who are under the age of 50. Part of that I am taking from an Associated Press article.

As most Americans know, last month the U.S. Preventive Services Task Force revised the recommendations for screening for breast cancer, advising women between the ages of 40 and 49 against receiving routine mammograms and women ages 50 and over to receive a mammogram just once every 2 years. The U.S. Preventive Services Task Force lowered its grade for these screenings to a C.

That sparked the political firestorm, as many women became confused about what services they could get and when

they could get them. The health care bills before Congress further confused the issue because they rely heavily on the recommendations of the task force. That is what is in the bill. The underlying Reid bill says—and the Mikulski amendment restates—that all health plans must cover preventive services that receive an A or B grade from the task force. Let's see, we just said that was a C grade.

Because breast cancer screenings for women under the age of 50 are no longer classified by the task force as an A or B, plans would not have to cover those services. So Senator MIKULSKI drafted an amendment to try to fix this problem, but I think it confuses the matter some more.

I say to the Senator, I appreciate the effort you have gone to, to try to clarify that and expand it to some other areas—and to not add another layer of bureaucracy—by saying that all services and screenings must be covered by health plans.

However, the previous amendment does not have any guidelines that are specifically for women or prevention.

Ms. MURKOWSKI. If I may comment on the Senator's last statement, this is very important for people to understand. There has been much said about the Mikulski amendment and what it does or does not do. But it is very important for women to understand the Mikulski amendment will not provide for those mammograms for women who are younger than age 50. Her amendment specifically provides that it is ''evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force.''

So you go to the task force report, and as the Senator has noted, women who fall between the ages of 40 and 49 receive a grade of a C, and the recommendation is, specifically: Do not screen routinely. Individualized decision to begin biannual screening, according to the patient's context and values. But they have received a C designation by USPSTF.

According to the Mikulski amendment, those women who are younger than 50 years of age will not be eligible or will not be covered under the mandatory screening requirement she has set forth in her amendment.

I think where she was trying to go was to ensure that these recommendations would not be used to deny coverage. She adds a paragraph stating that nothing shall preclude health plans from covering additional services recommended by the task force that are either not an A or a B recommendation. But the amendment does not require plans to cover services that are not an A or a B. In other words, if you are 45 years of age, you are in this C category, and the amendment does not require, then, that your preventive screening services be covered. So for those women who are in this age group—Congresswoman DEBBIE WASSERMAN SCHULTZ just went through a recent bout of cancer, and I think that was diagnosed at age 41. For those women who fall into this category, this amendment the Senator from Maryland has introduced does not address the concerns that have been raised by these recommendations coming out of this preventive task force. Again, I think we need to understand that what this amendment specifically allows for is first-dollar coverage for immunizations for children, children's health services as outlined with the HRSA—Human Resources Services Administration—guideline. But, in fact, the requirement to provide for screening coverage for women who are not in this A or B category—in other words, anybody younger than 50—we need to understand is not covered through this.

Our amendment, through allowing for a level of transparency, ensures that when you go to obtain your insurance, you can see very clearly what the professional medical organizations recommended are the guidelines and then what your insurer is proposing to offer you for your coverage. If it is not coverage you like, then shop around. This is what this insurance exchange is supposed to be all about.

Mr. ENZI. Mr. President, I congratulate the Senator from Alaska also.

Isn't it true that the Senator's amendment ensures that the Secretary of Health and Human Services won't be able to deny any of these services based on any recommendation? That is one of the things we have been concerned about. Again, that is an unelected bureaucrat who could come between you and your doctor and your health care. I know the Senator has covered that in her amendment, too, and I do appreciate it.

Ms. MURKOWSKI. It states very clearly on the second page that the Secretary shall not use any recommendation made by the U.S. Preventive Services Task Force to deny coverage and items serviced by a group health plan or a health insurance issuer. So, yes, we make it very clear that these recommendations from the USPSTF cannot be used to deny coverage.

I think the opportunity to have medical professionals, as this USPSTF is comprised of—we should have an entity that is kind of looking out and seeing what best practices are. But then that entity should not be the one that causes a determination as to whether coverage is going to be offered. You can use that as a resource, most certainly, just as we use as a resource the recommendation from, say, for instance, the American Congress of Obstetricians and Gynecologists, the American College of Surgeons, the American Society of Clinical Oncology, but it is not going to be the determining factor. I think that is where we need to make that separation, where my amendment separates from Senator MIKULSKI's.

Mr. ENZI. Mr. President, I also appreciate that the Senator from Alaska makes sure they can't deny care based on comparative effectiveness research, which actually was part of the stimulus bill that was run through at that point in time, and finally that the Senator's amendment includes a commonsense provision that would prohibit the Secretary from ever determining that abortion is a preventive service.

So I hope all of my colleagues, whether they are pro-life or pro-choice, would support this change to ensure that the controversial issues don't sidetrack the debate on the preventive issues because what we are talking about is the preventive issues, and I appreciate the Senator covering that.

Ms. MURKOWSKI. I am glad the Senator mentioned the issue of the abortion services. I think there is a vagueness in the amendment Senator MIKULSKI has offered. Some have suggested that it would allow those in the Human Resources Services Administration, HRSA, to define abortions as a preventive test, which could provide that health insurance plans then be mandated to cover it. That has generated some concern, obviously. Some have opposed the amendment, saying that if Congress were to grant any executive branch entity sweeping authority to define services that private plans must then cover, merely by declaring a given service to constitute preventive care, then that authority could be employed in the future to require all health plans to cover abortions.

So all we are doing with my amendment is just making very clear there are no vagaries, there is no second-guessing. It just makes very clear that the Secretary cannot make that determination that preventive services are to include abortion services.

Mr. ENZI. Mr. President, as I said before, my wife says that she had probably never mentioned the word ''colon'' twice in her whole life, and since then she has become an encyclopedia for people who have a very similar problem. She had a colonoscopy a short time before. She was still having problems, and they had said there is no problem, but she kept getting it checked until she found that there was a problem. So people need to listen to their bodies, and they need to listen to their doctors, and they shouldn't have a bureaucrat coming in between that. So I thank the Senator.

Ms. MURKOWSKI. I thank the Senator for the dialog here today. I think this is an important part of our discussion as we debate health care reform on the floor. We have had good conversations already yesterday and today about the cuts to Medicare, the impact we will feel as a nation if these substantive cuts advance. But I think this

discussion—and we are narrowing it so much on what the recommendations have been from this task force, but I think it is a good preview of what the American people can expect if we move in the direction of government-run health care, of bureaucrats, whether it is the Secretary of Health and Human Services or whether it is task forces that have been appointed by those in the administration, who are then able to make that determination as to what is best for you and your health care and your family's health care.

I think the discussion we have had today about ensuring that it is not best left to these entities, these appointed entities to make these determinations, but let's leave it to—or let's allow the information to come to us from the medical professionals. Senator COBURN has spoken so eloquently on the floor about relying on those who really know and understand, who live this and who practice this, rather than us as politicians who want to be doctors. I don't want to be a doctor. I want to be able to rely on the good judgment of a provider I trust, and I want him or her to be able to make those decisions based on their understanding of me and my health care needs and what is best for me and what the best practices are that are out there, rather than having a task force telling them: That is the protocol for Lisa. She is 52. She is able to get a mammogram every other year now. I want to know that it is me and my doctor who are making these decisions.

I hope Members will take a look at the amendment I will offer and consider how it allows for truly that kind of openness, that kind of transparency, and gives individuals the freedom of choice in their health care that I think we all want.

With that, I thank my colleague from Wyoming, and I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Senator WHITEHOUSE, Senator STABENOW, Senator DODD, and I be allowed to engage in a colloquy.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. I thank the Presiding Officer. I am delighted to be on the floor, along with the distinguished chairman of the Finance Committee and the distinguished Senator from Michigan, who has worked so hard on these issues.

I am sure I am not going to be the only person to say this, but I would like to respond briefly to the colloquy that just took place between the Senator from Wyoming and the Senator from Alaska because, as I understand it, the Mikulski amendment provides for preventive services that are in the A and B category as a floor, not a ceiling, at a minimum, and it instructs the Health Resources and Services Administration to provide recommendations and guidelines for comprehensive women's preventive care and screenings. Once that is done, then all plans would be required to be totally apart from the A or the B.

In terms of the Health Resources and Services Administration being an entity that wants to get between you and your doctor, these are actually scientists, not bureaucrats. It is an independent panel.

I think it comes with some irony to hear the concern expressed on the other side of the aisle repeatedly about bureaucrats coming between Americans and their doctors and telling them what care they can and cannot have when my experience in Rhode Island leading up to this debate, the Presiding Officer's experience in Illinois leading up to this debate, Senator STABENOW's experience in Michigan leading up to this debate—all of our experience in our home States leading up to this debate—has been that the problem has been that the private for-profit insurance industry is out there denying care every chance it gets.

I think the distinguished Senator from Illinois was presiding when I told the story of a family member of mine who died recently who was diagnosed with a very serious condition. He went to the National Institutes of Health to get the best possible treatment. He got the best specialist on his particular diagnosis in the country, and when he took that back to New York, his insurance company said: I am sorry, that is not the indicated care. That is just one experience I have had. Hundreds of Rhode Islanders have been in touch with me about their nightmare stories over and over again, whether it is because you have a preexisting condition and they won't insure you; or once you get diagnosed, they won't authorize your doctor to proceed with the care you need; or even if you go ahead and get the care, they will do everything they can to avoid paying the doctor and create every kind of administrative, bureaucratic headache for the doctor. The private insurance industry is standing between you and the care you need.

I have not once—not once since I have been here—heard anybody on the other side of the aisle express any concern about the bureaucrat between you and your doctor as long as it is an insurance company bureaucrat. It seems to me they actually approve of bureaucrats getting between you and your doctor as long as it is a bureaucrat who is an insurance company bureaucrat who has a profit motive to deny you health care. Then it is OK. Then they don't complain. But when it is independent scientists working hard to generate the best science that can be done so that people get the best information to make decisions, then suddenly we hear about bureaucrats.

I think the people listening to this should have that history in mind as they evaluate this claim that we are trying to put bureaucrats between Americans and their doctors. By stripping the abuses away from the insurance company, this bill does more to relieve that problem than any other piece of legislation I can think of.

I yield to the distinguished Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. I thank my colleague from Rhode Island because I couldn't agree more with what he just said in terms of who is standing between, in this case, a woman and her doctor or any patient and their doctor.

Right now, I assume the Senator would agree with me that the first person, unfortunately, the doctor may have to call is the insurance company to see whether he can treat somebody, to see what it is going to cost, is it covered. Right now, we know that half the women in this country, in fact, postpone, delay getting the preventive care they need because they can't afford it. So the amendment from the distinguished Senator from Maryland is all about making sure women can get the preventive care we need, whether it is the mammogram, whether it is the cervical cancer screenings, whether it is focused on pregnancy.

Would the Senator from Rhode Island agree that right now in the marketplace, I understand that about 60 percent of the insurance companies in the individual market don't cover maternity care?

They don't cover prenatal care. They don't cover maternity care, labor and delivery, and health care through the first year of a child's life. That is standing between a woman, her child, and her doctor. That is the ultimate standing between a woman and her doctor, since they were not going to cover that.

I think one of the most important things we are doing in this legislation is to have as basic coverage—something as basic as maternity care. When we are 29th in the world in the number of babies that make it through the first year of life, that live through the first year of life, that is something we should all be extremely outraged about, concerned about.

This legislation is about expanding health care coverage, preventive care, making sure babies and moms can get prenatal care, that babies have every chance in the world to make it through the first year of life because we have adequate care there. Yet the ultimate standing between a woman and her doctor is the insurance company saying: We don't think maternity coverage is basic care.

Mr. WHITEHOUSE. If the Senator will yield.

Ms. STABENOW. Yes.

Mr. WHITEHOUSE. That is the business model of the private health insurance industry now. They want to cherry-pick out anybody who might be sick, and that is why we have the preexisting condition exclusion.

Then they have an absolute army of insurance company officials whose job it is to deny care. I went to the Cranston, RI, community health center a few months ago. It is a small community health center providing health care in the Cranston, RI, area. It doesn't have a great big budget. I asked them how difficult it is to deal with the insurance companies in order to get approval and get claims paid. They said: Well, Senator, 50 percent of our personnel are engaged not in providing health care but in fighting with the insurance industry to get permission for care and to get claims paid.

Ms. STABENOW. Will the Senator repeat that to me? That is astounding. He said 50 percent?

Mr. WHITEHOUSE. Yes. Half of the staff of the community health center was dedicated to fighting with the insurance industry, and the other half was actually providing the health care.

In addition, they had to have a contract for experts, consultants, to help fight against the insurance industry. That was another $200,000—$200,000 for a little community health center, plus half of their staff.

What we have seen in the past 8 years is that the administrative expense of the insurance industry has doubled. That is what they are doing. It is like an arms race. They put on more people to try to prevent you from getting care because it saves them money when they do. They have a profit motive to deny people.

In the case of a member of my family whom they tried to deny, he had the fortitude to fight back and eventually they caved. But for every person like him who fights and gets the coverage they paid for and are entitled to, some will be too ill, too frightened, too old, too weak, too confused, or some simply don't have the resources, when they are burdened with a terrible diagnosis like that, to fight on two fronts. So they give up and the insurance company makes money.

It is systematized. Not once have I heard anybody on the other side of the aisle in the Senate complain about that. It is a scandal across this country. It is the way they do business. I don't think there is a person on the Senate floor who hasn't heard a story of a friend or a loved one or somebody they know and care about who has been through that process. It is not hypothetical. It is happening now, and it is happening to all of us. But it is only when we come in and try to fight that suddenly this concern is raised, this "oh my gosh, you are going to get bureaucrats." But they happen to have no profit motive. They will work for the government and will be trying to do the right thing and be experts. But suddenly it is no good.

Ms. STABENOW. As the Senator has said eloquently, we have all had situations like this happen in our families. Everybody listening and everybody involved in the Senate family has certainly had that happen to us. I have found it very interesting; every Tuesday morning we invite people from Michigan who are in town, to come by and we do something called "Good Morning, Michigan."

Not long ago, a woman came in and said:

> I'm finally excited. I am 65 and now I can choose my own doctor because I am going to be on Medicare.

Medicare is a single-payer, government-run health care system. I could not get my mother's Medicare card away from her if I had to wrestle her to the ground because, in fact, it has worked. It is focused on providing health care. That is their mission.

One of the things I think is indicative of the whole for-profit health care system—by the way, we are the only ones in the world who have a for-profit health care system—is when they talk as an industry, they talk about the "medical loss ratio." The medical loss ratio is how much they have to pay out on your health care. So the language of the insurance industry—now, it is different if there is a car accident or if your home is on fire. We understand you don't want to pay out for a car accident or for a home fire. But in this case, we have an institution set up, through which most of us—we have over 82 percent of us in the private for-profit insurance market through our employers. We are in a system where the provider, the insurance company, calls it a "medical loss" if they have to pay out on your insurance. I think that alone is something that, to me, sends a very big red flag, if they are trying to keep their medical loss ratio down.

We have in this legislation been doing things to keep that up. We want them to be paying out for most of the dollars paid on a premium in health care so the people are getting the health care they are paying for. That is what this legislation is all about. But as my friend from Rhode Island has indicated, point by point, when we look at every amendment in the Finance Committee—I would say virtually every amendment from our colleagues on the Republican side—and when we look at the amendments so far on the floor of the Senate, the first two being offered are about protecting the for-profit insurance companies, making sure excessive payments that are currently going out for for-profit companies under Medicare continue; making sure we are protecting the industry's ability—not the doctor's ability to decide what care you need, when you need it, and so on, but the insurance company's ability to decide what they will pay for, what is covered, when you will get it—and, by the way, if you get too sick, they will find a technicality and they will drop you.

All of those things we are addressing are to protect patients, protect taxpayers, consumers, in this legislation. Would the Senator not agree?

Mr. WHITEHOUSE. I do.

Ms. STABENOW. The sign behind the Senator is right. It is about saving lives, money, and Medicare.

Mr. WHITEHOUSE. As the Senator noted, there is an astonishing similarity between the interests of the private health insurance industry and the arguments made by our friends on the other side on the floor. It is amazing. They are identical, virtually, to one another. I have yet to hear an argument about health care coming from the other side of the aisle that does not reflect the interests and the welfare of the private insurance industry, about which for years I never heard them complain while they were denying care.

We have another example beyond Medicare. I am struck that today is the first day since the President's speech in which he announced another 30,000 men and women will be going over to Afghanistan in addition to the ones there. All of us in the Senate and in America are proud of our soldiers. We wish them well. Those of us who have visited Afghanistan know how challenging an environment it is and how difficult it is to be away from one's family. There can be no doubt in our minds that we want the best for our men and women in the service. Everybody agrees we want the best for them. Our friends on the other side also want the best for them.

When we give them health care, what do we give them that we think is the best? We give them government health care through TRICARE and through the Veterans' Administration. I have not heard a lot of complaining about that, about stripping our veterans out of the Veterans' Administration and letting them go to the tender mercies of the private health insurance industry because when there is not an issue that involves the essential interests of the private health insurance industry, then they will do the right thing and recognize that is best for our service men and women. That is best for our veterans and, of course, we all support that. It makes perfect sense. It belies the arguments we are hearing today.

Ms. STABENOW. I totally agree with the Senator. I thank him for his comments. What I find even more perplexing is that what we have on the floor is not a single-payer system, even though some of us would support that. It is not. It is, in fact, building on the

private system but creating more accountability. We are not saying there would not be a private insurance industry. What we are doing is saying that small businesses and individuals who cannot find affordable insurance today should be able to pool together in a larger risk pool. That has been, in fact, a Republican and Democratic idea going back years.

We are saying if they want to be able to ask us to cover these folks, we are saying to the insurance companies they have to stop the insurance abuses. We are not saying they can't offer insurance. In fact, this is a model like the Federal employee health care model, where people who don't have insurance today can get a better deal in a group pool, like a big business and a small business and individuals will purchase from private insurance companies. Many of us believe there ought to be a public option in there as well. But we are talking about private insurance companies participating.

All we are saying is, wait a minute. If you are going to have access to the individuals that now will have the opportunity to buy insurance, we want those rates to be down, and we want them to be affordable. We want to make sure there are no preexisting conditions. We want to know that if somebody pays a premium every month, and then somebody gets sick, that they don't get dropped on some technicality. We want to make sure that women aren't charged twice as much as men, which in many cases is happening today. Sometimes there is less coverage. We want to make sure maternity care is considered basic, that women's health is considered a basic part of a health insurance policy. We are not saying we are eliminating the private sector. We are not going to the VA model or even the Medicare model.

This is reasonable, modest, and should be widely supported on a bipartisan basis. These ideas have come from both Democrats and Republicans over the years, and yet we still get arguments that are wholly and completely protecting the interests of an industry that we are, in fact, trying to engage and provide affordable health care insurance.

Mr. BAUCUS. Mr. President, who has the floor? We are all talking.

The PRESIDING OFFICER. The Senator from Montana is recognized. A colloquy was going on and it was terrific.

Mr. BAUCUS. I ask my colleagues, is it not true that basically in America, although all of America spends about $2.5 trillion on health care, basically it is 50/50. It is 41 or 42 percent public and about 60 percent private. We in America have roughly a 50–50 system today; is that right?

Ms. STABENOW. I say to our colleague that I believe that is the case. In my State, we have 60 percent in the private market through employers.

Mr. BAUCUS. This legislation before us basically retains that current division. What we are doing is coming up with uniquely American ideas. We are not Great Britain, France, or Canada. We are roughly 50–50—a little more private in fact. In 2007, it was 46 percent public and about 54 percent private. Roughly, that is where we are. It might change ever so slightly. But we are not those other countries, we are America.

This legislation before us maintains that philosophy; is that correct?

Ms. STABENOW. Absolutely. In fact, I think it invites the private sector to participate in a new marketplace.

Mr. WHITEHOUSE. If I may interject, I add that it is a relatively familiar American principle to put public and private agencies side by side in competition, in fair competition, and let the best for the consumer win. We see it in public universities. Many of us have States with public universities that we are very proud of. They compete with private universities. I think every one of us has a public university in our State, and it is a model that works very well in education. Many of us—unfortunately not in Rhode Island—have public power authorities that compete with the private power industry.

In fact, some of the most ardent opponents of a public option go home and buy their electricity from a public electric cooperative or a public power authority. We see it in workers compensation insurance. A lot of health care is delivered through workers compensation insurance.

Mr. BAUCUS. But isn't that a pretty good system—don't put too many eggs in one basket? Doesn't each keep the others on their toes a little bit?

Mr. WHITEHOUSE. I think it is the oldest principle of competition, as the distinguished chairman of the Finance Committee pointed out.

Mr. BAUCUS. Doesn't this legislation provide for more competition than currently exists?

Mr. WHITEHOUSE. I think it does.

Mr. BAUCUS. For example, with exchanges, with health insurance market reform and with the ratings reform.

Mr. WHITEHOUSE. All of those, and a public option. All of that adds to a better environment. One of the interesting things about this is you only have a good and fair market. America is founded on market principles. We all believe in market principles. One of the things about the market is that people will cheat on it if there are not rules around the market. If you don't make sure that the bread is good, honest, healthy bread, some rascal will come and will sell cheap, lousy, contaminated bread in the market. You have to have discipline and walls to protect the integrity of the market.

That is what the health insurance market has lacked. That is overdue. I think it will enliven the market in health insurance and animate the market principle.

Mr. BAUCUS. I ask my colleagues, is there anything in this legislation which will interfere with the doctor-patient relationship; that is, to date people choose their own doctors, whichever doctor they want. They can, by and large, go to the hospital they want, although the doctor may send them to another hospital. Is there anything in this legislation that diminishes that freedom of choice patients would have to choose their doctor?

Mr. WHITEHOUSE. Nothing.

Ms. STABENOW. If I may add, I think one of the most telling ways to approach that is the fact that the American Medical Association, the physicians in this country, support what we are doing. They are the last ones who would support putting somebody—somebody else, I should say, because I believe we have insurance company bureaucrats frequently between our doctors and patients—but they would not be supporting us if it were doing what we have been hearing it is doing.

Mr. BAUCUS. What about the procedures doctors might want to choose for their patients? Is there anything in this legislation which interferes with the decision a physician might make as to which procedure to prescribe, in consultation with his or her patient?

Ms. STABENOW. As a member of the Finance Committee with the distinguished chairman, we have heard nothing. We have written nothing that would in any way interfere with procedures. In fact, I believe through the fact we are making insurance more affordable, we are going to make more procedures available because more people will be able to afford to get the care they need.

Mr. WHITEHOUSE. The American Academy of Family Physicians and the American Nurses Association support this legislation because they know that instead of interfering between the doctor and the patient, we are actually lifting out the interference that presently exists at the hands of the private insurance for-profit industry between the patient and the doctor. They want to see this, and that is one of the important reasons.

Another important reason, something the distinguished chairman of the Finance Committee is very responsible for, beginning all the way back at the start of this year when the Finance Committee, under his leadership, had the ''prepare to launch'' full-day effort on delivery system reform.

What you will see is doctors empowered in new ways to provide better care, to have better information.

Mr. BAUCUS. I might ask my friend—that is very true—Could he explain maybe how doctors may be, in this legislation, empowered to have

better information to help them provide even better care? What are some of the provisions?

Mr. WHITEHOUSE. There are a great number of ways and much of it is thanks to the chairman's leadership and Chairman DODD on the HELP Committee. We put together a strong package melded by Leader REID. The main ingredients are taking advantage of electronic health records so you are not running around with a paper record, you are not having to fill out that clipboard again, they are not having to do another expensive MRI because they cannot access the one you had last week. If you have drugs you are taking, the drug interactions that might harm you will be caught by the computer and signal the doctor so they can be aware of it and make a decision whether to change the medication. The electronic health record is a part of that.

Investment in quality reform is a huge issue. Hospital-acquired infections are prevalent throughout this country. They cost about $60,000 each on average. They are completely preventable. Nobody knows this better than Senator STABENOW from Michigan because it was in her home State that the Keystone Project began, which has since migrated around the country. It has gone statewide in my home State through the Rhode Island Quality Institute. It has been written up by the health care writer Dr. Atul Gawande in the New Yorker magazine. What the information from Senator STABENOW's home State of Michigan shows is that in 15 months, they saved 1,500 lives in intensive care units and over $150 million by better procedures to prevent hospital-acquired infections.

Ms. STABENOW. If I may add to that—and I thank the chairman for putting in language on the Keystone initiative in the bill—in this bill, we are, in fact, expanding what has been learned about saving lives and saving money by focusing on cutting down on infections in the intensive care units, by focusing on surgical procedures, things that actually will save dollars, don't cost a lot, and save lives. But they involve thinking a little differently, working a little bit differently as a team. Our physicians, hospitals, and nurses have found that if they made quality a priority, it became a priority.

There are so many things in this legislation that will save money, save lives, increase quality, and that is what this is all about, which is why so broadly we see the health care community, all the providers, nurses, doctors, and so on, supporting what we are doing.

Mr. BAUCUS. I think it is important not to overpromise because some of these initiatives, some of these programs will take a little time to take effect. In fact, some of the provisions do not take effect for a couple, 3 years. But still, wouldn't my colleagues agree that some of these are going to probably yield tremendous dividends in the future, especially generally the focus on quality, not outcomes, reimbursing physicians and hospitals based on quality, not outcomes, the pilot projects, the bundling, the counter care organizations and other similar efforts in this legislation. One of the two or both may want to comment on that point. I think it is a point worth making.

Mr. WHITEHOUSE. It is a very important point. Again, this is not something that emerged suddenly or overnight. The distinguished Senator from the Finance Committee has been working hard on this a long time, back even before ''prepare to launch,'' which is an early reflection of the work he has been doing.

As we look at this bill, and as people who have been watching this debate have seen, this legislation saves lives, saves money, and saves medicine. We can vouch for that through the findings of the Congressional Budget Office. But the Congressional Budget Office has been very conservative in its scoring.

Mr. BAUCUS. Very.

Mr. WHITEHOUSE. There is a letter the CBO wrote to Senator CONRAD. There is testimony and a colloquy he engaged in with me in the Budget Committee that makes clear that beyond the savings that are clear from this legislation, there is a promise of immense further savings. What he said is:

Changes in government policy—

Such as these——

have the potential to yield large reductions in both national health expenditures and Federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policies could move.

The chairman of the Finance Committee has developed those general directions through those hearings and it is now in the legislation. But the conclusion he reaches is:

The specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning.

The MIT report that came out the other day, Professor Gerber, Dr. Gerber said the toolbox to achieve these savings through experimentation and learning is in this bill. I think his phrase was everything you could ask for is in this bill.

As the distinguished chairman of the Finance Committee knows better than I do, there are big numbers at stake here. If you look at what President Obama's Council on Economic Advisers has estimated, there is $700 billion a year—when we talk numbers, we usually multiply by 10 because it is a 10-year window. So when people say there is this much in the bill, it is over 10 years. This is 1 year, $700 billion in waste.

The New England Health Care Institute estimated $850 billion annually in excess costs and waste. The Lewin Group, which has a relatively good opinion around here, and George Bush's former Treasury Secretary, Secretary O'Neill, have estimated it is over $1 trillion a year. So whether it is $700 billion or $850 billion or $1 trillion, even if these tools in the toolbox that we will refine through learning and experimentation achieve only a third, it is $200 billion or $300 billion a year.

Mr. BAUCUS. Right. Some people are worried, perhaps, gee, there they go back there in Congress. They talk about waste—which is good; we want to get rid of waste. But then when they talk about waste, they talk about cutting out the waste, some think: Gee, if they are cutting out the waste and they are cutting health care reimbursements, gee, won't that hurt health care in America? Won't that harm health care in America? Won't that reduce quality? If they are cutting so much, $600 billion, $700 billion, $800 billion—that is a lot of money—aren't they going to start cutting quality health care in America?

I see my good friend, the chairman of the HELP Committee, on the floor. He may want to join in this discussion as well, adding different points as to why the legislation we are putting together increases quality, does not cut quality, but it increases quality at the same time it reduces waste. I wonder if my colleagues might comment on all of that because it is an extremely, I think, important point to drive home our legislation improves quality health care.

Mr. DODD. I was going to raise the point, I say to my colleague and chairman of the Finance Committee, that there are a lot of good things about our health care system. We want to start off acknowledging that our providers, doctors do a magnificent, wonderful job. But we also know the system is fundamentally broken because it is based on quantity rather than quality.

That is my question. There is a question mark at the end of it. It is my opinion that is what it is. In other words, doctors and hospitals—the system—are rewarded based on how many patients you see, how many hospital beds are filled, how many tests get done, how many screenings are provided along the way. So it is all based on quantity. The more quantity you have, the system survives. Inherent in that is the question, if that is what drives the system, only quantity, then obviously what you are going to end up doing is have a sick care system, not a health care system.

If we asked, what are you trying to do over all—to fundamentally shift from a quantity-based system to a quality-based system where we try to keep people out of doctors' offices, out of hospitals, out of situations where

they need to be there. That is what we are trying to achieve. To do that, we need to incentivize the system in reverse. The incentives today are to fill all these places. We are trying to incentivize by keeping people healthier, living a better health style, stopping smoking, losing weight, eating better food—all of these things that are not only good for you but overall save money. Am I wrong?

Mr. BAUCUS. I think my colleague is exactly right. As he was speaking, I was thinking of that article a lot of us have referred to often, the June 1 New Yorker article by Atul Gawande, comparing El Paso, TX, and McAllen, TX. They are both border towns. In El Paso, health care expenditures per person are about half what they are in McAllen. And yet the outcomes in El Paso are better than they are in McAllen.

One might ask: Why in the world is that happening? Why is there twice as much spent in McAllen than El Paso and the outcomes are different? The answer is we have a system which allows the McAllens in the system, that allows payment in basic quantity and volume as opposed to quality.

I believe it depends on the community what the culture is. Some communities have a culture of patient-focused care. The current system allows that, but, unfortunately, if the culture in the community is more to make money, our reimbursement system today allows for that as well. So I think one of the things we are trying to do is to get more quality in the system—reimbursement to pay doctors and hospitals—more quality, as you have said—and that is going to even out a lot of the geographic disparities that have occurred in the country over time and so the quality will increase and the cost and the waste will decrease.

Mr. DODD. One last question I wished to raise, if I could, because our colleague from Montana said something yesterday that I think deserves being repeated, as I understood him, on the point he just made about the Gawande piece, which did that comparison between McAllen, TX, in Hidalgo County, which is the poorest county in the United States, and El Paso, and then I think you talked about Minnesota as well.

There is a fellow by the name of Don Berwick, a doctor who is an expert on integrated care, and one of the things he says—and I think you said this yesterday it deserves being repeated—it isn't just at the Cleveland Clinic or the Mayo Clinic where this happens—that kind of culture that exists at community hospitals and small hospitals all over the country where they have figured out integrated care; that is where doctors and hospitals have figured out how to provide services and reduce costs.

I have 31 hospitals in my State, and similar to all our colleagues, I have been visiting many of them and talking to people. Manchester Community Hospital is a very small hospital in Manchester, CT—a community hospital—and they have reduced costs and increased quality because they have figured out, between the provider physicians and the hospital, how to do that. My point is—and your point is—this is happening all across America in many places, and we need to be rewarding that when it occurs.

Mr. BAUCUS. There is no doubt about that. In fact, it is interesting the Senator mentioned his name because not too long ago I asked him that question. I said: Why, Dr. Berwick, is it that in some communities they get it and some they do not? His answer was that sometimes there is somebody—maybe it is a hospital or someone who is a pretty dominant player—who kind of starts it out and gets it right, and that is true.

He invited 10 integrated systems to Washington, DC, to kind of talk over what works and what doesn't work. These are not the big-named institutions; they are the lesser named institutions. In fact, one of them I can probably say is the Billings Clinic, in Billings, MT—not too widely known, but they participated last year—the same process and integration with the docs, the acute care, and the postacute care. They have significantly cut costs, they have significantly improved the quality, and they are very proud of what they have done.

Mr. WHITEHOUSE. May I offer a specific example from the bill as an illustration of this?

One of the very few areas in which the Congressional Budget Office is prepared to document savings from these quality improvements is in the area of hospital readmissions. The chairman of the Finance Committee worked very hard to get hospital readmission language in his bill, I think we had it in the HELP bill as well, Chairman DODD, and it is in the bill Leader REID put together. What it does is it strips, over 10 years, $7 billion—I think is the number—$7 billion of money that hospitals would otherwise be paid when somebody gets out of the hospital and is readmitted within 30 days for the same condition.

The reason they are willing to apply those savings is because now you can demonstrate that if you have better prerelease planning, then people will go out and they will do better on their own. They will do better at home or they will do better in a nursing home, and therefore they will not come back. So you save lives because the health care is better, and you save money because they do not come back to the hospital. You improve on the front end. The hospital will do that. They will invest and improve on the front end because they don't want to pay on the back end if they are not recovering their costs with the readmission. It is a win-win for everyone. The individual American who has to be readmitted to the hospital and undergo, once again, all the procedures and all the risks that being in a hospital entails because he or she didn't get a proper discharge plan is not helped out by having to go back to the hospital.

Mr. BAUCUS. I have very direct experience in this. My mother was in the hospital 3 years ago—in another hospital, not the Billings Clinic—and there was no discharge plan. There was no way to help deliver health care for her when she left the hospital and went into a rehab center—sort of a nursing home. Sure enough, she didn't get the proper meds, she didn't get the proper attention, the doctor did not see her every day or after that, and, lo and behold, she had to be readmitted to the hospital. She had a gastrointestinal issue, and, sure enough, they took care of her back in the hospital. But once she was discharged, they did it right. They improved upon the mistakes they had made.

So I saw it firsthand, and it irritated the dickens out of me, frankly, in seeing how they did not pay sufficient attention to my mother. If this happens to my mother, my gosh, I bet it is even worse in lots of other situations.

Mr. DODD. If my colleagues will yield, I wished to thank Senator WHITEHOUSE, who was on our committee for the duration of our markup and he did a stunning job. He was a very valuable member of the committee and he made some wonderful suggestions to our bill all the way through the process.

I was told the other night by a friend of mine—Jack Conners, who is very involved in Boston and sits on the board and chairs the board of the hospitals in Boston—I think my colleague from Rhode Island may recognize the name—the average elderly person discharged from the hospital gets, on average, four medications—on average. Within 1 month, that individual, in most cases living alone, maybe with someone else, but on in years and so less capable of understanding it all, is basically not taking the four medications—or only taking parts of them—and finding themselves right back in the hospital as a readmission.

In our bill, we do a little bit to address that, and I think there is some effort in the Finance Committee bill through telemedicine—there are ways now through technology to provide some advice. This might not be a bad idea in terms of employment issues. It wouldn't take much to train people to be a home health care provider and to stop in. Your mother was in a nursing home, but most people end up in their apartment.

Mr. BAUCUS. Well, she is now home and getting great attention. I made sure of that.

Mr. DODD. We could help people who are being discharged, and the savings, by employing some people to do it, I think, would vastly be less than the cost of sending them back to the hospital.

Mr. BAUCUS. An example of that. I was talking to the head of Denver Health. It is an integrated system. I have forgotten the name, but she was so enthusiastic about the integration she performed with Denver Health. I will give you one small example, and it is one you just mentioned. She said: We have patients here—heart patients—and when they are discharged we ask them: Are you taking your meds? Are you controlling your blood pressure? Are you taking your medication to control your blood pressure?

They say: Oh, yeah, yeah, yeah, I am taking my meds.

She says: Well, why is your blood pressure so high?

The response is: Well, I, I, I. Because they are integrated, they check with their pharmacy, which is part of their system, to check the refill rate of the patients. Sure enough, they find their patient's refill history shows they were not taking their meds. So they get the patients back and they say: You are not taking your meds.

They say: Oh, I guess I wasn't.

They tell them: We are checking on you.

So, sure enough, they take their meds, and they have a much better outcome, generally, with their cardio patients because of that integration.

Mr. DODD. It works.

Mr. WHITEHOUSE. Part of what the distinguished chairman worked so hard on was to put in place the program so we will be able to begin to reimburse doctors for those kinds of discussions.

Mr. BAUCUS. Absolutely.

Mr. WHITEHOUSE. Right now, our payment system is driving them away from having that kind of simple discussion. It doesn't always support the electronic prescribing that would let you know they are not picking up their meds. But President Obama did a great job on that, with the electronic health record funding he put through.

But this question of doing what you are paid to do, if all you are paid for are procedures, then the hospital doing the discharge summary, if they couldn't get paid for that, but they did get paid when the person came back and was readmitted and maybe $40,000, $50,000 a day, it doesn't take too long to figure out where their effort is going to be. It is not going to be in those areas that save money for the system but hurt them financially because we have set up the payment system with all these perverse incentives.

Mr. BAUCUS. I don't know how much longer my colleague wanted to speak, but some time ago I know Senator HATCH wanted to speak at 5 o'clock, so I am trying to be traffic cop here.

Mr. DODD. If I could, Mr. Chairman, make the case—because I think it needs to be said and, unfortunately, over, over, and over again—because it is argued on the other side that we are cutting back on providers of the hospitals, for instance. That is accurate. We are doing that. If that is all we were doing, the complaint would have great legitimacy. But what we have done in this bill is to try to create a justification for that and provide the resources that make those savings reasonable. If you are having fewer readmissions in a hospital, which the hospitals support, if you are doing the kinds of things we are talking about to keep people healthy so they do not go back in, then these numbers become realistic numbers.

It is not just saying we are cutting out funding. We are improving systems in bill. People pick up the bill all the time and say: Look at all the pages. It is because a lot of thought has gone into this to do exactly what Senator WHITEHOUSE and the chairman of the committee talked about all day yesterday. This isn't just a bunch of language here. It goes to the heart of this and how we intend to accommodate the interests of the individual by improving their quality and simultaneously reducing the cost.

Everyone has made those claims that is what we need to do—increase quality, reduce cost, increase access. So you can't just say it and not explain how you do it. What we have done in our bill is explain how we do that, how we increase access, how we improve quality for the individual and institutions and simultaneously bring down cost. That is what we spent the last year working on, to achieve exactly what is in these pages that people weigh and pick up all the time. If they would look into them, they would see the kind of achievements we have reached.

Those achievements have been recognized by the most important organizations affecting older Americans—AARP and the Commission to Preserve Social Security and Medicare. They have examined this. These are not friends of ours. These are people who objectively analyze what we are doing, and it is their analysis, their conclusion, reached independently, along with many others, that we have been able to reduce these costs, these savings, in this bill and simultaneously increase access and improve quality.

That has been the goal we have all talked about for years. This bill comes as close to achieving the reality of those three missions than has ever been done by this Congress, or any Congress for that matter. So when people talk about these cuts in Medicare, they need to be honest enough for people to realize what we have done is to stabilize Medicare, extend its solvency, and guarantee those benefits to people who rely on Medicare. That has all been achieved in this bill.

So when people start with these scare tactics and language to the contrary, listen to those organizations who don't bring any political brief to this, who don't have an R or a D at the end of their names. Their organizations are designed, supported, financed by, and applauded by the very individuals who count on having a solid, sound Medicare system. These organizations unanimously—unanimously—have said that guaranteed benefits in this bill remain intact. We stabilize Medicare, and we provide the kind of programs that will save lives and increase the quality of life for people. It is not only about staying alive but the quality of life and being able to live a quality life, independently, for as many years as possible.

At the end of the day, we all die one at a time in this country. No matter what else we do, that is the final analysis. But to the extent you can extend life and improve the quality of life and save the kind of money we ought to, that is the goal of this bill, and we largely achieve it.

I applaud, again, the Finance Committee, and the chairman, Max Baucus, who helped us get through and navigate these very difficult waters, and I thank our colleague from Rhode Island for his articulating these issues as well as his contributions during the HELP Committee proceedings on this bill. He brought many sound and very positive ideas to the table.

I wish to take a minute or two as well, if I could, to respond to our colleague and friend from New Hampshire, who, at some length, talked about his problems with what we call the CLASS Act that was part of our HELP Committee bill. I wish to briefly address those comments.

The CLASS Act was an issue Senator Kennedy championed for many years—the idea of providing an independent, privately funded source of assistance to people who become disabled but who want to continue working and earn a salary; who do not want to be limited by the constraints of a Medicaid system, which is very undesirable. Not a nickel of public moneys are used. Individuals make the contribution. If it vests for 5 years, and if you are faced with those kinds of disability issues, you can then collect approximately $75 per day to provide for your needs—maybe a driver, maybe someone providing meals—but you then have the opportunity to continue working as an individual, without any limitations on what you can make or earn.

Again, no public money is involved. It builds up. Thanks to JUDD GREGG in our committee it is actuarially sound. He offered an amendment which insisted on the actuarial soundness of this program. The CLASS Act assists individuals who need long-term services and supports with such things as:

assisted transportation, in-home meals, help with household chores, professional help getting ready for work, adult day care, and professional personal care. It also saves about $2 billion in Medicaid savings. There are very few provisions which almost instantaneously do that.

Again, these dollars have to remain for just this purpose. You cannot raid this fund for any other purpose—which was a concern legitimately raised by some, that this $75 billion may be used for other purposes. We have attempted to write into this legislation prohibitions to keep these moneys from being offered for any other purpose.

In fact, Senator GREGG, when he offered his amendment, said:

I offered an amendment, which was ultimately accepted, that would require the CLASS Act premiums be based on a 75-year actuarial analysis of the program's costs. My amendment ensures that instead of promising more than we can deliver, the program will be fiscally solvent and we won't be passing the buck—or really passing the debt—to future generations. I'm pleased the HELP Committee unanimously accepted this amendment.

Which we did. I hear some of my colleagues say this bill did not have anything but technical amendments of the 161 Republican amendments I took during committee markup—this was one of the amendments, Senator GREGG's amendment, which we accepted unanimously. My colleague from Utah was of course a member of the committee. He diligently paid attention to every amendment that was offered and I know remembers as we adopted one of his amendments dealing with biologics in the committee that Senator Kennedy strongly supported in conjunction with Senator HATCH. But this CLASS Act is a unique and creative idea. We thank our colleague from Massachusetts, no longer with us, for coming up with and conceptualizing this idea that individuals, with their own money, contributing to a fund, could eventually draw down to provide these benefits should they become disabled. Individuals often want to continue working and being self-sufficient without getting into Medicaid, which limits your income, restrains you entirely.

Here is a totally privately funded program, no public money, just what you are willing to contribute over a period of years to protect against that eventuality that you might become disabled, so you can continue to function.

I have one case here, Sara Baker, a 33-year-old woman in my home State of Connecticut living in Norwalk. Two years ago Sara's mother, who was only 57 years old at the time, suddenly suffered a massive stroke. The stroke left the right side of her body completely paralyzed. She lost 100 percent of her speech. Sara recalls that fateful day when she got the call. I will quote her:

I was living out west in Arizona—working, dating—living and loving my life. Then . . . I got the phone call. . . . In seconds, literally, my entire world fell apart. I swear I can still feel that feeling through my whole body when I think about it. So there I was in a state of complete and total lunacy, getting on a plane with one suitcase—home to Connecticut. Guess what? I never went back.

Sara's mother was transferred to a rehab hospital. Sara went to the hospital every single day for 2 months to be at her mother's side as she went through therapy. Sara's mother had worked as an RN for 17 years. Her mom and the hospital social worker both agreed, her health insurance was ''as good as they come.''

However, when it comes to long-term care, they don't come as good. Her mother was abruptly discharged from the rehab hospital after 60 days, when her insurance company decided she had made enough ''progress.''

Sara went 9 months without working, dipped into what savings she had, and then went into debt to provide the long-term services and supports her mother needed.

As she recalled, and I will quote her again:

I made the whole house wheelchair accessible. I became a team of doctors, nurses, aides, and a homemaker. I helped her shower, get dressed, cut food, gave medicine, took her blood pressure. . . . What would have happened if I wasn't there? Basically, one of two things—I could have hired someone to come to the house, all out of pocket of course, or the State could have depleted her assets—her home, savings, everything—and she would have been put in a nursing home funded by Medicaid.

Stories like Sara's are not the exception, unfortunately. They happen every minute of every day, all across our country. They are common in my State as well as any other State in the Nation. At any moment any one of us or someone we love can become disabled and need long-term services.

We also have an aging population. In my home State of Connecticut, the number of individuals 85 and over, the population most likely to need long-term care, will grow by more than 70 percent in the next 20 years.

Families such as Sara's are doing the right thing. They take care of each other, as most people understand we all would try and do. They do whatever they have to do. But the cost of long-term care can be devastating on middle-class working families. While 46 million Americans lack health insurance, more than 200 million lack any protection against the costs of long-term care. The CLASS Act will help fill that gap. It doesn't solve it all. It helps fill a gap. It is an essential part of health care reform. The CLASS Act will establish a voluntary—purely voluntary, there are no mandates on employers, no mandates on employees, no mandates on anyone—national insurance program.

If you decide, only you decide, voluntarily to contribute and participate in this, it happens. It is a long-term care insurance program financed by premium payments collected through payroll at the request of the individual, not a mandate on the employer. When individuals develop functional limitations, such as Sarah's mother, they can receive a cash benefit in the range of $75 a day, which comes to over $27,000 a year.

It is not intended to cover all the costs of long-term care but it could help many families like Sarah's. It could pay for respite care, allowing family caregivers to maintain employment. It could pay for home modifications. It could pay for assistive devices and equipment. It could pay for personal assistance services—allowing individuals with disabilities to maintain their independence, and community participation. It could allow individuals to stay in their homes versus having to go to a nursing home. It would prevent individuals from having to impoverish themselves by selling off everything they have, to then go through that title XIX window and become Medicaid recipients and then be constrained on what they could possibly earn.

Think about what if this young woman Sara had a family living out West, her own children instead of being single, how would she have done that? How would she have been able to pack up a whole family and move from the West to the East to take care of her mother in those days? Many families face these issues every day.

So while this proposal is not going to solve every problem, it is a very creative, innovative idea that does not involve a nickel of public money, not a nickel. It is all voluntary, depends upon the individual willing to make that contribution, to provide that level of assistance, Lord forbid they should end up in a situation where they find themselves disabled and need some long-term services to allow them to survive and be part of their community life, including going back to work, without impoverishing themselves, selling off everything they have in order to make themselves qualified for Medicaid assistance.

I applaud my colleague from Massachusetts. There are a lot of great things he did over the years. He was a champion of so much when it came to working families and their needs in health care. But this idea, the Kennedy idea of the CLASS Act, is one that has a wonderful legacy to it. It is the heart of this bill. It has been endorsed and supported by over 275 major organizations in the country. I have never seen a proposal such as this receive a level of support across the spectrum that the CLASS Act is getting.

I know there will be those who try to take this out of the bill. I will stand here hour after hour and defend this very creative, innovative idea that can

make a difference in the lives of millions of our fellow citizens, not only today but for years to come.

I again thank Senator Kennedy and his remarkable staff who did such a wonderful job on this as well, and I thank Senator GREGG, even though he is critical of the program. Senator GREGG's ideas were adopted unanimously in our markup of the bill and provided the actuarial soundness of this proposal for a long 75 years to come. For that we are grateful to him, for offering those amendments which were adopted by every Republican and every Democrat on the committee at the time of our markup last summer.

I see my colleague from Utah, and I have great respect for my friend from Utah. He and I have worked on so many issues together. Either he would get me in trouble politically or I would get him in trouble politically when we went to work on things. The very first major piece of legislation I ever worked on in the Chamber was to establish some Federal support for families who needed it for childcare. It was a long, drawn-out battle, but the person who stood with me almost a quarter of a century ago to make that happen—and today it has almost become commonplace for people to get that kind of assistance—but as long as I live, I will never forget I had a partner named ORRIN HATCH who made that possible. Whatever differences we have—and that is not the only thing we have worked on together, but it was the very first thing I worked on and he joined me in that effort—it became the law of the land and today millions of families manage to navigate that difficult time of making sure their families are going to get proper care and attention while they go out and work hard and try to provide for them as well. I thank him for that and many other things as well.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I thank my colleague. There is no question he is a great Senator. I have always enjoyed working with him and we have done an awful lot together. I want to compliment Senator WHITEHOUSE too, a terrific human being and great addition to this Senate and I have a lot of respect for him. He gives me heartburn from time to time, as does Senator DODD. On the other hand, they are great people and very sincere. Our chairman of the committee, Max Baucus, is a wonderful man. He is trying to do the best he can under the circumstances. I applaud him for it. Senator STABENOW from Michigan and I have not seen eye to eye on a lot of things, but we always enjoy being around each other.

This is a great place, there is no question about it. We have great people here. But that doesn't make us any less unhappy about what we consider to be an awful bill.

But right now, today, let me talk about a few specific things. Today the senior Senator from Illinois came to the floor and spoke about my efforts to reduce the costs associated with medical malpractice liability. I don't think his statement should go unanswered. Not only were a number of his statements simply incorrect as factual matters, but some of them even bordered on being offensive. I am not offended, I can live with it, I can take criticism, but some of them I think were a little bit over the top.

First of all, he referred to the recent letter I received from the CBO which indicated that the government would realize significant savings by enacting some simple tort reform measures. I don't know anybody in America who has any brains who doesn't realize we have to do something about tort reform when it comes to health care. According to the CBO, these measures would reduce the deficit by $54 billion over 10 years. That is a lot of money. Private sector savings would be even more significant. According to the CBO, we would likely see a reduction of roughly $125 billion in private health care spending over the same 10-year period, and that, in my view, is a low estimate. Democrats apparently want the American people to think these numbers are so insignificant that this issue should be ignored in this health care bill, and I have to respectfully disagree.

I may be one of the few Senators in this body who actually tried medical malpractice cases. I actually defended them. I defended doctors, hospitals, nurses, health care practitioners. I understand them.

There are cases where there should be huge recoveries. I would be the first to admit it. I saw the wrong eye taken out, the wrong leg taken off, the wrong kidney. You only have two of each of those. You bet your bottom dollar we settled those for significant amounts of money. But I also saw that the vast majority of the cases were frivolous, brought to get the defense costs which then only ranged from $50,000 to $200,000, depending on the jurisdiction. If a lawyer can get a number of those cases they can make a pretty good living by bringing those cases just to get the defense costs, which of course adds to all the costs of health care. There is no use kidding about it.

Furthermore, Senator DURBIN, the distinguished Senator from Illinois, cited the same CBO letter in order to claim that the tort reform measures supported by many on my side of the aisle would cause more people to die.

Give me a break.

I can only assume he is referring to the one paragraph in the CBO letter that addresses the effect of tort reform on health outcomes. In that single paragraph the CBO referred to three studies. One of these studies indicated that a reduction in malpractice lawsuits would lead to an increase in mortality rates—one of the three.

The other two studies cited by the CBO found that there would be no effects on health outcomes and no negative effects could be expected. So, let's be clear, the CBO did not reach a conclusion in this case. These studies were cited only to show that there is disagreement in this area and, once again, the majority of the studies cited said there would be no negative effects on health outcomes. Apparently, omitting data and studies that disagree with your conclusions is becoming common practice among policy makers these days.

In his speech earlier today, the distinguished Senator from Illinois also discounted the prominence of defensive medicine in our health care system, saying only that "some doctors" perform unnecessary and inappropriate procedures in order to avoid lawsuits. Once again, the facts would contradict this generalization. A number of studies demonstrate this. For example, a 2005 study of 800 Pennsylvania physicians—where I used to practice law—in high-risk specialties found that 93 percent of these physicians had practiced some form of defensive medicine. That was published in the Journal of the American Medical Association, June 1, 2005.

In addition, a 2002 nationwide survey of 300 physicians—this is the Harris Interactive "Fear of Litigation Study"—found that 79 percent of physicians ordered more tests than are necessary. Think about that. If 79 percent are ordering more tests than are necessary, you can imagine the multibillions of dollars in unnecessary defensive medicine that comes from that. But that is not the end of that "Fear of Litigation Study." Seventy-four percent of physicians referred patients to specialists who, in their judgment, did not need any such referral. Think about it—referring people to specialists that they knew they didn't need. Think of the cost, the billions of dollars in cost. Fifty-two percent of physicians suggested unnecessary invasive procedures. The word "invasive" is an important word. Fifty-two percent. Why? Because they are trying to protect themselves by making sure that everything could possibly be done. Forty-one percent of physicians prescribed unnecessary medications. This is a nationwide survey of 300 physicians.

The costs associated with defensive medicine are real—I would say unnecessary defensive medicine because I believe there are some defensive medicine approaches that we would want the doctors to do but not to the extent of these doctors ordering more tests than are necessary, ordering more specialists than are necessary, suggesting unnecessary invasive procedures, unnecessary medications. This is the medical profession itself that admits this.

In another study Pricewaterhouse found that defensive medicine accounts for approximately $210 billion every year or 10 percent of the total U.S. health care cost. Here are some more facts from the Pricewaterhouse study. Of the $2.2 trillion spent every year on health care in the United States, as much as $1.2 trillion can be attributed to wasteful spending—$1.2 trillion of $2.2 trillion. Yet, the Democrats want to deny that unnecessary defensive medicine is being utilized to a significant extent. According to this study, defensive medicine is the largest single area of waste in the health care system. It is on par with inefficient claim processing and care spent on preventable conditions.

Yet, despite these overwhelming numbers—and I know some Democrats will say that is Pricewaterhouse and they must have been doing it at the expense of somebody who had an interest. Pricewaterhouse and other accounting firms generally try to get it right. They got it right here. Those of us who were in that business can attest to it.

Yet, despite these overwhelming numbers, my friends on the other side have opted to overlook them and instead relate horrific stories associated with doctors' malpractice, apparently trying to imply that Republicans simply don't care about these truly tragic occurrences. However, nothing could be further from the truth. In fact, in all the proposals that have been offered during this debate, there has not been a single suggestion to prevent plaintiffs from obtaining the compensation for actual losses they have incurred, not one suggestion that they should. Instead, we have sought to impose some limits on the noneconomic damages. All economic damages damages awarded for actual loss, past, present, and future—are fine, fair game. We've sought only impose some limits on the noneconomic damages in order to define the playing field, encourage settlement, and introduce some level of predictability to the system.

It is no secret that personal injury lawyers—some of them—are prolific political contributors to those politicians who fight against tort reform. With a Democratic majority and a Democrat in the White House, their lobbying efforts during this Congress have reached unprecedented levels. Given this reality, it is obvious why trial lawyers have not been asked to give up anything in the current health care legislation.

Supporters of this health care bill will be asking the American people to pay higher health care premiums, for seniors to give up Medicare Advantage, which 25 percent of them have enlisted in, for businesses to pay higher taxes, for medical device manufacturers to pay more just to bring a device to the market that may save lives or make lives more worth living. The only group that has not been asked to sacrifice or change the way they do business happens to be the medical liability personal injury lawyers.

I would hope we would focus our efforts more on helping the American people than on preserving a fund-raising stream for politicians. Sadly, that doesn't appear to be happening in the current debate.

As I said, there are some very honest and decent attorneys out there who bring cases that are legitimate where there should be high rewards. But the vast majority, I can personally testify, are less than legitimate and the resulting costs are costing every American citizen an arm and a leg. It is something we ought to resolve. We ought to resolve it in a way that takes care of those who truly have injuries and get rid of these frivolous cases driving up the cost for every American.

Not too long ago, I talked to one of the leading heart specialists in Washington. He acknowledged, we all order a lot of tests and so forth that we don't need, that we know we don't need. But we do it so that the history we have of the patient shows we did everything possible to rule out everything that possibly could occur, even though we know we don't need to do it. To be honest, under the current system of lawsuits, I don't blame them. They are trying to protect themselves.

We should also discuss the shortage of doctors we have going into high-risk specialties. We have areas in this country where you can't get obstetricians and gynecologists to the people. Law schools will tell you, at least the ones I know, that there aren't that many young people going into obstetrics and gynecology today because they may not make as much money and the high cost of medical liability insurance is so high that they really can't afford to do it. And, of course, they don't want to get sued.

So much for that. I love my distinguished friend from Illinois, and he knows it. I care for him. But let me tell you, I think he knows better. He knows that I know better. I would be the first to come to bat for somebody who was truly injured because of the negligence of a physician. I don't have any problem with that at all.

I just thought I would make a few comments about this but, again, say that I understand some of the excesses that go on on the floor. But that was an excess this morning, even though I know my dear friend is sincere and dedicated and one of the better lawyers in this body. Having said that, I will end on that particular subject.

Let me once again take a few minutes to talk about the Medicare provisions in this Democratic Party health care bill.

Throughout the health care debate, we have heard the President pledge not to ''mess'' with Medicare. Unfortunately, that is not the case with the bill before the Senate. To be clear, the Reid bill reduces Medicare by $465 billion to fund a new government program. Unfortunately, seniors and the disabled in the United States are the ones who suffer the consequences as a result of these reductions. Everyone knows Medicare is extremely important to 43 million seniors and disabled Americans covered by the Medicare Program.

Throughout my Senate service, I have fought to preserve and protect Medicare for both beneficiaries and providers. Medicare is already in trouble today. The program faces tremendous challenges in the very near future. The Medicare trust fund will be insolvent by 2017, and the program has more than $37 trillion in unfunded liabilities. This is going to be saddled onto our children and grandchildren.

The Reid bill will make the situation much worse. Why is that the case? Again, the Reid bill cuts Medicare to fund the creation of a new government entitlement program. More specifically, the Reid bill will cut nearly $135 billion from hospitals—where are they going to get this money?—$120 billion from Medicare Advantage, almost $15 billion from nursing homes, more than $40 billion from home health care agencies, and close to $8 billion from hospice providers. These cuts will threaten beneficiary access to care as Medicare providers find it more and more challenging to provide health services to Medicare patients. Many doctors are not taking Medicare patients now because of low reimbursement rates.

Let me stress to my colleagues that cutting Medicare to pay for a new government entitlement program is irresponsible. Any reductions to Medicare should be used to preserve the program, not to create a new government bureaucracy.

As I just said, the President has consistently pledged: We are not going to mess with Medicare. Once again, this is another example of a straightforward pledge that has been broken over the last 11 months. Maybe you cannot blame the President because he is not sitting in this body. The body is breaking it.

This bill strips more than $120 billion out of the Medicare Advantage Program that currently covers 10.6 million seniors or almost one out of four seniors in the Medicare Program. According to the Congressional Budget Office, under this bill the value of the so-called ''additional benefits,'' such as vision care and dental care, will decline from $135 to $42 by 2019. That is a reduction of more than 70 percent in benefits. You heard me right: 70 percent.

During the Finance Committee's consideration of health care reform, I offered an amendment to protect these benefits for our seniors, many of whom

are low-income Americans and reside in rural States and rural areas. However, the majority party would not support this important amendment. The majority chose to skirt the President's pledge about no reduction in Medicare benefits for our seniors by characterizing the benefits being lost—vision care, dental care, and reduced hospital deductibles—as ''extra benefits.''

Let me make the point as clearly as I can. When we promise American seniors we will not reduce their benefits, let's be honest about that promise. So we are either going to protect benefits or not. It is that simple. Under this bill, if you are a senior who enjoys Medicare Advantage, the unfortunate answer is, no, they are not going to protect your benefits.

All day today, we had Members on the other side of the aisle claim that Medicare Advantage is not part of Medicare. This is absolutely—I have to tell you, it is absolutely unbelievable. I would invite every Member making this claim to turn to page 50 of the ''2010 Medicare and You Handbook.'' It says:

A Medicare Advantage is another health coverage choice you may have—

Get these words—

as part of Medicare.

Let me repeat that:

A Medicare Advantage is another health coverage choice you may have as part of Medicare.

Hey, that is the Medicare ''2010 Medicare and You Handbook.'' Who is kidding whom about it not being part of Medicare?

So the bottom line is simple: If you are cutting Medicare Advantage benefits, you are cutting Medicare.

I also heard the distinguished Senator from Connecticut this morning mention that the bureaucrat-controlled Medicare Commission will not cut benefits in Part A and Part B. Well, once again, my friends on the other side are only telling you half the story. So much for transparency. On page 1,005 of this bill, it states in plain English:

Include recommendations to reduce Medicare payments under C and D.

I am just waiting for Members on the other side of the aisle to come down and now claim that Part D is also not a part of Medicare. We all know it is.

It is also important to note that the Director of the nonpartisan Congressional Budget Office has told us in clear terms that this unfettered authority given to the Medicare Commission would result in higher premiums.

It is important details such as these that the majority does not want us to discuss and debate in full view of the American people. They call it slow-walking. They call it obstructionism. Making sure we take enough time to discuss a 2,074-page bill that will affect every American life and every American business is the sacred duty of every Senator in this Chamber. We will take as long as it takes to fully discuss this bill, and you can talk for a month about various parts of this bill that are outrageous and some that are really good, too, in all fairness—not many, however.

I have heard several Members from the other side of the aisle characterize the Medicare Advantage Program as a giveaway to the insurance industry. You know, when you cannot win an argument, you start blaming somebody else. So they want a government insurance company to take the place of the insurance industry. Well, maybe that is too much. They want it to compete with the insurance industry. But how do you compete with a government-sponsored entity? And there are comments that the so-called government plan will cost more than the current insurance businesses they are so criticizing. I am not happy with the insurance industry either, but, by gosh, let's be fair.

Let me give everyone watching at home a little history lesson on the creation of Medicare Advantage. I served as a member of the House-Senate conference committee which wrote the Medicare Modernization Act of 2003. The distinguished Senator from Montana would agree with me, it was months of hard, slogging work every day to try to come up with the Medicare Modernization Act of 2003. Among other things, this law created the Medicare Advantage Program. It gives people vision care, dental care, et cetera.

When conference committee members were negotiating the conference report back then, in 2003, several of us insisted that the Medicare Advantage Program was necessary in order to provide health care coverage choices to Medicare beneficiaries. At that time, there were many parts of the country where Medicare beneficiaries did not have adequate choices in coverage. In fact, the only choice offered to them was traditional fee-for-service Medicare, a one-size-fits-all, government-run health program.

By creating the Medicare Advantage Program, we were providing beneficiaries with choice in coverage and then empowering them to make their own health care decisions as opposed to the Federal Government making them for them. Today, every Medicare beneficiary may choose from several health plans.

We learned our lessons from Medicare+Choice, which was in effect at the time, and its predecessors. These plans collapsed, especially in rural areas, because Washington decided—again, government got involved—to set artificially low payment rates. In fact, in my home State of Utah, all of the Medicare+Choice plans eventually ceased operations because they were all operating in the red. You cannot continue to do that. It was really stupid what we were expecting them to do. I fear history could repeat itself if we are not careful.

During the Medicare Modernization Act conference, we fixed the problem. We increased reimbursement rates so all Medicare beneficiaries, regardless of where they lived—be it Fillmore, UT, or New York City—had choice in coverage. Again, we did not want beneficiaries stuck with a one-size-fits-all, Washington-run government plan.

There were both Democrats and Republicans on that committee, by the way, and the leader was, of course, the distinguished Senator from Montana. I admire him for the way he led it, and I admire him for trying to present what I think is the most untenable case here on the floor during this debate. He is a loyal Democrat. He is doing the best he can, and he deserves a lot of credit for sitting through all those meetings and all of that markup and everything else and sitting day-in and day-out on the floor here.

Today, Medicare Advantage works. Every Medicare beneficiary has access to a Medicare Advantage plan, if they so choose, and close to 90 percent of Medicare beneficiaries participating in the program are satisfied with their health coverage. But that can all change should this health care reform legislation currently being considered become law.

In States such as Utah, Idaho, Colorado, New Mexico—just to mention some Western States—Wyoming, Montana—you can name every State—rural America was not well served, and we did Medicare Advantage.

Choice in coverage has made a difference in the lives of more than 10 million Americans nationwide—almost 11 million Americans. The so-called ''extra benefits'' I mentioned earlier are being portrayed as gym memberships as opposed to lower premiums, copayments, and deductibles.

To be clear, the Silver Sneakers Program is one that has made a difference in the lives of many seniors because it encourages them to get out of their homes and remain active. It is prevention at its best. It has been helpful to those with serious weight issues, and it has been invaluable to women suffering from osteoporosis and joint problems. In fact, I have received several hundred letters telling me how much Medicare Advantage beneficiaries appreciate this program. They benefit from it. Their lives are better. They use health care less. They do not milk the system. They basically have a better chance of living and living in greater health.

Throughout these debates, throughout these markups, throughout these hearings that have led us to this point, every health care bill I know of has a prevention and wellness section in the bill that will encourage things such as

the Silver Sneakers Program that has benefited senior citizens so much and was not one of the major costs of Medicare Advantage.

Additionally, these beneficiaries receive other services such as coordinated chronic care management, which is important, coordinated chronic care management for seniors; dental coverage—really important for low-income seniors; vision care—can you imagine how important that is to people over 60 years of age? How about those who are over 70 or 80 years of age? And hearing aids—can you imagine how important that is to our senior citizens? This program helps these seniors, and it helps them the right way.

Let me read some letters from my constituents. These are real lives being affected by the cuts contemplated in the bill.

Remember, there is almost $500 billion cut by this bill from Medicare, which goes insolvent by 2017 and has an almost $38 trillion unfunded liability.

Let me read this letter from a constituent from Layton, UT:

I recently received my healthcare updater for 2010. I am in a Med Advantage plan with Blue Cross/Blue Shield. Thanks to the cuts in this program by Medicare, my monthly premiums have risen by 49% and my office visit co-pay has increased 150%. Senator HATCH, I am on a fixed income and this has really presented a problem for me and many others I know on the same program. And, at my age I certainly can't find a job that would help cover the gap. I worked all my life to enjoy my retirement and thanks to the current economy I've lost a lot of those monies that were intended to help supplement my income.

This letter is from a constituent from Logan, UT, where the great Utah State University is:

Please stop the erosion of Medicare Advantage for seniors. Very many of us are already denied proper medical and dental care not to mention those who cannot afford needed medications. Hardest hit are ones on Social Security who are just over the limit for extra help but cannot keep up with the rising medical costs that go way beyond the so-called "cost of living increases" which we are not getting this year anyway. If those in government who make these decisions had to live as we do day to day, I think we would find better conditions for seniors. The difference in decision making changes when you are hungry and cold your own self.

Here is a constituent from Pleasant Grove, UT:

Please do not phase out the Medicare Advantage program, senior citizens need it. Our supplement insurance rates go up every year and our income does not keep pace with the cost of living.

Here is a constituent from Salt Lake City, UT:

We met with our insurance agent this morning about the increased costs of our Medicare Advantage plans due to the health care reform bill now before Congress.

Our premium costs have already been significantly increased with the coverage substantially decreased. We are in our 80s and cannot afford these increases and are hurt by the decreased coverage. We are writing to you to have you stop the cuts and restore the coverage to Medicare Advantage plans. This is an issue that is very important and very real to us at this point in our lives. Please stop the cuts and restore coverage.

I can't support any bill that would jeopardize health care coverage for Medicare beneficiaries. I truly believe if this bill before the Senate becomes law, Medicare beneficiaries' health care coverage could be in serious trouble.

I have been in the Senate for over 30 years—33 to be exact. I pride myself on being bipartisan. I have coauthored many bipartisan health care bills since I first joined the Senate in 1977. Almost everyone in this Chamber wants a health care reform bill to be enacted this year. I don't know of anybody on either side who would not like to get a health care bill enacted.

On our side, we would like to do it in a bipartisan way, but this bill is certainly not bipartisan. It hasn't been from the beginning. We want it to be done right. History has shown that to be done right, it needs to be a bipartisan bill that passes the Senate with a minimum of 75 to 80 votes. We did it in 2003 when we considered the Medicare prescription drug legislation, and I believe we can do it again today if we have the will and if we get rid of the partisanship. I doubt there has ever been a bill of this magnitude affecting so many American lives that has passed this Chamber on an almost—or maybe in a complete—straight party-line vote. The Senate is not the House of Representatives. This body has a different constitutional mandate than the House. We are the deliberative body. We are the body that has in the past and should today be working through these difficult issues to find clear consensus. True bipartisanship is what is needed.

In the past, the Senate has approved many bipartisan health care bills that have eventually been signed into law. I know a lot of them have been mine, along with great colleagues on the other side who deserve the credit as well. The Balanced Budget Act in 1997 included the Hatch-Kennedy SCHIP program. How about the Ryan White Act. I stood right here on the Senate floor and called it the Ryan White bill. His mother was sitting in the audience at the time. How about the Orphan Drug Act. When I got here we found that there were only two or three orphan drugs being developed. These are drugs for population groups of less than 250,000 people. It is clear that the pharmaceutical companies could not afford to do the pharmaceutical work to come up with treatments or cures for orphan conditions. So we put some incentives in there; we put some tax benefits in there. We did some things that were unique. If I recall it correctly, it was about a $14 million bill.

Today we have over 300 orphan drugs, some of which have become blockbuster drugs along the line. They wouldn't have been developed if it hadn't been for that little, tiny orphan drug bill. That was a major bill when I was chairman of the Labor and Human Resources Committee. They now call it the Health, Education, Labor, and Pensions Committee.

How about the Americans With Disabilities Act. Tom Harkin stood there, I stood here, and we passed that bill through the Senate. It wasn't easy. There were people who thought it was too much Federal Government, too much this, too much that. But Senator HARKIN and I believed—as did a lot of Democrats and a lot of Republicans, as the final vote showed—that we should take care of persons with disabilities if they would meet certain qualifications.

How about the Hatch-Waxman Act. We passed that. Henry Waxman, a dear friend of mine, one of the most liberal people in all of the House of Representatives and who is currently the very powerful chairman of the Energy and Commerce Committee over there, we got together, put aside our differences, and we came up with Hatch-Waxman which basically almost everybody admits created the modern generic drug industry.

By the way, most people will admit that bill has saved at least $10 billion to consumers and more today, by the way, every year since 1984.

I could go on and on, but let me just say I have worked hard to try and bring our sides together so we can in a bipartisan way do what is right for the American people.

Let me just tell my colleagues, if the Senate passes this bill in its current form with a razor thin margin of 60 votes, this will become one more example of the arrogance of power being exerted since the Democrats secured a 60-vote majority in the Senate and took over the House and the White House. There are essentially no checks or balances found in Washington today, just an arrogance of power, with one party ramming through unpopular and devastating proposals such as this, one after another.

Well, let me say there is a better way to handle health care reform. For months I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraint while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the basis for sustainable, fiscally responsible, and bipartisan reform.

These include:

Reforming the health insurance market for every American by making sure no American is denied coverage simply based on a preexisting condition. Some of my colleagues on the other side have tried to blast the insurance industry,

saying they are an evil, powerful industry. We need to reform them, no question about it, and we can do it if we work together.

Protecting the coverage for almost 85 percent of Americans who already have coverage they like by making that coverage more affordable. This means reducing costs by rewarding quality and coordinated care, giving families more information on the cost and choices of their coverage and treatment options, and—I said it earlier—discouraging frivolous lawsuits that have permeated our society and made the lives of a high percentage of our doctors, especially in those very difficult fields of medicine, painful and those fields not very popular to go into today. And, of course, we could promote prevention and wellness measures.

We could give States flexibility to design their own unique approaches to health care reform. Utah is not New York, Colorado is not New Jersey, New York is not Utah, and New Jersey is not Colorado. Each State has its own demographics and its own needs and its own problems. Why don't we get the people who know those States best to make health care work? I know the legislators closer to the people are going to be very responsive to the people in their respective States. I admit some States might not do very well, but most of them would do much better than what we will do here with some big albatross of a bill that really does not have bipartisan support.

Actually, in talking about New York, what works in New York will most likely not work in Colorado, let alone Utah. As we move forward on health care reform, it is important to recognize that every State has its own unique mix of demographics. Each State has developed its own institutions to address its challenges, and each has its own successes. We can have 50 State laboratories determining how to do health care in this country in accordance with their own demographics, and we could learn from the States that are successful. We could learn from the States that make mistakes. We could learn from the States that cross-breed ideas. We could make insurance so that it crosses State lines.

Can you imagine what that would do to costs? We could do it. But there is no desire to do that today with this partisan bill.

There is an enormous reservoir of expertise, experience, and field-tested reform. We should take advantage of that by placing States at the center of health care reform efforts so they can use approaches that best reflect their needs and their challenges.

My home State of Utah has taken important and aggressive steps toward sustainable health care reform. They already have an exchange. They are trying some very innovative things. By anybody's measure the State of Utah has a pretty good health care system. Is it perfect? No. But we could help it to be, with a fraction of the Federal dollars that this bill is going to cost. This bill over 10 years is at least $2.5 trillion, and I bet my bottom dollar it will be over $3 trillion. That is on top of $2.4 trillion we are already spending, half of which they claim may be not well spent. We know a large percentage of that is not well spent.

Like I say, my home State of Utah has taken important and aggressive steps toward sustainable health care reform. The current efforts to introduce the defined contribution health benefits system and implement the Utah health exchange are laudable accomplishments.

A vast majority of Americans—I believe this to be really true—agree a one-size-fits-all Washington government solution is not the right approach. That is why seniors and everybody else except a very few are up in arms about these bills. That is what this bill is bound to force on us: a one-size-fits-all, Washington-run, controlled government program. I am not just talking about the government option. That is a small part of the argument today. If we pass this bill, we will have Washington governing all of our lives with regard to health care. I can't think of a worse thing to do when I look at the mess they have made with some very good programs.

Unfortunately, the path we are taking in Washington right now is to simply spend another $2.5 trillion of taxpayer money to further expand the role of the Federal Government. I just wish the majority would take a step back, keep their arrogance of power in check, and truly work on a real bipartisan bill that all of us can be proud of. They have the media with them selling this bill as less than $1 trillion. Give me a break. Between now and 2014, yes, they will charge everybody the taxes they can get and the costs they can get, but the bill isn't implemented until 2014, and even some aspects not until 2015. That is the only way, with that budgetary gimmick, they could get the costs to allegedly be down below $900 billion. But even the CBO—certainly the Senate Budget Committee—acknowledges that if you extrapolate—I think my colleagues on the other side acknowledge that if you extrapolate it out over a full 10 years, you have at least $2.5 trillion and in some circumstances as much as $3 trillion.

How can we justify that? With the problems we have today, a $12 trillion national debt, going up to $17 trillion if we do things like this? How can we justify it? How can we stick our kids and our grandkids and our great grandkids—my wife and I have all three, by the way, kids, grandkids, and great-grandkids. How can we stick them with the cost of this bill? This is just one bill. I hate to tell you some of the other things that are being put forth in not only this body but the other. How come we do it on bills that are totally partisan bills?

If we look at what has happened, the HELP Committee, the Health, Education, Labor and Pensions Committee, came up with a totally partisan bill. Not one Republican was asked to contribute to it. They just came up with what they wanted to do. It was led by one staff on Capitol Hill. It is a very partisan bill. Then the House came up with their bill. Not one Republican, to my knowledge, had even been asked to help, and it is a tremendously partisan bill—both of which are tremendously costly too.

Then the distinguished Senator from Montana tried to come up with a bill that would be bipartisan in the Finance Committee, but in the end, even with the Gang of 6—and I was in the original Gang of 7, but I couldn't stay because I knew what the bottom bill was going to be, and I knew I couldn't—I couldn't support it. So I voluntarily left, not because I wanted to cause any problems but because I didn't want to cause any problems. I found myself coming out of those meetings and decrying some of the ideas that were being pushed in those meetings. I just thought it was the honorable thing to do to absent myself from the Gang of 7. It became a Gang of 6 and then the three Republicans finally concluded that they couldn't support it either.

But I will give the distinguished chairman from Montana a great deal of credit because he sat through all of that. He worked through all of it. He worked through it in the committee, but then it became a partisan exercise in committee by and large.

Yes, there were a couple of amendments accepted: My gosh, look at that. Then what happened? They went to the majority leader's office in the Senate, and they brought the HELP bill and the bill from the Finance Committee, and they molded this bill, this 2,074-page bill with the help of the White House. Not one Republican I know of had anything to do with it, although I know my dear friend, the distinguished majority leader, did from time to time talk with at least one Republican, but only on, as far as I could see, one or two very important issues in the bill. There are literally thousands of important issues in this bill, not just one or two. There are some that are more important than others, but they are all important.

I am not willing to saddle the American people with this costly, overly expensive, bureaucratic nightmare this bill will be. I hope my colleagues on the other side will listen, and I hope we can start over on a step-by-step approach that takes in the needs of the respective States that is not a one-size-fits-all solution, that both Republicans

and Democrats can work on, which will literally follow the principles of federalism and get this done in a way that all of us can be proud of.

I don't have any illusions and, thus far, it doesn't look like that will happen. But it should happen. That is the way it should be done. I warn my friends on the other side, if they succeed in passing this bill without bipartisan support—if they get one or two Republicans, I don't consider that bipartisan support. You should at least get 75 to 80 votes on a bill this large, which is one-sixth of the American economy, 17 percent of the American economy. You should have to get 75 to 80 votes minimally. It would even be better if you can get more, as we did with CHIP and other bills. On some we have gotten unanimous votes—on bills that cost money, by the way. Republicans have voted for them, too. Republicans will vote for a good bill even if it costs some money. We are not about to vote for something costing $2.5 trillion to $3 trillion. I don't think the American people are going to stand for it.

Beware, my friends, of what you are doing. I can tell you right now this isn't going to work. I want to make that point as clear as I can.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Illinois is recognized.

Mr. BURRIS. Mr. President, as a lifelong public servant, I have always believed in the fundamental greatness of this country. I am sure this is a belief shared by every single one of my colleagues in this body. It is what drove us to serve in the first place, just as it has driven generations of Americans to serve in many capacities throughout our history. Democrat or Republican, liberal or conservative, we are united by our underlying faith in the democratic process and our respect for the people we have come here to represent. That is what makes this country great, the belief that together we can make progress. Together, we can shape our own destiny. That is why we gather here in this august Chamber, to bring the voices of the American people to Washington, to the very center of our democracy.

Earl Warren, the late Chief Justice of the Supreme Court, articulated this very well:

> Legislators represent people, not trees or acres. Legislators are elected by voters, not farms or cities or economic interests.

He said this in reference to a court case about elected representatives at the State level, but his insight rings especially true here in the highest lawmaking body in the land.

I ask my colleagues to reflect upon this simple truth for a moment. We address one another as ''the Senator from Illinois'' or ''the Senator from Texas'' or ''the Senator from Colorado'' or ''the Senator from Utah,'' but we do not speak for towns, or companies, or lines on a map. Our solemn duty is to listen to the people we represent and give voice to their concerns and interests here in Washington. We strive to do this every day, but far too often partisan politics get in the way.

When it comes to difficult issues such as health care reform, the voices of the people sometimes get lost in all of the talk about Republicans versus Democrats, red States versus blue States. The media gets caught up in the horse race and, more often than we would wish, the atmosphere of partisanship follows us into this Chamber.

As our health care reform bill has cleared the first hurdle and moved to the Senate floor, I urge my colleagues to listen to the people—not just to the party leadership—as they decide how to vote. If they shut out the health care insurance lobbyists, the special interests, and the partisan tug of war, they might be surprised at what they will hear from the American people.

In my home State of Illinois, the weight of consensus is hard to ignore. Folks stop me on the streets, stop me in hallways outside of my office, talk to me on airplanes; they call, write, and e-mail. They contact me every way possible. The message is always the same: We need real health care reform. They are telling me don't give up and don't back down. That is because the American people overwhelmingly support reform. They need health care reform now—not tomorrow or next year, they need it now.

I urge my colleagues to think of the uninsured people in their own States. Think about that. Who are the ones who are uninsured? These are the folks who need reform the most. We have all heard at least a few of the heartbreaking stories. Sadly, we will never be able to hear them all because there are too many. So it is time for us to listen and to take a stand on their behalf. It is time to bring comprehensive health care reform to every State in the Union, because in my home State of Illinois, 15 percent of the population is uninsured. In the most advanced country on Earth, this is simply unacceptable. We need to dramatically expand access to quality, affordable health care. But it is not just a blue States issue, it is an American issue. This is a problem that touches all of us. In fact, as we look across the map, we see that many of our States that need the most help are actually the red States.

Eighteen percent of the people in Tennessee and Utah don't have health insurance and cannot get the quality care they need. The number of uninsured stands at 20 percent in Alaska, and it is nearly 21 percent in Georgia, Florida, and Wyoming. In Oklahoma, Nevada, and Louisiana, more than 22 percent of the total population is uninsured, and 24 percent without health insurance in Mississippi. More than a quarter of the population in New Mexico can't get health insurance. In the great State of Texas, almost 27 percent of the population has no health coverage. These numbers speak for themselves. We need to expand coverage to include more of these people.

A recent study conducted by Harvard University shows that the uninsured are almost twice as likely to die in the hospital as similar patients who do have insurance. This human cost is unacceptable, and the financial cost is too much to bear.

While my friends on the other side seek to delay and derail health care reform at this crucial juncture, this bill seeks to save the health of our citizens, to save the lives of Americans, and to save money in the way coverage is offered and delivered. By extending coverage to these individuals and increasing access to preventive care, we can catch illnesses before they become serious.

That is why I am proud to support provisions such as the amendment offered by my colleague from the great State of Maryland, Senator MIKULSKI. This measure would guarantee women access to preventive care and health screenings at no cost. If more women could get regular screenings and tests, such as mammograms, we can catch illnesses such as breast cancer, heart disease, and diabetes. We can keep more people out of the emergency rooms, we can save lives, and we can save money.

The best way to expand access is to create a strong public option that will lower costs, increase competition, and restore accountability to the insurance industry.

I am fighting for every single Illinoisan to make sure they have access to quality, affordable health care, and to make sure they have real choices. I am fighting for every Illinoisan, because every one of us will benefit from comprehensive reform. But I recognize that those who are uninsured need help the most, and they need it now.

I ask my colleagues to consider this need and to think about how many of their constituents stand to benefit from our reform package.

It is no secret that my Republican friends seek to block and delay this legislation. Many of them represent the so-called red States, where opposing health care reform is seen as a good political move. In the cynical course of politics as usual, most of those red States will be written off because they typically support the Republican Party. But not this time. Health reform isn't about politics. It is not about one party or the other. It is about the lives that are at stake here that we are trying to help. It is about the people who suffer every day under a health care system that fails to live up to the promises of this great Nation.

When it comes to our health care legislation, a vote against reform is a vote against the people who so desperately need our help. That is why I am asking my Republican friends to rise above politics as usual when they make this choice.

Recently, some of my colleagues across the aisle have said our bill would slash Medicare. This is simply not the case. There is no cut in Medicare—no $465 billion cut. Our bill would do nothing of the kind. This is another cynical attempt to scare seniors into opposing health care reform. We have had enough of that.

The truth is this: According to the nonpartisan Congressional Budget Office, health care reform will lower seniors' Medicare premiums by $30 billion over the next 10 years by focusing on prevention and wellness, increasing efficiency and making the program more cost effective.

Our Republican friends can choose to engage in partisan games and spread fear and disinformation about health care reform, they can turn their backs on the people they swore to represent, or they can cast aside the tired constraints of partisanship and stand up for what is right. When they go home to the people who sent them to Washington, they can look those people in the eye and say: I fought for you. I stood up to the special interests, the campaign donors, and the political forces that tried to block reform. I didn't vote like a Senator who represents a red State or a blue State; I voted like a Senator who represented your State and all the good, hard-working people who desperately need this help.

That is the spirit that drove each of us to enter public service in the first place. That is what makes this country great, the belief that policy is decided by the interests of the people, not big corporations or political parties.

This country is more than just a set of lines on a map, and the more you cross those lines, the more you learn that ordinary Americans don't care who scores political points or who gets reelected. They care about results. They care about real costs and real health outcomes.

It is time for us to deliver. It is time to stand for the uninsured, the sick, the poor, and all those who cannot stand for themselves. I say to my colleagues, it is time to come together on the side of the American people and make health care reform a reality. This health care legislation that is being debated on this floor will save lives, it will save money, and it will save Medicare.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I ask unanimous consent that I and my two colleagues be able to engage in a colloquy.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENSIGN. Mr. President, I would like to start by talking about the bill in general.

Mr. DURBIN. Mr. President, will the Senator from Nevada yield for a question before he starts?

Mr. ENSIGN. Yes.

Mr. DURBIN. Can the Senator give us an indication of how long he expects the colloquy to last?

Mr. ENSIGN. Maybe 40 minutes, somewhere in there.

Mr. DURBIN. I thank the Senator.

Mr. ENSIGN. Mr. President, there is a lot of talk about this bill. I wish to make some general comments about it. First, following the comments of my colleague from Illinois, he said there are not $½ trillion in Medicare cuts. According to the Congressional Budget Office, there are $464 billion to $465 billion in Medicare cuts. So maybe not quite $½ trillion, but we are certainly getting close.

There are, however, $½ trillion in new taxes in this bill, 84 percent of which will be paid by those making less than $200,000 a year, a direct violation of the campaign pledge made by President Barack Obama, then-Candidate Obama.

This bill will result in increased premiums and health care costs for millions of Americans. This is a massive government takeover of our health care system. As a matter of fact, according to the National Center for Policy Analysis, in this 2,074 page bill—there are almost 1,700, 1,697 to be exact—references to the Secretary of Health and Human Services, giving her the authority to create, determine, or define things relating to health care policy in this bill. Basically, we are placing a bureaucrat in charge of health care policy instead of the patient and the doctor making the choices in health care.

I believe we cannot just be against this bill. What I do believe in is a step-by-step approach, an incremental approach, some good ideas on which we should be able to come together.

I think both sides agree we should eliminate preexisting conditions. Somebody who played by the rules, had insurance, happened to get a disease, they should not be penalized, charged outrageous prices, or have their insurance dropped. I think we can all agree on that.

We should be able to agree that if you can buy auto insurance across State lines, you should be able to buy health insurance in the State where it is the cheapest. Individuals should be able to find a State that has a policy that fits them and their family and be able to buy it there. If you can save money and you happen to be uninsured, especially today, it seems to make sense. Let's have that as one of our incremental steps.

I also believe this bill covers some of it, but I believe we need to incentivize people to engage in healthier behaviors. Seventy-five percent of all health care costs are caused by people's behaviors. Let me repeat that. Three-quarters of all health care costs are driven by people's poor choices in their behavior.

For instance, smoking. On average, it is around $1,400 a year to insure a smoker versus a nonsmoker. For somebody who is obese versus somebody with the proper body weight, it is about the same, $1,400 a year. For somebody who does not control their cholesterol versus somebody on regulating medication, it is several hundred dollars a year. For somebody who does not control their blood pressure versus somebody who does—let's give incentives through lower premiums to encourage people to engage in healthier behaviors. That will save money for the entire health care system and our Country will have healthier people with better quality lives.

Currently, big businesses, because of their number of employees, are allowed to take advantage of purchasing power. We ought to allow individuals and small businesses to join together in groups to take advantage of that purchasing power. They are called small business health plans.

I believe my colleagues are going to talk about an idea they have, something I talked about for years, the idea of medical liability reform. There are several models out there. They are going to talk about a loser pays model, which other countries have engaged in and they do not have nearly the frivolous lawsuits nor the defensive medicine we practice in this country.

How many doctors order unnecessary tests in the United States because of fear of frivolous lawsuits? Talk to any doctor, and they will tell you every one of them orders unnecessary tests simply to protect themselves against the possibility that a jury may say: Gee, why didn't you order this test even though it was not indicated at the time?

That accounts for a large amount of medical costs. As a matter of fact, the Congressional Budget Office said $100 billion between the private and public sector would be saved with a good medical liability reform bill.

I believe we need a patient-centered health care system, not an insurance company-centered health care system, not what this bill does, a government-centered health care system, where bureaucrats are in control of your health care. We need a patient-centered system.

Before us we have the Mikulski amendment. This is more of government-centered health care. There is a report out based on prevention that indicates that mammograms should not be paid for, basically, for women under

50 years of age, from 40 to 50 years of age, and women in the Medicare population age, the report indicates that they do not need annual mammograms. This was based mainly on cost. If you look at it from a cost standpoint, that is probably correct.

But think about it. If you are a woman and you get cancer and you could have had a mammogram diagnose it a lot earlier, you sure would rather have had that mammogram rather than have that mammogram denied.

The Senator from Maryland has proposed an amendment to try to fix the problem. The problem is, instead of one government entity determining whether somebody is going to get coverage, the amendment turns it over to the Secretary of Health and Human Services. Another government bureaucrat will determine whether something such as a mammogram will be paid for. According to the Associated Press, her amendment does not even mention mammograms.

Senator MURKOWSKI and Senator COBURN have come up with an alternative that actually puts the decision of whether to cover preventive services in the hands of experts in the field. Whether it be a mammogram for breast cancer, or an MRI, which most people think is going to be better than a mammogram for diagnosing breast cancer, or whether it is a test for prostate cancer for men. Those kinds of things should be determined by experts in the field, not by government bureaucrats.

The various colleges—the American College of Obstetrics and Gynecology, for instance, has come out with certain recommendations, along with the American College of Surgeons. Those are the experts with peer-reviewed science. Those are the individuals who should determine what the recommendations are as to whether we pay for preventive services, not government bureaucrats.

Unfortunately, the Mikulski amendment just gives that determination to a government bureaucrat. That is why we should reject the Mikulski amendment, and adopt the amendment offered by the Senator from Alaska, the Murkowski amendment puts the decision making in the hands of the of the experts, where that decision should be made.

Let me close with this point. We have seen a lot of comparisons where are people saying that other countries have a better health care system than the United States. Let me give you the example of cancer survival rates.

This chart compares the average cancer survival rates in the European Union and the United States, it makes the point as to whether a government bureaucrat is making a health decision or the doctor and the patient are making the health treatment decision.

For kidney cancer, the European Union has a 56 percent 5 year survival rate; the United States, 63 percent survival rate after 5 years. On colorectal cancer, about the same difference between the United States and the European Union. Look at breast cancer, 79 percent after 5 years in the European Union; 90 percent in the United States. The most dramatic difference is on prostate cancer, 78 percent survival after 5 years in the European Union; 99 percent survival rate in the United States.

These are dramatic differences. Where would you rather get your health care if you had one of these cancers? The United States or Europe?

Canada, has even worse results than this. As a matter of fact, Belinda Stronach, a member of the Canadian Parliament, led the charge against a private system side by side with the government-run system in Canada. She did not want the private system.

Tragically, a couple years later, she developed breast cancer. Did she stay in Canada to get treatment, where there is a government-run health care system? No. Where did she go? She came to the United States. She was actually treated at UCLA. Why, because we have a superior system of quality in the United States.

We have a problem with cost. Some of the incremental steps I talked about will address costs.

I wish to turn it over now to my colleagues who are going to talk about medical liability reform. Let's look out for the patient instead of the trial lawyers in the United States. Their idea on a loser pays system, I think, has a lot of merit, and it is something this body should consider very seriously.

I yield the floor to the Senator from Georgia, my good friend and colleague.

Mr. CHAMBLISS. Mr. President, I thank the Senator from Nevada for yielding. Senator GRAHAM and I do have an amendment we have filed today with respect to reforming the health care system in a real, meaningful way. It is an amendment that deals with tort reform, and it is a true loser pays system. We are going to talk about that in a few minutes.

Before I get to that, I wish to go back to some of the points the Senator from Nevada has talked about. I particularly appreciate his work on the mammogram issue, especially since this has been highlighted over the last couple weeks with regard to the recommendation that has come out of the independent board that advises HHS. I thank him for his work on that issue.

He is dead on. All of us know our wives are told every year, when they reach a certain age, they need to have a mammogram to make sure. Just like we do every year, go in and get a physical, they need to get their mammogram. The Senator talks about those kinds of checkups providing you with the kind of preventive health care that is going to hold down health care costs. I am a beneficiary of that. During a routine medical examination in 2004, it was determined I had prostate cancer. I was very fortunate it was picked up when it was, at an early stage. Instead of having to go through a lot of expensive procedures I might have had to go through, we were fortunate to be able to treat it. We are working on getting cured.

Senator ENSIGN is exactly right, this is the kind of test we need to make sure we encourage females to get and not put barriers in front of them.

Medicare is such a valuable insurance policy and program that 40 million Americans today take advantage of it. Mr. President, 1.2 million Georgians are Medicare beneficiaries. Again, I am one of those who is a Medicare beneficiary. So this is particularly important to me.

More importantly, in addition to these 40 million Medicare beneficiaries who are in the country today, there are another 80 million baby boomers who are headed toward Medicare coverage.

We have an independent Medicare Commission that was established by Congress years ago that is required to come to Congress every year and give Congress an update on the financial solvency of the Medicare Program. The purpose of that bipartisan Commission is to allow this body, along with our colleagues over in the House, the benefit of the work they do every year in looking at the amount of revenues that come in, in the form of the Medicare tax, and the outlays that go out, in the form of payments to medical suppliers for our Medicare beneficiaries.

In the spring of this year, 2009, the independent Medicare Trustees Report reported back to Congress and said that unless real, meaningful reforms are made in the Medicare system, Medicare is going to start paying out more in benefits than it takes in in tax revenues in the year 2017.

Mr. President, what that means is that in 2017, Medicare is going to be insolvent, and it is just a matter of time before Medicare goes totally broke. And those individuals who are baby boomers, who have been paying into this program for 40 years, 50 years, or whatever it may be, are all of a sudden going to reach the Medicare age, where they expect to reap the benefits of the Medicare taxes they have been paying for all these years, and guess what. Not only are benefits going to be reduced, but unless something happens, unless there is meaningful reform and it is done in the right way, there is not going to be a Medicare Program.

I want to go back to something the junior Senator from Illinois said a few minutes ago. In talking about this issue of cuts in Medicare, he said this bill we have up for debate now that was filed by Senator REID does not have

cuts in Medicare. He could not be more incorrect. And that is not a Republican statement. It is not a statement by anybody other than the Congressional Budget Office. I refer to a letter that has already been introduced during the course of this debate—a letter dated November 18—to the Honorable HARRY REID, the majority leader. I would refer the Senator to page 10 of that letter in which the Director of the Congressional Budget Office says this in reference to provisions affecting Medicare, Medicaid, and other programs:

Other components of the legislation would alter spending under Medicare, Medicaid and other Federal programs. In total, CBO estimates that enacting these provisions would reduce direct spending by $491 billion over the 2010–2019 period.

Then the letter goes on, on this page alone, to delineate three areas where Medicare provisions are going to be reduced or cut, and I would specifically refer to them, but first is a fee-for-service sector, and this is other than physician services. It is going to be reduced by $192 billion over 10 years. The Medicare Advantage Program—a program that literally thousands of Georgians take advantage of today and millions of Americans take advantage of—is going to be reduced by $118 billion over 10 years, over the period 2010 to 2019. Medicaid and Medicare payments to hospitals—what we call disproportionate share payments, DSH payments—are going to be reduced or cut by $43 billion over 10 years.

What does a reduction in these benefits mean to each individual community or each individual State? I can tell you what it means to the local hospital in the rural area of Georgia where I live. The reduction in DSH payments is going to amount to a reduction in income at Colquitt Regional Medical Center in Moultrie, GA, by $16.8 million over a 10-year period. These cuts in Medicare are going to result in a reduction in payments to Emory Hospital in Atlanta in the amount of $367 million over a 10-year period.

So anybody who says these aren't cuts in Medicare spending simply has not read the bill and certainly has not read the letter from the Director of the Congressional Budget Office to Senator REID dated November 18, 2009.

I want to turn this over to my colleague from South Carolina after this final statement with reference to reductions in Medicare spending.

There is a specific reduction of $8 billion in this bill over a 10-year period in hospice benefits.

Again, we have heard a number of personal stories around here, and I have a particular personal story myself. My father-in-law died when he was 99 years old. It was 3 years ago. The last 2 years of his life, he lived in an assisted-living home and he had hospice come in 2 or 3 or 4 days a week, for whatever he needed. Had he not had the benefit of hospice, he would have had to go in a hospital, and no telling how much in the way of Medicare medical expenses he would have incurred. But thank goodness we had hospice available, and he spent 2 days in the hospital. Otherwise, he was able to live in his assisted-living home, have my wife go by and spend quality time with him, which she will tell you today were the best 2 to 3 years of her life as far as her relationship with her father was concerned, because she had hospice there to take care of him. Yet here we are talking about reducing a benefit by $8 billion that saved no telling how many thousands of dollars in the case of my family, and you can multiply that across America, and it is pretty easy to see we don't need to be reducing a benefit that is going to save us money in the long run.

I would like to turn it over to my friend from South Carolina, who also has some comments regarding Medicare, and then we will talk about our loser pays bill.

Mr. GRAHAM. I thank my friend from Georgia, and I will try to be brief.

I guess to say that we need to do health care reform is pretty obvious to a lot of people. The inflationary increases in the private sector, to businesses, particularly in the health care area, are unsustainable. A lot of individuals are having to pay for their own health care costs and are getting double-digit increases in premiums. In the public sector, the Medicare and Medicaid Programs are unsustainable. Medicare alone is $38 trillion underfunded.

Over the next 75 years, we have promised benefits to the baby-boom generation and current retirees, and we are $38 trillion short of being able to honor those benefits.

What has happened? We have created a government program that everyone likes, respects, and is trying to save, and actuarially it is not going to make it unless we reform it. So what have we done? In the name of health care reform, we have taken a program many senior citizens rely upon—all senior citizens, practically—and we have reduced the amount of money we are going to spend on that program and then taken the money from Medicare to create another program the government will eventually run. It makes no sense.

We need to look at saving Medicare from impending bankruptcy. Why would we reduce Medicare by $464 billion and take the money out of Medicare, which is already financially in trouble, to create a new program? It makes no sense to me. That is not what we should be trying to do, from my point of view, to reform health care.

The Medicare cuts Senator CHAMBLISS was talking about, they are real. The way our Democratic colleagues and friends try to get to revenue neutrality on the additional spending, to get it down to where it doesn't score in a deficit format, is they take $464 billion out of Medicare to offset the spending that is required by their bill.

Here is the question for the country: How many people in America really believe this Congress or any other Congress is actually going to reduce Medicare spending by $464 billion over 10 years? I would argue that if you believe that, you should not be driving. There is absolutely no history to justify that conclusion.

In the 111th Congress, there were 200 bills proposed—and I was probably on some of them—to increase the amount of payments to Medicare. In 1997, we passed a balanced budget agreement when President Clinton was President slowing down the growth rate of Medicare. That worked fine for a while, until doctors started complaining, along with hospitals, about the revenue reductions. Every year since about 1999, 2000, we have been forgiving the reductions that were due under the balanced budget agreement because none of us want to go back to our doctors and say we are going to honor those cuts that were created in 1997 because it is creating a burden on our doctors. Will that happen in the future? You better believe it will happen in the future. In 2007, Senators CORNYN and GREGG introduced an amendment to reduce Medicare spending by $33.8 billion under the reconciliation instructions. It got 23 votes. I remember not long ago the Republican majority proposed reducing Medicare by $10 billion. Not one Member of the Democratic Senate voted for that reduction. They had to fly the Vice President back from Pakistan to break a tie over $10 billion.

So my argument to the American people is quite simple: We are not going to reduce Medicare by $464 billion, and if we don't do that, the bill is not paid for, and that creates a problem of monumental proportions. If we do reduce Medicare by $464 billion and take the money out of Medicare to create another government program, we will do a very dishonest thing to seniors. We are damned if we do and damned if we don't. And during the whole campaign, I don't remember anybody suggesting that we needed to cut Medicare to create health care reform for non-Medicare services, but that is exactly what we are doing.

To my Democratic colleagues: There will come a day when Republicans and Democrats are going to have to sit down and seriously deal with the underfunding of Medicare and with the impending bankruptcy of Medicare. Everything we are doing in this bill may make sense to save Medicare from bankruptcy, but it doesn't make sense to pay for another government-run health care program outside of Medicare. It makes no sense to take the savings we are trying to find in Medicare and not use them to save Medicare

from what I think is going to be a budget disaster.

So let it be said that this attempt to pay for health care, to make it revenue neutral, will require the Congress to do something with Medicare that it has never done before and is not going to do in the future. So the whole concept is going to fall like a house of cards.

The way we have tried to pay for this bill has so many gimmicks in it, it would make an Enron accountant blush.

Now, as to tort reform, quite frankly, I used to practice law and did mostly plaintiffs' work. I am not a big fan of Washington taking over State legal systems. I prefer to let States do what they are best at doing and let the Federal Government do a few things well—and we are doing a lot of things poorly. But if we are going to take over the entire health care system, if that is going to be the option available to us, then we also need to nationalize the way we deal with lawsuits.

And to the AMA: There will come a day, if we keep going down the road here, where the Federal Government will determine how you get to be a doctor. There will be no State medical societies, and we will have a national system to police doctors. That is what is coming if we continue to nationalize health care.

So, with Senator CHAMBLISS, I have tried to come up with a more reasoned approach when it comes to legal reform. I have always believed people deserve their day in court. There is no better way to resolve a dispute than to have a jury do it. I would rather have a jury of independent-minded citizens decide a case than a bunch of politicians or any special interest group. So the jury trial, to me, is a sacrosanct concept that has served this country well.

But one thing I have always been perplexed about in America is that the risk of suing somebody is very one-sided. Most developed nations have a loser pays rule. I think you should have your day in court, but there ought to be a downside to bringing another person into the legal system. So I think a loser pays rule will do more to modify behavior than any attempt to cap damages. Let both wallets be on the table. You can have your day in court, but if you lose, you are going to have to pay some of the other side's legal cost, which will make you think twice.

As to the indigent person, most people who sue each other are not indigent. The judge would have the ability to modify the consequences of a loser pays rule, but we need to know going in that both wallets are on the table. Under our proposal, we have mandatory arbitration where the doctor and the patient will submit the case to an arbitration panel. If either side turns down the recommendation of the panel, they can go to court. But then the loser pay rule kicks in.

I think that will do more to weed out frivolous lawsuits than arbitrarily capping what the case may be worth in the eyes of a jury. I think it really does create a financial incentive not to bring frivolous lawsuits that does not exist today.

If there is a $500,000 damage cap, most of the people I know would say: I will take the $500,000. That is not much of a deterrent. But if we told someone they can bring this suit if the arbitration didn't go their way, but if they go into court after arbitration they risk some of their financial assets, people will think twice. I think that is why this is a good idea. The National Chamber of Commerce has endorsed it, and I am proud of the fact that they have endorsed it.

I would rather not go down this road, but if we are going to nationalize health care we also need to do something about the legal system that is going to be affected by the nationalization of health care.

A final comment I would like to make about what we are doing is that it is probably worrisome to people at home that we are about to change one-sixth of the economy and cannot find one Republican vote to help. I guess there are two ways to look at that: It is the problem of the Republican Party or maybe the bill is structured in a way that is so extreme there is no middle to it. I would argue that what we have done is abandon the middle for the extreme. It is pretty extreme, in my view, to take a program that is $38 trillion underfunded, cut it, and take the money to create a new program rather than saving the one that is in trouble. It is pretty extreme, in my view, to take a country that is so far in debt you cannot see the future and add $2.5 trillion of more debt onto a nation that is already debt laden in the name of reforming health care.

When you look at the second 10-year window of this bill, it adds $2.5 trillion to the national debt. Is that necessary to reform health care? Do we need any more money spent on health care or should we just take what we spend and spend it more wisely? The first 10 years is a complete gimmick. What we do in the first 10 years of this bill is collect the $1/2 trillion in taxes for the 10-year period, and we don't pay any benefits until the first 4 years are gone. That is not fair. That is a gimmick. That catches up with you in the second 10-year period.

So the reason we do not have any bipartisan support is because we have come up with a concept that has no middle to it. This is a power grab by the Federal Government. This is a chance to set in motion a single-payer health care plan that the most liberal Members of the House and the Senate have been dreaming of. This is a liberal bill written by and for liberals, and it is not going to get any moderate support on the Republican side—and there is some over here to be had—and they are going to have a hard time convincing those red State Democrats that this is good public policy. That is where we find ourselves, trying to change one-sixth of the economy in a way that you don't have any hope of bringing people together.

I would argue we should stop and start over.

I thank my good friend from Georgia for trying to find a way to change lawsuit abuse in a more reasoned fashion.

Mr. CHAMBLISS. I thank my colleague from South Carolina, Senator GRAHAM, for his thoughtful process that we went through in thinking through the loser pays bill and the amendment we have filed. Just like you, having practiced law for 26 years before I was elected to the House, the same year you were, and then we were elected over here, I tried plaintiffs cases as well as defendants cases. I never represented a defendant in a malpractice case. I was always on the other side.

I have great sympathy for individuals who are wronged by a physician who is negligent. You and I agree that anybody who is the victim of negligent action ought to have their day in court. That is what we provide for under our bill. There is absolutely no question about the fact that anybody who is subject to negligent acts on the part of a physician, they can have their day in court, and they should have their day in court if that is what they decide they want to do.

But under a loser pays provision like we have designed, we can eliminate, hopefully, the frivolous lawsuits that add significantly to the cost of health care delivery in this country. In 2003, direct tort litigation costs in America accounted for 2.2 percent of our GDP. That is double the percentage of Canada, Great Britain, Germany, France, and Australia—all of which have loser pays systems.

The State of Alaska has had a loser pays system since 1884 and tort claims in the State of Alaska constitute a smaller percentage of total litigation than the national average.

Florida, which applied a loser pays rule to medical malpractice suits from 1981 to 1985, saw 54 percent of their plaintiffs drop their suits voluntarily.

It does make a difference on frivolous suits. In the State of Florida during that same period of time, the jury awards for plaintiffs rose significantly. Just as in our situation, anybody who had a legitimate case in Florida during that period of time had the right to have their case adjudicated by a jury. Those who made the decision to do so received more significant awards. That is the way the system ought to work.

This is a win-win situation for the cost of health care delivery. It is a benefit to the physicians—sure, because they eliminate part of their significant cost of delivering health care services. But it also is a huge benefit to those individuals in America who are subject to negligent acts on the part of physicians.

I ask unanimous consent that a letter to Senator GRAHAM and myself from Bruce Josten at the U.S. Chamber of Commerce, dated November 3, 2009, be printed in the RECORD, and I yield the floor.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

NOVEMBER 3, 2009.

Hon. LINDSEY GRAHAM,
U.S. Senate,
Washington, DC.
Hon. SAXBY CHAMBLISS,
U.S. Senate,
Washington, DC.

DEAR SENATORS GRAHAM AND CHAMBLISS: The U.S. Chamber of Commerce, the world's largest business federation representing more than three million businesses and organizations of every size, sector, and region, thanks you for introducing S. 2662, the "Fair Resolution of Medical Liability Disputes Act of 2009."

This legislation represents a positive and significant step toward providing a more reliable justice system for the victims of medical malpractice. Your bill encourages the states to establish alternative methods for resolving medical liability claims and provides them with the latitude to develop unique approaches that fit the needs of their diverse populations. The Chamber commends you for making this important and thoughtful effort to bring needed reforms to America's medical liability systems.

The issue of medical liability reform is central to any serious effort to overhaul America's healthcare system. The Congressional Budget Office recently determined that medical liability reform would reduce total national healthcare spending by $11 billion in 2009 and reduce the federal budget deficit by $54 billion over 10 years. The Chamber believes these estimates of healthcare savings may be too conservative. Yet nonetheless, the $54 billion in deficit reduction is significant, representing over 10 percent of the net cost of the insurance coverage provisions agreed to in the Finance Committee's "America's Healthy Future Act of 2009." We are confident that you will be a forceful and effective advocate for medical liability improvements that will expand access to justice for injured patients and lower the cost of healthcare.

There is bipartisan agreement that for healthcare reform to be successful, it must "bend the growth curve," making healthcare delivery more efficient and slowing healthcare inflation. Medical liability reform should play a critical role in any such effort. The Chamber appreciates your work on this legislation and looks forward to working with you and the Senate in the coming weeks and months to refine your legislation and advance commonsense changes to our system of resolving medical liability claims.

Sincerely,

R. BRUCE JOSTEN.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Could the Chair inform me how much time was used on the Republican side during the last group of speakers?

The PRESIDING OFFICER. That was 42 minutes 14 seconds.

Mr. DURBIN. I thank the Chair. I am going to proceed to speak in the same manner and yield to the Senator from Vermont. Our time will be less than that in total.

I see the Senator from Louisiana is here. We are going to be speaking less than 42 minutes. We guarantee him that much. We will follow the same process, if there is no objection, that was just followed with three Republican speakers who spoke in that 42-minute period of time.

I ask unanimous consent that Senator SANDERS be recognized after me to speak and that our total time be no more than 42 minutes.

Mr. VITTER. I object.

The PRESIDING OFFICER. Is there objection? Objection is heard.

Mr. DURBIN. Mr. President, I just offered that to the Republican side, and they asked me for permission and I gave permission, unanimous consent.

We will speak as long as we like. We will enter into a colloquy. I hope the Senator from Louisiana will reconsider.

Let me try to address a few of the issues that have been raised on the Senate floor. First, on the issue of medical malpractice, this is an issue often brought up on the other side of the aisle.

The first thing I would like to say is this is the bill we are debating. It is 2,074 pages, and one extra page makes it 2075 pages. It has taken us a year to put this together. There have been a series of committee hearings that have led to the creation of this legislation. It has been posted on the Web site for anyone interested. If they go to Google, for example, and put in "Senate Democrats," they will be led to a Web site which will let them read every word of this bill. It has now been out there for 12 days at least, and it will continue to be there for review by anyone interested.

If you then Google "Senate Republicans" and go to their Web site on health care and look for the Senate Republican health care reform bill, you will find—this bill, the Democratic bill, because there is no Senate Republican health care bill. For a year, and with an enormous number of speeches, they have come to the floor and talked about health care but have never sat down and prepared a bill to deal with the health care system, which leads us to several conclusions.

This is hard work and they have not engaged in that hard work. It is easier to be critical of this work product. They have chosen that route. That is their right to do. This is the Senate. We are the majority party. We are trying to move through a bill. But all of the ideas they have talked about tonight and other evenings have not resulted in a bill.

Second, it may be that they do not want to see a change in the current system; they are happy with the health care system as it exists today. That is possible. In fact, I think it drives some of them to the point where they criticize our bill but do not want to change the system because they like it.

I guess there are some things to like about it. There are good hospitals and doctors in America. Some people are doing very well with the current system. But we also know there are some big problems. We know the current system is not affordable. We know the cost of health insurance has gone up 131 percent in the last 10 years; that 10 years ago a family of four paid about $6,000 a year for health insurance. Now that is up to $12,000 a year. We anticipate in 8 years or so it will be up to $24,000 a year. Roughly 40 percent or more of a person's gross income will be paid in health insurance.

That is absolutely unsustainable. So businesses are unable to offer health insurance as well as individuals are unable to buy health insurance. The Republicans have not proposed anything, nothing that will make health insurance more affordable. This bill addresses that issue. They have nothing.

Second, we know there are about 50 million Americans without health insurance. These are people who work for businesses that cannot afford to offer a benefits package. They are people who are recently unemployed, and they are people in such low-income categories they cannot afford to buy their own health insurance, and their children—50 million. This bill we have before us will give coverage to 94 percent of the people in America, the largest percentage of people insured in the history of our country.

The Republicans have failed to produce a bill that expands coverage for anyone in America. Under the Republican approach, nothing would be done to help the 50 million uninsured.

The third issue is one about health insurance companies. Everybody has an experience there. It is, unfortunately, not good for most, because when you pay premiums all your life and then need the health insurance, many times it is not there. What we do is give consumers bargaining power and a fighting chance with health insurance. That, to me, is a reasonable approach. It eliminates discrimination against people because of a preexisting condition and putting caps on the amount of money that is being paid. We extend the coverage for children under family health plans from age 24 to age 26. We do things that give people peace of mind that when they need health insurance for themselves and their family it will be there.

The Republicans fail to offer anything that deals with health insurance reform. That is a fact. They have said a lot about Medicare.

I would like to tell you that tomorrow, or soon, I will be cosponsoring and Senator BENNET of Colorado will be offering an amendment which could not be clearer on the issue of this bill and the Medicare Program. The amendment is so short and brief and direct and understandable, I want to read a couple of highlights:

Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed benefits under title XVIII of the Social Security Act.

That is Medicare. What Senator BENNET is saying is that people will have their Medicare benefits guaranteed. Nothing in this bill will infringe on their Medicare benefits, despite everything that has been said.

The Bennet amendment goes on to say:

Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

All of the speeches made in the last 3 days about how this bill threatens Medicare—it does not—will be completely cleared up by the Bennet amendment. I hope some Republicans who have a newfound love of the Medicare Program, which was started many years ago, will join us in voting for this amendment. It would be great to see if their speeches to save Medicare will result in their votes for the Bennet amendment. This is a critically important amendment. I commend him for being so straightforward and showing real leadership on an issue of this magnitude.

I know the Senator from Vermont is interested in speaking. I am prepared to yield for comments and questions. Before I do, I wish to say by way of introduction that we heard one of our Republican colleagues say this is a single-payer bill, that at the end of the day we will have created a single-payer system. I think the Senator from Vermont is familiar with the concept of single payer, and I would invite his comments or questions through the Chair to me about his feelings on this issue.

Mr. SANDERS. I thank my friend from Illinois for asking that question because, coincidentally, we have just introduced and brought to the desk legislation for a single-payer national health care program. I suggest to my friend from Illinois and my Republican friends that it is a very different bill than the legislation we are now looking at. In no way, shape, or form is the legislation being debated now a single-payer national health care program. As my friend from Illinois understands—and I ask his views on this—I have heard some of our Republican friends talk about how strong this current health care system is that we have right now. I ask my friend from Illinois, do you think we can do better than being the only major country in the industrialized world that does not guarantee health care to all of its people? Can we do better than that?

Mr. DURBIN. In response to the Senator from Vermont, we must do better. This is the only civilized, developed, industrialized country in the world where a person can literally die because they don't have health insurance. Forty-five thousand people a year die because they don't have health insurance. What does that mean? One illustration: If you had a $5,000 copay on your health insurance policy—and people face that—and you go to the doctor and the doctor says: Durbin, we think you need a colonoscopy, and I realize I have to pay the first $5,000 and the colonoscopy is going to cost $3,000, and I say I am going to skip it—which people do, and bad things happen—I develop colon cancer and die, my insurance has failed me. Basic preventive care is not there. We are the only civilized, developed country where that is a fact.

Mr. SANDERS. I ask my friend from Illinois, has he talked to physicians who have, on that issue, told him that they have lost patients who walked into their office and they say: Why didn't you come in here 6 months ago or a year ago? And that patient says: I didn't have any money, and I thought maybe the pain in my stomach or my chest would get better.

I have had that conversation with physicians in Vermont. I wonder if the Senator has talked to physicians who have said the same thing.

Mr. DURBIN. A lady I met 2 weeks ago in southern Illinois, 60 years old, a hostess at a hotel who serves breakfast in the morning—they are there as we travel around our States—has never had health insurance in her life, is diabetic, and told me that her income is so low, $12,000 a year, she could not afford to go to a physician to check out some lumps she had discovered. That is the reality of the current health care system in the wealthiest, greatest Nation on Earth.

Mr. SANDERS. We have heard discussions of death panels. I think the Senator might agree with me that when we talk about death panels, we are talking in reality about 45,000 people who die every single year because they don't get to a doctor on time. That seems to me to be what a death panel is.

In the midst of all this, with 46 million uninsured, with 45,000 people dying every year because they don't get to a doctor when they should, when premiums have doubled in the last 9 years, when we have almost 1 million Americans going bankrupt because of medically related bills, I ask my friend from Illinois, isn't it time for a change? Isn't it time this country now moves forward and provides health care for all of our people in a comprehensive and cost-effective way?

Mr. DURBIN. Mr. President, I certainly agree with the Senator from Vermont. I would add one more statistic. Of the nearly 1 million people filing for bankruptcy in America each year because of health care costs, medical bills they can't pay, three-fourths of them have health insurance. Three-fourths of them were paying premiums. These were the people turned down when they needed coverage. These were the people who ran into caps on coverage on their policies. These are folks who had to battle it out and lost the battle with the insurance companies to try to get lifesaving drugs. That is the reality of the current system.

The fact is, the Republican side of the aisle has not produced an alternative. We have. We have worked long and hard to do it. They have not.

Mr. SANDERS. I ask my friend from Illinois if we are not only dealing with the personal health care issue of 46 million uninsured and people dying, but are we not dealing with a major economic issue? How are businesses going to compete with the rest of the world when every single year they are seeing huge increases in their health insurance premiums, and rather than investing in the business that they are supposed to be in, they are having to spend enormous sums of money as health care costs soar? I know small businesses in Vermont tell me that in some cases not only can they not provide health insurance to their workers, they cannot even provide it for themselves. I have to believe there is a similar situation in Illinois.

Mr. DURBIN. It is. We are sent many books and some of them I have a chance to glance at. This is the recent one I received, entitled ''Bend the Health Care Trend.'' They have here information which says: American health care spending reached $2.4 trillion in 2008 and will exceed $4 trillion by 2018. We expect a doubling of basic health insurance premiums in 8 to 10 years, and we know what you just described is reality. Even businesses owned by a couple, a husband and wife, are finding themselves not only unable to provide health insurance for their employees, because of its cost, they can't cover themselves.

I had a friend of mine, one of my boyhood friends, I grew up with him and his wife. His small business had one of their employees under the health insurance plan, and his wife had a baby with a serious illness. As a result, their premiums went through the roof. He had to cancel his group health insurance. He had to cancel the insurance he

gave to his employees. He gave his employees the $300 a month, whatever it was they were paying, and said: We are all on our own now. We have to go in the private market. The couple with the sick baby couldn't find any health insurance. My friend, who was in his 60s, and his wife are in a pitched battle every year about how much they have to pay for health insurance and the company, the only one that will cover them, each year excludes whatever they turned a claim in for last year. So that is the reality of health insurance for small businesses.

I also want to tell my friend from Vermont, about one-third of all realtors in America are uninsured, have no health insurance. They are independent contractors, and they have no health insurance, one out of three.

Mr. SANDERS. While we are talking about the economics of health care, I wonder if my friend from Illinois has had the same experience I have had in Vermont where people tell me they are staying on the job, not because they want to stay on their job but because the job is providing decent health insurance. They can't go where they want to go because the new job may not provide insurance or they are afraid about the interval when they may not have any health insurance at all. I wonder if my friend from Illinois happened to see the piece in the paper, unbelievable, where a middle-aged fellow joined the U.S. military because his wife was suffering from cancer, and he couldn't find a way to get health care for her so he joined the military. Does the Senator think this is what should be going on in the greatest country in the world?

Mr. DURBIN. We can do better. I would say to those who call our plan a single-payer plan, what we are trying to do is to get fair treatment from private health insurance companies for consumers and families across America and to give them choices. The Senator from Vermont, I assume, is part of the Federal Employees Health Benefits Program. So am I. Most Members of Congress belong to the program. Eight million Federal employees and Members of Congress are part of this program. It may be the best health insurance in America. And we can shop. I just got a notice in the mail that says open enrollment is coming. If you don't like the way you were treated by your health insurance plan last year, you can change. You can pick a new one. If it is a generous plan, more money will be taken out of your check. If it is not, less money will be taken out. We can shop. What we do on the insurance exchanges in this bill is say to these Americans who wouldn't otherwise have options, go shopping. Find the best health insurance plan for your family. Exercise your choice.

I would say to Senator HARRY REID, who drafted this bill, I thank him for his hard work. He includes a public option, a not-for-profit health insurance plan with lower costs that people can choose, if they care to. Giving people that choice, giving them an option to go shopping for the most affordable, best health insurance plan is what we enjoy as Members of Congress and what every American family should.

Mr. SANDERS. I ask my friend from Illinois, does he think some of our Republican friends feel so threatened and so upset by giving the American people the option to choose a public Medicare-type plan as opposed to a private insurance plan? Do you think that maybe, just maybe, some of our friends are more interested in representing the interests of the big private insurance companies rather than the needs of the American people?

Mr. DURBIN. I say to my colleague from Vermont, I am waiting for the first Republican Senator to offer an amendment to this bill to abolish Medicare. If they really believe that government health insurance is such a bad idea, they ought to step right up and show it.

Mr. SANDERS. I would say to my friend from Illinois that that is an interesting proposal and, in fact, I was almost thinking of offering an amendment at one point. We have a lot of people in this country who stand up and say: Get the government out of health care. Well, I think some of my Republican friends have kind of echoed that message. I do think that the Senator from Illinois is right. We may bring forth an amendment to allow our Republican friends to say: Let's abolish the Veterans' Administration. Because, as you know, that is a government-run program which most veterans in my State and I think around the country are very proud of. They think it is a good program. From what the statistics tell us, it is a very cost-effective way to provide quality health care to all of our veterans. Maybe we should bring forward an amendment to those who say get the government out of health care. If you want to abolish the Veterans' Administration, go for it. And what about TRICARE. Maybe you want to abolish TRICARE. Go for it. Maybe you want to abolish SCHIP which is providing high quality health insurance for millions of kids. Maybe we might work together and bring forth an amendment.

Let our Republican friends who say get the government out of health care, let them abolish the Veterans' Administration, Medicare, SCHIP, Medicaid, let them do that. We will see how many votes they might get.

Mr. DURBIN. There is another way that Senators who loathe the idea of government-run health insurance plans can show personally their commitment to that idea, by coming to the floor and publicly announcing they will not participate in the Federal Employees Health Benefit Program which provides health insurance for Members of Congress. I have yet to hear the first Member, critical of government health plans, come forward and say: So in a show of unity and personal commitment, I am going to opt out.

Mr. SANDERS. I suggest to my friend from Illinois that we could take it a step further. I go to the Capitol physician's office. That is where I go. We pay extra money for it. I have Blue Cross/Blue Shield, but I go there. Do you know who runs the Capitol physician's office, which I suspect the vast majority of the Members of Congress go to and get very fine primary health care?

Well, it is that terrible government agency, the U.S. Navy. So maybe some of our friends who are busy denouncing government health care might want to say they do not want to take advantage of that very fine, high quality health care, and that speaks for the whole military as well. While we are at it, maybe you should abolish health care for the U.S. military, which is all government run and, by the way, generally regarded as pretty good quality health care.

I would ask my friend his views on that.

Mr. DURBIN. I do not think you will hear that. I think you will hear a lot of speeches about socialized medicine, socialism, and the big reach of government.

When it comes right down to it, there is not a single Member from the other side who stepped up and said: Therefore, I will offer an amendment to abolish it. They will have their chance in this bill, and if they want to, they can. I do not think the people who have this coverage today would like to see it gone.

Mr. SANDERS. It might be an interesting amendment, I would say to my friend. There is another area where it is a semigovernment nonprofit, which I know the Senator from Illinois feels very strongly about, and that is the Federally Qualified Community Health Centers begun by Senator Kennedy over 40 years ago, where we now have over 1,200 community health centers all over this country. In fact, I know this is widely supported in a bipartisan or tripartisan way, because the Federally Qualified Community Health Centers provide quality health care and dental care and low-cost prescription drugs and mental health counseling.

I might say to my friend from Illinois, one of the provisions in that 2,000-page bill he is holding up is legislation he and I and others have worked hard on, which is to substantially expand the Community Health Center Program into every underserved area in America. We talk about 46 million people being uninsured in this country. We have 60 million people who do not have access to a doctor on a regular basis.

If we expand the Community Health Center Program, if we expand to a significant degree the National Health Service Corps so we can help young people become primary health care physicians by paying off their very substantial medical debts, would my friend agree with me that this would be a major step forward in improving primary health care in America?

Mr. DURBIN. The Senator from Vermont has been a leader on this issue. I can recall when President Obama came forward with his stimulus bill, the recovery and reinvestment bill, that the Senator from Vermont was one of the leaders to put additional funds in the bill to build clinics all across America—in rural areas we represent, in the towns and cities we represent as well—for the very reason the Senator mentioned: Because for a lot of people who I represent in downstate, southern Illinois, in some of the rural regions, it is a long drive to a doctors clinic for primary care. So these community health clinics, FHQA clinics, are going to offer people primary care.

I think as a result of this bill, when we enact it—and I feel very good about the enactment of this because I think we sense this is a moment in history we should not miss—we are going to see this network grow across America. And it has proven itself to be so good.

In the city of Chicago, I have visited these community health clinics. I will bet the Senator does in Vermont. What I find there—many times I will walk in the door. The administrator will be there. We will start talking. I will meet the doctors. I will meet the nurses. When I finally get a chance to drink a cup of coffee and talk to them for a few minutes, I say—and I mean it—if I were sick, I would feel confident walking into the front door of this clinic, that I would be in the best of hands—better than the most expensive clinic in my State.

Mr. SANDERS. My friend from Illinois makes the point. And I have visited virtually all of them in the State of Vermont. We have gone from 2 to 8, with 40 satellites. We have over 100,000 people in the State of Vermont who now use these Federally Qualified Health Centers.

I know my friend from Illinois is also aware that when you talk about health care, you have to talk about dental care.

Mr. DURBIN. Yes.

Mr. SANDERS. Because what is true in Vermont is true in Illinois. You have a whole lot of people who do not have access to a dentist, which these Federally Qualified Health Centers now provide, and mental health counseling, and low-cost prescription drugs.

So I thank my friend from Illinois. I am sure the Senator and I are going to work together to make sure we, in fact, are successful in keeping people out of the emergency room, keeping them out of the hospital, by enabling them to get the medical care they need when they need it. I look forward to working with my friend on that.

Mr. DURBIN. I might say, the Senator from Vermont has also raised an important issue. We know we are going to need more primary care physicians, so there are provisions in this bill to encourage young people to pursue primary care—internists, family practitioners—because those are the frontline people who are needed more frequently for preventive care and basic checkups, so people have a chance to see a good doctor before they get sick or become seriously ill and it is much more expensive.

Mr. SANDERS. Right.

Mr. DURBIN. So we are pushing forward for more and more health care professionals. Again, the Republican critics of this legislation have offered nothing—nothing—when it comes to encouraging the growth in the number of our health care workers in America. This ought to be something that is nonpartisan. I would think that at some point they would agree that many things in here are essential for the future of our country. I think that is one of them.

Mr. SANDERS. Would my friend from Illinois agree, it does not make a whole lot of sense for people who do not have health insurance today to go into an emergency room and run up a huge cost or to get terribly ill because they do not go to a doctor when they should and end up in the hospital? Wouldn't it make a lot more sense, both for the personal health of the individual and saving money for the system, to provide health care to people when they need it?

Mr. DURBIN. I agree with the Senator from Vermont. I would say we have some of the best health care in America but also the most expensive health care in America. We spend more per person than any other nation on Earth, and a lot of it has to do with money not being well spent. People who do not have access to a medical home, which we establish in this bill, people who do not have access to a community health care clinic, in desperation, will take a baby with a high fever in to an emergency room.

Mr. SANDERS. Right.

Mr. DURBIN. They will wait for hours to finally see a doctor. Once there, they will have the most expensive care they could ever face, when they could have gone for a doctor's appointment.

Mr. SANDERS. Exactly.

Mr. DURBIN. And taken care of it for a fraction of the cost. That is not good for the hospitals because many of them are giving charity care they do not get compensated for, and they pass that cost along to other patients, and it certainly is not good for the families involved.

Mr. SANDERS. At this point, let me thank my friend from Illinois for allowing me to engage in this colloquy with him. I am going to yield back the floor to him and thank him for his very good work.

Mr. DURBIN. I thank the Senator from Vermont.

I say, at this point in time, we have three or four amendments before the Senate on health care reform. We started the debate on Monday. We are now wrapping up Wednesday. We are about to go into the 4th day of the debate on one of the most important bills in the history of the U.S. Senate, and we have yet to reach an agreement with the Republican side of the aisle to have the amendments voted on.

If we are only doing four amendments or three amendments in 4 days, this is not going to be the kind of debate the American people expected. They expected us to bring issues before the floor here, debate them, with a reasonable period of time, and then vote and move to another issue. Certainly, there are a lot of things to talk about.

So I hope the Republican side of the aisle will have a change of heart and will start to join us in this dialog, will offer their amendments in a timely fashion—we will give them their opportunity to debate them—and then bring them to a vote. But the fact is, we have not had a single vote this week on health care reform amendments because of objections from the other side. That is not in the interest of moving forward this important legislation and giving Members an opportunity to present their amendments and have them voted on in a timely fashion.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent that after any leader time on Thursday, December 3, and the Senate resumes consideration of H.R. 3590, it be in order for any of the majority or Republican bill managers to be recognized for a total period of time not to extend beyond 10 minutes, equally divided and controlled; that the time until 11:45 a.m. be for debate with respect to the Mikulski amendment No. 2791 and the McCain motion to commit; and during this time it be in order for Senator MURKOWSKI to call up her amendment with respect to mammography, a copy of which is at the desk; and that it also be in order for Senator BENNET of Colorado to call up amendment No. 2826, a side-by-side amendment with respect to the McCain motion to commit; that no other amendments or motions to commit be in order during the pendency of these amendments and motion; that at 11:45 a.m., the Senate proceed to vote in relation to the Mikulski amendment No. 2791; that upon disposition of the Mikulski amendment, the Senate then

proceed to vote in relation to the Murkowski amendment; that upon disposition of these two amendments, the Senate continue to debate until 2:45 p.m. the Bennet of Colorado amendment No. 2826 and the McCain motion to commit, with the time equally divided and controlled between Senators BAUCUS and MCCAIN or their designees; that at 2:45 p.m., the Senate proceed to vote in relation to the Bennet of Colorado amendment No. 2826; that upon disposition of that amendment, the Senate then proceed to vote in relation to the McCain motion to commit; that prior to the second vote in each sequence, there be 2 minutes of debate, equally divided and controlled in the usual form; that each of the above referenced amendments or motion be subject to an affirmative 60-vote threshold, and that if the amendments or motion do not achieve that threshold, then they be withdrawn; further, that if any of the above listed achieve the 60-vote threshold, then the amendment or motion be agreed to, and the motion to reconsider be laid upon the table; further, that it be in order if there is a request for the yeas and nays to be ordered with respect to that amendment or motion, regardless of achieving the 60-vote threshold, that if the yeas and nays are ordered, the vote would occur immediately with no further debate in order with respect to this particular consent.

The PRESIDING OFFICER. Is there objection?

Mr. VITTER. Mr. President, reserving my right to object.

The PRESIDING OFFICER. The Republican leader.

Mr. McCONNELL. Mr. President, reserving the right to object, and I will not object, I would just like to point out we have had some difficulty actually on both sides getting to the two votes that are designated in this consent agreement.

Our side of the aisle, the Republican side of the aisle, was prepared to vote on both of those amendments tonight. Then a problem developed on the other side, which I understand because we had had a problem on our side earlier. But I do just want to make it clear that Republicans were prepared and fully ready and willing to vote on the two amendments in the consent agreement tonight.

Mr. President, I do not object.

Mr. VITTER. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Thank you, Mr. President.

Mr. President, I certainly concur with the distinguished majority whip's goal of more amendments and more votes.

With regard to this very important screening and mammography issue, my goal has been a very focused one. I have a filed second-degree amendment that has a very simple, focused objective, which I believe is extremely noncontroversial. I believe it would be supported by everyone in this body, and that is simply to ensure that there is no legal force and effect to the recent recommendations issued in November of 2009 by the U.S. Preventative Services Task Force with regard to breast cancer screening, use of mammography, and self-examination.

As everyone knows, those new recommendations were shocking in that they took a giant step back from the previous recommendations and took a giant step back in terms of recommended screening, which virtually every expert I know of strongly disagrees with.

So this filed, simple second-degree amendment simply says that those new recommendations of November of this year have no force and effect. I will read the amendment. It is very short. To be clear, it does nothing more than that.

> [F]or the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

So we are simply ensuring that those new recommendations—which I strongly disagree with, experts strongly disagree with, I believe all of my colleagues do—have no legal force and effect. So I would simply ask that the unanimous consent proposed be modified so that the Mikulski amendment incorporates this language. I would propose that as an alternative unanimous consent request.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request from the Senator from Illinois?

Mr. VITTER. Yes, I continue to reserve my right to object. I am very disappointed about objecting to this important and what should be noncontroversial provision. I would suggest another solution, which is to take the unanimous consent request on the floor and modify it so there is simply a vote on this second-degree amendment, amendment No. 2808, immediately before the vote on the Mikulski amendment.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I am not sure I would support or oppose the amendment offered by the Senator from Louisiana, but this matter has been on the floor now for 3 days. I say to the Senator, there is a pending amendment here on your side of the aisle from Senator MURKOWSKI on this issue, and I would hope that the Senator has approached her to incorporate his language. I do not know if the Senator approached Senator MIKULSKI. But at this point we think we have some effort being made at fairness on both sides, that there will be Democratic amendments and Republican amendments both offered—Mikulski and Murkowski and McCain and Bennet—and so I would object because I believe we have the basis for a fair agreement at this point.

The PRESIDING OFFICER. Objection is heard. Is there objection to the original request of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving my right to object, again, I am very disappointed to hear that. I have approached both sides. Senator MURKOWSKI has incorporated similar language, and I was hoping we could come together, 100 to nothing, to actually pass this on to the bill, whichever alternative tomorrow is voted up—and maybe they both will be—but whichever is voted up or whichever is voted down, I think it is very important to come together and state that we don't want these new task force recommendations to have any force and effect.

So let me propose a third and final alternative unanimous consent request: that at any point after these votes, but before cloture is filed on the pending matter, this amendment No. 2808 receive a vote on the Senate floor as a first-degree amendment to the underlying bill.

Mr. DURBIN. Mr. President, reserving the right to object, may I suggest to my friend from Louisiana, would you consider approaching Senators MIKULSKI and/or MURKOWSKI the first thing tomorrow and see if they are prepared to work with you on this? This Mikulski amendment has been pending for 3 days.

Mr. VITTER. Mr. President, if I could——

Mr. DURBIN. Well, then, I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request?

Mr. VITTER. Mr. President, reserving my right to object, just so I can respond directly, I didn't mean to cut the Senator off. If he has any further statement, I will be happy to listen to it. But just so I can respond directly, the first thing today, I approached both those Members and everyone involved in this debate about this language and certainly the majority side has had this language for at least 7½ hours. The equivalent of this language has been incorporated into the Murkowski amendment, but my hope is that the same thing be accepted in the Mikulski amendment because it is not clear

which is going to be adopted. I don't see the great controversy here. So that was my hope. And that is why I approached those two Senators and the majority side 7½ hours ago about it with specific language.

So I renew my last unanimous consent request I made in that spirit.

Mr. DURBIN. Reserving the right to object, the staff advises me that they are reaching out to Senator MIKULSKI at this moment. I don't know if we can be in contact with her this evening, but I would ask the Senator from Louisiana if he would consider allowing us to go forward with this unanimous consent request and hope we can still modify it tomorrow, if there is an agreement with Senator MIKULSKI at that point. I don't think that jeopardizes the right of the Senator from Louisiana to offer this at a later time during the course of this debate.

Based on that, I would continue to object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original unanimous consent of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving the right to object, merely to respond through the Chair, I would say I have been working in that spirit. I have given the language to the majority side. I have been working both at the staff level and Member level with many folks. This should be noncontroversial. I don't know of any Senator who disagrees with this. So I will accept that offer. I will not object to this pending unanimous consent, but I truly hope the offer is made in good faith because I believe, when anyone reads this language, they will agree with it.

Again, it simply says these latest recommendations by the U.S. Preventive Services Task Force, made 2 weeks ago, will not have any legal force and effect. I believe all of us—certainly, it is my impression and, I guess, we will find out tomorrow morning—I believe all of us want to stop them from having force and effect because it is a great step backward in terms of breast cancer screening and mammography and even education about self-examination.

So I certainly take that offer and look forward to the majority side rereading this language and hopefully accepting it tomorrow morning because I can't imagine, on substantive grounds, objecting to the language.

Thank you. With that, I will not object.

The PRESIDING OFFICER. Without objection, the request from the Senator from Illinois is agreed to.

Mr. DURBIN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. DURBIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2808 TO AMENDMENT NO. 2791

Mr. DURBIN. Mr. President, I ask unanimous consent that the previous order with respect to H.R. 3590 be modified to provide that the Vitter amendment No. 2808 to the Mikulski amendment No. 2791 be agreed to and the motion to reconsider be laid upon the table; that the order be further modified to provide that the vote with respect to the Mikulski amendment should now reflect the Mikulski amendment, as amended.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2808) was agreed to, as follows:

(Purpose: To prevent the United States Preventive Service Task Force recommendations from restricting mammograms for women)

On page 2 of the amendment, after line 15 insert the following:

"(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Fore regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009."

MORNING BUSINESS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

REMEMBERING MARY JOSEPHINE OBERST

Mr. McCONNELL. Mr. President, today I rise to honor the life of a Kentucky heroine, Ms. Mary Josephine Oberst of Owensboro. Ms. Oberst passed away on November 13, 2009, at the age of 95. A native Kentuckian, she proudly served her country as a member of the Army Nurse Corps beginning in 1937. In July 1941, Ms. Oberst was sent to the Philippines, and in early May the following year, when Bataan and Corregidor fell to the Japanese during the Battle of the Philippines, more than 60 nurses, including Ms. Oberst, were taken as prisoners of war, POWs, by the Japanese. These nurses, later christened the "Angels of Bataan," were held as POWs for 33 months. During this time, Ms. Oberst continued her duties as a nurse, caring for fellow prisoners, even though she herself suffered from malaria and significant weight loss. In early February 1945, the 44th Tank Battalion rescued the POWs who were later brought back to the United States.

After overcoming the medical conditions which resulted from her imprisonment, Ms. Oberst was appointed captain and continued to serve as a member of the Army Nurse Corps. She worked in hospitals in Louisville, KY; Fort Knox, KY; and Ashford, WV, until her retirement from the Corps in 1947. Ms. Oberst was honored for her duty with several military service awards, including the Bronze Star Medal. Mary Josephine Oberst was a woman of high character, who faithfully served our country. Today, I wish to honor her life and her service, as well as give my condolences to her family for their loss.

AMINATOU HAIDAR

Mr. LEAHY. Mr. President, I want to bring to the attention of Senators who may not already be aware, a situation that has been unfolding in Morocco and the Canary Islands.

Last year, I had the privilege of meeting Ms. Aminatou Haidar, called by some the "Saharawi Gandhi," who received the 2008 human rights award from the Robert F. Kennedy Center for Justice and Human Rights. Ms. Haidar is a focus of attention again today because she is on a hunger strike in the Canary Islands after being summarily deported by the Moroccan Government on her way home to Western Sahara from the United States, where, coincidently, she had been to receive the "Civil Courage Prize" from the Train Foundation.

Ms. Haidar is no newcomer to difficulties with the Moroccan authorities. She was first imprisoned in 1987 when she was a 20-year-old college student, after calling for a vote on independence for Western Sahara. When she was released after 4 years, during which she was badly mistreated, she continued her advocacy for the right of the Saharawi people to choose their own future.

Arrested again in 2005 and separated from her two daughters, she led a group of 37 other Saharawi prisoners on a 51-day hunger strike for better prison conditions, investigations into allegations of torture, and the release of political prisoners.

Since her 2006 release, she has continued her nonviolent struggle, which has brought widespread attention to the cause of the Saharawi people. The United Nations Security Council has repeatedly endorsed a referendum on self-determination for the people of Western Sahara.

On November 13, when Ms. Haidar arrived at the airport in El-Ayoun, she was detained by Moroccan authorities. She was told that by insisting on writing her place of residence as "Western Sahara" on her immigration form, she was in effect waiving her Moroccan citizenship. Her passport was taken, and she was forcibly put on a plane

without travel documents to the Canary Islands, a Spanish archipelago located 60 miles west of the disputed border between Morocco and Western Sahara.

She remains there at the airport, separated from her daughters, in the 17th day of a hunger strike, and her health is reportedly rapidly deteriorating. She has refused an offer of a Spanish passport, insisting that she will not be a ''foreigner in her own country,'' and the Moroccan Government refuses to reinstate her passport. She is, in effect, a stateless person.

This is unacceptable. Article 12 of the International Covenant on Civil and Political Rights, which Morocco has ratified, states in part, ''Everyone shall be free to leave any country, including his own. . . . No one shall be arbitrarily deprived of the right to enter his own country.''

The situation in Western Sahara is a difficult one for the Saharawi people and the Moroccan Government. It is a protracted dispute in which the international community has invested a great deal to try to help resolve, without success. I recall the time and energy former Secretary of State James Baker devoted to it. The solution he proposed was rejected by the Moroccan Government.

Morocco and the United States are friends and allies, and I have commended the Moroccan Government for positive steps it has taken in the past to improve respect for human rights and civil liberties. On a recent trip to North Africa, Secretary Clinton was complimentary of Morocco's efforts to reach a peaceful solution in Western Sahara. But the Saharawi people, including Aminatou Haidar, have passionately advocated for the right to self-determination, and the international community, including the U.N., has long supported a referendum on self-determination, which has thus far been blocked by the Moroccan Government.

I have no opinion on what the political status of Western Sahara should be, but I am disappointed that the Moroccan authorities have acted in this way because it only adds to the mistrust and further exacerbates a conflict that has proven hard enough to resolve. Nothing positive will be achieved by denying the basic rights of someone of Ms. Haidar's character and reputation, or restricting the right to travel of other residents of Western Sahara, as the Moroccan authorities have increasingly done in the last 2 months.

In the past, the United States has opposed proposals to extend the U.N.'s mandate in Western Sahara, currently limited to peacekeeping, to human rights monitoring. The recent crackdown on Ms. Haidar and other Saharawis who continue to insist on a referendum on self-determination suggests that human rights monitoring is needed and should be seriously considered when the U.N. mission comes up for renewal in April. I encourage the Department of State to review this question and to consult with the Congress about it.

I am confident that our relations with Morocco, already strong, will continue to deepen in the future. We share many important interests. But the United States was also instrumental in the creation of the Universal Declaration of Human Rights, and while we sometimes fall short ourselves, we will continue to strive to defend those whose fundamental rights are denied, wherever it occurs.

I appreciate the efforts the Department of State has made to try to help resolve this situation. I urge the Moroccan Government to reconsider its decision to deport Ms. Haidar, which will not advance its interests in the conflict over Western Sahara. It should return her passport, readmit her, and let her return to her home and family.

60TH ANNIVERSARY OF THE VOICE OF AMERICA'S UKRAINIAN SERVICE

Mr. CARDIN. Mr. President, for six decades the Voice of America's, VOA, Ukrainian-language service has been providing an invaluable service through its consistent broadcasting of factual and comprehensive news and information to the people of Ukraine.

During the first four decades of its existence, the Ukrainian service reached a Ukrainian population starving for information under an extremely strictly controlled, propagandistic Soviet media environment. Ukrainians went to great lengths and some risks to overcome Soviet censorship, which included the jamming of VOA and other shortwave international broadcasting.

During the Cold War VOA Ukrainian provided its listeners with uncensored news about such monumental events as the Hungarian Revolution, the Prague Spring, rise of Solidarity, and the fall of the Berlin Wall. A variety of shows worked to open the outside world to Ukrainian listeners, including a Popular Music Show, a Youth Show, and the long running series Democracy in Action, which was about how democracy works in the United States.

The Ukrainian service also focused on developments within Ukraine itself. VOA broadcasts about Soviet human rights violations in Ukraine, including its coverage of activities of the Helsinki process and the Helsinki Commission, gave sustenance to Helsinki Monitors and other Ukrainian human rights activists, especially those languishing in the gulag for daring to call upon the Soviet government to live up to its Helsinki Final Act obligations. They knew that they were not forgotten. Furthermore, the Ukrainian service also provided objective information about the Chornobyl nuclear disaster and the development of Ukraine's movement for democracy and independence, culminating in the December 1, 1991, referendum in Ukraine in which an overwhelming majority of Ukrainians voted for the restoration of their nation's independence.

For nearly two decades since, VOA's Ukrainian service has continued to fill an important role in Ukraine's evolving democracy. VOA reported on the challenges that Ukraine faced and on the U.S.'s considerable support and assistance for Ukraine, including in the dismantling of the nuclear arsenal it inherited from the Soviet Union. During the Orange Revolution, VOA Ukrainian helped to reassure millions of Ukrainians that the international community would not sanction electoral fraud.

As Ukraine has evolved, so has the Ukrainian Service. While no longer broadcasting on radio as it did for most of its 60 years, it reaches more Ukrainians than ever with daily broadcasts over Ukrainian television—something unthinkable during Soviet rule—and reporting on its website. It continues to report on what is happening in Ukraine, but also it continues to cover every aspect of American life and society. As Chairman of the Helsinki Commission, I commend the ongoing role of VOA's Ukrainian service in helping Ukraine fulfill its aspirations in becoming a more fully democratic, independent, and secure.

WORLD AIDS DAY

Mr. CARDIN. Mr. President, I rise today in recognition of World AIDS Day, an international commemoration held each year on December 1 to raise awareness of HIV and AIDS around the world. The theme for this year's World AIDS Day is ''universal access and human rights.''

Around the world, 33 million people were living with HIV in 2007, including 2.7 million new infections. In the U.S., more than 1.2 million people are infected with HIV. According to the Joint United Nations Program on HIV/AIDS, or UNAIDS, global reports indicated that 2 million people died from AIDS-related causes in 2007.

Globally, sub-Saharan Africa is the hardest-hit region when it comes to HIV infection, accounting for two-thirds of all people living with HIV and for three-quarters of AIDS deaths in 2007. Sadly, 75 percent of young people worldwide who are diagnosed with HIV are girls living in sub-Saharan Africa.

According to the results of a global youth survey conducted in 99 countries, 50 percent of young people have a dangerously low knowledge of how the disease is contracted and can be prevented. Another report by UNAIDS collected data from 64 countries and found

that fewer than 40 percent of young people have basic information about HIV. This knowledge gap is particularly disturbing when taking into account a UNICEF report that indicates that 4.9 million young people, ages 15–24, are living with HIV worldwide.

Despite these statistics, recent advances in prevention and treatment of HIV give hope for the future. Globally, approximately 38 percent of the 730,000 children under 15 who needed antiretroviral drugs to treat HIV in 2008 were receiving the necessary therapy, according to UNAIDS. This is a huge increase from just a little over 10 percent in 2005.

The percentage of pregnant women living with HIV who received antiretroviral treatment to prevent mother-to-child transmission has increased from 9 percent in 2004 to 33 percent in 2007.

Despite recent improvements in treatment coverage and declining mother-to-child transmission of HIV, problems remain in preventing and treating the disease. In addition, the number of new HIV infections continues to outpace the advances made in treatment numbers for every two people put on antiretroviral drugs, another five become newly infected with the disease. Clearly, prevention measures are essential to continue the fight against HIV/AIDS.

No State in the U.S. is immune from the effects of HIV/AIDS, and the epidemic is deeply felt among Marylanders as well. At the end of 2007, Maryland had 28,270 people living with HIV and AIDS. That same year, Maryland ranked fourth in the U.S. for the number of AIDS cases per 100,000 people.

The Maryland Department of Health and Mental Hygiene has estimated that there are between 6,000 and 9,000 Marylanders who are unaware that they are infected with HIV. Of the 1.2 million people in the United States who are estimated to be infected with HIV, as many as 21 percent are unaware that they have the virus.

To address this problem, it is crucial that HIV screening be readily available and accessible to everyone at little or no cost. This will increase the rate of diagnosis in individuals that have HIV and will accelerate their treatment.

The Patient Protection and Affordable Care Act will address this need and will help achieve the goals outlined by the theme of this year's World AIDS Day campaign of ''universal access and human rights.''

First and foremost, the bill eliminates discrimination based on pre-existing conditions. Individuals with HIV will no longer be rejected from insurance coverage because of their disease.

The bill also encourages outreach to enroll vulnerable and underserved populations in Medicare and CHIP, including adults and children with HIV/AIDS. It provides personal responsibility education grants to States to create HIV/AIDS education programs for adolescents.

The bill will also cover preventive services recommended by the U.S. Preventive Services Task Force, including HIV testing for all pregnant women. This testing will be provided at no individual cost, making it universally accessible to all women in the U.S. Testing pregnant women for HIV is vital for prevention efforts, allowing women who test positive to begin antiretroviral drugs to prevent transmission to their baby.

Furthermore, the Mikulski amendment, which I have cosponsored, would allow coverage for HIV testing for all women, regardless of risk, based on expert recommendations from the Health Resources and Services Administration.

The Patient Protection and Affordable Care Act also provides grants to encourage training health care workers to treat individuals with HIV/AIDS and other vulnerable populations.

Because of the numerous provisions in the bill that will help the prevention and treatment of HIV/AIDS, several groups have expressed their support for the Patient Protection and Affordable Care Act. Among the groups that I have heard from is the HIV Medicine Association, an organization representing 3,600 physicians, scientists, and health care professionals who work on the frontlines of the HIV/AIDS epidemic in communities across the country.

We must continue to fight HIV/AIDS, and I urge my colleagues to support the measures outlined in the Patient Protection and Affordable Care Act that will further our efforts to combat this disease.

RECOGNIZING REAL SALT LAKE SOCCER TEAM

Mr. HATCH. Mr. President, I rise and offer my congratulations to the Real Salt Lake soccer team, the newly crowned champions of Major League Soccer. While Utah has a number of sports teams with proud traditions—both collegiate and professional—Real Salt Lake has brought to my home State its first major professional championship since 1971, when the Utah Stars won the ABA title. Fans throughout Utah are thrilled.

Real Salt Lake came to Utah in 2004 and faced difficulties during its first three seasons. In just its fourth season, however, Real Salt Lake made an improbable run to the Western Conference Finals, despite only sneaking into the playoffs on the last day of the regular season. They eventually lost that game by a score of 1–0, but with their first playoff appearance, and opening their new world class soccer-specific stadium, their future was filled with promising signs.

In 2009 Real Salt Lake delivered on that promise. Once again, it was the last team to qualify for the playoffs and was the lowest overall seed. Despite barely squeaking into the playoffs, this team of overachievers sure made some noise once they got there. They quickly reeled off a string of consecutive upsets against glitzier opponents with established stars, dispatching top-seeded and defending MLS champion Columbus and then powerhouse Chicago and its star Cuauhtemoc Blanco.

On November 22, the title game in Seattle pitted the little-known upstarts of Real Salt Lake against the Western Conference champions, the Los Angeles Galaxy and its mega-stars Landon Donovan and David Beckham. After 90 minutes of regulation play and 30 minutes of overtime, the game remained tied at 1–1. In the penalty kick shootout, Real Salt Lake emerged victorious 5–4 as Donovan's potential game-tying spot kick sailed harmlessly over the crossbar. Real Salt Lake had delivered the first championship of its kind in Utah in nearly four decades—and it couldn't have come in a more exciting fashion or to a more deserving group of athletes.

In the end, it wasn't the Galaxy of stars that prevailed; it was Real Salt Lake with its philosophy that mirrors the words emblazoned on the sign in its home locker room: ''THE TEAM IS THE STAR.'' That teamwork was certainly on display in the title tilt against Los Angeles. It was reflected in Real Salt Lake Robbie Findley's breakout 64th-minute strike that knotted the score at 1–1 and made the team's overtime and penalty kick heroics possible. It was reflected in the play of Salt Lake goalkeeper and Cup final MVP Nick Rimando, who turned away penalties from L.A.'s Jovan Kirovski and Edson Buddle before besting Donovan. Finally, RSL's determination to overcome the odds also mirrors that of its owner, Dave Checketts, coach Jason Kreis and general manager Garth Lagerwey—all of whom turned the team into a champion despite the naysayers who said it couldn't be done.

No, Real Salt Lake's roster did not have the league's biggest stars. But in the words of midfielder Clint Mathis, better known as Cletus, RSL was ''the better team in every game.'' As much as anything else, that explains why champion Real Salt Lake is now the brightest light in MSL's firmament.

Once again, I congratulate Real Salt Lake on this accomplishment. Senator BENNETT and I have introduced a resolution expressing the Senate's congratulations for Real Salt Lake and I urge my colleagues to offer their support.

Mr. BENNETT. Mr. President, I wish to commend and congratulate Real Salt Lake for winning the 2009 Major League Soccer Cup. I am delighted to

do so, and feel it is a privilege to honor the MLS Cup champions on the Senate floor. The story of Real Salt Lake is more than just a story about a soccer team capturing the MLS title; it is a story about banding together to overcome obstacles and defying the odds after being counted out and dismissed by ''the experts.'' In many ways, the story of Real Salt Lake is part and parcel of the American experience.

On November 22, 2009, in Seattle, WA, Real Salt Lake, or RSL, faced off against the better-known and widely acclaimed L.A. Galaxy. Just to give a sense of what RSL was up against, listed on the roster for the Galaxy were U.S. National Team star Landon Donovan, and the internationally acclaimed, indeed iconic, David Beckham. The RSL roster, on the other hand, didn't include what's known as a ''designated player,'' or in other words, a recognized superstar. If that wasn't enough, the Galaxy entered the postseason riding high, having finished at the top of the Western Conference in the regular season with a 12–6–12 record, and were expected by most to perform well if not to win the championship. RSL had a far different experience during their regular season, finishing with an 11–12–7 record. Indeed, they barely managed to make it into the eight team playoff that would determine the MLS Cup Champion.

Considering these facts, it would have been easy for RSL to give up. But that wasn't their attitude. When asked about not having a star player, instead of bemoaning that fact, the team's captain, Kyle Beckerman, said, ''We've really bought into the 'star is the team' here in Salt Lake. When we work as a team and [are] doing well it's because everybody's playing well. It pays off.'' This team unity had initially paid off in the postseason for RSL as they defeated the defending champion Columbus Crew, and beat the Chicago Fire in the Eastern Conference finals. Despite this, many doubted whether they could win against the Galaxy in the championship game. When asked about their chances, head coach Jason Kreis sarcastically replied, ''Wow, it sounds like we better not even go. We don't even have a chance, do we?'' He knew RSL possessed something special.

Even in the final match, such outspoken optimism would be tested. By halftime, RSL was trailing 1–0. Two of their key players were unable to continue playing, sidelined by injury and illness. If ever there was a time to give up, it seemed that this was it. But that wasn't their attitude. Coach Kreis made a pair of substitutions, and encouraged his players to ''be confident,'' and play aggressive. And, well you can see where this is going. After 90 minutes of play, 30 minutes of overtime, and seven rounds of penalty kicks that included two blocked shots by RSL goalkeeper Nick Rimando, defender Robbie Russell converted the final penalty kick to seal the victory, establishing RSL as the champions of Major League Soccer.

Now I wish to place this victory into some context. This was significant for Utah in that it was the first professional sports crown to go to the State of Utah since the Utah Stars basketball team won the American Basketball Association title back in 1971. RSL's victory was notable not only because Jason Kreis, at the age of 36, became the youngest manager in MLS history to lead his team to the title, but also because RSL became the first franchise in professional sports history to win a championship after finishing the regular season without a winning record. Think about that for a minute—if there is ever a reason to dismiss a team, a losing record in the regular season should be it. But that wasn't RSL's attitude. Rather than dwelling in self-pity and regret, RSL fought on, determined to prove their detractors wrong. They believed they could beat the entire league, and they went out and did just that. Their story exemplifies the American values of hard work, resilience, and overcoming the odds.

Once again, I congratulate RSL for their victory; I join with their fans in celebration of this championship; and I hope that this is one of many more championships to come for Utah.

ADDITIONAL STATEMENTS

COACHED FOR LIFE

• Mr. BAUCUS. Mr. President, today I wish to speak about the life lessons we learn from participating in athletic activities and from the coaches who teach our young athletes. Michael T. Powers, author of many inspirational books once said, ''High school sports: where lessons of life are still being learned, and where athletes still compete for the love of the game and their teammates.'' High school sports are a way of life across Montana and they create an important sense of community in small towns and cities all over Big Sky country. In many areas across the state, small high schools will pool their resources to field football teams each fall; many play six or eight man games.

This year Ed Flaherty, a native Montanan co-authored the book ''Coached for Life'' about the experience he and his teammates had on the State champion Great Falls Central High School football team in 1962. I was inspired by the stories of these young men and how the lessons learned on the field from their coaches shaped who they became as people and their experiences later in life.

The young men that made up Great Falls Central's 1962 Championship squad truly embody the best of Montana ideals and values, like hard work and taking responsibility. They labored tirelessly both on and off the field and achieved not only athletic glory, but also learned the value of a good education and how to be role models and ambassadors for their school. Great Falls has always been a working class town and many families made significant financial sacrifices to allow their children to attend Great Falls Central, a private Catholic school. Coaches Bill Mehrens and John ''Poncho'' McMahon, reminded the players each day that playing football at Central was a privilege and that they had a responsibility to their teammates, their school, and the community to give it their all on each and every snap on the practice field, in the game, and in the classroom. No doubt the coaches pushed these young men each and every day, they did it to instill discipline and to make them the best they could be.

The 1962 season was a special one for Great Falls Central. The goal of the team was to win the State championship. A year earlier, the coaches drove some of their players north 115 miles to Havre to watch the State championship game, not only to scout two of the best teams in the State but also to witness a championship win. The Central players took it all in and knew they wanted to be the ones holding up the trophy the following season. The Mustangs achieved that goal, making it through the 1962 season undefeated and beating their rival, the defending State champions, Havre High 34–6 in the Montana Class A State championship game in front of more than 5,000 elated fans on their home field.

Having gone through this experience, the men later in life were able to rise up against the many challenges that were thrown their way. At a team reunion in 2002, 40 years after their championship run, the players and coaches got together to reflect and share their life stories. Some have gone on to be teachers and coaches, passing on the life lessons they learned from Mehrens and McMahon. Some, like Ed Flaherty, have achieved successful careers in business and in turn gave back to their communities. Some served their country heroically in the military. All have taken the lessons they learned from the fall of 1962 and have helped their communities and become leaders. Ed Flaherty has compiled these stories in his book and brings to life that amazing season and what it truly means to be coached for life.•

TRIBUTE TO HARRY R. BADER

• Mr. BEGICH. Mr. President, I wish congratulate Fairbanks, AK, resident Mr. Harry R. Bader for being the first Civilian Response Corps-Active Officer in the United States Agency for International Development, USAID, to be

trained and ready for world-wide deployment.

Mr. Bader's specialized training, which will allow him to work in high threat environments, was recognized by the Administrator of USAID in a November 23, 2009, ceremony in Washington, DC. Currently, Mr. Bader is the USAID Deputy Environmental Officer for the Democracy, Conflict and Humanitarian Assistance Bureau.

USAID's Civilian Response Corps is a commendable program. The Corps plays an integral part in U.S. national security strategy. One of their missions is to bring coordination to military and civilian efforts in order to stabilize fragile states and to improve the effectiveness of counter-insurgency operations.

As an active officer, Mr. Bader's environmental security specialty will be brought to bear in those areas of the developing world where scarcity or degradation of natural resource contribute to conflict. His task will be to find ways to reduce the means and motivations for violence.

Mr. Bader's diverse educational and professional backgrounds make him well suited to excel as a Civilian Response Corps-Active Officer. He has a law degree from Harvard and B.A. from Washington State University. His career has been one of distinction and variety as a professor, author, researcher, lecturer, natural resource manager and consultant.

He taught at the University of Alaska Fairbanks as an associate professor of resources policy at the School of Natural Resources Management. During his tenure, he served on the Alaska Sea Grant Legal Research Team, which was created in response to the Exxon Valdez Oil Spill to help strengthen oversight of hazardous materials.

At the Alaska Department of Natural Resources, Mr. Bader was the northern region land manager in Fairbanks, where he was responsible for the stewardship of 40 million acres of public land in the arctic and boreal regions of Alaska. He often collaborated with industry and academia in developing land use policy.

Until recently, Mr. Bader was active with the Betula group, a consulting firm he founded which specializes in resource management issues in challenging social and physical environments. He travelled to Tajikistan, Iraq, and Ukraine lending his expertise in the development of democracy and governance. Mr. Bader is also perusing a midcareer doctorate at the Yale School of Forestry and Environmental Studies.

I applaud Harry on this appointment and am confident he will make contributions to security and environmental improvement wherever he is assigned by the Corps.●

TRIBUTE TO DONALD DOWD

● Mr. KERRY. Mr. President, I congratulate Don Dowd for his longtime public service to New England and to the Commonwealth of Massachusetts. For more than half a century Mr. Dowd has been a fixture in the culture, civic life, and politics of our region of the United States. I also congratulate one of the many organizations with which Mr. Dowd has been associated—Special Olympics Massachusetts, part of the international Special Olympics organized by Eunice Shriver in 1968.

Special Olympics Massachusetts has just moved into a new state-of-the-art office and training center in Marlborough. The Yawkey Sports Training Center has training rooms, a gymnasium and outdoor soccer fields, all right in the heart of Massachusetts, less than a 90-minute drive from 90 percent of the population of the Commonwealth.

Mr. Dowd has been one of the biggest and most active supporters of Special Olympics, a global force for understanding and change, involving 2.5 million athletes representing more than 140 countries. Special Olympics Massachusetts currently serves more than 10,000 athletes and involves 11,000 volunteers and 1,600 coaches. With its new training center, which opened this fall, Special Olympics Massachusetts hopes to expand the program to 20,000 athletes by 2010. Mr. Dowd began his public service career as the Assistant Regional Director of the U.S. Postal Service for the six New England States during the Presidency of John F. Kennedy. He was political adviser to Robert F. Kennedy's Presidential campaign in 1968. And he was an aide and close friend to Senator Edward M. Kennedy throughout Ted's entire 47-year career in the Senate. Mr. Dowd coordinated the 1979 opening of the John F. Kennedy Presidential Library and has served as a member of the John F. Kennedy Library Foundation Board since its inception. Mr. Dowd continues to do consulting work since his retirement from his regional executive position with the Coca-Cola Company.

He is a lifelong resident of Springfield, MA, and as such once played a little known role in getting Ted Kennedy to make a cameo appearance in a video production. Twentieth Century Fox had invited every town named Springfield to enter videos to make the case that their town should be the Springfield in ''The Simpsons'' animated movie and television program, and it was no secret that the mayor in the Simpsons cartoon was a spoof on Ted.

Mr. President, I thank Mr. Dowd for his service and dedication to our region and our country. And I congratulate Special Olympics Massachusetts on their new facilities and express my appreciation for all it contributes to the physical, social, and psychological development of people with intellectual disabilities.●

RECOGNIZING SHAW AND TENNEY

● Ms. SNOWE. Mr. President, today I wish to honor a Maine small business with a long standing reputation for producing elegant and practical instruments used by the maritime industry. Founded in 1858, Shaw and Tenney of Orono, ME, has been producing renown, specialty handcrafted wooden oars and paddles for over a century and a half. Indeed, Shaw and Tenney is the oldest continuing producer of solid wooden paddles and oars in America, as well as the third oldest manufacturer of marine products in the country.

This historic company got its start on the banks of the Stillwater River near Orono where its founder, Frank Tenney, first launched his signature oars and paddles as part of the Orono Manufacturing Company. During the 19th century, Maine rivers and coastal waters served as a critical highway network for transporting people and goods throughout the State. Small boats such as skiffs, peapods, and canoes were several of the major vessels employed in promoting greater commerce, and Mr. Tenney's quality oars and paddles served as an indispensible tool in helping to propel major industries to new heights across the State. In the 1890s, Mr. Tenney merged his small manufacturing company with the Boston-based George Shaw Company, which produced similar goods. Together they formed what is now formally known as Shaw and Tenney.

The newly merged business soon moved to downtown Orono's Main Street and remained there until nearly 1950, when it relocated again to the company's current location at 20 Water Street. The Tenney family retained ownership until about 1970 when the company underwent three short-lived transitions to new owners. The current proprietors, Steve and Nancy Holt, share the privilege of carrying forward the legacy of this unique novelty company. Since the Holts came aboard, they have expanded the company's product line to include other specialty products such as masts, spars, boat hooks, and flagpoles. At the same time, the Holts take pride in producing the same quality product that's earned Shaw and Tenney its stellar reputation for dependable marine instruments.

More than just ordinary oars and paddles, the Shaw and Tenney product line is composed of individual pieces of art specially handcrafted to be both practical and refined. Much of the company's well-earned success lies in the quality of the raw material used to construct its distinguished oars and paddles. To make its flat- and spoon-bladed oars, Shaw and Tenney mostly utilizes clear, solid, eastern red spruce supplied by two mills located within a

50-mile radius of the company's facility. In fact, clear red spruce has the highest strength-to-weight ratio of any North American softwood, providing the finished products with a noticeable lightweight durability. Each piece of lumber is carefully critiqued before generating the exceptional, distinct oar or paddle.

Shaw and Tenney's artifacts are showcased across the country and, indeed, the world. Its traditional rowing oars can be found at places as diverse as California's Disneyland and the Royal Saudi Naval Force's whale boats. Domestic travelers will also notice Shaw and Tenney oars in Las Vegas as gondoliers ferry visitors around the city's reproduction of Venice's Grand Canal. Furthermore, many U.S. Marines give the company's paddles as a gift when an officer leaves the ranks and it is not uncommon for customers to request fancy oars to use as balusters or stair rails in their homes.

Shaw and Tenney has truly crafted a legendary product that highlights the ingenuity and craftsmanship of Mainers. Since its start on the banks of a small Maine river, this impressive small business has blossomed into a trusted and worldwide leader in its specialized industry. Congratulations to everyone at Shaw and Tenney for over 150 years of their extraordinary handiwork, and I offer my best wishes for their continued success in the future.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 12:53 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 3029. An act to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle and simple cycle power generation systems.

H.R. 3598. An act to ensure consideration of water intensity in the Department of Energy's energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources.

H.R. 3667. An act to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the ''Clyde L. Hillhouse Post Office Building''.

ENROLLED BILLS SIGNED

At 2:54 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the Speaker has signed the following enrolled bills:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1860. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

The enrolled bills were subsequently signed by the President pro tempore (Mr. BYRD).

At 3:12 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bill, without amendment:

S. 1422. An act to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 3029. An act to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems; to the Committee on Energy and Natural Resources.

H.R. 3598. An act to ensure consideration of water intensity in the Department of Energy's energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources; to the Committee on Energy and Natural Resources.

H.R. 3667. An act to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida as the ''Clyde L. Hillhouse Post Office Building''; to the Committee on Homeland Security and Governmental Affairs.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, December 2, 2009, she had presented to the President of the United States the following enrolled bills:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1860. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3779. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Pistachios Grown in California; Changes to Handling Regulations'' (Docket No. AMS–FV–09–0031; FV09–983–1 FR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3780. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Walnuts Grown in California; Increased Assessment Rate and Changes to Regulations Governing Reporting and Recordkeeping'' (Docket No. AMS–FV–09–0020; FV09–984–3 FR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3781. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Tomatoes Grown in Florida; Decreased Assessment Rate'' (Docket No. AMS–FV–09–0063; FV09–966–2 IFR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3782. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Domestic Dates Produced or Packed in Riverside County, CA; Increased Assessment Rate'' (Docket No. AMS–FV–09–0045; FV09–987–2 FR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3783. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Onions Grown in South Texas; Decreased Assessment Rate'' (Docket No. AMS–FV–09–0044; FV09–959–2 FIR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3784. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Pistachios Grown in California; Order Amending Marketing Order No. 983'' (Docket No. AO–FV–08–0147; Docket No. AMS–FV–08–0051; FV08–983–1) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3785. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Apricots Grown in Designated Counties in Washington; Decreased Assessment Rate'' (Docket No. AMS–FV–09–0038; FV09–922–1 FIR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3786. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Applications for Food

and Drug Administration Approval to Market a New Drug; Postmarketing Reports; Reporting Information About Authorized Generic Drugs'' (Docket No. FDA–2008–N–0341) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3787. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Listing of Color Additives Exempt From Certification; Paracoccus Pigment'' (Docket No. FDA–2007–C–0456) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3788. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled ''Defense Federal Acquisition Regulation Supplement; Whistleblower Protections for Contractor Employees'' (DFARS Case 2008–D012) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Armed Services.

EC–3789. A communication from the Assistant Secretary, Bureau of Political-Military Affairs, Department of State, transmitting, pursuant to law, an addendum to a certification, transmittal number: DDTC 128–09, of the proposed sale or export of defense articles, including technical data, and defense services to a Middle East country regarding any possible effects such a sale might have relating to Israel's Qualitative Military Edge over military threats to Israel; to the Committee on Armed Services.

EC–3790. A communication from the Secretary of Defense, transmitting a report on the approved retirement of Lieutenant General Maurice L. McFann, Jr., United States Air Force, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.

EC–3791. A communication from the Assistant Secretary (Legislative Affairs) Department of Defense, transmitting, pursuant to law, a report relative to the certification of protected documents; to the Committee on Armed Services.

EC–3792. A communication from the Under Secretary of Defense (Personnel and Readiness), transmitting, pursuant to law, a report relative to the quarterly reporting of withdrawals or diversions of equipment from Reserve component units; to the Committee on Armed Services.

EC–3793. A communication from the Secretary, Division of Trading and Markets, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendments to Rules for Nationally Recognized Statistical Rating Organizations'' (RIN3235–AK14) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3794. A communication from the Associate Director, Office of Foreign Assets Control, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Sudanese Sanctions Regulations; Iranian Transactions Regulations'' (31 CFR Parts 538 and 560) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3795. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Electronic Fund Transfers'' (Regulation E; Docket No. R–1343) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3796. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six-month periodic report on the national emergency with respect to Burma that was declared in Executive Order 13047 of May 20, 1997; to the Committee on Banking, Housing, and Urban Affairs.

EC–3797. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six-month periodic report on the national emergency with respect to stabilization of Iraq that was declared in Executive Order 13303 of May 22, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–3798. A communication from the Administrator and Chief Executive Officer, Bonneville Power Administration, Department of Energy, transmitting, pursuant to law, the Administration's Annual Report for fiscal year 2009; to the Committee on Energy and Natural Resources.

EC–3799. A communication from the Departmental Freedom of Information Officer, Office of the Secretary, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Amendment to the Freedom of Information Act Regulations'' (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Environment and Public Works.

EC–3800. A communication from the Deputy Assistant Administrator for Regulatory Programs, Office of Protected Resources, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Endangered and Threatened Wildlife; Sea Turtle Conservation'' (RIN0648–AX20) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Environment and Public Works.

EC–3801. A communication from the Chief of the Trade and Commercial Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Electronic Payment and Refund of Quarterly Harbor Maintenance Fees'' (RIN1505–AB97) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Finance.

EC–3802. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Applicable Federal Rates—December 2009'' (Rev. Rul. 2009–38) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Finance.

EC–3803. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Coordinated Issue: Margins and Other Unsubstantiated Additions to Insurance Company Reserves for Unpaid Losses and Claims'' (LMSB4–1109–041) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Finance.

EC–3804. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Temporary Closing of the Determination Letter Program for Adopters of Pre-Approved Defined Benefit Plans'' (Announcement 2009–85) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3805. A communication from the Acting Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''2010 Limitations Adjusted As Provided in Section 415(d), etc.'' (Notice 2009–94) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3806. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Agreements for Payment of Tax Liabilities in Installments'' ((RIN1545–AU97)(TD 9473)) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3807. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Notice: Tier 2 Tax Rates for 2010'', received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3808. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Notice Requirements for Certain Pension Plan Amendments Significantly Reducing the Rate of Future Benefit Accrual'' ((RIN1545–BG48)(TD 9472)) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3809. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to the Case—Zablocki Act, 1 U.S.C. 112b, as amended, the report of the texts and background statements of international agreements, other than treaties (List 2009–0201–2009–0212); to the Committee on Foreign Relations.

EC–3810. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, an annual report relative to the Benjamin A. Gilman International Scholarship Program for 2009; to the Committee on Foreign Relations.

EC–3811. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, a report relative to U.S. military personnel and U.S. civilian contractors involved in the anti-narcotics campaign in Colombia; to the Committee on Foreign Relations.

EC–3812. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad relative to the manufacture of Propellant Actuated Devices (PAD) used on the Crew Escape System on the F–2 aircraft for end-use by Japan; to the Committee on Foreign Relations.

EC–3813. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant

to the Arms Export Control Act, the certification of a proposed permanent export license for the export of defense articles, to include technical data, related to firearms relative to the sale of 4,000 Colt Defense LLC M4 Carbine Model R0977017, 5.6mm, 14.5'' barrel, Safe/Semi/Full Auto Rifles for end use by the Government of Kuwait's National Guard in the amount of $1,000,000 or more; to the Committee on Foreign Relations.

EC–3814. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed permanent export license for the export of defense articles, to include technical data, related to firearms relative to the sale of 252 sets of M60E4/Mk43 Mod 1 Machine Guns and basic accessories for end use by the Mexican Federal Police in the amount of $1,000,000 or more; to the Committee on Foreign Relations.

EC–3815. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed transfer of major defense equipment with an original acquisition value of more than $14,000,000 for Chile; to the Committee on Foreign Relations.

EC–3816. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed transfer of major defense equipment with an original acquisition value of more than $25,000,000 for the Kingdom of Jordan; to the Committee on Foreign Relations.

EC–3817. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to sale of the Sensor Fuzed Weapon in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3818. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to Canada relative to the design, manufacture, and delivery of the Telstar 14R Commercial Communication Satellite in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3819. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles that are controlled under Category VIII of the United States Munitions List relative to the transfer of 55–L–714A Engines and Tailpipe Kits for the CH–47 to support the United Kingdom in the amount of $100,000,000 or more; to the Committee on Foreign Relations.

EC–3820. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the export of defense articles, including, technical data, and defense services relative to the design and manufacture of Troop Door Air Deflectors and Ramp Attached Torque Boxes for the C–17 Globemaster III for end use by the U.S. Air Force in the amount of $100,000,000 or more; to the Committee on Foreign Relations.

EC–3821. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed amendment to a technical assistance agreement for the export of defense articles, including, technical data, and defense services to Canada relative to the sale of fifteen CH–47F Chinook Helicopters; to the Committee on Foreign Relations.

EC–3822. A communication from the Deputy Director, Office of Human Services Legislation, Department of Health and Human Services, transmitting, pursuant to law, a report entitled ''Report to Congress on the Provision of Services to Head Start Children with Disabilities''; to the Committee on Health, Education, Labor, and Pensions.

EC–3823. A communication from the Deputy Assistant Secretary for Program Operation, Employee Benefits Security Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled ''Investment Advice—Participants and Beneficiaries—Withdrawal of Final Rule'' (RIN1210—AB13) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3824. A communication from the Chief Human Capital Officer, Corporation for National and Community Service, transmitting, pursuant to law, the report of a vacancy in the position of Chief Executive Officer of the Corporation for National and Community Service and a nomination for the position; to the Committee on Health, Education, Labor, and Pensions.

EC–3825. A communication from the Assistant General Counsel for Regulatory Services, Office of Elementary and Secondary Education, Department of Education, transmitting, pursuant to law, the report of a rule entitled ''Race to the Top Fund—Final Priorities, Definitions, and Selection Criteria'' (RIN1810–AB07) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3826. A communication from the Assistant Secretary, Employment and Training Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled ''Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade and Globalization Adjustment Assistance Act of 2009'' (TEGL No. 22–08) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3827. A communication from the Secretary of the Interior, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report to Congress for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3828. A communication from the Acting Chief Financial Officer, Department of Homeland Security, transmitting, pursuant to law, the Department's Annual Financial Report for Fiscal Year 2009.; to the Committee on Homeland Security and Governmental Affairs.

EC–3829. A communication from the Chair, U.S. Election Assistance Commission, transmitting, pursuant to law, the Commission's Fiscal Year 2009 Annual Financial Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3830. A communication from the Director, National Science Foundation, transmitting, pursuant to law, the URL address for the Agency's Financial Report, Annual Performance Report, and Performance Highlight Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3831. A communication from the President, Federal Financing Bank, transmitting, pursuant to law, the Bank's Annual Report for Fiscal Year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3832. A communication from the Chairman, Merit System Protection Board, transmitting, pursuant to law, a report entitled ''As Supervisors Retire: An Opportunity to Reshape Organizations''; to the Committee on Homeland Security and Governmental Affairs.

EC–3833. A communication from the Chairman, Federal Communications Commission, transmitting, pursuant to law, the Commission's Fiscal Year 2009 Agency Financial Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3834. A communication from the Board Members, Railroad Retirement Board, transmitting, pursuant to law, a report entitled ''Railroad Retirement Board's Performance and Accountability Report for Fiscal Year 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3835. A communication from the Secretary of Veterans Affairs, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3836. A communication from the Chairman, Railroad Retirement Board, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3837. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the Department of Health and Human Services Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3838. A communication from the Administrator, General Services Administration, transmitting, pursuant to law, the Agency's Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3839. A communication from the Acting Chief Executive Officer, Corporation for National and Community Service, transmitting, pursuant to law, the Corporation's Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3840. A communication from the Secretary of Labor, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3841. A communication from the General Counsel, National Labor Relations Board, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through

September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3842. A communication from the Chairman, Federal Trade Commission, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3843. A communication from the Deputy General Counsel, National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled ''Patents and Other Intellectual Property Rights'' (RIN2700—AD45) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3844. A communication from the Chairman of the National Transportation Safety Board, transmitting, pursuant to law, a report relative to the actions taken to ensure that audits are conducted of its programs and operations for fiscal year 2009; to the Committee on Commerce, Science, and Transportation.

EC–3845. A communication from the Assistant Secretary of the Employment and Training Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled ''Temporary Agricultural Employment of H–2A Aliens in the United States'' (RIN1205–AB55) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on the Judiciary.

EC–3846. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1882); to the Committee on the Judiciary.

EC–3847. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1964); to the Committee on the Judiciary.

EC–3848. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1962); to the Committee on the Judiciary.

EC–3849. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1963); to the Committee on the Judiciary.

EC–3850. A communication from the Chairman of the Federal Election Commission, transmitting, pursuant to law, the report of a rule entitled ''Final Rule and Explanation and Justification for Campaign Travel'' (Notice 2009–27) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Rules and Administration.

EC–3851. A communication from the Deputy General Counsel, Office of Policy and Strategic Planning, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''The American Recovery and Reinvestment Act of 2009; Secondary Market First Lien Position 504 Loan Pool Guarantee'' (RIN3245–AF90) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3852. A communication from the Deputy General Counsel, Office of Surety Guarantees, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''American Recovery and Reinvestment Act: Surety Bond Guarantees; Size Standards'' (RIN3245–AF94) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3853. A communication from the Deputy General Counsel, HUBZone Program Office, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''HUBZone and Government Contracting'' (RIN3245–AF44) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3854. A communication from the Director of Regulations Management, Veterans Benefits Administration, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled ''Servicemembers' Group Life Insurance — Dependent Coverage'' (RIN2900–AN39) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Veterans' Affairs.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. LEVIN for the Committee on Armed Services.

*Terry A. Yonkers, of Maryland, to be an Assistant Secretary of the Air Force.

*Clifford L. Stanley, of Pennsylvania, to be Under Secretary of Defense for Personnel and Readiness.

*Lawrence G. Romo, of Texas, to be Director of the Selective Service.

*Frank Kendall III, of Virginia, to be Principal Deputy Under Secretary of Defense for Acquisition, Technology, and Logistics.

*Erin C. Conaton, of the District of Columbia, to be Under Secretary of the Air Force.

Air Force nomination of Maj. Gen. Kurt A. Cichowski, to be Lieutenant General.

Air Force nomination of Maj. Gen. Janet C. Wolfenbarger, to be Lieutenant General.

Air Force nomination of Col. Frank J. Sullivan, to be Brigadier General.

Army nomination of Maj. Gen. Guy C. Swan III, to be Lieutenant General.

Army nomination of Brig. Gen. William N. Phillips, to be Lieutenant General.

Army nomination of Maj. Gen. Richard P. Formica, to be Lieutenant General.

Army nomination of Maj. Gen. Michael L. Oates, to be Lieutenant General.

Army nomination of Brig. Gen. Charles J. Barr, to be Major General.

Navy nomination of Capt. Sean R. Filipowski, to be Rear Admiral (lower half).

Navy nomination of Rear Adm. John T. Blake, to be Vice Admiral.

Navy nomination of Vice Adm. Bernard J. McCullough III, to be Vice Admiral.

Navy nomination of Rear Adm. Michael A. LeFever, to be Vice Admiral.

Navy nomination of Rear Adm. William R. Burke, to be Vice Admiral.

Mr. LEVIN. Mr. President, for the Committee on Armed Services I report favorably the following nomination lists which were printed in the RECORDS on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Air Force nominations beginning with Jeffrey K. Atkisson and ending with Roger L. Willis, Jr., which nominations were received by the Senate and appeared in the Congressional Record on September 21, 2009.

Air Force nominations beginning with Christopher C. Abate and ending with Christopher J. Zuhlke, which nominations were received by the Senate and appeared in the Congressional Record on September 21, 2009.

Air Force nomination of Elisha T. Powell IV, to be Colonel.

Army nomination of James C. Lewis, to be Major.

Army nominations beginning with Anuli L. Anyachebelu and ending with John M. Stang, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nominations beginning with Anthony C. Bostick and ending with Joseph G. Williamson, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nominations beginning with Risa D. Bator and ending with Thomas R. Yarber, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nominations beginning with James R. Andrews and ending with Shanda M. Zugner, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nomination of Edwin S. Fuller, to be Major.

Army nomination of Robert J. Schultz, to be Lieutenant Colonel.

Army nominations beginning with Clement D. Ketchum and ending with John Lopez, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009.

Army nominations beginning with Carey L. Mitchell and ending with Melissa F. Tucker, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009.

Army nominations beginning with Craig R. Bottoni and ending with Akash S. Taggarse, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009.

Army nomination of Leon L. Robert, to be Colonel.

Army nomination of Michael C. Metcalf, to be Colonel.

Army nominations beginning with Todd E. Farmer and ending with Steven R. Watt, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Mark D. Crowley and ending with Michael J. Stevenson, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Nathanael L. Allen and ending with X001320, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Scott C. Armstrong and ending with D004309, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Michael W. Anastasia and ending with D003756, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nomination of Scott E. McNeil, to be Colonel.

Army nomination of Scott E. Zipprich, to be Colonel.

Army nomination of Mary B. McQuary, to be Colonel.

Army nominations beginning with Marvin R. Manibusan and ending with Francisco J. Neuman, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009.

Army nominations beginning with Patrick S. Callender and ending with Steven L. Shugart, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009.

Army nominations beginning with Michael A. Bennett and ending with Kevin M. Walker, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009.

Navy nominations beginning with Timothy M. Sherry and ending with Robert N. Mills, which nominations were received by the Senate and appeared in the Congressional Record on October 22, 2009.

Navy nomination of Matthew P. Luff, to be Lieutenant Commander.

Navy nomination of Everett F. Magann, to be Captain.

Navy nomination of William V. Dolan, to be Captain.

Navy nominations beginning with Brian D. Barth and ending with Stacy M. Wuthier, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. MENENDEZ:

S. 2823. A bill to amend chapter 417 of title 49, United States Code, to require air carriers and ticket agents to notify consumers of all taxes and fees applicable to airline tickets in a timely manner, to prohibit the imposition of fuel surcharges that do not correlate to the fuel costs incurred by air carriers, and for other purposes: to the Committee on Commerce, Science, and Transportation.

By Mr. KOHL (for himself and Mr. DURBIN):

S. 2824. A bill to establish a small dollar loan-loss guarantee fund, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mrs. MURRAY (for herself and Ms. CANTWELL):

S. Res. 366. A resolution extending condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; considered and agreed to.

ADDITIONAL COSPONSORS

S. 435

At the request of Mr. CASEY, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 435, a bill to provide for evidence-based and promising practices related to juvenile delinquency and criminal street gang activity prevention and intervention to help build individual, family, and community strength and resiliency to ensure that youth lead productive, safe, healthy, gang-free, and law-abiding lives.

S. 491

At the request of Mr. WEBB, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 491, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 497

At the request of Mr. DURBIN, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 497, a bill to amend the Public Health Service Act to authorize capitation grants to increase the number of nursing faculty and students, and for other purposes.

S. 777

At the request of Mr. BROWN, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 777, a bill to promote industry growth and competitiveness and to improve worker training, retention, and advancement, and for other purposes.

S. 850

At the request of Mr. KERRY, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 850, a bill to amend the High Seas Driftnet Fishing Moratorium Protection Act and the Magnuson-Stevens Fishery Conservation and Management Act to improve the conservation of sharks.

S. 1019

At the request of Mr. HARKIN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1019, a bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for the purchase of hearing aids.

S. 1052

At the request of Mr. CONRAD, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 1052, a bill to amend the small, rural school achievement program and the rural and low-income school program under part B of title VI of the Elementary and Secondary Education Act of 1965.

S. 1304

At the request of Mr. GRASSLEY, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 1304, a bill to restore the economic rights of automobile dealers, and for other purposes.

S. 1353

At the request of Mr. LEAHY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1353, a bill to amend title 1 of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits.

S. 1374

At the request of Mr. BROWN, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1374, a bill to amend the Worker Adjustment and Retraining Notification Act to minimize the adverse effects of employment dislocation, and for other purposes.

S. 1638

At the request of Mr. WICKER, the name of the Senator from Montana (Mr. TESTER) was added as a cosponsor of S. 1638, a bill to permit Amtrak passengers to safely transport firearms and ammunition in their checked baggage.

S. 1744

At the request of Mr. SCHUMER, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 1744, a bill to require the Administrator of the Federal Aviation Administration to prescribe regulations to ensure that all crewmembers on air carriers have proper qualifications and experience, and for other purposes.

S. 1822

At the request of Mr. MERKLEY, the names of the Senator from Arkansas (Mr. PRYOR) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 1822, a bill to amend the Emergency Economic Stabilization Act of 2008, with respect to considerations of the Secretary of the Treasury in providing assistance under that Act, and for other purposes.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 2097

At the request of Mr. THUNE, the names of the Senator from Oklahoma (Mr. INHOFE) and the Senator from West Virginia (Mr. BYRD) were added as cosponsors of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2128

At the request of Mr. LEMIEUX, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2727

At the request of Mr. LUGAR, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 2727, a bill to provide for continued application of arrangements under the Protocol on Inspections and Continuous Monitoring Activities Relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol's termination on December 5, 2009.

S. 2730

At the request of Mr. BROWN, the names of the Senator from Illinois (Mr. DURBIN), the Senator from Vermont (Mr. SANDERS), the Senator from Michigan (Mr. LEVIN) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2781

At the request of Ms. MIKULSKI, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2794

At the request of Mr. SCHUMER, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 2794, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat.

S. 2812

At the request of Mr. BINGAMAN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 2812, a bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs, and for other purposes.

S. CON. RES. 39

At the request of Mr. MENENDEZ, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. Con. Res. 39, a concurrent resolution expressing the sense of the Congress that stable and affordable housing is an essential component of an effective strategy for the prevention, treatment, and care of human immunodeficiency virus, and that the United States should make a commitment to providing adequate funding for the development of housing as a response to the acquired immunodeficiency syndrome pandemic.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2791

At the request of Ms. MIKULSKI, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of amendment No. 2791 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2793

At the request of Mr. DORGAN, the names of the Senator from Vermont (Mr. SANDERS) and the Senator from Minnesota (Mr. FRANKEN) were added as cosponsors of amendment No. 2793 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2795

At the request of Mr. LEAHY, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of amendment No. 2795 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KOHL (for himself and Mr. DURBIN):

S. 2824. A bill to establish a small dollar loan-loss guarantee fund, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. KOHL. Mr. President, I rise to introduce the Safe Affordable Loan Act. This legislation will increase the access for low and moderate income Americans to mainstream financial institutions while reducing the relevance of pay day lenders. Additionally, the bill will encourage community banks and credit unions to provide small dollar loan amounts to families across their communities.

There are approximately 30 million Americans operating on the fringe of the financial system. They are known as the ''unbanked.'' The average income for these individuals is approximately $26,390, with little to no savings. Additionally, these consumers rely on check cashing services or payday lenders as a way to access credit. Most of these operations charge excessive fees and interest rates that leave consumers financially devastated. Without access to mainstream financial services, consumers can be trapped in a cycle of debt with little hope of escape.

In 2008, the FDIC launched a Small Dollar Loan program which offers volunteer participants CRA credit to provide consumers with affordable small dollar loans. I am proud that two banks from Wisconsin, Mitchell Bank in Milwaukee and Benton State Bank in Benton are participating in this valuable program. While this program has been beneficial to communities across the country, only 31 banks have chosen to participate. That is a drop in the bucket compared to the 23,000 payday lender operations. Without other incentives, banks will shy away from lending consumers small amounts, leaving them to rely on payday lenders and other loan alternatives.

The legislation I am proposing would create a loan-loss reserve fund that financial institutions could access in order to mitigate some of the risk associated with offering small dollar loans. Financial institutions will be able to access the reserve fund and could potentially recover 60 percent of a lost loan, provided that their loans meet certain affordability requirements. The institutions must offer loans that have no prepayment penalties, have a repayment period longer than 60 days and has an interest rate of 36 percent APR or lower. Additionally, the loan size cannot exceed $2,500. In order to protect the government from excessive risk taking by the financial institutions, the fund administrator will take into consideration the overall default rate of the loan program that the institution offers to determine the reimbursement rate. Furthermore, the financial institutions would be required to report payment history to the credit reporting bureaus which will help consumers build credit or repair bad credit.

As we consider changes to our financial system, we should include reforms that will help increase access to many of those who are left out. I look forward to working with my colleagues on this important issue in the Banking Committee to move it towards passage.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 366—EXTENDING CONDOLENCES TO THE FAMILIES OF SERGEANT MARK RENNINGER, OFFICER TINA GRISWOLD, OFFICER RONALD OWENS, AND OFFICER GREG RICHARDS

Mrs. MURRAY (for herself and Ms. CANTWELL) submitted the following resolution; which was considered and agreed to:

S. RES. 366

Whereas on the morning of November 29, 2009, 4 members of the Lakewood Police Department were slain by gunfire in a senseless act of violence while preparing for their shift in Lakewood, Washington;

Whereas the 4 officers have been members of the Lakewood Police Department since its founding 5 years ago, were valuable members of the community, and were deeply respected for their service;

Whereas Sergeant Mark Renninger, who served 13 years in law enforcement, first with the Tukwila Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas Officer Tina Griswold, who served 14 years in law enforcement, first with the Lacey Police Department and most recently with the Lakewood Police Department, is survived by her husband and 2 children;

Whereas Officer Ronald Owens, who served 12 years in law enforcement, first with the Washington State Patrol and most recently with the Lakewood Police Department, is survived by his daughter;

Whereas Officer Greg Richards, who served 8 years in law enforcement, first with the Kent Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas the senseless violence against and murder of law enforcement officers, who are sworn to serve, protect, and preserve the peace of the communities, is a particularly heinous crime; and

Whereas in the face of this senseless tragedy, the people of the City of Lakewood, the surrounding communities, and the State of Washington have come together in support of the law enforcement community and the families of the victims: Now, therefore, be it

Resolved, That the Senate—

(1) extends its condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; and

(2) stands with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they celebrate the lives and mourn the loss of these 4 dedicated public servants and law enforcement heroes.

AMENDMENTS SUBMITTED & PROPOSED

SA 2798. Mr. INOUYE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2799. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2800. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2801. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2802. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2803. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2804. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2805. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2806. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2807. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2808. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2791 proposed by Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2809. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2810. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2811. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2812. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2813. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2814. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2815. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2816. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2817. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2818. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2819. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2820. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2821. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2822. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2823. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2824. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2825. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2826. Mr. BENNET (for himself, Mr. HARKIN, Mr. DODD, Mr. BROWN, Mr. DURBIN, Mrs. LINCOLN, Mr. WYDEN, Mr. BEGICH, Mr. BAYH, and Mrs. SHAHEEN) submitted an

amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2827. Mr. TESTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2828. Mr. WHITEHOUSE (for himself, Mr. KERRY, Mr. FEINGOLD, and Mr. FRANKEN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2829. Mr. GRAHAM (for himself and Mr. CHAMBLISS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2830. Mr. BROWNBACK (for himself and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2831. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2832. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2833. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2834. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2835. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2836. Ms. MURKOWSKI (for herself, Mrs. HUTCHISON, and Mr. JOHANNS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2837. Mr. SANDERS (for himself, Mr. BURRIS, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2838. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2839. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2840. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2841. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2842. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2843. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2844. Mr. SANDERS (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2845. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2846. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2847. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2848. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2849. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2850. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2851. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2852. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2853. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2854. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2855. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2856. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2857. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2858. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2859. Ms. SNOWE (for herself, Ms. LANDRIEU, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2798. Mr. INOUYE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title V, add the following:

SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a training demonstration program for family nurse practitioners (referred to in this section as the ''program'') to employ and provide intensive, one-year training for nurse practitioners who have graduated from a nurse practitioner program not more than 18 months prior to commencing such training, for careers as primary care providers in Federally qualified health centers (referred to in this section as ''FQHCs'') and nurse-managed health clinics, in order to increase access to primary care in impoverished, urban, and rural underserved communities.

(b) PURPOSE.—The purpose of the program is to enable each grant recipient to—

(1) provide new nurse practitioners with a depth, breadth, volume, and intensity of clinical training necessary to serve as primary care providers in the complex settings of FQHCs and nurse-managed health clinics;

(2) train new nurse practitioners to work under a model of primary care, including the use of electronic health records, planned care and chronic care models, and interdisciplinary team-based care, that is consistent with—

(A) the principles of health care set forth by the Institute of Medicine; and

(B) the needs of vulnerable populations;

(3) create a model of FQHC- and nurse-managed health clinic-based training for nurse practitioners that may be replicated nationwide; and

(4) provide additional intensive learning experiences with high-volume, high-risk, or high-burden problems commonly encountered in FQHCs and nurse-managed health clinics, such as HIV/AIDS, prenatal care, orthopedics, geriatrics, diabetes, asthma, and obesity prevention.

(c) GRANTS.—The Secretary shall award grants to eligible entities that meet the eligibility requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.

(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)); or

(B) be a nurse-managed health clinic, as defined in section 330A-1 of the Public Health Service Act (as added by section 5208 of this Act); and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(e) PRIORITY IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year and the half-time employment of a qualified program coordinator;

(2) will provide that each such program will entail 12-full months of full-time, paid employment for each awardee, and will offer each awardee benefits consistent with the benefits offered to other full-time employees of such entity;

(3) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics, in which the awardee is the primary provider for the patient, per week, and during such clinics, ensure that the assigned staff nurse practitioner or physician shall be available exclusively to the awardees and have no other assigned clinical or administrative duties;

(4) will provide to each awardee specialty rotations consisting of 3 sessions per week, either within or outside of the FQHC or nurse-managed health clinic, based upon the capability of the FQHC or nurse-managed health clinic to provide specialty training in prenatal care and women's health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas, such as HIV/AIDS, dermatology, cardiology, diabetes, asthma, urgent care (minor trauma), and pain management;

(5) enable awardees to practice alongside other primary care providers so that the awardees may consult with such primary care providers as necessary;

(6) provide educational and didactic sessions on high-volume, high-risk health problems;

(7) have implemented (or will complete, not later than the beginning of the program, implementation of) health information technology, and will make use of an electronic training evaluation system;

(8) provide continuous training to a FQHC standard of a high performance health system that includes access to health care, continuity, planned care, team-based, prevention-focused care that includes the use of electronic health records and other health information technology;

(9) have a record of recruiting, training, caring for, and otherwise demonstrating competency in advancing the primary care of individuals who are from underrepresented minority groups or from a poor urban or rural, or otherwise disadvantaged background;

(10) have a record of training health care professionals in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities; and

(11) have a record of collaboration with other safety net providers, schools, colleges, and universities that provide health professions training, establish formal relationships, and submit joint applications with rural health clinics, area health education centers, and community health centers located in underserved areas, or that serve underserved populations.

(f) ELIGIBILITY OF AWARDEES.—

(1) IN GENERAL.—To be eligible for acceptance to a nurse practitioner training program funded through a grant awarded under this section, an individual shall—

(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a nurse-managed health clinic.

(2) PREFERENCE.—In selecting awardees under the program, each recipient of a grant under this section shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

(3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 90 days after the completion of the program.

(4) AWARDEE DEFINED.—In this section, the term ''awardee'' means an individual who has been accepted into a nurse practitioner training program funded through a grant awarded under this section.

(g) DURATION OF AWARDS.—Each grant awarded under this section shall be for a period of 3 years. A grant recipient may carry over funds from one fiscal year to another without obtaining approval from the Secretary.

(h) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed $600,000 per year, as determined by the Secretary, taking into account—

(1) the financial need of the FQHC or nurse-managed health clinic, considering Federal, State, local, and other operational funding provided to the FQHC or nurse-managed health clinic; and

(2) other factors, as the Secretary determines appropriate.

(i) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to FQHCs and nurse-managed health clinics that plan to establish, or that have established, a nurse practitioner residency training program. The Secretary shall award a technical assistance grant to 1 FQHC that has expertise in establishing a nurse practitioner residency program, for the purpose of providing technical assistance to other recipients of grants under this section.

(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.

SA 2799. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. ENTITLEMENT REFORM.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce the Federal budgetary commitment to health care by January 1, 2019, as compared to Federal budgetary commitment to health care by January 1, 2019 that would have resulted if such Act (and amendments) is not implemented.

SA 2800. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. LOWERING COSTS FOR FAMILIES.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce annual health insurance premiums by $2,500 for the average American family.

SA 2801. Mr. CORNYN submitted an amendment intended to be proposed to

amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 354, after line 2, insert the following:

''(D) STATE ELECTION.—

''(i) IN GENERAL.—At the election of a State, with respect to any calendar year, if such State determines that such an election will promote job creation or increase wages in such State, subparagraphs (A) and (B) may be applied to months in such calendar year by substituting '499' for '50' each place it appears.

''(ii) TIMING AND MANNER OF ELECTION.—Such election with respect to any calendar year shall apply to all months in such calendar year and shall be made at such time and in such manner as the Secretary may provide.

SA 2802. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 97, line 19, insert ''or after'' after ''enrolled on''.

SA 2803. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. MEMBERS OF CONGRESS REQUIRED TO HAVE COVERAGE UNDER MEDICAID INSTEAD OF THROUGH FEHBP.

(a) IN GENERAL.—Notwithstanding chapter 89 of title 5, United States Code, title XIX of the Social Security Act, or any provision of this Act, effective January 1, 2010—

(1) each Member of Congress shall be eligible for medical assistance under the Medicaid plan of the State in which the Member resides; and

(2) any employer contribution under chapter 89 of title 5 of such Code on behalf of the Member may be paid only to the State agency responsible for administering the Medicaid plan in which the Member enrolls and not to the offeror of a plan offered through the Federal employees health benefit program under such chapter.

(b) PAYMENTS BY FEDERAL GOVERNMENT.—The Secretary of Health and Human Services, in consultation with the Director of the Office of Personnel Management, shall establish procedures under which the employer contributions that would otherwise be made on behalf of a Member of Congress if the Member were enrolled in a plan offered through the Federal employees health benefit program may be made directly to the State agencies described in subsection (a).

(c) INELIGIBLE FOR FEHBP.—Effective January 1, 2010, no Member of Congress shall be eligible to obtain health insurance coverage under the program chapter 89 of title 5, United States Code.

(d) DEFINITION.—In this section, the term ''Member of Congress'' means any member of the House of Representatives or the Senate.

SA 2804. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NONAPPLICATION OF MEDICAID ELIGIBILITY EXPANSIONS UNTIL REDUCTION IN MEDICAID FRAUD RATE.

Notwithstanding any other provision of this Act, any provision of this Act or an amendment made by this Act that imposes federally-mandated expansions of eligibility for Medicaid shall not apply to any State before the date on which the Secretary of Health and Human Services certifies that the average payment error rate measurement (commonly referred to as ''PERM'') for all State Medicaid programs does not exceed 3.9 percent.

SA 2805. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 1___. REQUIREMENT OF ELIMINATION OF THE FEDERAL DEFICIT.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no Federal outlays authorized under this Act (or such an amendment) may take effect until the Office of Management and Budget certifies that the Federal budget deficit has been eliminated.

SA 2806. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. ENSURING LOWER HEALTH CARE COSTS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce projected National Health Expenditures by January 1, 2019, as compared to the projected National Health Expenditures by January 1, 2019 that would have resulted if such Act (and amendments) is not implemented.

SA 2807. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1000, strike line 19 and all that follows through line 2 on page 1053.

SA 2808. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2791 proposed by Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2 of the amendment, after line 15 insert the following:

''(5) for the purposes of this Act, and for the purposes of any other provisions of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.''

SA 2809. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with epilepsy.

SA 2810. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 723, strike line 3 and all that follows through page 739, line 17.

SA 2811. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with childhood cancer.

SA 2812. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 842, strike line 3 and all that follows through page 846, line 10.

SA 2813. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

SEC. 3211. PROTECTING CHOICE AND COMPETITION FOR MEDICARE BENEFICIARIES.

No provisions of, or amendments made by, this Act that change the Medicare Advantage program under part C of title XVIII of the Social Security Act in a manner that would result in decreased choice and competition for Medicare beneficiaries shall take effect and are repealed.

SA 2814. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with juvenile diabetes.

SA 2815. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with autism.

SA 2816. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with cancer.

SA 2817. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 828, strike line 5 and all that follows through page 836, line 22.

SA 2818. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with chronic obstructive pulmonary disease (COPD).

SA 2819. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 974, strike line 12 and all that follows through page 999, line 16.

SA 2820. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers located in rural areas.

SA 2821. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 869, strike line 17 and all that follows through page 903, line 15.

SA 2822. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time

homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1000, strike line 19 and all that follows through page 1053, line 2.

SA 2823. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2006.

SA 2824. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2953.

SA 2825. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. __. BUREAUCRAT LIMITATION.

For each new bureaucrat added to any department or agency of the Federal Government for the purpose of implementing the provisions of this Act (or any amendment made by this Act), the head of such department or agency shall ensure that the addition of such new bureaucrat is offset by a reduction of 1 existing bureaucrat at such department or agency.

SA 2826. Mr. BENNET (for himself, Mr. HARKIN, Mr. DODD, Mr. BROWN, Mr. DURBIN, Mrs. LINCOLN, Mr. WYDEN, Mr. BEGICH, Mr. BAYH, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1134, between lines 3 and 4, insert the following:

Subtitle G—Protecting and Improving Guaranteed Medicare Benefits

SEC. 3601. PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS.

(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by, this Act shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act.

(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

SA 2827. Mr. TESTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1203, strike line 19 and all that follows through page 1209, line 20 and insert the following:

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming, with not less than 20 percent of such grants being made to State or local government agencies and community-based organizations located in or serving, or both, rural areas.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;

(B) a local governmental agency;

(C) a national network of community-based organizations;

(D) a State or local non-profit organization; or

(E) an Indian tribe; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(c) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban, rural, and frontier areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) ACTIVITIES.—An eligible entity shall implement activities detailed in the community transformation plan under paragraph (2).

(C) IN-KIND SUPPORT.—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) EVALUATION.—

(A) IN GENERAL.—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities

(B) TYPES OF MEASURES.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;

(ii) changes in proper nutrition;

(iii) changes in physical activity;

(iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary, including differential susceptibility, mortality, or morbidity due to chronic diseases such as cancer, diabetes, and cardiovascular disease.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) DISSEMINATION.—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) TRAINING.—

(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans

(3) EVALUATION.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(e) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 4201A. REDUCTION OF HEALTH DISPARITIES IN RURAL AREAS.

(a) AUTHORIZATION OF INITIATIVE.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in collaboration or conjunction with the Director of the National Center for Health Disparities and Deputy Assistant Secretary for Minority Health, shall establish an initiative—

(A) that is specifically directed toward addressing the issue of health disparities attributable to chronic diseases in rural and frontier areas by creating and promoting educational, screening, and outreach programs that reduce the prevalence, morbidity, and mortality of chronic diseases or susceptibility to such diseases; and

(B) whose goal is to significantly improve access to, and utilization of, beneficial chronic disease interventions in rural communities experiencing health disparities in order to reduce such disparities.

(2) HEALTH DISPARITY POPULATION.—

(A) IN GENERAL.—For purposes of carrying out the initiative described in paragraph (1), a population shall be considered a health disparity population if there is a significant disparity in the overall rate of chronic disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.

(B) CHRONIC DISEASES.—In this paragraph, the term ''chronic disease'' includes hypertension, diabetes, cancer, and heart disease.

(b) COMMON ADMINISTRATIVE STRUCTURE.—The initiative described in subsection (a) shall—

(1) utilize a common administrative structure to ensure coordinated implementation, oversight, and accountability;

(2) be amenable to regional organization in order to meet the specific needs of rural communities throughout the United States; and

(3) involve elements located in rural communities and areas.

(c) DESIGN.—The initiative described in subsection (a) shall be designed to reach rural communities and populations that experience a disproportionate share of chronic disease burden, including African Americans, American Indians or Alaska Natives, Hawaiian Natives and other Pacific Islanders, Asians, Hispanics or Latinos, and other underserved rural populations.

(d) ESTABLISHMENT OF INITIATIVE AND GRANTS.—In carrying out the initiative described in subsection (a), the Secretary of Health and Human Services shall, from funds appropriated to carry out this section—

(1) use 50 percent for the establishment of such initiative; and

(2) use 50 percent to award competitive grants or contracts to organizations, universities, or similar entities to carry out the initiative, with preference given to entities having a demonstrable track record of service to rural communities, including tribally-affiliated colleges or universities.

SA 2828. Mr. WHITEHOUSE (for himself, Mr. KERRY, Mr. FEINGOLD, and Mr. FRANKEN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—MEDICAL BANKRUPTCIES

SECTION ____1. SHORT TITLE.

This title may be cited as the ''Medical Bankruptcy Fairness Act of 2009''.

SEC. ____2. DEFINITIONS.

Section 101 of title 11, the United States Code, is amended by inserting after paragraph (39A) the following:

''(39B) The term 'medical debt' means any debt incurred directly or indirectly as a result of the diagnosis, cure, mitigation, treatment, or prevention of injury, deformity, or disease, or for the purpose of affecting any structure or function of the body.

''(39C) The term 'medically distressed debtor' means a debtor who, during any 12-month period during the 3 years before the date of the filing of the petition—

''(A) incurred or paid medical debts for the debtor or a dependent of the debtor, or a nondependent member of the immediate family of the debtor (including any parent, grandparent, sibling, child, grandchild, or spouse of the debtor), that were not paid by any third party payor and were in excess of 25 percent of the debtor's annual adjusted gross income (as such term is defined under section 62 of the Internal Revenue Code of 1986), set forth in the most recent Federal income tax return filed by the debtor, or by the debtor and the debtor's spouse, prior to the commencement of the case;

''(B) was a member of a household in which 1 or more members (including the debtor) lost all or substantially all of the member's domestic support obligation income, taking into consideration any disability insurance payments, for 4 or more weeks, due to a medical problem of a person obligated to pay such domestic support; or

''(C) experienced a downgrade in employment status that correlates to a reduction in wages or work hours or results in unemployment, to care for an ill, injured, or disabled dependent of the debtor, or an ill, injured, or disabled nondependent member of the immediate family of the debtor (including any parent, grandparent, sibling, child, grandchild, or spouse of the debtor), for not less than 30 days.''.

SEC. ____3. EXEMPTIONS.

(a) EXEMPT PROPERTY.—Section 522 of title 11, the United States Code, is amended by adding at the end the following:

''(r) For a debtor who is a medically distressed debtor, if the debtor elects to exempt property—

''(1) listed in subsection (b)(2), then in lieu of the exemption provided under subsection (d)(1), the debtor may elect to exempt the debtor's aggregate interest, not to exceed $250,000 in value, in real property or personal property that the debtor or a dependent of the debtor uses as a residence, in a cooperative that owns property that the debtor or a dependent of the debtor uses as a residence, or in a burial plot for the debtor or a dependent of the debtor; or

''(2) listed in subsection (b)(3), then if the exemption provided under applicable law specifically for property of the kind described in paragraph (1) is for less than $250,000 in value, the debtor may elect in lieu of such exemption to exempt the debtor's aggregate interest, not to exceed $250,000 in value, in any such real or personal property, cooperative, or burial plot.''.

(b) CONFORMING AMENDMENTS.—Sections 104(b)(1) and 104(b)(2) of title 11, the United States Code, are each amended by inserting ''522(r),'' after ''522(q),''.

SEC. ____4. DISMISSAL OF A CASE OR CONVERSION TO A CASE UNDER CHAPTER 11 OR 13.

Section 707(b) of title 11, the United States Code, is amended by adding at the end the following:

''(8) No judge, United States trustee (or bankruptcy administrator, if any), trustee, or other party in interest may file a motion under paragraph (2) if the debtor is a medically distressed debtor.''.

SEC. ____5. CREDIT COUNSELING.

Section 109(h)(4) of title 11 United States Code, is amended by inserting ''a medically distressed debtor or'' after ''with respect to''.

SEC. ____6. NONDISCHARGEABILITY OF CERTAIN ATTORNEYS FEES.

Section 523(a) of title 11, United States Code, is amended—

(1) in paragraph (18), by striking ''or'' at the end;

(2) in paragraph (19), by striking the period at the end and inserting ''; or''; and

(3) by inserting after paragraph (19) the following:

''(20) in a case arising under chapter 7 of this title, owed to an attorney as reasonable compensation for representing the debtor in connection with the case.''.

SEC. ____7. EFFECTIVE DATE; APPLICATION OF AMENDMENTS.

(a) EFFECTIVE DATE.—Except as provided in subsection (b), this title and the amendments made by this title shall take effect on the date of enactment of this Act.

(b) APPLICATION OF AMENDMENTS.—The amendments made by this title shall apply only with respect to cases commenced under title 11, United States Code, on or after the date of enactment of this Act.

SEC. ____8. ATTESTATION BY DEBTOR.

Any debtor who seeks relief as a medically distressed debtor in accordance with the amendments made by this title shall attest in writing and under penalty of perjury that the medical expenses of the debtor were genuine, and were not specifically incurred to

bring the debtor within the coverage of the medical bankruptcy provisions, as provided in this title and the amendments made by this title.

SA 2829. Mr. GRAHAM (for himself and Mr. CHAMBLISS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—MEDICAL LIABILITY REFORM

SEC. __01. SHORT TITLE.

This title may be cited as the ''Fair Resolution of Medical Liability Disputes Act of 2009''.

SEC. __02. FINDINGS.

Congress finds that—

(1) the health care and insurance industries are industries affecting interstate commerce, and the health care malpractice litigation systems throughout the United States affect interstate commerce by contributing to the high cost of health care and premiums for malpractice insurance purchased by health care providers; and

(2) the Federal Government, as a direct provider of health care and as a source of payment for health care, has a major interest in health care and a demonstrated interest in assessing the quality of care, access to care, and the costs of care through the evaluative activities of several Federal agencies.

SEC. __03. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under this title that provides for the resolution of covered health care malpractice claims in a manner other than through a civil action in Federal or State court.

(2) COVERED HEALTH CARE MALPRACTICE ACTION.—The term ''covered health care malpractice action'' means a civil action in which a covered health care malpractice claim is made against a health care provider or health care professional.

(3) COVERED HEALTH CARE MALPRACTICE CLAIM.—The term ''covered health care malpractice claim'' means a malpractice claim (excluding product liability claims) relating to the provision of, or the failure to provide, health care services involving a defendant covered health care professional or provider.

(4) COVERED HEALTH CARE PROFESSIONAL.—The term ''covered health care professional'' means an individual, including a physician, nurse, chiropractor, nurse midwife, physical therapist, social worker, or physician assistant—

(A) who provides health care services in a State;

(B) for whom individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of such Act (42 U.S.C. 1395j et seq.) comprise not less than 25 percent of the total patients of such professional, as determined by the Secretary; and

(C) who is required by State law or regulation to be licensed or certified by a State a condition for providing such services in the State.

(5) COVERED HEALTH CARE PROVIDER.—The term ''covered health care provider'' means an organization or institution—

(A) that is engaged in the delivery of health care services in a State;

(B) for which individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of such Act (42 U.S.C. 1395j et seq.) comprise not less than 25 percent of the total patients of such organization or institution, as determined by the Secretary; and

(C) that is required by State law or regulation to be licensed or certified by the State as a condition for engaging in the delivery of such services in the State.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. __04. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A covered health care malpractice action may not be brought in any State court during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Attorney General under section __06(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section __06(b).

(2) FEDERAL DIVERSITY ACTIONS.—A covered health care malpractice action may not be brought in a Federal court under section 1332 of title 28, United States Code, during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under the alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

(1) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(2) if the ADR determines that the defendant is liable, the ADR reaches a decision regarding the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—

(A) IN GENERAL.—Not later than 60 days after a decision is issued with respect to a covered health care malpractice claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction, selected by the arbitrator, indicating whether the party intends to contest the decision.

(B) SEALED STATEMENTS.—Each sealed statement submitted to a court under subparagraph (A) shall remain sealed until the earlier of—

(i) the date on which all affected parties have submitted such statement; or

(ii) the submission deadline described in subparagraph (A).

(2) REQUIREMENTS FOR FILING ACTION.—A covered health care malpractice action may not be brought by a party unless—

(A) such party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the covered health care malpractice claim that is the subject of the action is issued under the applicable alternative dispute resolution system; and

(B) any party has filed the notice of intent required by paragraph (1).

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—A decision reached under an alternative dispute resolution system that is not contested under subsection (c) shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a covered health care malpractice action adjudicated in a State or Federal trial court.

(e) STANDARD OF JUDICIAL REVIEW.—The standard of judicial review of a claim filed under subsection (c) shall be de novo.

(f) AWARD OF COSTS AND ATTORNEYS' FEES AFTER INITIAL ADR RESOLUTION.—

(1) IN GENERAL.—In the case of a covered health care malpractice action brought in any State or Federal court after ADR, if the final judgment or order issued (exclusive of costs, expenses, and attorneys' fees incurred after judgment or trial) in the action is not more favorable to a party contesting the ADR decision than the ADR decision, the opposing party may file with the court, not later than 10 days after the final judgment or order is issued, a petition for payment of costs and expenses, including attorneys' fees, incurred with respect to the claim or claims after the date of the ADR decision.

(2) AWARD OF COSTS AND EXPENSES.—If the court finds, under a petition filed under paragraph (1), with respect to a claim or claims, that the judgment or order finally obtained is not more favorable to the party contesting the ADR decision with respect to the claim or claims than the ADR decision, the court shall order the contesting party to pay the costs and expenses of the opposing party, including attorneys' fees, incurred with respect to the claim or claims after the date of the ADR decision, unless the court finds that requiring the payment of such costs and expenses would be manifestly unjust.

(3) LIMITATION.—Attorneys' fees awarded under this subsection shall be in an amount reasonably attributable to the claim or claims involved, calculated on the basis of an hourly rate of the attorney, which may not exceed that which the court considers acceptable in the community in which the attorney practices law, taking into account the attorney's qualifications and experience and the complexity of the case. Attorneys' fees under this subsection may not exceed—

(A) the actual cost incurred by the party for attorneys' fees payable to an attorney for services in connection with the claim or claims; or

(B) if no such cost was incurred by the party due to a contingency fee agreement, a reasonable cost that would have been incurred by the party for noncontingent attorneys' fees payable to an attorney for services in connection with the claim or claims.

(g) APPLICABILITY.—The requirements of this section shall apply only to each covered health care malpractice claim arising out of an event (or events) occurring on or after the date that is 270 days after the date of enactment of this Act.

SEC. __05. BASIC REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

The alternative dispute resolution system of a State meets the requirements of this section if the system—

(1) applies to all covered health care malpractice claims under the jurisdiction of the courts of such State;

(2) requires that a written opinion resolving the dispute be issued not later than 180 days after the date on which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute; and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Attorney General);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system; and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator of the Agency for Healthcare Research and Quality of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

SEC. __06. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than 270 days after the date of enactment of this Act and periodically thereafter, the Attorney General, in consultation with the Secretary, shall determine whether the alternative dispute resolution systems of each State meet the requirements of this title.

(2) BASIS FOR CERTIFICATION.—The Attorney General shall certify the alternative dispute resolution system of a State under this subsection for a calendar year if the Attorney General determines under paragraph (1) that such system meets the requirements of section __05.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than 270 days after the date of enactment of this Act, the Attorney General, in consultation with the Secretary, shall establish by rulemaking an alternative Federal ADR system for the resolution of covered health care malpractice claims during a calendar year, to be used for a calendar year in States that do not have an alternative dispute resolution system that is certified under subsection (a) for such year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section __05 shall apply to claims brought under such system;

(B) the claims brought under such system shall be heard and resolved by medical and legal experts appointed as arbitrators by the Attorney General, in consultation with the Secretary; and

(C) with respect to a State in which such system is in effect, the Attorney General may (at the request of such State) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of health care malpractice claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year such State shall reimburse the United States, at such time and in such manner as the Secretary may require, for the costs incurred by the United States during such year as a result of the application of the system with respect to the State.

SEC. __07. GAO STUDY OF PRIVATE LITIGATION INSURANCE.

The Comptroller General of the United States shall—

(1) undertake a study of the effectiveness of private litigation insurance markets, such as those in the United Kingdom and Germany, in providing affordable access to courts, evaluating the merit of prospective claims, and ensuring that prevailing parties in ''loser pays'' systems are reimbursed for attorneys' fees; and

(2) not later than 270 days after the date of enactment of this Act, submit to Congress a report describing the results of such study.

SA 2830. Mr. BROWNBACK (for himself and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 143 of the amendment, after line 7, add the following:

SEC. 10011. CERTIFICATION.

(a) IN GENERAL.—This title (other than this section), and the amendments made by this title, shall become effective only if the Secretary of Health and Human Services certifies to Congress that the implementation of this title, and the amendments made by this title, will—

(1) pose no additional risk to the public's health and safety; and

(2) result in a significant reduction in the cost of covered products to the American consumer.

(b) EFFECTIVE DATE.—Notwithstanding any other provision of this title, or of any amendment made by this title—

(1) any reference in this title, or in such amendments, to the date of enactment of this title shall be deemed to be a reference to the date of the certification under subsection (a); and

(2) each reference to ''January 1, 2012'' in section 10006(c) shall be substituted with ''90 days after the effective date of this title''.

SA 2831. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NONAPPLICATION OF ANY MEDICAID ELIGIBILITY EXPANSION UNTIL REDUCTION IN MEDICAID FRAUD RATE.

Notwithstanding any other provision of this Act, with respect to a State, any provision of this Act or an amendment made by this Act that imposes a federally-mandated expansion of eligibility for Medicaid shall not apply to the State before the date on which the State Medicaid Director certifies to the Secretary of Health and Human Services that the Medicaid payment error rate measurement (commonly referred to as ''PERM'') for the State does not exceed 5 percent.

SA 2832. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

SEC. _____. DISTRIBUTION OF REMAINING BALANCES IN FLEXIBLE SPENDING ARRANGEMENTS UPON TERMINATION FROM EMPLOYMENT.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and by inserting after subsection (h) the following new subsection:

''(i) DISTRIBUTION OF REMAINING BALANCES IN FLEXIBLE SPENDING ARRANGEMENTS UPON TERMINATION FROM EMPLOYMENT.—

''(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a health flexible spending arrangement or a dependent care flexible spending arrangement solely because under the plan or arrangement a participant is permitted access to any unused balance in the participant's accounts under such plan or arrangement in the manner provided under paragraph (2).

''(2) DISTRIBUTION UPON TERMINATION.—

''(A) IN GENERAL.—A plan or arrangement shall permit a participant (or any designated heir of the participant) to receive a cash payment equal to the aggregate unused account

balances in the plan or arrangement as of the date the individual is separated (including by death or disability) from employment with the employer maintaining the plan or arrangement.

''(B) INCLUSION IN INCOME.—Any payment under subparagraph (A) shall be includible in gross income for the taxable year in which such payment is distributed to the employee.

''(3) TERMS RELATING TO FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section—

''(A) FLEXIBLE SPENDING ARRANGEMENTS.—A flexible spending arrangement is a benefit program which provides employees with coverage under which specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions).

''(B) HEALTH AND DEPENDENT CARE ARRANGEMENTS.—The terms 'health flexible spending arrangement' and 'dependent care flexible spending arrangement' means any flexible spending arrangement (or portion thereof) which provides payments for expenses incurred for medical care (as defined in section 213(d)) or dependent care (within the meaning of section 129), respectively.''.

(b) CONFORMING AMENDMENTS.—

(1) The heading for section 125 of the Internal Revenue Code of 1986 is amended by inserting ''**AND FLEXIBLE SPENDING ARRANGEMENTS**'' after ''**PLANS**''.

(2) The item relating to section 125 in the table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting ''and flexible spending arrangements'' after ''plans''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SA 2833. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NONAPPLICATION OF ANY MEDICAID ELIGIBILITY EXPANSION UNTIL ENROLLMENT OF AT LEAST 90 PERCENT OF CURRENTLY ELIGIBLE INDIVIDUALS.

Notwithstanding any other provision of this Act, with respect to a State, any provision of this Act or an amendment made by this Act that imposes a federally-mandated expansion of eligibility for Medicaid shall not apply to the State before the date on which the State Medicaid Director certifies to the Secretary of Health and Human Services that at least 90 percent of the individuals eligible for medical assistance under the State's Medicaid plan, including under any waiver of such plan, are enrolled in the plan or waiver.

SA 2834. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 340, between lines 21 and 22, insert the following:

(e) EXPEDITED JUDICIAL REVIEW.—If any action is brought to challenge the constitutionality of section 5000A of the Internal Revenue Code of 1986, as added by subsection (b), the following rules shall apply:

(1) The action shall be filed in the United States District Court for the District of Columbia and shall be heard by a 3-judge court convened pursuant to section 2284 of title 28, United States Code.

(2) A copy of the complaint shall be delivered promptly to the Clerk of the House of Representatives and the Secretary of the Senate.

(3) A final decision in the action shall be reviewable only by appeal directly to the Supreme Court of the United States. Such appeal shall be taken by the filing of a notice of appeal within 10 days, and the filing of a jurisdictional statement within 30 days, of the entry of the final decision.

(4) It shall be the duty of the United States District Court for the District of Columbia and the Supreme Court of the United States to advance on the docket and to expedite to the greatest possible extent the disposition of the action and appeal.

SA 2835. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by a critical access hospital (as defined in section 1861(mm)(1)).

SA 2836. Ms. MURKOWSKI (for herself, Mrs. HUTCHISON, and Mr. JOHANNS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 17, strike lines 11 through 14.

On page 17, line 15, strike ''(2)'' and insert ''(1).''

On page 17, line 20, strike ''(3)'' and insert ''(2)''.

On page 17, between lines 24 and 25, insert the following:

''Notwithstanding any other provision of law, the Secretary shall not use any recommendation made by the United States Preventive Services Task Force to deny coverage of an item or service by a group health plan or health insurance issuer offering group or individual health insurance coverage or under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C.1320a–7b(f))) or private insurance.

''(b) DETERMINATIONS OF BENEFITS COVERAGE.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, in determining which preventive items and services to provide coverage for under the plan or coverage, consult the medical guidelines and recommendations of relevant professional medical organizations of relevant medical practice areas (such as the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiation Oncology, the American College of Obstetricians and Gynecologists, and other similar organizations), including guidelines and recommendations relating to the coverage of women's preventive services (such as mammograms and cervical cancer screenings). The plan or issuer shall disclose such guidelines and recommendations to enrollees as part of the summary of benefits and coverage explanation provided under section 2715.''.

On page 17, line 25, strike ''(b)'' and insert ''(c)''.

On page 18, lines 3 and 4, strike ''or (a)(2)''.

On page 18, line 4, strike ''(a)(3)'' and insert ''(a)(2)''

On page 18, line 11, strike ''(c)'' and insert ''(d)''.

On page 124, between lines 22 and 23, insert the following:

(d) RULE OF CONSTRUCTION WITH RESPECT TO PREVENTIVE SERVICES.—Nothing in this Act (or an amendment made by this Act) shall be construed to authorize the Secretary, or any other governmental or quasi-governmental entity, to define or classify abortion or abortion services as ''preventive care'' or as a ''preventive service''.

On page 1680, strike lines 10 through 12, and insert the following:

''(A) to permit the Secretary to use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f)) or private insurance; or''.

SA 2837. Mr. SANDERS (for himself, Mr. BURRIS, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1, strike line 6 and all the follows to the end and insert the following:

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—AMERICAN HEALTH SECURITY

Sec. 1000. Short title.

Subtitle A—Establishment of a State-Based American Health Security Program; Universal Entitlement; Enrollment

Sec. 1001. Establishment of a State-based American Health Security Program.

Sec. 1002. Universal entitlement.
Sec. 1003. Enrollment.
Sec. 1004. Portability of benefits.
Sec. 1005. Effective date of benefits.
Sec. 1006. Relationship to existing Federal health programs.

Subtitle B—Comprehensive Benefits, Including Preventive Benefits and Benefits for Long-Term Care

Sec. 1101. Comprehensive benefits.
Sec. 1102. Definitions relating to services.
Sec. 1103. Special rules for home and community-based long-term care services.
Sec. 1104. Exclusions and limitations.
Sec. 1105. Certification; quality review; plans of care.

Subtitle C—Provider Participation

Sec. 1201. Provider participation and standards.
Sec. 1202. Qualifications for providers.
Sec. 1203. Qualifications for comprehensive health service organizations.
Sec. 1204. Limitation on certain physician referrals.

Subtitle D—Administration

PART I—GENERAL ADMINISTRATIVE PROVISIONS

Sec. 1301. American Health Security Standards Board.
Sec. 1302. American Health Security Advisory Council.
Sec. 1303. Consultation with private entities.
Sec. 1304. State health security programs.
Sec. 1305. Complementary conduct of related health programs.

PART II—CONTROL OVER FRAUD AND ABUSE

Sec. 1310. Application of Federal sanctions to all fraud and abuse under American Health Security Program.
Sec. 1311. Requirements for operation of State health care fraud and abuse control units.

Subtitle E—Quality Assessment

Sec. 1401. American Health Security Quality Council.
Sec. 1402. Development of certain methodologies, guidelines, and standards.
Sec. 1403. State quality review programs.
Sec. 1404. Elimination of utilization review programs; transition.

Subtitle F—Health Security Budget; Payments; Cost Containment Measures

PART I—BUDGETING AND PAYMENTS TO STATES

Sec. 1501. National health security budget.
Sec. 1502. Computation of individual and State capitation amounts.
Sec. 1503. State health security budgets.
Sec. 1504. Federal payments to States.
Sec. 1505. Account for health professional education expenditures.

PART II—PAYMENTS BY STATES TO PROVIDERS

Sec. 1510. Payments to hospitals and other facility-based services for operating expenses on the basis of approved global budgets.
Sec. 1511. Payments to health care practitioners based on prospective fee schedule.
Sec. 1512. Payments to comprehensive health service organizations.
Sec. 1513. Payments for community-based primary health services.
Sec. 1514. Payments for prescription drugs.
Sec. 1515. Payments for approved devices and equipment.
Sec. 1516. Payments for other items and services.
Sec. 1517. Payment incentives for medically underserved areas.
Sec. 1518. Authority for alternative payment methodologies.

PART III—MANDATORY ASSIGNMENT AND ADMINISTRATIVE PROVISIONS

Sec. 1520. Mandatory assignment.
Sec. 1521. Procedures for reimbursement; appeals.

Subtitle G—Financing Provisions; American Health Security Trust Fund

Sec. 1530. Amendment of 1986 code; Section 15 not to apply.

PART I—AMERICAN HEALTH SECURITY TRUST FUND

Sec. 1531. American Health Security Trust Fund.

PART II—TAXES BASED ON INCOME AND WAGES

Sec. 1535. Payroll tax on employers.
Sec. 1536. Health care income tax.

Subtitle H—Conforming Amendments to the Employee Retirement Income Security Act of 1974

Sec. 1601. ERISA inapplicable to health coverage arrangements under State health security programs.
Sec. 1602. Exemption of State health security programs from ERISA preemption.
Sec. 1603. Prohibition of employee benefits duplicative of benefits under State health security programs; coordination in case of workers' compensation.
Sec. 1604. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
Sec. 1605. Effective date of subtitle.

Subtitle I—Additional Conforming Amendments

Sec. 1701. Repeal of certain provisions in Internal Revenue Code of 1986.
Sec. 1702. Repeal of certain provisions in the Employee Retirement Income Security Act of 1974.
Sec. 1703. Repeal of certain provisions in the Public Health Service Act and related provisions.
Sec. 1704. Effective date of subtitle.

TITLE II—HEALTH CARE QUALITY IMPROVEMENTS

Sec. 2001. Health care delivery system research; Quality improvement technical assistance.
Sec. 2002. Establishing community health teams to support the patient-centered medical home.
Sec. 2003. Medication management services in treatment of chronic disease.
Sec. 2004. Design and implementation of regionalized systems for emergency care.
Sec. 2005. Program to facilitate shared decisionmaking.
Sec. 2006. Presentation of prescription drug benefit and risk information.
Sec. 2007. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.
Sec. 2008. Improving women's health.
Sec. 2009. Patient navigator program.
Sec. 2010. Authorization of appropriations.

TITLE III—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

Sec. 3001. National Prevention, Health Promotion and Public Health Council.
Sec. 3002. Prevention and Public Health Fund.
Sec. 3003. Clinical and community Preventive Services.
Sec. 3004. Education and outreach campaign regarding preventive benefits.

Subtitle B—Increasing Access to Clinical Preventive Services

Sec. 3101. School-based health centers.
Sec. 3102. Oral healthcare prevention activities.

Subtitle C—Creating Healthier Communities

Sec. 3201. Community transformation grants.
Sec. 3202. Healthy aging, living well; evaluation of community-based prevention and wellness programs.
Sec. 3203. Removing barriers and improving access to wellness for individuals with disabilities.
Sec. 3204. Immunizations.
Sec. 3205. Nutrition labeling of standard menu items at Chain Restaurants.
Sec. 3206. Demonstration project concerning individualized wellness plan.
Sec. 3207. Reasonable break time for nursing mothers.

Subtitle D—Support for Prevention and Public Health Innovation

Sec. 3301. Research on optimizing the delivery of public health services.
Sec. 3302. Understanding health disparities: data collection and analysis.
Sec. 3303. CDC and employer-based wellness programs.
Sec. 3304. Epidemiology-Laboratory Capacity Grants.
Sec. 3305. Advancing research and treatment for pain care management.
Sec. 3306. Funding for Childhood Obesity Demonstration Project.

Subtitle E—Miscellaneous Provisions

Sec. 3401. Sense of the Senate concerning CBO scoring.
Sec. 3402. Effectiveness of Federal health and wellness initiatives.

TITLE IV—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

Sec. 4001. Purpose.
Sec. 4002. Definitions.

Subtitle B—Innovations in the Health Care Workforce

Sec. 4101. National health care workforce commission.
Sec. 4102. State health care workforce development grants.
Sec. 4103. Health care workforce assessment.

Subtitle C—Increasing the Supply of the Health Care Workforce

Sec. 4201. Federally supported student loan funds.
Sec. 4202. Nursing student loan program.
Sec. 4203. Health care workforce loan repayment programs.
Sec. 4204. Public health workforce recruitment and retention programs.
Sec. 4205. Allied health workforce recruitment and retention programs.
Sec. 4206. Grants for State and local programs.
Sec. 4207. Funding for National Health Service Corps.

Sec. 4208. Nurse-managed health clinics.
Sec. 4209. Elimination of cap on commissioned corps.
Sec. 4210. Establishing a Ready Reserve Corps.

Subtitle D—Enhancing Health Care Workforce Education and Training

Sec. 4301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.
Sec. 4302. Training opportunities for direct care workers.
Sec. 4303. Training in general, pediatric, and public health dentistry.
Sec. 4304. Alternative dental health care providers demonstration project.
Sec. 4305. Geriatric education and training; career awards; comprehensive geriatric education.
Sec. 4306. Mental and behavioral health education and training grants.
Sec. 4307. Cultural competency, prevention, and public health and individuals with disabilities training.
Sec. 4308. Advanced nursing education grants.
Sec. 4309. Nurse education, practice, and retention grants.
Sec. 4310. Loan repayment and scholarship program.
Sec. 4311. Nurse faculty loan program.
Sec. 4312. Authorization of appropriations for parts B through D of title VIII.
Sec. 4313. Grants to promote the community health workforce.
Sec. 4314. Fellowship training in public health.
Sec. 4315. United States Public Health Sciences Track.

Subtitle E—Supporting the Existing Health Care Workforce

Sec. 4401. Centers of excellence.
Sec. 4402. Health care professionals training for diversity.
Sec. 4403. Interdisciplinary, community-based linkages.
Sec. 4404. Workforce diversity grants.
Sec. 4405. Primary care extension program.

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

Sec. 4501. Demonstration projects To address health professions workforce needs; extension of family-to-family health information centers.
Sec. 4502. Increasing teaching capacity.
Sec. 4503. Graduate nurse education demonstration.

Subtitle G—Improving Access to Health Care Services

Sec. 4601. Spending for Federally Qualified Health Centers (FQHCs).
Sec. 4602. Negotiated rulemaking for development of methodology and criteria for designating medically underserved populations and health professions shortage areas.
Sec. 4603. Reauthorization of the Wakefield Emergency Medical Services for Children Program.
Sec. 4604. Co-locating primary and specialty care in community-based mental health settings.
Sec. 4605. Key National indicators.

Subtitle H—General Provisions

Sec. 4701. Reports.

TITLE V—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Physician Ownership and Other Transparency

Sec. 5001. Transparency reports and reporting of physician ownership or investment interests.
Sec. 5002. Prescription drug sample transparency.

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

Sec. 5101. Required disclosure of ownership and additional disclosable parties information.
Sec. 5102. Accountability requirements for skilled nursing facilities and nursing facilities.
Sec. 5104. Standardized complaint form.
Sec. 5105. Ensuring staffing accountability.

PART II—TARGETING ENFORCEMENT

Sec. 5111. Civil money penalties.
Sec. 5112. National independent monitor demonstration project.
Sec. 5113. Notification of facility closure.
Sec. 5114. National demonstration projects on culture change and use of information technology in nursing homes.

PART III—IMPROVING STAFF TRAINING

Sec. 5121. Dementia and abuse prevention training.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

Sec. 5201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.

Subtitle D—Patient-Centered Outcomes Research

Sec. 5301. Patient-Centered Outcomes Research.

Subtitle F—Elder Justice Act

Sec. 5401. Short title of subtitle.
Sec. 5402. Definitions.
Sec. 5403. Elder Justice.

Subtitle G—Sense of the Senate Regarding Medical Malpractice

Sec. 5501. Sense of the Senate regarding medical malpractice.

TITLE VI—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

Sec. 6001. Short title.
Sec. 6002. Approval pathway for biosimilar biological products.
Sec. 6003. Savings.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

Sec. 6101. Expanded participation in 340B program.
Sec. 6102. Improvements to 340B program integrity.
Sec. 6103. GAO study to make recommendations on improving the 340B program.

TITLE I—AMERICAN HEALTH SECURITY

SEC. 1000. SHORT TITLE.

This title may be cited as the ''American Health Security Act of 2009''

Subtitle A—Establishment of a State-Based American Health Security Program; Universal Entitlement; Enrollment

SEC. 1001. ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM.

(a) IN GENERAL.—There is hereby established in the United States a State-Based American Health Security Program to be administered by the individual States in accordance with Federal standards specified in, or established under, this title.

(b) STATE HEALTH SECURITY PROGRAMS.—In order for a State to be eligible to receive payment under section 1504, a State must establish a State health security program in accordance with this title.

(c) STATE DEFINED.—

(1) IN GENERAL.—In this title, subject to paragraph (2), the term ''State'' means each of the 50 States and the District of Columbia.

(2) ELECTION.—If the Governor of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands certifies to the President that the legislature of the Commonwealth or territory has enacted legislation desiring that the Commonwealth or territory be included as a State under the provisions of this title, such Commonwealth or territory shall be included as a ''State'' under this title beginning January 1 of the first year beginning 90 days after the President receives the notification.

SEC. 1002. UNIVERSAL ENTITLEMENT.

(a) IN GENERAL.—Every individual who is a resident of the United States and is a citizen or national of the United States or lawful resident alien (as defined in subsection (d)) is entitled to benefits for health care services under this title under the appropriate State health security program. In this section, the term ''appropriate State health security program'' means, with respect to an individual, the State health security program for the State in which the individual maintains a primary residence.

(b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

(1) IN GENERAL.—The American Health Security Standards Board (in this title referred to as the ''Board'') may make eligible for benefits for health care services under the appropriate State health security program under this title such classes of aliens admitted to the United States as nonimmigrants as the Board may provide.

(2) CONSIDERATION.—In providing for eligibility under paragraph (1), the Board shall consider reciprocity in health care services offered to United States citizens who are nonimmigrants in other foreign states, and such other factors as the Board determines to be appropriate.

(c) TREATMENT OF OTHER INDIVIDUALS.—

(1) BY BOARD.—The Board also may make eligible for benefits for health care services under the appropriate State health security program under this title other individuals not described in subsection (a) or (b), and regulate the nature of the eligibility of such individuals, in order—

(A) to preserve the public health of communities;

(B) to compensate States for the additional health care financing burdens created by such individuals; and

(C) to prevent adverse financial and medical consequences of uncompensated care,

while inhibiting travel and immigration to the United States for the sole purpose of obtaining health care services.

(2) BY STATES.—Any State health security program may make individuals described in paragraph (1) eligible for benefits at the expense of the State.

(d) LAWFUL RESIDENT ALIEN DEFINED.—For purposes of this section, the term ''lawful resident alien'' means an alien lawfully admitted for permanent residence and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A, or 234A of the Immigration and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

SEC. 1003. ENROLLMENT.

(a) IN GENERAL.—Each State health security program shall provide a mechanism for the enrollment of individuals entitled or eligible for benefits under this title. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States and at the time of immigration into the United States or other acquisition of lawful resident status in the United States;

(2) provide for the enrollment, as of January 1, 2011, of all individuals who are eligible to be enrolled as of such date; and

(3) include a process for the enrollment of individuals made eligible for health care services under subsections (b) and (c) of section 1002.

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall make applications for enrollment under the program available—

(1) at employment and payroll offices of employers located in the State;

(2) at local offices of the Social Security Administration;

(3) at social services locations;

(4) at out-reach sites (such as provider and practitioner locations); and

(5) at other locations (including post offices and schools) accessible to a broad cross-section of individuals eligible to enroll.

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual's enrollment for benefits under this title, the State health security program shall provide for the issuance of a health security card that shall be used for purposes of identification and processing of claims for benefits under the program. The State health security program may provide for issuance of such cards by employers for purposes of carrying out enrollment pursuant to subsection (a)(2).

SEC. 1004. PORTABILITY OF BENEFITS.

(a) IN GENERAL.—To ensure continuous access to benefits for health care services covered under this title, each State health security program—

(1) shall not impose any minimum period of residence in the State, or waiting period, in excess of 3 months before residents of the State are entitled to, or eligible for, such benefits under the program;

(2) shall provide continuation of payment for covered health care services to individuals who have terminated their residence in the State and established their residence in another State, for the duration of any waiting period imposed in the State of new residency for establishing entitlement to, or eligibility for, such services; and

(3) shall provide for the payment for health care services covered under this title provided to individuals while temporarily absent from the State based on the following principles:

(A) Payment for such health care services is at the rate that is approved by the State health security program in the State in which the services are provided, unless the States concerned agree to apportion the cost between them in a different manner.

(B) Payment for such health care services provided outside the United States is made on the basis of the amount that would have been paid by the State health security program for similar services rendered in the State, with due regard, in the case of hospital services, to the size of the hospital, standards of service, and other relevant factors.

(b) CROSS-BORDER ARRANGEMENTS.—A State health security program for a State may negotiate with such a program in an adjacent State a reciprocal arrangement for the coverage under such other program of health care services to enrollees residing in the border region.

SEC. 1005. EFFECTIVE DATE OF BENEFITS.

Benefits shall first be available under this title for items and services furnished on or after January 1, 2011.

SEC. 1006. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE, MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—

(1) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraph (2)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished after December 31, 2010;

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished after such date;

(C) no individual is entitled to medical assistance under an SCHIP plan under title XXI of such Act for any item or service furnished after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 2011, and which had not ended as of such date, for which benefits are provided under title XVIII, under a State plan under title XIX, or a State child health plan under title XXI, of the Social Security Act, the Secretary of Health and Human Services and each State plan, respectively, shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, for any part of a coverage period occurring after December 31, 2010.

(c) CHAMPUS.—No benefits shall be made available under sections 1079 and 1086 of title 10, United States Code, for items or services furnished after December 31, 2010.

(d) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—Nothing in this title shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

Subtitle B—Comprehensive Benefits, Including Preventive Benefits and Benefits for Long-Term Care

SEC. 1101. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the succeeding provisions of this title, individuals enrolled for benefits under this title are entitled to have payment made under a State health security program for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) HOSPITAL SERVICES.—Inpatient and outpatient hospital care, including 24-hour-a-day emergency services.

(2) PROFESSIONAL SERVICES.—Professional services of health care practitioners authorized to provide health care services under State law, including patient education and training in self-management techniques.

(3) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—Community-based primary health services (as defined in section 1102(a)).

(4) PREVENTIVE SERVICES.—Preventive services (as defined in section 1102(b)).

(5) LONG-TERM, ACUTE, AND CHRONIC CARE SERVICES.—

(A) Nursing facility services.

(B) Home health services.

(C) Home and community-based long-term care services (as defined in section 1102(c)) for individuals described in section 1103(a).

(D) Hospice care.

(E) Services in intermediate care facilities for individuals with mental retardation.

(6) PRESCRIPTION DRUGS, BIOLOGICALS, INSULIN, MEDICAL FOODS.—

(A) Outpatient prescription drugs and biologics, as specified by the Board consistent with section 1515.

(B) Insulin.

(C) Medical foods (as defined in section 1102(e)).

(7) DENTAL SERVICES.—Dental services (as defined in section 1102(h)).

(8) MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES.—Mental health and substance abuse treatment services (as defined in section 1102(f)).

(9) DIAGNOSTIC TESTS.—Diagnostic tests.

(10) OTHER ITEMS AND SERVICES.—

(A) OUTPATIENT THERAPY.—Outpatient physical therapy services, outpatient speech pathology services, and outpatient occupational therapy services in all settings.

(B) DURABLE MEDICAL EQUIPMENT.—Durable medical equipment.

(C) HOME DIALYSIS.—Home dialysis supplies and equipment.

(D) AMBULANCE.—Emergency ambulance service.

(E) PROSTHETIC DEVICES.—Prosthetic devices, including replacements of such devices.

(F) ADDITIONAL ITEMS AND SERVICES.—Such other medical or health care items or services as the Board may specify.

(b) PROHIBITION OF BALANCE BILLING.—No person may impose a charge for covered services for which benefits are provided under this title.

(c) NO DUPLICATE HEALTH INSURANCE.—Each State health security program shall prohibit the sale of health insurance in the State if payment under the insurance duplicates payment for any items or services for which payment may be made under such a program.

(d) STATE PROGRAM MAY PROVIDE ADDITIONAL BENEFITS.—Nothing in this title shall be construed as limiting the benefits that may be made available under a State health security program to residents of the State at the expense of the State.

(e) EMPLOYERS MAY PROVIDE ADDITIONAL BENEFITS.—Nothing in this title shall be construed as limiting the additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

SEC. 1102. DEFINITIONS RELATING TO SERVICES.

(a) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—In this title, the term ''community-based primary health services'' means ambulatory health services furnished—

(1) by a rural health clinic;

(2) by a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act), and which, for purposes of this title, include services furnished by State and local health agencies;

(3) in a school-based setting;

(4) by public educational agencies and other providers of services to children entitled to assistance under the Individuals with Disabilities Education Act for services furnished pursuant to a written Individualized Family Services Plan or Individual Education Plan under such Act; and

(5) public and private nonprofit entities receiving Federal assistance under the Public Health Service Act.

(b) PREVENTIVE SERVICES.—

(1) IN GENERAL.—In this title, the term ''preventive services'' means items and services—

(A) which—

(i) are specified in paragraph (2); or

(ii) the Board determines to be effective in the maintenance and promotion of health or minimizing the effect of illness, disease, or medical condition; and

(B) which are provided consistent with the periodicity schedule established under paragraph (3).

(2) SPECIFIED PREVENTIVE SERVICES.—The services specified in this paragraph are as follows:

(A) Basic immunizations.

(B) Prenatal and well-baby care (for infants under 1 year of age).

(C) Well-child care (including periodic physical examinations, hearing and vision screening, and developmental screening and examinations) for individuals under 18 years of age.

(D) Periodic screening mammography, Pap smears, and colorectal examinations and examinations for prostate cancer.

(E) Physical examinations.

(F) Family planning services.

(G) Routine eye examinations, eyeglasses, and contact lenses.

(H) Hearing aids, but only upon a determination of a certified audiologist or physician that a hearing problem exists and is caused by a condition that can be corrected by use of a hearing aid.

(3) SCHEDULE.—The Board shall establish, in consultation with experts in preventive medicine and public health and taking into consideration those preventive services recommended by the Preventive Services Task Force and published as the Guide to Clinical Preventive Services, a periodicity schedule for the coverage of preventive services under paragraph (1). Such schedule shall take into consideration the cost-effectiveness of appropriate preventive care and shall be revised not less frequently than once every 5 years, in consultation with experts in preventive medicine and public health.

(c) HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.—In this title, the term ''home and community-based long-term care services'' means the following services provided to an individual to enable the individual to remain in such individual's place of residence within the community:

(1) Home health aide services.

(2) Adult day health care, social day care or psychiatric day care.

(3) Medical social work services.

(4) Care coordination services, as defined in subsection (g)(1).

(5) Respite care, including training for informal caregivers.

(6) Personal assistance services, and homemaker services (including meals) incidental to the provision of personal assistance services.

(d) HOME HEALTH SERVICES.—

(1) IN GENERAL.—The term ''home health services'' means items and services described in section 1861(m) of the Social Security Act and includes home infusion services.

(2) HOME INFUSION SERVICES.—The term ''home infusion services'' includes the nursing, pharmacy, and related services that are necessary to conduct the home infusion of a drug regimen safely and effectively under a plan established and periodically reviewed by a physician and that are provided in compliance with quality assurance requirements established by the Secretary.

(e) MEDICAL FOODS.—In this title, the term ''medical foods'' means foods which are formulated to be consumed or administered enterally under the supervision of a physician and which are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

(f) MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES.—

(1) SERVICES DESCRIBED.—In this title, the term ''mental health and substance abuse treatment services'' means the following services related to the prevention, diagnosis, treatment, and rehabilitation of mental illness and promotion of mental health:

(A) INPATIENT HOSPITAL SERVICES.—Inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse for up to 60 days during a year, reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of inpatient residential services furnished to the individual under subparagraph (B) during the year after such services have been furnished to the individual for 120 days during the year (rounded to the nearest day), but only if (with respect to services furnished to an individual described in section 1104(b)(1)) such services are furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1104(b)(2).

(B) INTENSIVE RESIDENTIAL SERVICES.—Intensive residential services (as defined in paragraph (2)) furnished to an individual for up to 120 days during any calendar year, except that—

(i) such services may be furnished to the individual for additional days during the year if necessary for the individual to complete a course of treatment to the extent that the number of days of inpatient hospital services described in subparagraph (A) that may be furnished to the individual during the year (as reduced under such subparagraph) is not less than 15; and

(ii) reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of intensive community-based services furnished to the individual under subparagraph (D) during the year after such services have been furnished to the individual for 90 days (or, in the case of services described in subparagraph (D)(ii), for 180 days) during the year (rounded to the nearest day).

(C) OUTPATIENT SERVICES.—Outpatient treatment services of mental illness or substance abuse (other than intensive community-based services under subparagraph (D)) for an unlimited number of days during any calendar year furnished in accordance with standards established by the Secretary for the management of such services, and, in the case of services furnished to an individual described in section 1104(b)(1) who is not an inpatient of a hospital, in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1104(b)(2).

(D) INTENSIVE COMMUNITY-BASED SERVICES.—Intensive community-based services (as described in paragraph (3))—

(i) for an unlimited number of days during any calendar year, in the case of services described in section 1861(ff)(2)(E) that are furnished to an individual who is a seriously mentally ill adult, a seriously emotionally disturbed child, or an adult or child with serious substance abuse disorder (as determined in accordance with criteria established by the Secretary);

(ii) in the case of services described in section 1861(ff)(2)(C), for up to 180 days during any calendar year, except that such services may be furnished to the individual for a number of additional days during the year equal to the difference between the total number of days of intensive residential services which the individual may receive during the year under part A (as determined under subparagraph (B)) and the number of days of such services which the individual has received during the year; or

(iii) in the case of any other such services, for up to 90 days during any calendar year, except that such services may be furnished to the individual for the number of additional days during the year described in clause (ii).

(2) INTENSIVE RESIDENTIAL SERVICES DEFINED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term ''intensive residential services'' means inpatient services provided in any of the following facilities:

(i) Residential detoxification centers.

(ii) Crisis residential programs or mental illness residential treatment programs.

(iii) Therapeutic family or group treatment homes.

(iv) Residential centers for substance abuse treatment.

(B) REQUIREMENTS FOR FACILITIES.—No service may be treated as an intensive residential service under subparagraph (A) unless the facility at which the service is provided—

(i) is legally authorized to provide such service under the law of the State (or under a State regulatory mechanism provided by State law) in which the facility is located or is certified to provide such service by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

(ii) meets such other requirements as the Secretary may impose to assure the quality of the intensive residential services provided.

(C) SERVICES FURNISHED TO AT-RISK CHILDREN.—In the case of services furnished to an individual described in section 1104(b)(1), no service may be treated as an intensive residential service under this subsection unless the service is furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1104(b)(2).

(D) MANAGEMENT STANDARDS.—No service may be treated as an intensive residential

service under subparagraph (A) unless the service is furnished in accordance with standards established by the Secretary for the management of such services.

(3) INTENSIVE COMMUNITY-BASED SERVICES DEFINED.—

(A) IN GENERAL.—The term ''intensive community-based services'' means the items and services described in subparagraph (B) prescribed by a physician (or, in the case of services furnished to an individual described in section 1104(b)(1), by an organized system of care for mental health and substance abuse services in accordance with such section) and provided under a program described in subparagraph (D) under the supervision of a physician (or, to the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional) pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program) which sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan, but does not include any item or service that is not furnished in accordance with standards established by the Secretary for the management of such services.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are—

(i) partial hospitalization services consisting of the items and services described in subparagraph (C);

(ii) psychiatric rehabilitation services;

(iii) day treatment services for individuals under 19 years of age;

(iv) in-home services;

(v) case management services, including collateral services designated as such case management services by the Secretary;

(vi) ambulatory detoxification services; and

(vii) such other items and services as the Secretary may provide (but in no event to include meals and transportation),

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(C) ITEMS AND SERVICES INCLUDED AS PARTIAL HOSPITALIZATION SERVICES.—For purposes of subparagraph (B)(i), partial hospitalization services consist of the following:

(i) Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law).

(ii) Occupational therapy requiring the skills of a qualified occupational therapist.

(iii) Services of social workers, trained psychiatric nurses, behavioral aides, and other staff trained to work with psychiatric patients (to the extent authorized under State law).

(iv) Drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered).

(v) Individualized activity therapies that are not primarily recreational or diversionary.

(vi) Family counseling (the primary purpose of which is treatment of the individual's condition).

(vii) Patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment).

(viii) Diagnostic services.

(D) PROGRAMS DESCRIBED.—A program described in this subparagraph is a program (whether facility-based or freestanding) which is furnished by an entity—

(i) legally authorized to furnish such a program under State law (or the State regulatory mechanism provided by State law) or certified to furnish such a program by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

(ii) meeting such other requirements as the Secretary may impose to assure the quality of the intensive community-based services provided.

(g) CARE COORDINATION SERVICES.—

(1) IN GENERAL.—In this title, the term ''care coordination services'' means services provided by care coordinators (as defined in paragraph (2)) to individuals described in paragraph (3) for the coordination and monitoring of home and community-based long term care services to ensure appropriate, cost-effective utilization of such services in a comprehensive and continuous manner, and includes—

(A) transition management between inpatient facilities and community-based services, including assisting patients in identifying and gaining access to appropriate ancillary services; and

(B) evaluating and recommending appropriate treatment services, in cooperation with patients and other providers and in conjunction with any quality review program or plan of care under section 1105.

(2) CARE COORDINATOR.—

(A) IN GENERAL.—In this title, the term ''care coordinator'' means an individual or nonprofit or public agency or organization which the State health security program determines—

(i) is capable of performing directly, efficiently, and effectively the duties of a care coordinator described in paragraph (1); and

(ii) demonstrates capability in establishing and periodically reviewing and revising plans of care, and in arranging for and monitoring the provision and quality of services under any plan.

(B) INDEPENDENCE.—State health security programs shall establish safeguards to assure that care coordinators have no financial interest in treatment decisions or placements. Care coordination may not be provided through any structure or mechanism through which quality review is performed.

(3) ELIGIBLE INDIVIDUALS.—An individual described in this paragraph is an individual described in section 1103 (relating to individuals qualifying for long term and chronic care services).

(h) DENTAL SERVICES.—

(1) IN GENERAL.—In this title, subject to subsection (b), the term ''dental services'' means the following:

(A) Emergency dental treatment, including extractions, for bleeding, pain, acute infections, and injuries to the maxillofacial region.

(B) Prevention and diagnosis of dental disease, including examinations of the hard and soft tissues of the oral cavity and related structures, radiographs, dental sealants, fluorides, and dental prophylaxis.

(C) Treatment of dental disease, including non-cast fillings, periodontal maintenance services, and endodontic services.

(D) Space maintenance procedures to prevent orthodontic complications.

(E) Orthodontic treatment to prevent severe malocclusions.

(F) Full dentures.

(G) Medically necessary oral health care.

(H) Any items and services for special needs patients that are not described in subparagraphs (A) through (G) and that—

(i) are required to provide such patients the items and services described in subparagraphs (A) through (G);

(ii) are required to establish oral function (including general anesthesia for individuals with physical or emotional limitations that prevent the provision of dental care without such anesthesia);

(iii) consist of orthodontic care for severe dentofacial abnormalities; or

(iv) consist of prosthetic dental devices for genetic or birth defects or fitting for such devices.

(I) Any dental care for individuals with a seizure disorder that is not described in subparagraphs (A) through (H) and that is required because of an illness, injury, disorder, or other health condition that results from such seizure disorder.

(2) LIMITATIONS.—Dental services are subject to the following limitations:

(A) PREVENTION AND DIAGNOSIS.—

(i) EXAMINATIONS AND PROPHYLAXIS.—The examinations and prophylaxis described in paragraph (1)(B) are covered only consistent with a periodicity schedule established by the Board, which schedule may provide for special treatment of individuals less than 18 years of age and of special needs patients.

(ii) DENTAL SEALANTS.—The dental sealants described in such paragraph are not covered for individuals 18 years of age or older. Such sealants are covered for individuals less than 10 years of age for protection of the 1st permanent molars. Such sealants are covered for individuals 10 years of age or older for protection of the 2d permanent molars.

(B) TREATMENT OF DENTAL DISEASE.—Prior to January 1, 2016, the items and services described in paragraph (1)(C) are covered only for individuals less than 18 years of age and special needs patients. On or after such date, such items and services are covered for all individuals enrolled for benefits under this title, except that endodontic services are not covered for individuals 18 years of age or older.

(C) SPACE MAINTENANCE.—The items and services described in paragraph (1)(D) are covered only for individuals at least 3 years of age, but less than 13 years of age and—

(i) are limited to posterior teeth;

(ii) involve maintenance of a space or spaces for permanent posterior teeth that would otherwise be prevented from normal eruption if the space were not maintained; and

(iii) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(3) DEFINITIONS.—For purposes of this title:

(A) MEDICALLY NECESSARY ORAL HEALTH CARE.—The term ''medically necessary oral health care'' means oral health care that is required as a direct result of, or would have a direct impact on, an underlying medical condition. Such term includes oral health care directed toward control or elimination of pain, infection, or reestablishment of oral function.

(B) SPECIAL NEEDS PATIENT.—The term ''special needs patient'' includes an individual with a genetic or birth defect, a developmental disability, or an acquired medical disability.

(i) NURSING FACILITY; NURSING FACILITY SERVICES.—Except as may be provided by the Board, the terms ''nursing facility'' and ''nursing facility services'' have the meanings given such terms in sections 1919(a) and 1905(f), respectively, of the Social Security Act.

(j) SERVICES IN INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH MENTAL RETARDATION.—Except as may be provided by the Board—

(1) the term ''intermediate care facility for individuals with mental retardation'' has the meaning specified in section 1905(d) of the Social Security Act (as in effect before the enactment of this title); and

(2) the term ''services in intermediate care facilities for individuals with mental retardation'' means services described in section 1905(a)(15) of such Act (as so in effect) in an intermediate care facility for individuals with mental retardation to an individual determined to require such services in accordance with standards specified by the Board and comparable to the standards described in section 1902(a)(31)(A) of such Act (as so in effect).

(k) OTHER TERMS.—Except as may be provided by the Board, the definitions contained in section 1861 of the Social Security Act shall apply.

SEC. 1103. SPECIAL RULES FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.

(a) QUALIFYING INDIVIDUALS.—For purposes of section 1101(a)(5)(C), individuals described in this subsection are the following individuals:

(1) ADULTS.—Individuals 18 years of age or older determined (in a manner specified by the Board)—

(A) to be unable to perform, without the assistance of an individual, at least 2 of the following 5 activities of daily living (or who has a similar level of disability due to cognitive impairment)—

(i) bathing;

(ii) eating;

(iii) dressing;

(iv) toileting; and

(v) transferring in and out of a bed or in and out of a chair;

(B) due to cognitive or mental impairments, to require supervision because the individual behaves in a manner that poses health or safety hazards to himself or herself or others; or

(C) due to cognitive or mental impairments, to require queuing to perform activities of daily living.

(2) CHILDREN.—Individuals under 18 years of age determined (in a manner specified by the Board) to meet such alternative standard of disability for children as the Board develops. Such alternative standard shall be comparable to the standard for adults and appropriate for children.

(b) LIMIT ON SERVICES.—

(1) IN GENERAL.—The aggregate expenditures by a State health security program with respect to home and community-based long-term care services in a period (specified by the Board) may not exceed 65 percent (or such alternative ratio as the Board establishes under paragraph (2)) of the average of the amount of payment that would have been made under the program during the period if all the home-based long-term care beneficiaries had been residents of nursing facilities in the same area in which the services were provided.

(2) ALTERNATIVE RATIO.—The Board may establish for purposes of paragraph (1) an alternative ratio (of payments for home and community-based long term care services to payments for nursing facility services) as the Board determines to be more consistent with the goal of providing cost-effective long-term care in the most appropriate and least restrictive setting.

SEC. 1104. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Subject to section 1101(e), benefits for service are not available under this title unless the services meet the standards specified in section 1101(a).

(b) SPECIAL DELIVERY REQUIREMENTS FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES PROVIDED TO AT-RISK CHILDREN.—

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—A State health security program shall ensure that mental health services and substance abuse treatment services are furnished through an organized system of care, as described in paragraph (2), if—

(A) the services are provided to an individual less than 22 years of age;

(B) the individual has a serious emotional disturbance or a substance abuse disorder; and

(C) the individual is, or is at imminent risk of being, subject to the authority of, or in need of the services of, at least 1 public agency that serves the needs of children, including an agency involved with child welfare, special education, juvenile justice, or criminal justice.

(2) REQUIREMENTS FOR SYSTEM OF CARE.—In this subsection, an ''organized system of care'' is a community-based service delivery network, which may consist of public and private providers, that meets the following requirements:

(A) The system has established linkages with existing mental health services and substance abuse treatment service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile justice, criminal justice, health care, mental health, and substance abuse prevention and treatment.

(C) The system provides for the involvement of the families of children to whom mental health services and substance abuse treatment services are provided in the planning of treatment and the delivery of services.

(D) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multiagency teams, which are recognized and followed by the applicable agencies and providers in the area.

(E) The system ensures the delivery and coordination of the range of mental health services and substance abuse treatment services required by individuals under 22 years of age who have a serious emotional disturbance or a substance abuse disorder.

(F) The system provides for the management of the individualized treatment plans described in subparagraph (D) and for a flexible response to changes in treatment needs over time.

(c) TREATMENT OF EXPERIMENTAL SERVICES.—In applying subsection (a), the Board shall make national coverage determinations with respect to those services that are experimental in nature. Such determinations shall be made consistent with a process that provides for input from representatives of health care professionals and patients and public comment.

(d) APPLICATION OF PRACTICE GUIDELINES.—In the case of services for which the American Health Security Quality Council (established under section 1401) has recognized a national practice guideline, the services are considered to meet the standards specified in section 1101(a) if they have been provided in accordance with such guideline or in accordance with such guidelines as are provided by the State health security program consistent with subtitle E. For purposes of this subsection, a service shall be considered to have been provided in accordance with a practice guideline if the health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline.

(e) SPECIFIC LIMITATIONS.—

(1) LIMITATIONS ON EYEGLASSES, CONTACT LENSES, HEARING AIDS, AND DURABLE MEDICAL EQUIPMENT.—Subject to section 1101(e), the Board may impose such limits relating to the costs and frequency of replacement of eyeglasses, contact lenses, hearing aids, and durable medical equipment to which individuals enrolled for benefits under this title are entitled to have payment made under a State health security program as the Board deems appropriate.

(2) OVERLAP WITH PREVENTIVE SERVICES.—The coverage of services described in section 1101(a) (other than paragraph (3)) which also are preventive services are required to be covered only to the extent that they are required to be covered as preventive services.

(3) MISCELLANEOUS EXCLUSIONS FROM COVERED SERVICES.—Covered services under this title do not include the following:

(A) Surgery and other procedures (such as orthodontia) performed solely for cosmetic purposes (as defined in regulations) and hospital or other services incident thereto, unless—

(i) required to correct a congenital anomaly;

(ii) required to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery; or

(iii) otherwise determined to be medically necessary and appropriate under section 1101(a).

(B) Personal comfort items or private rooms in inpatient facilities, unless determined to be medically necessary and appropriate under section 1101(a).

(C) The services of a professional practitioner if they are furnished in a hospital or other facility which is not a participating provider.

(f) NURSING FACILITY SERVICES AND HOME HEALTH SERVICES.—Nursing facility services and home health services (other than post-hospital services, as defined by the Board) furnished to an individual who is not described in section 1103(a) are not covered services unless the services are determined to meet the standards specified in section 1101(a) and, with respect to nursing facility services, to be provided in the least restrictive and most appropriate setting.

SEC. 1105. CERTIFICATION; QUALITY REVIEW; PLANS OF CARE.

(a) CERTIFICATIONS.—State health security programs may require, as a condition of payment for institutional health care services

and other services of the type described in such sections 1814(a) and 1835(a) of the Social Security Act, periodic professional certifications of the kind described in such sections.

(b) QUALITY REVIEW.—For requirement that each State health security program establish a quality review program that meets the requirements for such a program under subtitle E, see section 1304(b)(1)(H).

(c) PLAN OF CARE REQUIREMENTS.—A State health security program may require, consistent with standards established by the Board, that payment for services exceeding specified levels or duration be provided only as consistent with a plan of care or treatment formulated by one or more providers of the services or other qualified professionals. Such a plan may include, consistent with subsection (b), case management at specified intervals as a further condition of payment for services.

Subtitle C—Provider Participation

SEC. 1201. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under a State health security program under this title is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the services under section 1202;

(2) has filed with the State health security program a participation agreement described in subsection (b); and

(3) meets such other qualifications and conditions as are established by the Board or the State health security program under this title.

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between a State health security program and a provider shall provide at least for the following:

(A) Services to eligible persons will be furnished by the provider without discrimination on the ground of race, national origin, income, religion, age, sex or sexual orientation, disability, handicapping condition, or (subject to the professional qualifications of the provider) illness. Nothing in this subparagraph shall be construed as requiring the provision of a type or class of services which services are outside the scope of the provider's normal practice.

(B) No charge will be made for any covered services other than for payment authorized by this title.

(C) The provider agrees to furnish such information as may be reasonably required by the Board or a State health security program, in accordance with uniform reporting standards established under section 1301(g)(1), for—

(i) quality review by designated entities;

(ii) the making of payments under this title (including the examination of records as may be necessary for the verification of information on which payments are based);

(iii) statistical or other studies required for the implementation of this title; and

(iv) such other purposes as the Board or State may specify.

(D) The provider agrees not to bill the program for any services for which benefits are not available because of section 1104(d).

(E) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider who or which has had a participation agreement under this subsection terminated for cause.

(F) In the case of a provider paid under a fee-for-service basis under section 1511, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered services within 30 days (or such shorter period as a State health security program may require) after the date of providing such services.

(2) TERMINATION OF PARTICIPATION AGREEMENTS.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Board or a State health security program for failure to meet the requirements of this title; or

(ii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Board or a State health security program terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

SEC. 1202. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets—

(1) all the requirements of State law to provide such services;

(2) applicable requirements of Federal law to provide such services; and

(3) any applicable standards established under subsection (b).

(b) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Board shall establish, evaluate, and update national minimum standards to assure the quality of services provided under this title and to monitor efforts by State health security programs to assure the quality of such services. A State health security program may also establish additional minimum standards which providers must meet.

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services, individual health care practitioners, and comprehensive health service organizations. Except as the Board may specify in order to carry out this title, a hospital, nursing facility, or other institutional provider of services shall meet standards for such a facility under the medicare program under title XVIII of the Social Security Act. Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) training and competence of personnel (including continuing education requirements);

(C) comprehensiveness of service;

(D) continuity of service;

(E) patient satisfaction (including waiting time and access to services); and

(F) performance standards (including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation).

(3) TRANSITION IN APPLICATION.—If the Board provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) EXCHANGE OF INFORMATION.—The Board shall provide for an exchange, at least annually, among State health security programs of information with respect to quality assurance and cost containment.

SEC. 1203. QUALIFICATIONS FOR COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—For purposes of this title, a comprehensive health service organization (in this section referred to as a ''CHSO'') is a public or private organization which, in return for a capitated payment amount, undertakes to furnish, arrange for the provision of, or provide payment with respect to—

(1) a full range of health services (as identified by the Board), including at least hospital services and physicians services; and

(2) out-of-area coverage in the case of urgently needed services;

to an identified population which is living in or near a specified service area and which enrolls voluntarily in the organization.

(b) ENROLLMENT.—

(1) IN GENERAL.—All eligible persons living in or near the specified service area of a CHSO are eligible to enroll in the organization; except that the number of enrollees may be limited to avoid overtaxing the resources of the organization.

(2) MINIMUM ENROLLMENT PERIOD.—Subject to paragraph (3), the minimum period of enrollment with a CHSO shall be twelve months, unless the enrolled individual becomes ineligible to enroll with the organization.

(3) WITHDRAWAL FOR CAUSE.—Each CHSO shall permit an enrolled individual to disenroll from the organization for cause at any time.

(c) REQUIREMENTS FOR CHSOS.—

(1) ACCESSIBLE SERVICES.—Each CHSO, to the maximum extent feasible, shall make all services readily and promptly accessible to enrollees who live in the specified service area.

(2) CONTINUITY OF CARE.—Each CHSO shall furnish services in such manner as to provide continuity of care and (when services are furnished by different providers) shall provide ready referral of patients to such services and at such times as may be medically appropriate.

(3) BOARD OF DIRECTORS.—In the case of a CHSO that is a private organization—

(A) CONSUMER REPRESENTATION.—At least one-third of the members of the CHSO's board of directors must be consumer members with no direct or indirect, personal or family financial relationship to the organization.

(B) PROVIDER REPRESENTATION.—The CHSO's board of directors must include at least one member who represents health care providers.

(4) PATIENT GRIEVANCE PROGRAM.—Each CHSO must have in effect a patient grievance program and must conduct regularly surveys of the satisfaction of members with services provided by or through the organization.

(5) MEDICAL STANDARDS.—Each CHSO must provide that a committee or committees of health care practitioners associated with the organization will promulgate medical standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutics committee, and monitor and review the quality of all health services (including drugs, education, and preventive services).

(6) PREMIUMS.—Premiums or other charges by a CHSO for any services not paid for under this title must be reasonable.

(7) UTILIZATION AND BONUS INFORMATION.—Each CHSO must—

(A) comply with the requirements of section 1876(i)(8) of the Social Security Act (relating to prohibiting physician incentive

plans that provide specific inducements to reduce or limit medically necessary services); and

(B) make available to its membership utilization information and data regarding financial performance, including bonus or incentive payment arrangements to practitioners.

(8) PROVISION OF SERVICES TO ENROLLEES AT INSTITUTIONS OPERATING UNDER GLOBAL BUDGETS.—The organization shall arrange to reimburse for hospital services and other facility-based services (as identified by the Board) for services provided to members of the organization in accordance with the global operating budget of the hospital or facility approved under section 1510.

(9) BROAD MARKETING.—Each CHSO must provide for the marketing of its services (including dissemination of marketing materials) to potential enrollees in a manner that is designed to enroll individuals representative of the different population groups and geographic areas included within its service area and meets such requirements as the Board or a State health security program may specify.

(10) ADDITIONAL REQUIREMENTS.—Each CHSO must meet—

(A) such requirements relating to minimum enrollment;

(B) such requirements relating to financial solvency;

(C) such requirements relating to quality and availability of care; and

(D) such other requirements,

as the Board or a State health security program may specify.

(d) PROVISION OF EMERGENCY SERVICES TO NONENROLLEES.—A CHSO may furnish emergency services to persons who are not enrolled in the organization. Payment for such services, if they are covered services to eligible persons, shall be made to the organization unless the organization requests that it be made to the individual provider who furnished the services.

SEC. 1204. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.

(a) APPLICATION TO AMERICAN HEALTH SECURITY PROGRAM.—Section 1877 of the Social Security Act, as amended by subsections (b) and (c), shall apply under this title in the same manner as it applies under title XVIII of the Social Security Act; except that in applying such section under this title any references in such section to the Secretary or title XVIII of the Social Security Act are deemed references to the Board and the American Health Security Program under this title, respectively.

(b) EXPANSION OF PROHIBITION TO CERTAIN ADDITIONAL DESIGNATED SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by adding at the end the following:

''(M) Ambulance services.

''(N) Home infusion therapy services.''.

(c) CONFORMING AMENDMENTS.—Section 1877 of such Act is further amended—

(1) in subsection (a)(1)(A), by striking ''for which payment otherwise may be made under this title'' and inserting ''for which a charge is imposed'';

(2) in subsection (a)(1)(B), by striking ''under this title'';

(3) by amending paragraph (1) of subsection (g) to read as follows:

''(1) DENIAL OF PAYMENT.—No payment may be made under a State health security program for a designated health service for which a claim is presented in violation of subsection (a)(1)(B). No individual, third party payor, or other entity is liable for payment for designated health services for which a claim is presented in violation of such subsection.''; and

(4) in subsection (g)(3), by striking ''for which payment may not be made under paragraph (1)'' and inserting ''for which such a claim may not be presented under subsection (a)(1)''.

Subtitle D—Administration

PART I—GENERAL ADMINISTRATIVE PROVISIONS

SEC. 1301. AMERICAN HEALTH SECURITY STANDARDS BOARD.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Standards Board.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Board shall be composed of—

(A) the Secretary of Health and Human Services; and

(B) 6 other individuals (described in paragraph (2)) appointed by the President with the advice and consent of the Senate.

The President shall first nominate individuals under subparagraph (B) on a timely basis so as to provide for the operation of the Board by not later than January 1, 2010.

(2) SELECTION OF APPOINTED MEMBERS.—With respect to the individuals appointed under paragraph (1)(B):

(A) They shall be chosen on the basis of backgrounds in health policy, health economics, the healing professions, and the administration of health care institutions.

(B) They shall provide a balanced point of view with respect to the various health care interests and at least 2 of them shall represent the interests of individual consumers.

(C) Not more than 3 of them shall be from the same political party.

(D) To the greatest extent feasible, they shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS OF APPOINTED MEMBERS.—Individuals appointed under paragraph (1)(B) shall serve for a term of 6 years, except that the terms of 5 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, 4, and 5 years. During a term of membership on the Board, no member shall engage in any other business, vocation or employment.

(c) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Board in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Board.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint an appointed member of the Board for a second term in the same manner as the original appointment. A member who has served for 2 consecutive 6-year terms shall not be eligible for reappointment until 2 years after the member has ceased to serve.

(4) REMOVAL FOR CAUSE.—Upon confirmation, members of the Board may not be removed except by the President for cause.

(d) CHAIR.—The President shall designate 1 of the members of the Board, other than the Secretary, to serve at the will of the President as Chair of the Board.

(e) COMPENSATION.—Members of the Board (other than the Secretary) shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) GENERAL DUTIES OF THE BOARD.—

(1) IN GENERAL.—The Board shall develop policies, procedures, guidelines, and requirements to carry out this title, including those related to—

(A) eligibility;

(B) enrollment;

(C) benefits;

(D) provider participation standards and qualifications, as defined in subtitle C;

(E) national and State funding levels;

(F) methods for determining amounts of payments to providers of covered services, consistent with part II of subtitle D;

(G) the determination of medical necessity and appropriateness with respect to coverage of certain services;

(H) assisting State health security programs with planning for capital expenditures and service delivery;

(I) planning for health professional education funding (as specified in subtitle E); and

(J) encouraging States to develop regional planning mechanisms (described in section 1304(a)(3)).

(2) REGULATIONS.—Regulations authorized by this title shall be issued by the Board in accordance with the provisions of section 553 of title 5, United States Code.

(g) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Board shall establish uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, services and finances of State health security programs, approved plans, providers, and the costs of facilities and practitioners providing services. Such standards shall include, to the maximum extent feasible, health outcome measures.

(B) REPORTS.—The Board shall analyze regularly information reported to it, and to State health security programs pursuant to such requirements and standards.

(2) ANNUAL REPORT.—Beginning January 1, of the second year beginning after the date of the enactment of this title, the Board shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this title.

(C) Benefits under this title.

(D) Expenditures and financing under this title.

(E) Cost-containment measures and achievements under this title.

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

(H) Long-range plans and goals for the delivery of health services.

(I) Differences in the health status of the populations of the different States, including income and racial characteristics.

(J) Necessary changes in the education of health personnel.

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this title.

(M) Opportunities for improvements under this title.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Board may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, state, or local basis, of any aspect of the operation of this title, including studies of the effect of the Act upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(B) develop and test methods of providing through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy, access, and quality; methods of consumer and peer review and peer control of the utilization of drugs, of laboratory services, and of other services; and methods of consumer and peer review of the quality of services;

(C) develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

(D) develop and test, for use by providers of services, records and information retrieval systems useful in the furnishing of preventive or diagnostic services;

(E) develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of independent pharmacies for the cost of furnishing drugs as a covered service; and

(F) make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this title.

(4) REPORT ON USE OF EXISTING FEDERAL HEALTH CARE FACILITIES.—Not later than 1 year after the date of the enactment of this title, the Board shall recommend to the Congress one or more proposals for the treatment of health care facilities of the Federal Government.

(h) EXECUTIVE DIRECTOR.—

(1) APPOINTMENT.—There is hereby established the position of Executive Director of the Board. The Director shall be appointed by the Board and shall serve as secretary to the Board and perform such duties in the administration of this subtitle as the Board may assign.

(2) DELEGATION.—The Board is authorized to delegate to the Director or to any other officer or employee of the Board or, with the approval of the Secretary of Health and Human Services (and subject to reimbursement of identifiable costs), to any other officer or employee of the Department of Health and Human Services, any of its functions or duties under this title other than—

(A) the issuance of regulations; or

(B) the determination of the availability of funds and their allocation to implement this title.

(3) COMPENSATION.—The Executive Director of the Board shall be entitled to compensation at a level equivalent to level III of the Executive Schedule, in accordance with section 5314 of title 5, United States Code.

(i) INSPECTOR GENERAL.—The Inspector General Act of 1978 (5 U.S.C. App.) is amended—

(1) in section 12(1), by inserting after ''Corporation;'' the first place it appears the following: ''the Chair of the American Health Security Standards Board;'';

(2) in section 12(2), by inserting after ''Resolution Trust Corporation,'' the following: ''the American Health Security Standards Board,''; and

(3) by inserting before section 9 the following:

''SPECIAL PROVISIONS CONCERNING AMERICAN HEALTH SECURITY STANDARDS BOARD

''SEC. 8M. The Inspector General of the American Health Security Standards Board, in addition to the other authorities vested by this Act, shall have the same authority, with respect to the Board and the American Health Security Program under this Act, as the Inspector General for the Department of Health and Human Services has with respect to the Secretary of Health and Human Services and the medicare and medicaid programs, respectively.''.

(j) STAFF.—The Board shall employ such staff as the Board may deem necessary.

(k) ACCESS TO INFORMATION.—The Secretary of Health and Human Services shall make available to the Board all information available from sources within the Department or from other sources, pertaining to the duties of the Board.

SEC. 1302. AMERICAN HEALTH SECURITY ADVISORY COUNCIL.

(a) IN GENERAL.—The Board shall provide for an American Health Security Advisory Council (in this section referred to as the ''Council'') to advise the Board on its activities.

(b) MEMBERSHIP.—The Council shall be composed of—

(1) the Chair of the Board, who shall serve as Chair of the Council; and

(2) twenty members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

The appointed members shall include, in accordance with subsection (e), individuals who are representative of State health security programs, public health professionals, providers of health services, and of individuals (who shall constitute a majority of the Council) who are representative of consumers of such services, including a balanced representation of employers, unions, consumer organizations, and population groups with special health care needs. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(c) TERMS OF MEMBERS.—Each appointed member shall hold office for a term of 4 years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which the member's predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, 5 at the end of the first year, 5 at the end of the second year, 5 at the end of the third year, and 5 at the end of the fourth year after the date of enactment of this Act.

(d) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The Board may reappoint an appointed member of the Council for a second term in the same manner as the original appointment.

(e) QUALIFICATIONS.—

(1) PUBLIC HEALTH REPRESENTATIVES.—Members of the Council who are representative of State health security programs and public health professionals shall be individuals who have extensive experience in the financing and delivery of care under public health programs.

(2) PROVIDERS.—Members of the Council who are representative of providers of health care shall be individuals who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professional health practitioners.

(3) CONSUMERS.—Members who are representative of consumers of such care shall be individuals, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the consumption of such services.

(f) DUTIES.—

(1) IN GENERAL.—It shall be the duty of the Council—

(A) to advise the Board on matters of general policy in the administration of this title, in the formulation of regulations, and in the performance of the Board's duties under section 1301; and

(B) to study the operation of this title and the utilization of health services under it, with a view to recommending any changes in the administration of the Act or in its provisions which may appear desirable.

(2) REPORT.—The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board shall promptly transmit the report to the Congress, together with a report by the Board on any recommendations of the Council that have not been followed.

(g) STAFF.—The Council, its members, and any committees of the Council shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

(h) MEETINGS.—The Council shall meet as frequently as the Board deems necessary, but not less than 4 times each year. Upon request by 7 or more members it shall be the duty of the Chair to call a meeting of the Council.

(i) COMPENSATION.—Members of the Council shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(j) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Council.

SEC. 1303. CONSULTATION WITH PRIVATE ENTITIES.

The Secretary and the Board shall consult with private entities, such as professional societies, national associations, nationally recognized associations of experts, medical schools and academic health centers, consumer groups, and labor and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to assure the broadest and most informed input in the administration of this title. Nothing in this title shall prevent the Secretary from adopting guidelines developed by such a private entity if, in the Secretary's and Board's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this title.

SEC. 1304. STATE HEALTH SECURITY PROGRAMS.

(a) SUBMISSION OF PLANS.—

(1) IN GENERAL.—Each State shall submit to the Board a plan for a State health security program for providing for health care services to the residents of the State in accordance with this title.

(2) REGIONAL PROGRAMS.—A State may join with 1 or more neighboring States to submit to the Board a plan for a regional health security program instead of separate State health security programs.

(3) REGIONAL PLANNING MECHANISMS.—The Board shall provide incentives for States to develop regional planning mechanisms to promote the rational distribution of, adequate access to, and efficient use of, tertiary care facilities, equipment, and services.

(b) REVIEW AND APPROVAL OF PLANS.—

(1) IN GENERAL.—The Board shall review plans submitted under subsection (a) and determine whether such plans meet the requirements for approval. The Board shall not approve such a plan unless it finds that the plan (or State law) provides, consistent with the provisions of this title, for the following:

(A) Payment for required health services for eligible individuals in the State in accordance with this title.

(B) Adequate administration, including the designation of a single State agency responsible for the administration (or supervision of the administration) of the program.

(C) The establishment of a State health security budget.

(D) Establishment of payment methodologies (consistent with part II of subtitle E).

(E) Assurances that individuals have the freedom to choose practitioners and other health care providers for services covered under this title.

(F) A procedure for carrying out long-term regional management and planning functions with respect to the delivery and distribution of health care services that—

(i) ensures participation of consumers of health services and providers of health services; and

(ii) gives priority to the most acute shortages and maldistributions of health personnel and facilities and the most serious deficiencies in the delivery of covered services and to the means for the speedy alleviation of these shortcomings.

(G) The licensure and regulation of all health providers and facilities to ensure compliance with Federal and State laws and to promote quality of care.

(H) Establishment of an independent ombudsman for consumers to register complaints about the organization and administration of the State health security program and to help resolve complaints and disputes between consumers and providers.

(I) Publication of an annual report on the operation of the State health security program, which report shall include information on cost, progress towards achieving full enrollment, public access to health services, quality review, health outcomes, health professional training, and the needs of medically underserved populations.

(J) Provision of a fraud and abuse prevention and control unit that the Inspector General determines meets the requirements of section 1309(a).

(K) Prohibit payment in cases of prohibited physician referrals under section 1204.

(2) CONSEQUENCES OF FAILURE TO COMPLY.—If the Board finds that a State plan submitted under paragraph (1) does not meet the requirements for approval under this section or that a State health security program or specific portion of such program, the plan for which was previously approved, no longer meets such requirements, the Board shall provide notice to the State of such failure and that unless corrective action is taken within a period specified by the Board, the Board shall place the State health security program (or specific portions of such program) in receivership under the jurisdiction of the Board.

(c) STATE HEALTH SECURITY ADVISORY COUNCILS.—

(1) IN GENERAL.—For each State, the Governor shall provide for appointment of a State Health Security Advisory Council to advise and make recommendations to the Governor and State with respect to the implementation of the State health security program in the State.

(2) MEMBERSHIP.—Each State Health Security Advisory Council shall be composed of at least 11 individuals. The appointed members shall include individuals who are representative of the State health security program, public health professionals, providers of health services, and of individuals (who shall constitute a majority) who are representative of consumers of such services, including a balanced representation of employers, unions and consumer organizations. To the greatest extent feasible, the membership of each State Health Security Advisory Council shall represent the various geographic regions of the State and shall reflect the racial, ethnic, and gender composition of the population of the State.

(3) DUTIES.—

(A) IN GENERAL.—Each State Health Security Advisory Council shall review, and submit comments to the Governor concerning the implementation of the State health security program in the State.

(B) ASSISTANCE.—Each State Health Security Advisory Council shall provide assistance and technical support to community organizations and public and private non-profit agencies submitting applications for funding under appropriate State and Federal public health programs, with particular emphasis placed on assisting those applicants with broad consumer representation.

(d) STATE USE OF FISCAL AGENTS.—

(1) IN GENERAL.—Each State health security program, using competitive bidding procedures, may enter into such contracts with qualified entities, such as voluntary associations, as the State determines to be appropriate to process claims and to perform other related functions of fiscal agents under the State health security program.

(2) RESTRICTION.—Except as the Board may provide for good cause shown, in no case may more than 1 contract described in paragraph (1) be entered into under a State health security program.

SEC. 1305. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary of Health and Human Services shall direct all activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this title.

PART II—CONTROL OVER FRAUD AND ABUSE

SEC. 1310. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER AMERICAN HEALTH SECURITY PROGRAM.

The following sections of the Social Security Act shall apply to State health security programs in the same manner as they apply to State medical assistance plans under title XIX of such Act (except that in applying such provisions any reference to the Secretary is deemed a reference to the Board):

(1) Section 1128 (relating to exclusion of individuals and entities).

(2) Section 1128A (civil monetary penalties).

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

SEC. 1311. REQUIREMENTS FOR OPERATION OF STATE HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) REQUIREMENT.—In order to meet the requirement of section 1304(b)(1)(J), each State health security program must establish and maintain a health care fraud and abuse control unit (in this section referred to as a ''fraud unit'') that meets requirements of this section and other requirements of the Board. Such a unit may be a State medicaid fraud control unit (described in section 1903(q) of the Social Security Act).

(b) STRUCTURE OF UNIT.—The fraud unit must—

(1) be a single identifiable entity of the State government;

(2) be separate and distinct from the State agency with principal responsibility for the administration of the State health security program; and

(3) meet 1 of the following requirements:

(A) It must be a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations.

(B) If it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Board, that—

(i) assure its referral of suspected criminal violations relating to the State health insurance plan to the appropriate authority or authorities in the States for prosecution; and

(ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions.

(C) It must have a formal working relationship with the office of the State Attorney General and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Board and which provide effective coordination of activities between the fraud unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the State health insurance plan.

(c) FUNCTIONS.—The fraud unit must—

(1) have the function of conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of health care services and activities of providers of such services under the State health security program;

(2) have procedures for reviewing complaints of the abuse and neglect of patients of providers and facilities that receive payments under the State health security program, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action; and

(3) provide for the collection, or referral for collection to a single State agency, of overpayments that are made under the State health security program to providers and

that are discovered by the fraud unit in carrying out its activities.

(d) RESOURCES.—The fraud unit must—

(1) employ such auditors, attorneys, investigators, and other necessary personnel;

(2) be organized in such a manner; and

(3) provide sufficient resources (as specified by the Board),

as is necessary to promote the effective and efficient conduct of the unit's activities.

(e) COOPERATIVE AGREEMENTS.—The fraud unit must have cooperative agreements (as specified by the Board) with—

(1) similar fraud units in other States;

(2) the Inspector General; and

(3) the Attorney General of the United States.

(f) REPORTS.—The fraud unit must submit to the Inspector General an application and annual reports containing such information as the Inspector General determines to be necessary to determine whether the unit meets the previous requirements of this section.

Subtitle E—Quality Assessment

SEC. 1401. AMERICAN HEALTH SECURITY QUALITY COUNCIL.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Quality Council (in this subtitle referred to as the ''Council'').

(b) DUTIES OF THE COUNCIL.—The Council shall perform the following duties:

(1) PRACTICE GUIDELINES.—The Council shall review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act. The Council shall determine whether the guideline should be recognized as a national practice guideline to be used under section 1104(d) for purposes of determining payments under a State health security program.

(2) STANDARDS OF QUALITY, PERFORMANCE MEASURES, AND MEDICAL REVIEW CRITERIA.—The Council shall review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act. The Council shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of services provided by State health security programs, health care institutions, or health care professionals.

(3) CRITERIA FOR ENTITIES CONDUCTING QUALITY REVIEWS.—The Council shall develop minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality review for State quality review programs under section 1403. Such criteria shall require such an entity to be administratively independent of the individual or board that administers the State health security program and shall ensure that such entities do not provide financial incentives to reviewers to favor one pattern of practice over another. The Council shall ensure coordination and reporting by such entities to assure national consistency in quality standards.

(4) REPORTING.—The Council shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually specifically on findings from outcomes research and development of practice guidelines that may affect the Board's determination of coverage of services under section 401(f)(1)(G).

(5) OTHER FUNCTIONS.—The Council shall perform the functions of the Council described in section 1402.

(c) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Council shall be composed of 10 members appointed by the President. The President shall first appoint individuals on a timely basis so as to provide for the operation of the Council by not later than January 1, 2010.

(2) SELECTION OF MEMBERS.—Each member of the Council shall be a member of a health profession. Five members of the Council shall be physicians. Individuals shall be appointed to the Council on the basis of national reputations for clinical and academic excellence. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS OF MEMBERS.—Individuals appointed to the Council shall serve for a term of 5 years, except that the terms of 4 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, and 4 years.

(d) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint a member of the Council for a second term in the same manner as the original appointment. A member who has served for 2 consecutive 5-year terms shall not be eligible for reappointment until 2 years after the member has ceased to serve.

(e) CHAIR.—The President shall designate 1 of the members of the Council to serve at the will of the President as Chair of the Council.

(f) COMPENSATION.—Members of the Council who are not employees of the Federal Government shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

SEC. 1402. DEVELOPMENT OF CERTAIN METHODOLOGIES, GUIDELINES, AND STANDARDS.

(a) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Council shall adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers (as defined in subsection (e)).

(b) CENTERS OF EXCELLENCE.—The Council shall develop guidelines for certain medical procedures designated by the Board to be performed only at tertiary care centers which can meet standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome. Reimbursement under this Act for such a designated procedure may only be provided if the procedure was performed at a center that meets such standards.

(c) REMEDIAL ACTIONS.—The Council shall develop standards for education and sanctions with respect to outliers so as to assure the quality of health care services provided under this Act. The Council shall develop criteria for referral of providers to the State licensing board if education proves ineffective in correcting provider practice behavior.

(d) DISSEMINATION.—The Council shall disseminate to the State—

(1) the methodologies adopted under subsection (a);

(2) the guidelines developed under subsection (b); and

(3) the standards developed under subsection (c);

for use by the States under section 1403.

(e) OUTLIER DEFINED.—In this title, the term ''outlier'' means a health care provider whose pattern of practice, relative to applicable practice guidelines, suggests deficiencies in the quality of health care services being provided.

SEC. 1403. STATE QUALITY REVIEW PROGRAMS.

(a) REQUIREMENT.—In order to meet the requirement of section 404(b)(1)(H), each State health security program shall establish 1 or more qualified entities to conduct quality reviews of persons providing covered services under the program, in accordance with standards established under subsection (b)(1) (except as provided in subsection (b)(2)) and subsection (d).

(b) FEDERAL STANDARDS.—

(1) IN GENERAL.—The Council shall establish standards with respect to—

(A) the adoption of practice guidelines (whether developed by the Federal Government or other entities);

(B) the identification of outliers (consistent with methodologies adopted under section 1402(a));

(C) the development of remedial programs and monitoring for outliers; and

(D) the application of sanctions (consistent with the standards developed under section 1402(c)).

(2) STATE DISCRETION.—A State may apply under subsection (a) standards other than those established under paragraph (1) so long as the State demonstrates to the satisfaction of the Council on an annual basis that the standards applied have been as efficacious in promoting and achieving improved quality of care as the application of the standards established under paragraph (1). Positive improvements in quality shall be documented by reductions in the variations of clinical care process and improvement in patient outcomes.

(c) QUALIFICATIONS.—An entity is not qualified to conduct quality reviews under subsection (a) unless the entity satisfies the criteria for competence for such entities developed by the Council under section 1401(b)(3).

(d) INTERNAL QUALITY REVIEW.—Nothing in this section shall preclude an institutional provider from establishing its own internal quality review and enhancement programs.

SEC. 1404. ELIMINATION OF UTILIZATION REVIEW PROGRAMS; TRANSITION.

(a) INTENT.—It is the intention of this title to replace by January 1, 2013, random utilization controls with a systematic review of patterns of practice that compromise the quality of care.

(b) SUPERSEDING CASE REVIEWS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the program of quality review provided under the previous sections of this title supersede all existing Federal requirements for utilization review programs, including requirements for random case-by-case reviews and programs requiring pre-certification of medical procedures on a case-by-case basis.

(2) TRANSITION.—Before January 1, 2013, the Board and the States may employ existing utilization review standards and mechanisms as may be necessary to effect the transition to pattern of practice-based reviews.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) as precluding the case-by-case review of the provision of care—

(i) in individual incidents where the quality of care has significantly deviated from acceptable standards of practice; and

(ii) with respect to a provider who has been determined to be an outlier; or

(B) as precluding the case management of catastrophic, mental health, or substance abuse cases or long-term care where such management is necessary to achieve appropriate, cost-effective, and beneficial comprehensive medical care, as provided for in section 1104.

Subtitle F—Health Security Budget; Payments; Cost Containment Measures

PART I—BUDGETING AND PAYMENTS TO STATES

SEC. 1501. NATIONAL HEALTH SECURITY BUDGET.

(a) NATIONAL HEALTH SECURITY BUDGET.—

(1) IN GENERAL.—By not later than September 1 before the beginning of each year (beginning with 2010), the Board shall establish a national health security budget, which—

(A) specifies the total expenditures (including expenditures for administrative costs) to be made by the Federal Government and the States for covered health care services under this title; and

(B) allocates those expenditures among the States consistent with section 1504.

Pursuant to subsection (b), such budget for a year shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The national health security budget shall consist of at least 4 components:

(A) A component for quality assessment activities (described in subtitle E).

(B) A component for health professional education expenditures.

(C) A component for administrative costs.

(D) A component (in this subtitle referred to as the ''operating component'') for operating and other expenditures not described in subparagraphs (A) through (C), consisting of amounts not included in the other components. A State may provide for the allocation of this component between capital expenditures and other expenditures.

(3) ALLOCATION AMONG COMPONENTS.—Taking into account the State health security budgets established and submitted under section 1503, the Board shall allocate the national health security budget among the components in a manner that—

(A) assures a fair allocation for quality assessment activities (consistent with the national health security spending growth limit); and

(B) assures that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for covered health care services (consistent with the national health security spending growth limit under subsection (b)(2)).

(b) BASIS FOR TOTAL EXPENDITURES.—

(1) IN GENERAL.—The total expenditures specified in such budget shall be the sum of the capitation amounts computed under section 1502(a) and the amount of Federal administrative expenditures needed to carry out this title.

(2) NATIONAL HEALTH SECURITY SPENDING GROWTH LIMIT.—For purposes of this part, the national health security spending growth limit described in this paragraph for a year is (A) zero, or, if greater, (B) the average annual percentage increase in the gross domestic product (in current dollars) during the 3-year period beginning with the first quarter of the fourth previous year to the first quarter of the previous year minus the percentage increase (if any) in the number of eligible individuals residing in any State the United States from the first quarter of the second previous year to the first quarter of the previous year.

(c) DEFINITIONS.—In this title:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment and includes return on equity capital.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

SEC. 1502. COMPUTATION OF INDIVIDUAL AND STATE CAPITATION AMOUNTS.

(a) CAPITATION AMOUNTS.—

(1) INDIVIDUAL CAPITATION AMOUNTS.—In establishing the national health security budget under section 1501(a) and in computing the national average per capita cost under subsection (b) for each year, the Board shall establish a method for computing the capitation amount for each eligible individual residing in each State. The capitation amount for an eligible individual in a State classified within a risk group (established under subsection (d)(2)) is the product of—

(A) a national average per capita cost for all covered health care services (computed under subsection (b));

(B) the State adjustment factor (established under subsection (c)) for the State; and

(C) the risk adjustment factor (established under subsection (d)) for the risk group.

(2) STATE CAPITATION AMOUNT.—

(A) IN GENERAL.—For purposes of this title, the term ''State capitation amount'' means, for a State for a year, the sum of the capitation amounts computed under paragraph (1) for all the residents of the State in the year, as estimated by the Board before the beginning of the year involved.

(B) USE OF STATISTICAL MODEL.—The Board may provide for the computation of State capitation amounts based on statistical models that fairly reflect the elements that comprise the State capitation amount described in subparagraph (A).

(C) POPULATION INFORMATION.—The Bureau of the Census shall assist the Board in determining the number, place of residence, and risk group classification of eligible individuals.

(b) COMPUTATION OF NATIONAL AVERAGE PER CAPITA COST.—

(1) FOR 2010.—For 2010, the national average per capita cost under this paragraph is equal to—

(A) the average per capita health care expenditures in the United States in 2008 (as estimated by the Board);

(B) increased to 2009 by the Board's estimate of the actual amount of such per capita expenditures during 2009; and

(C) updated to 2010 by the national health security spending growth limit specified in section 1501(b)(2) for 2010.

(2) FOR SUCCEEDING YEARS.—For each succeeding year, the national average per capita cost under this subsection is equal to the national average per capita cost computed under this subsection for the previous year increased by the national health security spending growth limit (specified in section 1501(b)(2)) for the year involved.

(c) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the Board shall develop for each State a factor to adjust the national average per capita costs to reflect differences between the State and the United States in—

(A) average labor and nonlabor costs that are necessary to provide covered health services;

(B) any social, environmental, or geographic condition affecting health status or the need for health care services, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d);

(C) the geographic distribution of the State's population, particularly the proportion of the population residing in medically underserved areas, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d); and

(D) any other factor relating to operating costs required to assure equitable distribution of funds among the States.

(2) MODIFICATION OF HEALTH PROFESSIONAL EDUCATION COMPONENT.—With respect to the portion of the national health security budget allocated to expenditures for health professional education, the Board shall modify the State adjustment factors so as to take into account—

(A) differences among States in health professional education programs in operation as of the date of the enactment of this title; and

(B) differences among States in their relative need for expenditures for health professional education, taking into account the health professional education expenditures proposed in State health security budgets under section 1503(a).

(3) BUDGET NEUTRALITY.—The State adjustment factors, as modified under paragraph (2), shall be applied under this subsection in a manner that results in neither an increase nor a decrease in the total amount of the Federal contributions to all State health security programs under subsection (b) as a result of the application of such factors.

(4) PHASE-IN.—In applying State adjustment factors under this subsection during the 5-year period beginning with 2010, the Board shall phase-in, over such period, the use of factors described in paragraph (1) in a manner so that the adjustment factor for a State is based on a blend of such factors and a factor that reflects the relative actual average per capita costs of health services of the different States as of the time of enactment of this title.

(5) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the State adjustment factors under this subsection.

(d) ADJUSTMENTS FOR RISK GROUP CLASSIFICATION.—

(1) IN GENERAL.—The Board shall develop an adjustment factor to the national average per capita costs computed under subsection (b) for individuals classified in each risk group (as designated under paragraph (2)) to reflect the difference between the average national average per capita costs and the national average per capita cost for individuals classified in the risk group.

(2) RISK GROUPS.—The Board shall designate a series of risk groups, determined by age, health indicators, and other factors that represent distinct patterns of health care services utilization and costs.

(3) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the

risk adjustment factors under this subsection.

SEC. 1503. STATE HEALTH SECURITY BUDGETS.

(a) ESTABLISHMENT AND SUBMISSION OF BUDGETS.—

(1) IN GENERAL.—Each State health security program shall establish and submit to the Board for each year a proposed and a final State health security budget, which specifies the following:

(A) The total expenditures (including expenditures for administrative costs) to be made under the program in the State for covered health care services under this title, consistent with subsection (b), broken down as follows:

(i) By the 4 components (described in section 1501(a)(2)), consistent with subsection (b).

(ii) Within the operating component—

(I) expenditures for operating costs of hospitals and other facility-based services in the State;

(II) expenditures for payment to comprehensive health service organizations;

(III) expenditures for payment of services provided by health care practitioners; and

(IV) expenditures for other covered items and services.

Amounts included in the operating component include amounts that may be used by providers for capital expenditures.

(B) The total revenues required to meet the State health security expenditures.

(2) PROPOSED BUDGET DEADLINE.—The proposed budget for a year shall be submitted under paragraph (1) not later than June 1 before the year.

(3) FINAL BUDGET.—The final budget for a year shall—

(A) be established and submitted under paragraph (1) not later than October 1 before the year, and

(B) take into account the amounts established under the national health security budget under section 1501 for the year.

(4) ADJUSTMENT IN ALLOCATIONS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of a final budget, a State may change the allocation of amounts among components.

(B) NOTICE.—No such change may be made unless the State has provided prior notice of the change to the Board.

(C) DENIAL.—Such a change may not be made if the Board, within such time period as the Board specifies, disapproves such change.

(b) EXPENDITURE LIMITS.—

(1) IN GENERAL.—The total expenditures specified in each State health security budget under subsection (a)(1) shall take into account Federal contributions made under section 1504.

(2) LIMIT ON CLAIMS PROCESSING AND BILLING EXPENDITURES.—Each State health security budget shall provide that State administrative expenditures, including expenditures for claims processing and billing, shall not exceed 3 percent of the total expenditures under the State health security program, unless the Board determines, on a case-by-case basis, that additional administrative expenditures would improve health care quality and cost effectiveness.

(3) WORKER ASSISTANCE.—A State health security program may provide that, for budgets for years before 2013, up to 1 percent of the budget may be used for purposes of programs providing assistance to workers who are currently performing functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of the program.

(c) APPROVAL PROCESS FOR CAPITAL EXPENDITURES PERMITTED.—Nothing in this subtitle shall be construed as preventing a State health security program from providing for a process for the approval of capital expenditures based on information derived from regional planning agencies.

SEC. 1504. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with an approved State health security program is entitled to receive, from amounts in the American Health Security Trust Fund, on a monthly basis each year, of an amount equal to one-twelfth of the product of—

(1) the State capitation amount (computed under section 1502(a)(2)) for the State for the year; and

(2) the Federal contribution percentage (established under subsection (b)).

(b) FEDERAL CONTRIBUTION PERCENTAGE.—The Board shall establish a formula for the establishment of a Federal contribution percentage for each State. Such formula shall take into consideration a State's per capita income and revenue capacity and such other relevant economic indicators as the Board determines to be appropriate. In addition, during the 5-year period beginning with 2010, the Board may provide for a transition adjustment to the formula in order to take into account current expenditures by the State (and local governments thereof) for health services covered under the State health security program. The weighted-average Federal contribution percentage for all States shall equal 86 percent and in no event shall such percentage be less than 81 percent nor more than 91 percent.

(c) USE OF PAYMENTS.—All payments made under this section may only be used to carry out the State health security program.

(d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

(1) SPENDING EXCESS.—If a State exceeds it's budget in a given year, the State shall continue to fund covered health services from its own revenues.

(2) SURPLUS.—If a State provides all covered health services for less than the budgeted amount for a year, it may retain its Federal payment for that year for uses consistent with this title.

SEC. 1505. ACCOUNT FOR HEALTH PROFESSIONAL EDUCATION EXPENDITURES.

(a) SEPARATE ACCOUNT.—Each State health security program shall—

(1) include a separate account for health professional education expenditures; and

(2) specify the general manner, consistent with subsection (b), in which such expenditures are to be distributed among different types of institutions and the different areas of the State.

(b) DISTRIBUTION RULES.—The distribution of funds from the account must take into account the potentially higher costs of placing health professional students in clinical education programs in health professional shortage areas.

PART II—PAYMENTS BY STATES TO PROVIDERS

SEC. 1510. PAYMENTS TO HOSPITALS AND OTHER FACILITY-BASED SERVICES FOR OPERATING EXPENSES ON THE BASIS OF APPROVED GLOBAL BUDGETS.

(a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—Payment for operating expenses for institutional and facility-based care, including hospital services and nursing facility services, under State health security programs shall be made directly to each institution or facility by each State health security program under an annual prospective global budget approved under the program. Such a budget shall include payment for outpatient care and non-facility-based care that is furnished by or through the facility. In the case of a hospital that is wholly owned (or controlled) by a comprehensive health service organization that is paid under section 1513 on the basis of a global budget, the global budget of the organization shall include the budget for the hospital.

(b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

(1) IN GENERAL.—The prospective global budget for an institution or facility shall—

(A) be developed through annual negotiations between—

(i) a panel of individuals who are appointed by the Governor of the State and who represent consumers, labor, business, and the State government; and

(ii) the institution or facility; and

(B) be based on a nationally uniform system of cost accounting established under standards of the Board.

(2) CONSIDERATIONS.—In developing a budget through negotiations, there shall be taken into account at least the following:

(A) With respect to inpatient hospital services, the number, and classification by diagnosis-related group, of discharges.

(B) An institution's or facility's past expenditures.

(C) The extent to which debt service for capital expenditures has been included in the proposed operating budget.

(D) The extent to which capital expenditures are financed directly or indirectly through reductions in direct care to patients, including (but not limited to) reductions in registered nursing staffing patterns or changes in emergency room or primary care services or availability.

(E) Change in the consumer price index and other price indices.

(F) The cost of reasonable compensation to health care practitioners.

(G) The compensation level of the institution's or facility's work force.

(H) The extent to which the institution or facility is providing health care services to meet the needs of residents in the area served by the institution or facility, including the institution's or facility's occupancy level.

(I) The institution's or facility's previous financial and clinical performance, based on utilization and outcomes data provided under this title.

(J) The type of institution or facility, including whether the institution or facility is part of a clinical education program or serves a health professional education, research or other training purpose.

(K) Technological advances or changes.

(L) Costs of the institution or facility associated with meeting Federal and State regulations.

(M) The costs associated with necessary public outreach activities.

(N) In the case of a for-profit facility, a reasonable rate of return on equity capital, independent of those operating expenses necessary to fulfill the objectives of this title.

(O) Incentives to facilities that maintain costs below previous reasonable budgeted levels without reducing the care provided.

(P) With respect to facilities that provide mental health services and substance abuse treatment services, any additional costs involved in the treatment of dually diagnosed individuals.

The portion of such a budget that relates to expenditures for health professional education shall be consistent with the State health security budget for such expenditures.

(3) PROVISION OF REQUIRED INFORMATION; DIAGNOSIS-RELATED GROUP.—No budget for an institution or facility for a year may be approved unless the institution or facility has submitted on a timely basis to the State health security program such information as the program or the Board shall specify, including in the case of hospitals information on discharges classified by diagnosis-related group.

(c) ADJUSTMENTS IN APPROVED BUDGETS.—

(1) ADJUSTMENTS TO GLOBAL BUDGETS THAT CONTRACT WITH COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.—Each State health security program shall develop an administrative mechanism for reducing operating funds to institutions or facilities in proportion to payments made to such institutions or facilities for services contracted for by a comprehensive health service organization.

(2) AMENDMENTS.—In accordance with standards established by the Board, an operating and capital budget approved under this section for a year may be amended before, during, or after the year if there is a substantial change in any of the factors relevant to budget approval.

(d) DONATIONS PERMISSIBLE.—The States health security programs may permit institutions and facilities to raise funds from private sources to pay for newly constructed facilities, major renovations, and equipment. The expenditure of such funds, whether for operating or capital expenditures, does not obligate the State health security program to provide for continued support for such expenditures unless included in an approved global budget.

SEC. 1511. PAYMENTS TO HEALTH CARE PRACTITIONERS BASED ON PROSPECTIVE FEE SCHEDULE.

(a) FEE FOR SERVICE.—

(1) IN GENERAL.—Every independent health care practitioner is entitled to be paid, for the provision of covered health services under the State health security program, a fee for each billable covered service.

(2) GLOBAL FEE PAYMENT METHODOLOGIES.—The Board shall establish models and encourage State health security programs to implement alternative payment methodologies that incorporate global fees for related services (such as all outpatient procedures for treatment of a condition) or for a basic group of services (such as primary care services) furnished to an individual over a period of time, in order to encourage continuity and efficiency in the provision of services. Such methodologies shall be designed to ensure a high quality of care.

(3) BILLING DEADLINES; ELECTRONIC BILLING.—A State health security program may deny payment for any service of an independent health care practitioner for which it did not receive a bill and appropriate supporting documentation (which had been previously specified) within 30 days after the date the service was provided. Such a program may require that bills for services for which payment may be made under this section, or for any class of such services, be submitted electronically.

(b) PAYMENT RATES BASED ON NEGOTIATED PROSPECTIVE FEE SCHEDULES.—With respect to any payment method for a class of services of practitioners, the State health security program shall establish, on a prospective basis, a payment schedule. The State health security program may establish such a schedule after negotiations with organizations representing the practitioners involved. Such fee schedules shall be designed to provide incentives for practitioners to choose primary care medicine, including general internal medicine and pediatrics, over medical specialization. Nothing in this section shall be construed as preventing a State from adjusting the payment schedule amounts on a quarterly or other periodic basis depending on whether expenditures under the schedule will exceed the budgeted amount with respect to such expenditures.

(c) BILLABLE COVERED SERVICE DEFINED.—In this section, the term ‘‘billable covered service’’ means a service covered under section 1101 for which a practitioner is entitled to compensation by payment of a fee determined under this section.

SEC. 1512. PAYMENTS TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—Payment under a State health security program to a comprehensive health service organization to its enrollees shall be determined by the State—

(1) based on a global budget described in section 1510; or

(2) based on the basic capitation amount described in subsection (b) for each of its enrollees.

(b) BASIC CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic capitation amount described in this subsection for an enrollee shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for covered health care services for an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the organization.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of covered health care services that are not provided by the comprehensive health service organization under section 1203(a).

SEC. 1513. PAYMENTS FOR COMMUNITY-BASED PRIMARY HEALTH SERVICES.

(a) IN GENERAL.—In the case of community-based primary health services, subject to subsection (b), payments under a State health security program shall—

(1) be based on a global budget described in section 1510;

(2) be based on the basic primary care capitation amount described in subsection (c) for each individual enrolled with the provider of such services; or

(3) be made on a fee-for-service basis under section 1511.

(b) PAYMENT ADJUSTMENT.—Payments under subsection (a) may include, consistent with the budgets developed under this title—

(1) an additional amount, as set by the State health security program, to cover the costs incurred by a provider which serves persons not covered by this title whose health care is essential to overall community health and the control of communicable disease, and for whom the cost of such care is otherwise uncompensated;

(2) an additional amount, as set by the State health security program, to cover the reasonable costs incurred by a provider that furnishes case management services (as defined in section 1915(g)(2) of the Social Security Act), transportation services, and translation services; and

(3) an additional amount, as set by the State health security program, to cover the costs incurred by a provider in conducting health professional education programs in connection with the provision of such services.

(c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic primary care capitation amount described in this subsection for an enrollee with a provider of community-based primary health services shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for such an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the provider.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of community-based primary health services that are not provided by the provider.

(d) COMMUNITY-BASED PRIMARY HEALTH SERVICES DEFINED.—In this section, the term ‘‘community-based primary health services’’ has the meaning given such term in section 1102(a).

SEC. 1514. PAYMENTS FOR PRESCRIPTION DRUGS.

(a) ESTABLISHMENT OF LIST.—

(1) IN GENERAL.—The Board shall establish a list of approved prescription drugs and biologicals that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this title.

(2) EXCLUSIONS.—The Board may exclude reimbursement under this title for ineffective, unsafe, or over-priced products where better alternatives are determined to be available.

(b) PRICES.—For each such listed prescription drug or biological covered under this title, for insulin, and for medical foods, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this title as the cost of a drug to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with product manufacturers and distributors in determining the applicable product price or prices.

(c) CHARGES BY INDEPENDENT PHARMACIES.—Each State health security program shall provide for payment for a prescription drug or biological or insulin furnished by an independent pharmacy based on the drug's cost to the pharmacy (not in excess of the applicable product price established under subsection (b)) plus a dispensing fee. In accordance with standards established by the Board, each State health security program, after consultation with representatives of the pharmaceutical profession, shall establish schedules of dispensing fees, designed to afford reasonable compensation to independent pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of prescription drugs

dispensed, differences in services provided, the need to maintain expenditures within the budgets established under this title, and other relevant factors.

SEC. 1515. PAYMENTS FOR APPROVED DEVICES AND EQUIPMENT.

(a) ESTABLISHMENT OF LIST.—The Board shall establish a list of approved durable medical equipment and therapeutic devices and equipment (including eyeglasses, hearing aids, and prosthetic appliances), that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this title.

(b) CONSIDERATIONS AND CONDITIONS.—In establishing the list under subsection (a), the Board shall take into consideration the efficacy, safety, and cost of each item contained on such list, and shall attach to any item such conditions as the Board determines appropriate with respect to the circumstances under which, or the frequency with which, the item may be prescribed.

(c) PRICES.—For each such listed item covered under this title, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this title as the cost of the item to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with equipment and device manufacturers and distributors in determining the applicable product price or prices.

(d) EXCLUSIONS.—The Board may exclude from coverage under this title ineffective, unsafe, or overpriced products where better alternatives are determined to be available.

SEC. 1516. PAYMENTS FOR OTHER ITEMS AND SERVICES.

In the case of payment for other covered health services, the amount of payment under a State health security program shall be established by the program—

(1) in accordance with payment methodologies which are specified by the Board, after consultation with the American Health Security Advisory Council, or methodologies established by the State under section 1519; and

(2) consistent with the State health security budget.

SEC. 1517. PAYMENT INCENTIVES FOR MEDICALLY UNDERSERVED AREAS.

(a) MODEL PAYMENT METHODOLOGIES.—In addition to the payment amounts otherwise provided in this title, the Board shall establish model payment methodologies and other incentives that promote the provision of covered health care services in medically underserved areas, particularly in rural and inner-city underserved areas.

(b) CONSTRUCTION.—Nothing in this subtitle shall be construed as limiting the authority of State health security programs to increase payment amounts or otherwise provide additional incentives, consistent with the State health security budget, to encourage the provision of medically necessary and appropriate services in underserved areas.

SEC. 1518. AUTHORITY FOR ALTERNATIVE PAYMENT METHODOLOGIES.

A State health security program, as part of its plan under section 1304(a), may use a payment methodology other than a methodology required under this part so long as—

(1) such payment methodology does not affect the entitlement of individuals to coverage, the weighting of fee schedules to encourage an increase in the number of primary care providers, the ability of individuals to choose among qualified providers, the benefits covered under the program, or the compliance of the program with the State health security budget under part I; and

(2) the program submits periodic reports to the Board showing the operation and effectiveness of the alternative methodology, in order for the Board to evaluate the appropriateness of applying the alternative methodology to other States.

PART III—MANDATORY ASSIGNMENT AND ADMINISTRATIVE PROVISIONS

SEC. 1520. MANDATORY ASSIGNMENT.

(a) NO BALANCE BILLING.—Payments for benefits under this title shall constitute payment in full for such benefits and the entity furnishing an item or service for which payment is made under this title shall accept such payment as payment in full for the item or service and may not accept any payment or impose any charge for any such item or service other than accepting payment from the State health security program in accordance with this title.

(b) ENFORCEMENT.—If an entity knowingly and willfully bills for an item or service or accepts payment in violation of subsection (a), the Board may apply sanctions against the entity in the same manner as sanctions could have been imposed under section 1842(j)(2) of the Social Security Act for a violation of section 1842(j)(1) of such Act. Such sanctions are in addition to any sanctions that a State may impose under its State health security program.

SEC. 1521. PROCEDURES FOR REIMBURSEMENT; APPEALS.

(a) PROCEDURES FOR REIMBURSEMENT.—In accordance with standards issued by the Board, a State health security program shall establish a timely and administratively simple procedure to assure payment within 60 days of the date of submission of clean claims by providers under this title.

(b) APPEALS PROCESS.—Each State health security program shall establish an appeals process to handle all grievances pertaining to payment to providers under this title.

Subtitle G—Financing Provisions; American Health Security Trust Fund

SEC. 1530. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO APPLY.

(a) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(b) SECTION 15 NOT TO APPLY.—The amendments made by part II shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

PART I—AMERICAN HEALTH SECURITY TRUST FUND

SEC. 1531. AMERICAN HEALTH SECURITY TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the American Health Security Trust Fund (in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this title.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 2011), out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the aggregate increase in tax liabilities under the Internal Revenue Code of 1986 which is attributable to the application of the amendments made by this subtitle. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 2011) the amounts that would otherwise have been appropriated to carry out the following programs:

(A) The medicare program, under parts A, B, and D of title XVIII of the Social Security Act (other than amounts attributable to any premiums under such parts).

(B) The medicaid program, under State plans approved under title XIX of such Act.

(C) The Federal employees health benefit program, under chapter 89 of title 5, United States Code.

(D) The TRICARE program (formerly known as the CHAMPUS program), under chapter 55 of title 10, United States Code.

(E) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Board, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this title.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act shall apply to the Trust Fund under this title in the same manner as they applied to the Federal Hospital Insurance Trust Fund under part A of title XVIII of such Act, except that the American Health Security Standards Board shall constitute the Board of Trustees of the Trust Fund.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund after the settlement of claims for payments under title XVIII have been completed, shall be transferred into the American Health Security Trust Fund.

PART II—TAXES BASED ON INCOME AND WAGES

SEC. 1535. PAYROLL TAX ON EMPLOYERS.

(a) IN GENERAL.—Section 3111 (relating to tax on employers) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

"(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 8.7 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).".

(b) SELF-EMPLOYMENT INCOME.—section 1401 (relating to rate of tax on self-employment income) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 8.7 percent of the amount of the self-employment income for such taxable year.''.

(c) COMPARABLE TAXES FOR RAILROAD SERVICES.—

(1) TAX ON EMPLOYERS.—Section 3221 is amended by redesignating subsection (c) as subsections (d) and inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 8.7 percent of the compensation paid by such employer for services rendered to such employer.''.

(2) TAX ON EMPLOYEE REPRESENTATIVES.—Section 3211 (relating to tax on employee representatives) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new paragraph:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on the income of each employee representative a tax equal to 8.7 percent of the compensation received during the calendar year by such employee representative for services rendered by such employee representative.''.

(3) NO APPLICABLE BASE.—Subparagraph (A) of section 3231(e)(2) is amended by adding at the end thereof the following new clause:

''(iv) HEALTH CARE TAXES.—Clause (i) shall not apply to the taxes imposed by sections 3221(c) and 3211(c).''.

(4) TECHNICAL AMENDMENT.—

(A) Subsection (d) of section 3211, as redesignated by paragraph (2), is amended by striking ''and (b)'' and inserting '', (b), and (c)''.

(B) Subsection (d) of section 3221, as redesignated by paragraph (1), is amended by striking ''and (b)'' and inserting '', (b), and (c)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to remuneration paid after December 31, 2010.

SEC. 1536. HEALTH CARE INCOME TAX.

(a) GENERAL RULE.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

''PART VIII—HEALTH CARE INCOME TAX ON INDIVIDUALS

''Sec. 59B. Health care income tax.

''SEC. 59B. HEALTH CARE INCOME TAX.

''(a) IMPOSITION OF TAX.—In the case of an individual, there is hereby imposed a tax (in addition to any other tax imposed by this subtitle) equal to 2.2 percent of the taxable income of the taxpayer for the taxable year.

''(b) NO CREDITS AGAINST TAX; NO EFFECT ON MINIMUM TAX.—The tax imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

''(1) the amount of any credit allowable under this chapter, or

''(2) the amount of the minimum tax imposed by section 55.

''(c) SPECIAL RULES.—

''(1) TAX TO BE WITHHELD, ETC.—For purposes of this title, the tax imposed by this section shall be treated as imposed by section 1.

''(2) REIMBURSEMENT OF TAX BY EMPLOYER NOT INCLUDIBLE IN GROSS INCOME.—The gross income of an employee shall not include any payment by his employer to reimburse the employee for the tax paid by the employee under this section.

''(3) OTHER RULES.—The rules of section 59A(d) shall apply to the tax imposed by this section.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

''PART VIII—HEALTH CARE INCOME TAX ON INDIVIDUALS''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

Subtitle H—Conforming Amendments to the Employee Retirement Income Security Act of 1974

SEC. 1601. ERISA INAPPLICABLE TO HEALTH COVERAGE ARRANGEMENTS UNDER STATE HEALTH SECURITY PROGRAMS.

Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking ''(b) or (c)'' and inserting ''(b), (c), or (d)''; and

(2) by adding at the end the following new subsection:

''(d) The provisions of this title shall not apply to any arrangement forming a part of a State health security program established pursuant to section 1001(b) of the American Health Security Act of 2009.''.

SEC. 1602. EXEMPTION OF STATE HEALTH SECURITY PROGRAMS FROM ERISA PREEMPTION.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) (as amended by sections 174(b)(3)(B) and 182(b) of this title) is amended by adding at the end the following new paragraph:

''(8) Subsection (a) of this section shall not apply to State health security programs established pursuant to section 1001(b) of the American Health Security Act of 2009.''.

SEC. 1603. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER STATE HEALTH SECURITY PROGRAMS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF STATE HEALTH SECURITY PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION

''SEC. 519. (a) Subject to subsection (b), no employee benefit plan may provide benefits which duplicate payment for any items or services for which payment may be made under a State health security program established pursuant to section 1001(b) of the American Health Security Act of 2009.

''(b)(1) Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the State health security plan for the State in which the services are furnished for the cost of such services.

''(2) In this subsection:

''(A) The term 'workers compensation carrier' means an insurance company that underwrites workers compensation medical benefits with respect to 1 or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits.

''(B) The term 'workers compensation medical benefits' means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee.

''(C) The term 'workers compensation services' means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term-care services) commonly used for treatment of work-related injuries and illnesses.''.

(b) CONFORMING AMENDMENT.—Section 4(b) of such Act (29 U.S.C. 1003(b)) is amended by adding at the end the following: ''Paragraph (3) shall apply subject to section 519(b) (relating to reimbursement of State health security plans by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 518 the following new items:

''Sec. 519. Prohibition of employee benefits duplicative of state health security program benefits; coordination in case of workers' compensation.''.

SEC. 1604. REPEAL OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(A) by striking paragraph (7); and

(B) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

(2) Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking ''paragraph (1) or (4) of section 606,''.

(3) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended—

(A) in paragraph (7), by striking ''section 206(d)(3)(B)(i)),'' and all that follows and inserting ''section 206(d)(3)(B)(i)).''; and

(B) by striking paragraph (8).

(4) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the items relating to part 6 of subtitle B of title I of such Act.

SEC. 1605. EFFECTIVE DATE OF SUBTITLE.

The amendments made by this subtitle shall take effect January 1, 2012.

Subtitle I—Additional Conforming Amendments

SEC. 1701. REPEAL OF CERTAIN PROVISIONS IN INTERNAL REVENUE CODE OF 1986.

The provisions of titles III and IV of the Health Insurance Portability and Accountability Act of 1996, other than subtitles D and H of title III and section 342, are repealed and the provisions of law that were amended or repealed by such provisions are hereby restored as if such provisions had not been enacted.

SEC. 1702. REPEAL OF CERTAIN PROVISIONS IN THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is repealed and the items relating to such part in the table of contents in section 1 of such Act are repealed.

(b) CONFORMING AMENDMENT.—Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended by striking paragraph (9).

SEC. 1703. REPEAL OF CERTAIN PROVISIONS IN THE PUBLIC HEALTH SERVICE ACT AND RELATED PROVISIONS.

(a) IN GENERAL.—Titles XXII and XXVII of the Public Health Service Act are repealed.

(b) ADDITIONAL AMENDMENTS.—

(1) Section 1301(b) of such Act (42 U.S.C. 300e(b)) is amended by striking paragraph (6).

(2) Sections 104 and 191 of the Health Insurance Portability and Accountability Act of 1996 are repealed.

SEC. 1704. EFFECTIVE DATE OF SUBTITLE.

The amendments made by this title shall take effect January 1, 2013.

TITLE II—HEALTH CARE QUALITY IMPROVEMENTS

SEC. 2001. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Title IX of the 5 Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as so redesignated, by striking ''931'' and inserting ''941''; and

(4) by inserting after section 926 the following:

"PART D—HEALTH CARE QUALITY IMPROVEMENT PROGRAMS

"SEC. 931. HEALTH CARE DELIVERY SYSTEM RESEARCH.

''(a) PURPOSE.—The purposes of this section are to—

''(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as 'best practices') in health care quality, safety, and value; and

''(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

''(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), or any other relevant agency or department designated by the Director, shall—

''(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

''(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

''(A) best practices for quality improvement practices in the delivery of health care services; and

''(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

''(3) identify health care providers, including health care systems, single institutions, and individual providers, that—

''(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and

''(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

''(4) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

''(5) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

''(6) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

''(7) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

''(8) provide for the development of best practices in the delivery of health care services that—

''(A) have a high likelihood of success, based on structured review of empirical evidence;

''(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

''(C) are designed to be readily adapted by health care providers in a variety of settings; and

''(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and in engaging patients and their families in improving the care and patient health outcomes;

''(9) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children's health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

''(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

''(c) RESEARCH FUNCTIONS OF CENTER.—

''(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

''(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

''(A) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

''(B) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

''(C) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

''(D) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

''(i) the implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

''(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Entercoccus infections and other emerging infections; and

''(iii) practical methods for reducing preventable hospital admissions and readmissions;

''(E) expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

''(F) identify and mitigate hazards by—

''(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

''(ii) using the results of such analyses to develop scientific methods of response to such events;

''(G) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

''(H) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

''(d) DISSEMINATION OF RESEARCH FINDINGS.—

''(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

''(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the health information technology extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

''(e) PRIORITIZATION.—The Director shall identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account—

''(1) the cost to Federal health programs;

''(2) consumer assessment of health care experience;

''(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

''(4) the potential impact of such processes or systems on health status and function of

patients, including vulnerable populations including children;

''(5) the areas of insufficient evidence identified under subsection (c)(2)(B); and

''(6) the evolution of meaningful use of health information technology, as defined in section 3000.

''(f) FUNDING.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal years 2010 through 2014.

''SEC. 932. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

''(a) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), shall award—

''(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

''(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

''(b) ELIGIBLE ENTITIES.—

''(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

''(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(2) IMPLEMENTATION AWARD.—To be eligible to receive an implementation grant or contract under subsection (a)(2), an entity—

''(A) may be a hospital or other health care provider or consortium or providers, as determined by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(c) APPLICATION.—

''(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for a sustainable business model that may include a system of—

''(i) charging fees to institutions and providers that receive technical support from the entity; and

''(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations; and

''(B) such other information as the Director may require.

''(2) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

''(i) financial cost, staffing requirements, and timeline for implementation; and

''(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

''(B) such other information as the Director may require.

''(d) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) EVALUATION.—

''(1) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

''(A) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 931;

''(B) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

''(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

''(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

''(f) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.''.

SEC. 2002. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as ''health teams'') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants;

(5) agree to provide services to eligible individuals with chronic conditions in accordance with the payment methodology established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs; and

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term ''primary care'' means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 2003. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 2001, is further amended by inserting after section 932 the following:

''SEC. 933. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

''(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established in section 931 (referred to in this section as the 'Center'), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this section as 'MTM') services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

''(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

''(2) submit to the Secretary a plan for achieving long-term financial sustainability;

''(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3502 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W;

''(4) submit a plan for meeting the requirements under subsection (c); and

''(5) submit to the Secretary such other information as the Secretary may require.

''(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law including applicable collaborative pharmacy practice agreements, include—

''(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

''(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

''(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

''(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

''(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

''(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

''(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

''(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

''(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

''(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

''(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who—

''(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

''(2) take any 'high risk' medications;

''(3) have 2 or more chronic diseases, as identified by the Secretary; or

''(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

''(e) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

''(f) REPORTING TO THE SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures endorsed by the entity with a contract under section 1890 of the Social Security Act, as determined by the Secretary.

''(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall—

''(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

''(2) assess changes in overall health care resource use by targeted individuals;

''(3) assess patient and prescriber satisfaction with MTM services;

''(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

''(5) identify and evaluate other factors that may impact clinical and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

''(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

''(h) GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.''.

SEC. 2004. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(A) in the section heading, by inserting ''**FOR TRAUMA SYSTEMS**'' after ''**GRANTS**''; and

(B) in subsection (a), by striking ''Administrator of the Health Resources and Services Administration'' and inserting ''Assistant Secretary for Preparedness and Response'';

(2) by inserting after section 1203 the following:

''SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

''(b) ELIGIBLE ENTITY; REGION.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a State or a partnership of 1 or more States and 1 or more local governments; or

''(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

''(2) REGION.—The term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

''(3) EMERGENCY SERVICES.—The term 'emergency services' includes acute, prehospital, and trauma care.

''(c) PILOT PROJECTS.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—

''(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;

''(2) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion;

''(3) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

''(4) includes a consistent region-wide prehospital, hospital, and interfacility data management system that—

''(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

''(B) reports data to appropriate Federal and State databanks and registries; and

''(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

''(d) APPLICATION.—

''(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

''(2) APPLICATION INFORMATION.—Each application shall include—

''(A) an assurance from the eligible entity that the proposed system—

''(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office);

''(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

''(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

''(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

''(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

''(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents; and

''(B) such other information as the Secretary may require.

''(e) REQUIREMENT OF MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

''(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

''(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

''(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

''(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

''(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

''(4) the State and local legislation necessary to implement and to maintain the system;

''(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

''(6) recommendations on the utilization of available funding for future regionalization efforts.

''(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).''; and

(3) in section 1232—

(A) in subsection (a), by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated $24,000,000 for each of fiscal years 2010 through 2014.''; and

(B) by inserting after subsection (c) the following:

''(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.''.

(b) SUPPORT FOR EMERGENCY MEDICINE RESEARCH.—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after the section 498C the following:

''SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.

''(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

''(1) the basic science of emergency medicine;

''(2) the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;

''(3) the translation of basic scientific research into improved practice; and

''(4) the development of timely and efficient delivery of health services.

''(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

''(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

''(2) the role of pediatric emergency services as an integrated component of the overall health system;

''(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

''(4) pediatric training in professional education; and

''(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

''(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, the implementation of coordinated emergency care systems.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 2005. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

Part D of title IX of the Public Health Service Act, as amended by section 2003, is further amended by adding at the end the following:

''SEC. 934. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

''(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decisionmaking, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

''(b) DEFINITIONS.—In this section:

''(1) PATIENT DECISION AID.—The term 'patient decision aid' means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

''(2) PREFERENCE SENSITIVE CARE.—The term 'preference sensitive care' means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregivers or authorized representatives regarding the benefits, harms and scientific evidence for each treatment option, the use of such care should depend on the informed patient choice among clinically appropriate treatment options.

''(c) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR PATIENT DECISION AIDS FOR PREFERENCE SENSITIVE CARE.—

''(1) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS AND CERTIFY PATIENT DECISION AIDS.—

''(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care and a certification process for patient decision aids for use in the Federal health programs and by other interested parties, the Secretary shall have in effect a contract with the entity with a contract under section 1890 of the Social Security Act. Such contract shall provide that the entity perform the duties described in paragraph (2).

''(B) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this section, the Secretary shall enter into the first contract under subparagraph (A).

''(C) PERIOD OF CONTRACT.—A contract under subparagraph (A) shall be for a period of 18 months (except such contract may be renewed after a subsequent bidding process).

''(2) DUTIES.—The following duties are described in this paragraph:

''(A) DEVELOP AND IDENTIFY STANDARDS FOR PATIENT DECISION AIDS.—The entity shall synthesize evidence and convene a broad range of experts and key stakeholders to develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.

''(B) ENDORSE PATIENT DECISION AIDS.—The entity shall review patient decision aids and develop a certification process whether patient decision aids meet the standards developed and identified under subparagraph (A). The entity shall give priority to the review and certification of patient decision aids for preference sensitive care.

''(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS AND PATIENTS.—

''(1) IN GENERAL.—The Secretary, acting through the Director, and in coordination with heads of other relevant agencies, such as the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall establish a program to award grants or contracts—

''(A) to develop, update, and produce patient decision aids for preference sensitive care to assist health care providers in educating patients, caregivers, and authorized representatives concerning the relative safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options;

''(B) to test such materials to ensure such materials are balanced and evidence based in aiding health care providers and patients, caregivers, and authorized representatives to make informed decisions about patient care and can be easily incorporated into a broad array of practice settings; and

''(C) to educate providers on the use of such materials, including through academic curricula.

''(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)—

''(A) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

''(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy;

''(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

''(D) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

''(3) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are available to the public.

''(4) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under this section of the Agency and other agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

''(e) GRANTS TO SUPPORT SHARED DECISIONMAKING IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

''(2) SHARED DECISIONMAKING RESOURCE CENTERS.—

''(A) IN GENERAL.—The Secretary shall provide grants for the establishment and support of Shared Decisionmaking Resource Centers (referred to in this subsection as 'Centers') to provide technical assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

''(B) OBJECTIVES.—The objective of a Center is to enhance and promote the adoption of patient decision aids and shared decisionmaking through—

''(i) providing assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids; and

''(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

''(3) SHARED DECISIONMAKING PARTICIPATION GRANTS.—

''(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

''(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decisionmaking Resource Centers or comparable training.

''(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than those certified under the process identified in subsection (c).

''(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

''(f) FUNDING.—For purposes of carrying out this section there are authorized to be

appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.''.

SEC. 2006. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Commissioner of Food and Drugs, shall determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers.

(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall review all available scientific evidence and research on decisionmaking and social and cognitive psychology and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that provides—

(1) the determination by the Secretary under subsection (a); and

(2) the reasoning and analysis underlying that determination.

(d) AUTHORITY.—If the Secretary determines under subsection (a) that the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) CLARIFICATION.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 2007. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) REPORTS.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 2008. IMPROVING WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

''SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

''(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

''(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

''(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

''(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

''(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

''(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

''(5) establish a National Women's Health Information Center to—

''(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

''(B) facilitate access to such information;

''(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

''(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

''(6) coordinate efforts to promote women's health programs and policies with the private sector; and

''(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and between the Office and health professionals and the general public.

''(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

''(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

''(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

''(d) REPORTS.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of

enactment of this section and are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

''(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Centers;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

''(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

''(1) unique to, significantly more serious for, or significantly more prevalent in women; and

''(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) of the Public Health Service Act (42 U.S.C. 287d(a)) is amended by inserting ''and who shall report directly to the Director'' before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ''who shall report directly to the Administrator'' before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3), the following:

''(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.''.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX of the Public Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 925 and 926 as sections 926 and 927, respectively; and

(2) by inserting after section 924 the following:

"SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

''(b) PURPOSE.—The official designated under subsection (a) shall—

''(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

''(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Agency;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Agency policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).''.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

"SEC. 713. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

''(d) DEFINITIONS.—For purposes of this section:

''(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

''(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

"SEC. 1011. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Commissioner, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women's health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

''(3) provide information to women and health care providers on those areas in which differences between men and women exist;

''(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

''(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

''(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(h) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of it's powers or duties transferred unless such termination, reorganization, or transfer is approved by Congress through the adoption of a concurrent resolution of approval.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 2009. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 256a) is amended—

(1) by striking subsection (d)(3) and inserting the following:

''(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.'';

(2) in subsection (e), by adding at the end the following:

''(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved.''; and

(3) in subsection (m)—

(A) in paragraph (1), by striking ''and $3,500,000 for fiscal year 2010.'' and inserting ''$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''; and

(B) in paragraph (2), by striking ''2010'' and inserting ''2015''.

SEC. 2010. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this title (or an amendment made by this title), there is authorized to be appropriated such sums as may be necessary to carry out this title (and such amendments made by this title).

TITLE III—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 3001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the ''National Prevention, Health Promotion and Public Health Council'' (referred to in this section as the ''Council'').

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Agriculture;

(3) the Secretary of Education;

(4) the Chairman of the Federal Trade Commission;

(5) the Secretary of Transportation;

(6) the Secretary of Labor;

(7) the Secretary of Homeland Security;

(8) the Administrator of the Environmental Protection Agency;

(9) the Director of the Office of National Drug Control Policy;

(10) the Director of the Domestic Policy Council;

(11) the Assistant Secretary for Indian Affairs;

(12) the Chairman of the Corporation for National and Community Service; and

(13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) PURPOSES AND DUTIES.—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(3) provide recommendations to the President and Congress concerning the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and public health goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition;

(4) consider and propose evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on individual and community levels across the United States;

(5) establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;

(6) submit the reports required under subsection (g); and

(7) carry out other activities determined appropriate by the President.

(e) MEETINGS.—The Council shall meet at the call of the Chairperson.

(f) ADVISORY GROUP.—

(1) IN GENERAL.—The President shall establish an Advisory Group to the Council to be known as the ''Advisory Group on Prevention, Health Promotion, and Integrative and Public Health'' (hereafter referred to in this section as the ''Advisory Group''). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.

(2) COMPOSITION.—

(A) IN GENERAL.—The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.

(B) REPRESENTATION.—In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes a diverse group of licensed health professionals, including integrative health practitioners who have expertise in—

(i) worksite health promotion;

(ii) community services, including community health centers;

(iii) preventive medicine;

(iv) health coaching;

(v) public health education;

(vi) geriatrics; and

(vii) rehabilitation medicine.

(3) PURPOSES AND DUTIES.—The Advisory Group shall develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

(g) NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY.—Not later than 1 year after the date of enactment of this Act, the Chairperson, in consultation with the Council, shall develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(1) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(2) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care practices to ensure Federal efforts are consistent with available standards and evidence.

(h) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress, a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet these goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification

(smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(7) contains specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under paragraph (4).

(i) PERIODIC REVIEWS.—The Secretary and the Comptroller General of the United States shall jointly conduct periodic reviews, not less than every 5 years, and evaluations of every Federal disease prevention and health promotion initiative, program, and agency. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

SEC. 3002. PREVENTION AND PUBLIC HEALTH FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the ''Fund''), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

(1) for fiscal year 2010, $500,000,000;

(2) for fiscal year 2011, $750,000,000;

(3) for fiscal year 2012, $1,000,000,000;

(4) for fiscal year 2013, $1,250,000,000;

(5) for fiscal year 2014, $1,500,000,000; and

(6) for fiscal year 2015, and each fiscal year thereafter, $2,000,000,000.

(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs.

(d) TRANSFER AUTHORITY .—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

SEC. 3003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES.

(a) PREVENTIVE SERVICES TASK FORCE.—Section 915 of the Public Health Service Act (42 U.S.C. 299b-4) is amended by striking subsection (a) and inserting the following:

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) ESTABLISHMENT AND PURPOSE.—The Director shall convene an independent Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, Congress and other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

''(2) DUTIES.—The duties of the Task Force shall include—

''(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

''(B) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

''(C) improved integration with Federal Government health objectives and related target setting for health improvement;

''(D) the enhanced dissemination of recommendations;

''(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing the Guide recommendations; and

''(F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

''(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide's recommendations.

''(4) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(5) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

''(6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(b) COMMUNITY PREVENTIVE SERVICES TASK FORCE.—

(1) IN GENERAL.—Part P of title III of the Public Health Service Act, as amended by paragraph (2), is amended by adding at the end the following:

''SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

''(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policy-makers. Community preventive services include any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.

''(b) DUTIES.—The duties of the Task Force shall include—

''(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups;

''(2) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling;

''(3) improved integration with Federal Government health objectives and related target setting for health improvement;

''(4) the enhanced dissemination of recommendations;

''(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the Guide recommendations; and

''(6) providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not

adequately addressed by current recommendations.

''(c) ROLE OF AGENCY.—The Director shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.

''(d) COORDINATION WITH PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(e) OPERATION.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(2) TECHNICAL AMENDMENTS.—

(A) Section 399R of the Public Health Service Act (as added by section 2 of the ALS Registry Act (Public Law 110-373; 122 Stat. 4047)) is redesignated as section 399S.

(B) Section 399R of such Act (as added by section 3 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110–374; 122 Stat. 4051)) is redesignated as section 399T.

SEC. 3004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall provide for the planning and implementation of a national public–private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through the American Health Security Program;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies; and

(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine to provide ongoing advice on evidence-based scientific information for policy, program development, and evaluation.

(c) MEDIA CAMPAIGN.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) REQUIREMENT OF CAMPAIGN.—The campaign implemented under paragraph (1)—

(A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(C) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(E) may include the use of humor and nationally recognized positive role models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(d) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(e) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration.

(f) PERSONALIZED PREVENTION PLANS.—

(1) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(2) USE.—The website developed under paragraph (1) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(g) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(h) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding provided through the Centers for Disease Control and Prevention for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this section.

(i) PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.—

(1) INFORMATION TO STATES.—The Secretary of Health and Human Services shall provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available through the American Health Security Program.

(2) INFORMATION TO ENROLLEES.—Each State shall design a public awareness campaign regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the States' efforts to increase awareness of coverage of obesity-related services.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 3101. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a program to award grants to eligible entities to support the operation of school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity shall—

(A) be a school-based health center or a sponsoring facility of a school-based health center; and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum an assurance that funds awarded under the grant shall not be used to provide any service that is not authorized or allowed by Federal, State, or local law.

(3) LIMITATION ON USE OF FUNDS.—An eligible entity shall use funds provided under a grant awarded under this subsection only for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, as specified by the Secretary. No funds provided under a grant awarded under this section shall be used for expenditures for personnel or to provide health services.

(4) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2013, $50,000,000 for the purpose of carrying out this subsection. Funds appropriated under this paragraph shall remain available until expended.

(5) DEFINITIONS.—In this subsection, the terms ''school-based health center'' and ''sponsoring facility'' have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)).

(b) GRANTS FOR THE OPERATION OF SCHOOL-BASED HEALTH CENTERS.—Part Q of title III of the Public Health Service Act (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

"SEC. 399Z–1. SCHOOL-BASED HEALTH CENTERS.

''(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—In this section:

''(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by school-based health centers, which shall include the following:

''(A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services.

''(B) MENTAL HEALTH.—Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

''(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—

''(A) IN GENERAL.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area by the Secretary.

''(B) CRITERIA.—The Secretary shall prescribe criteria for determining the specific shortages of personal health services for medically underserved children and adolescents under subparagraph (A) that shall—

''(i) take into account any comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

''(ii) include factors indicative of the health status of such children and adolescents of an area, the accessibility of health services, the availability of health professionals to such children and adolescents, and other factors as determined appropriate by the Secretary.

''(3) SCHOOL-BASED HEALTH CENTER.—The term 'school-based health center' means a health clinic that—

''(A) meets the definition of a school-based health center under section 2110(c)(9)(A) of the Social Security Act and is administered by a sponsoring facility (as defined in section 2110(c)(9)(B) of the Social Security Act);

''(B) provides, at a minimum, comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with established standards, community practice, reporting laws, and other State laws, including parental consent and notification laws that are not inconsistent with Federal law; and

''(C) does not perform abortion services.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the costs of the operation of school-based health centers (referred to in this section as 'SBHCs') that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an SBHC (as defined in subsection (a)(3)); and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) evidence that the applicant meets all criteria necessary to be designated an SBHC;

''(B) evidence of local need for the services to be provided by the SBHC;

''(C) an assurance that—

''(i) SBHC services will be provided to those children and adolescents for whom parental or guardian consent has been obtained in cooperation with Federal, State, and local laws governing health care service provision to children and adolescents;

''(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the SBHC;

''(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system and through its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

''(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers co-located at the school;

''(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

''(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

''(D) such other information as the Secretary may require.

''(d) PREFERENCES AND CONSIDERATION.—In reviewing applications:

''(1) The Secretary may give preference to applicants who demonstrate an ability to serve the following:

''(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents.

''(B) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services.

''(2) The Secretary may give consideration to whether an applicant has received a grant under subsection (a) of section 3101 of the Patient Protection and Affordable Care Act.

''(e) WAIVER OF REQUIREMENTS.—The Secretary may—

''(1) under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an SBHC for not to exceed 2 years; and

''(2) upon a showing of good cause, waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time to be determined by the Secretary.

''(f) USE OF FUNDS.—

''(1) FUNDS.—Funds awarded under a grant under this section—

''(A) may be used for—

''(i) acquiring and leasing equipment (including the costs of amortizing the principle of, and paying interest on, loans for such equipment);

''(ii) providing training related to the provision of required comprehensive primary health services and additional health services;

''(iii) the management and operation of health center programs;

''(iv) the payment of salaries for physicians, nurses, and other personnel of the SBHC; and

''(B) may not be used to provide abortions.

''(2) CONSTRUCTION.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property.

''(3) LIMITATIONS.—

''(A) IN GENERAL.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC shall not be eligible to receive additional funding under this section.

''(B) NO OVERLAPPING GRANT PERIOD.—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

''(g) MATCHING REQUIREMENT.—

''(1) IN GENERAL.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in-kind) to carry out the activities supported by the grant.

''(2) WAIVER.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year for the SBHC if the Secretary determines that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

''(h) SUPPLEMENT, NOT SUPPLANT.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

''(i) EVALUATION.—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section.

''(j) AGE APPROPRIATE SERVICES.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

''(k) PARENTAL CONSENT.—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if such individual is considered a minor under applicable State law.

''(l) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

SEC. 3102. ORAL HEALTHCARE PREVENTION ACTIVITIES.

(a) IN GENERAL.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES

"SEC. 399LL. ORAL HEALTHCARE PREVENTION EDUCATION CAMPAIGN.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with professional oral health organizations, shall, subject to the availability of appropriations, establish a 5-year national, public education campaign (referred to in this section as the 'campaign') that is focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

''(b) REQUIREMENTS.—In establishing the campaign, the Secretary shall—

''(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; and

''(2) utilize science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.

''(c) PLANNING AND IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall begin implementing the 5-year campaign. During the 2-year period referred to in the previous sentence, the Secretary shall conduct planning activities with respect to the campaign.

''SEC. 399LL-1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a clinic of a hospital owned or operated by a State (or by an instrumentality or a unit of government within a State), a State or local department of health, a dental program of the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act), a health system provider, a private provider of dental services, medical, dental, public health, nursing, nutrition educational institutions, or national organizations involved in improving children's oral health; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—A grantee shall use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities.

''(d) USE OF INFORMATION.—The Secretary shall utilize information generated from grantees under this section in planning and implementing the public education campaign under section 399LL.

''SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part, such sums as may be necessary.''.

(b) SCHOOL-BASED SEALANT PROGRAMS.—Section 317M(c)(1) of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) is amended by striking ''may award grants to States and Indian tribes'' and inserting ''shall award a grant to each of the 50 States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)''.

(c) ORAL HEALTH INFRASTRUCTURE.—Section 317M of the Public Health Service Act (42 U.S.C. 247b-14) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c), the following:

''(d) ORAL HEALTH INFRASTRUCTURE.—

''(1) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.''.

(d) UPDATING NATIONAL ORAL HEALTHCARE SURVEILLANCE ACTIVITIES.—

(1) PRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as ''PRAMS'') as it relates to oral healthcare.

(B) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(i) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory with respect to States for purposes of the State reports under clause (i).

(C) FUNDING.—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term ''tooth-level surveillance'' means a clinical examination where an examiner looks at each dental surface, on each tooth in the mouth and as expanded by the Division of Oral Health of the Centers for Disease Control and Prevention.

(3) MEDICAL EXPENDITURES PANEL SURVEY.—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(4) NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.—

(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 to increase the participation of States in the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) REQUIREMENTS.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

Subtitle C—Creating Healthier Communities

SEC. 3201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;

(B) a local governmental agency;

(C) a national network of community-based organizations;

(D) a State or local non-profit organization; or

(E) an Indian tribe; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(c) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) ACTIVITIES.—An eligible entity shall implement activities detailed in the community transformation plan under paragraph (2).

(C) IN-KIND SUPPORT.—An eligible entity may provide in-kind resources such as staff,

equipment, or office space in carrying out activities under this section.

(4) EVALUATION.—

(A) IN GENERAL.—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities

(B) TYPES OF MEASURES.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;

(ii) changes in proper nutrition;

(iii) changes in physical activity;

(iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) DISSEMINATION.—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) TRAINING.—

(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans

(3) EVALUATION.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(e) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 3202. HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS.

(a) HEALTHY AGING, LIVING WELL.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and

(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC HEALTH INTERVENTIONS.—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.—

(i) IN GENERAL.—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age.

(ii) TYPES OF SCREENING ACTIVITIES.—Screening activities conducted under this subparagraph may include—

(I) mental health/behavioral health and substance use disorders;

(II) physical activity, smoking, and nutrition; and

(III) any other measures deemed appropriate by the Secretary.

(iii) MONITORING.—Grantees under this section shall maintain records of screening results under this subparagraph to establish the baseline data for monitoring the targeted population

(D) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—

(i) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in subparagraph (C)(ii), receive clinical referral/treatment for follow-up services to reduce such risk.

(ii) PUBLIC HEALTH INTERVENTION PROGRAM.—A State or local health department shall use amounts received under a grant under this subsection to enter into contracts with community health centers or rural health clinics and mental health and substance use disorder service providers to assist in the referral/treatment of at risk patients to community resources for clinical follow-up and help determine eligibility for other public programs.

(E) GRANTEE EVALUATION.—An eligible entity shall use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of the pilot program under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among individuals who are 63 years of age and older who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(b) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS.—

(1) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for individuals who are 65 years of age and older.

(2) EVALUATION OF PREVENTION AND WELLNESS PROGRAMS.—

(A) IN GENERAL.—The Secretary shall evaluate community prevention and wellness programs including those that are sponsored by the Administration on Aging, are evidence-based, and have demonstrated potential to help individuals who are 65 years of age and oldervreduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—The evaluation under subparagraph (A) shall consist of the following:

(i) EVIDENCE REVIEW.—The Secretary shall review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for individuals who are 65 years of age and older. The Secretary may determine the scope of the evidence review and such issues to be considered, which shall include, at a minimum—

(I) physical activity, nutrition, and obesity;

(II) falls;

(III) chronic disease self-management; and

(IV) mental health.

(ii) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS.—The Assistant Secretary for Aging, shall, to the extent feasible and practicable, conduct an evaluation of existing community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which individuals who are 65 years of age and older participate in such programs—

(I) reduce their health risks, improve their health outcomes, and adopt and maintain healthy behaviors; and

(II) improve their ability to manage their chronic conditions.

(3) REPORT.—Not later than September 30, 2013, the Secretary shall submit to Congress a report that includes—

(A) recommendations for such legislation and administrative action as the Secretary

determines appropriate to promote healthy lifestyles and chronic disease self-management for individuals aged 65 and older;

(B) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(C) the results of the evaluation under paragraph (2)(B)(ii).

(4) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $50,000,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the this subsection.

SEC. 3203. REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

''SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT.

''(a) STANDARDS.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the Food and Drug Administration, promulgate regulatory standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.) setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

''(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The standards issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

''(c) REVIEW AND AMENDMENT.—The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.).''.

SEC. 3204. IMMUNIZATIONS.

(a) STATE AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

''(l) AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—

''(1) IN GENERAL.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

''(2) STATE PURCHASE.—A State may obtain additional quantities of such adult vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary under this subsection.''.

(b) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:

''(m) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to award grants to States to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations.

''(2) STATE PLAN.—To be eligible for a grant under paragraph (1), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes the interventions to be implemented under the grant and how such interventions match with local needs and capabilities, as determined through consultation with local authorities.

''(3) USE OF FUNDS.—Funds received under a grant under this subsection shall be used to implement interventions that are recommended by the Task Force on Community Preventive Services (as established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) or other evidence-based interventions, including—

''(A) providing immunization reminders or recalls for target populations of clients, patients, and consumers;

''(B) educating targeted populations and health care providers concerning immunizations in combination with one or more other interventions;

''(C) reducing out-of-pocket costs for families for vaccines and their administration;

''(D) carrying out immunization-promoting strategies for participants or clients of public programs, including assessments of immunization status, referrals to health care providers, education, provision of on-site immunizations, or incentives for immunization;

''(E) providing for home visits that promote immunization through education, assessments of need, referrals, provision of immunizations, or other services;

''(F) providing reminders or recalls for immunization providers;

''(G) conducting assessments of, and providing feedback to, immunization providers;

''(H) any combination of one or more interventions described in this paragraph; or

''(I) immunization information systems to allow all States to have electronic databases for immunization records.

''(4) CONSIDERATION.—In awarding grants under this subsection, the Secretary shall consider any reviews or recommendations of the Task Force on Community Preventive Services.

''(5) EVALUATION.—Not later than 3 years after the date on which a State receives a grant under this subsection, the State shall submit to the Secretary an evaluation of progress made toward improving immunization coverage rates among high-risk populations within the State.

''(6) REPORT TO CONGRESS.—Not later than 4 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall submit to Congress a report concerning the effectiveness of the demonstration program established under this subsection together with recommendations on whether to continue and expand such program.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.''.

(c) REAUTHORIZATION OF IMMUNIZATION PROGRAM.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)) is amended—

(1) in paragraph (1), by striking ''for each of the fiscal years 1998 through 2005''; and

(2) in paragraph (2), by striking ''after October 1, 1997,''.

(d) RULE OF CONSTRUCTION REGARDING ACCESS TO IMMUNIZATIONS.—Nothing in this section (including the amendments made by this section), or any other provision of this Act (including any amendments made by this Act) shall be construed to decrease children's access to immunizations.

SEC. 3205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''; and

(2) in subitem (ii), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

''(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

''(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

''(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

''(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

''(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated

with the standard menu item, on the menu board, including a drive-through menu board, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

''(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

''(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

''(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

''(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

''(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

''(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

''(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

''(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

''(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

''(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

''(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

''(II) WRITTEN FORMS.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

''(viii) VENDING MACHINES.—

''(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

''(aa) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

''(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

''(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

''(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

''(II) REGISTRATION.—Within 120 days of enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

''(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

''(x) REGULATIONS.—

''(I) PROPOSED REGULATION.—Not later than 1 year after the date of enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

''(II) CONTENTS.—In promulgating regulations, the Secretary shall—

''(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

''(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

''(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

''(xi) DEFINITION.—In this clause, the term 'menu' or 'menu board' means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.''

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343-1(a)(4)) is amended by striking ''except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)'' and inserting ''except that this paragraph does not apply to food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)''.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under subsection (a)(4) of such section;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 3206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

''(s) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized well ness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

''(2) AGREEMENTS.—The Secretary shall enter into agreements with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

''(3) WELLNESS PLANS.—

''(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual's identified risk factors:

''(i) Nutritional counseling.

''(ii) A physical activity plan.

''(iii) Alcohol and smoking cessation counseling and services.

''(iv) Stress management.

''(v) Dietary supplements that have health claims approved by the Secretary.

''(vi) Compliance assistance provided by a community health center employee.

''(B) RISK FACTORS.—Wellness plan risk factors shall include—

''(i) weight;

''(ii) tobacco and alcohol use;

''(iii) exercise rates;

''(iv) nutritional status; and

''(v) blood pressure.

''(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual involved and a control group of individuals with respect to the risk factors described in subparagraph (B).

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.''.

SEC. 3207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

''(r)(1) An employer shall provide—

''(A) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk; and

''(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

''(2) An employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

''(3) An employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.

''(4) Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.''.

Subtitle D—Support for Prevention and Public Health Innovation

SEC. 3301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall provide funding for research in the area of public health services and systems.

(b) REQUIREMENTS OF RESEARCH.—Research supported under this section shall include—

(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020, and including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(c) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

SEC. 3302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS.

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

''SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

''(a) DATA COLLECTION.—

''(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

''(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

''(B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated;

''(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and

''(D) any other demographic data as deemed appropriate by the Secretary regarding health disparities.

''(2) COLLECTION STANDARDS.—In collecting data described in paragraph (1), the Secretary or designee shall—

''(A) use Office of Management and Budget standards, at a minimum, for race and ethnicity measures;

''(B) develop standards for the measurement of sex, primary language, and disability status;

''(C) develop standards for the collection of data described in paragraph (1) that, at a minimum—

''(i) collects self-reported data by the applicant, recipient, or participant; and

''(ii) collects data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated;

''(D) survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

''(i) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

''(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 510 of the Rehabilitation Act of 1973; and

''(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities; and

''(E) require that any reporting requirement imposed for purposes of measuring quality under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities by race, ethnicity, sex, primary language, and disability status.

''(3) DATA MANAGEMENT.—In collecting data described in paragraph (1), the Secretary, acting through the National Coordinator for Health Information Technology shall—

''(A) develop national standards for the management of data collected; and

''(B) develop interoperability and security systems for data management.

''(b) DATA ANALYSIS.—

''(1) IN GENERAL.—For each federally conducted or supported health care or public health program or activity, the Secretary shall analyze data collected under paragraph (a) to detect and monitor trends in health disparities (as defined for purposes of section 485E) at the Federal and State levels.

''(c) DATA REPORTING AND DISSEMINATION.—

''(1) IN GENERAL.—The Secretary shall make the analyses described in (b) available to—

''(A) the Office of Minority Health;

''(B) the National Center on Minority Health and Health Disparities;

''(C) the Agency for Healthcare Research and Quality;

''(D) the Centers for Disease Control and Prevention;

''(E) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

''(F) the Office of Rural health;

''(G) other agencies within the Department of Health and Human Services; and

''(H) other entities as determined appropriate by the Secretary.

''(2) REPORTING OF DATA.—The Secretary shall report data and analyses described in (a) and (b) through—

''(A) public postings on the Internet websites of the Department of Health and Human Services; and

''(B) any other reporting or dissemination mechanisms determined appropriate by the Secretary.

''(3) AVAILABILITY OF DATA.—The Secretary may make data described in (a) and (b) available for additional research, analyses, and dissemination to other Federal agencies, non-governmental entities, and the public, in accordance with any Federal agency's data user agreements.

''(d) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual.

''(e) PROTECTION AND SHARING OF DATA.—

''(1) PRIVACY AND OTHER SAFEGUARDS.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that—

''(A) all data collected pursuant to subsection (a) is protected—

''(i) under privacy protections that are at least as broad as those that the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033); and

''(ii) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary; and

''(B) all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected pursuant to subsection (a).

''(2) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (c)(1).

''(f) DATA ON RURAL UNDERSERVED POPULATIONS.—The Secretary shall ensure that any data collected in accordance with this section regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations.

''(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

''(h) REQUIREMENT FOR IMPLEMENTATION.—Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.

''(i) CONSULTATION.—The Secretary shall consult with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the Bureau of the Census, the Commissioner of Social Security, and the head of other appropriate Federal agencies in carrying out this section.''.

SEC. 3303. CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), by section 3102, is further amended by adding at the end the following:

''PART U—EMPLOYER-BASED WELLNESS PROGRAM

''SEC. 399MM. TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS.

''In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, the Director shall—

''(1) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including—

''(A) measuring the participation and methods to increase participation of employees in such programs;

''(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and

''(C) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

''(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

''SEC. 399MM–1. NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY.

''(a) IN GENERAL.—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, not later than 2 years after the date of enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

''(b) REPORT.—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

''SEC. 399MM–2. PRIORITIZATION OF EVALUATION BY SECRETARY.

''The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

''SEC. 399MM–3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.

''Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.''.

SEC. 3304. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

Title XXVIII of the Public Health Service Act (42 U.S.C. 300hh et seq.) is amended by adding at the end the following:

''Subtitle C—Strengthening Public Health Surveillance Systems

''SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

''(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—

''(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

''(2) enhancing laboratory practice as well as systems to report test orders and results electronically;

''(3) improving information systems including developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

''(4) developing and implementing prevention and control strategies.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2010 through 2013, of which—

''(1) not less than $95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

''(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

''(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).''.

SEC. 3305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—

(1) CONVENING.—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as ''the Conference'').

(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under paragraph (1), the Secretary of Health and Human Services may enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference's findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

''SEC. 409J. PAIN RESEARCH.

''(a) RESEARCH INITIATIVES.—

''(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

''(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

''(3) DEFINITION.—In this subsection, the term 'Pain Consortium' means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

''(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the 'Committee'), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The Committee shall be composed of the following voting members:

''(i) Not more than 7 voting Federal representatives appoint by the Secretary from agencies that conduct pain care research and treatment.

''(ii) 12 additional voting members appointed under subparagraph (B).

''(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

''(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

''(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

''(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

''(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

''(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

''(5) DUTIES.—The Committee shall—

''(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

''(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

''(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication of effort;

''(D) make recommendations on how best to disseminate information on pain care; and

''(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

''(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.''.

(c) PAIN CARE EDUCATION AND TRAINING.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

''SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

''(a) IN GENERAL.—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

''(b) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on—

''(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

''(2) applicable laws, regulations, rules, and policies on controlled substances, including the degree to which misconceptions and concerns regarding such laws, regulations, rules, and policies, or the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

''(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

''(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

''(5) recent findings, developments, and improvements in the provision of pain care.

''(c) EVALUATION OF PROGRAMS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

''(d) PAIN CARE DEFINED.—For purposes of this section the term 'pain care' means the assessment, diagnosis, treatment, or management of acute or chronic pain regardless of causation or body location.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under this subsection shall remain available until expended.''.

SEC. 3306. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

''(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.''.

Subtitle E—Miscellaneous Provisions

SEC. 3401. SENSE OF THE SENATE CONCERNING CBO SCORING.

(a) FINDING.—The Senate finds that the costs of prevention programs are difficult to estimate due in part because prevention initiatives are hard to measure and results may occur outside the 5 and 10 year budget windows.

(b) SENSE OF CONGRESS.—It is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.

SEC. 3402. EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program; and

(2) submit to Congress a report concerning such evaluation, which shall include conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions.

TITLE IV—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

SEC. 4001. PURPOSE.

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, minority, health disparity, and rural populations by—

(1) gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, including research on the supply, demand, distribution, diversity, and skills needs of the health care workforce;

(2) increasing the supply of a qualified health care workforce to improve access to and the delivery of health care services for all individuals;

(3) enhancing health care workforce education and training to improve access to and the delivery of health care services for all individuals; and

(4) providing support to the existing health care workforce to improve access to and the delivery of health care services for all individuals.

SEC. 4002. DEFINITIONS.

(a) THIS TITLE.—In this title:

(1) ALLIED HEALTH PROFESSIONAL.—The term ''allied health professional'' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ''healthcare career pathway'' means a rigorous, engaging, and high quality set of courses and services that—

(A) includes an articulated sequence of academic and career courses, including 21st century skills;

(B) is aligned with the needs of healthcare industries in a region or State;

(C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers;

(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;

(E) meets State academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable industry standards; and

(F) leads to 2 or more credentials, including—

(i) a secondary school diploma; and

(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.

(3) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).

(4) LOW INCOME INDIVIDUAL, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—

(A) LOW-INCOME INDIVIDUAL.—The term ''low-income individual'' has the meaning given that term in section 101 of the Workforce investment Act of 1998 (29 U.S.C. 2801).

(B) STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.—The terms ''State workforce investment board'' and ''local workforce investment board'', refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.

(5) POSTSECONDARY EDUCATION.—The term ''postsecondary education'' means—

(A) a 4-year program of instruction, or not less than a 1-year program of instruction

that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of higher education; or

(B) a certificate or registered apprenticeship program at the postsecondary level offered by an institution of higher education or a non-profit educational institution.

(6) REGISTERED APPRENTICESHIP PROGRAM.—The term ''registered apprenticeship program'' means an industry skills training program at the postsecondary level that combines technical and theoretical training through structure on the job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to enhance job proficiency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.

(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 799B of the Public Health Service Act (42 U.S.C. 295p) is amended—

(1) by striking paragraph (3) and inserting the following:

''(3) PHYSICIAN ASSISTANT EDUCATION PROGRAM.—The term 'physician assistant education program' means an educational program in a public or private institution in a State that—

''(A) has as its objective the education of individuals who, upon completion of their studies in the program, be qualified to provide primary care medical services with the supervision of a physician; and

''(B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant.''; and

(2) by adding at the end the following:

''(12) AREA HEALTH EDUCATION CENTER.—The term 'area health education center' means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under subsection (a)(1) or (a)(2) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.

''(13) AREA HEALTH EDUCATION CENTER PROGRAM.—The term 'area health education center program' means cooperative program consisting of an entity that has received an award under subsection (a)(1) or (a)(2) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center program and one or more area health education centers, which carries out the required activities described in section 751(c), satisfies the program requirements in such section, has as one of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.

''(14) CLINICAL SOCIAL WORKER.—The term 'clinical social worker' has the meaning given the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).

''(15) CULTURAL COMPETENCY.—The term 'cultural competency' shall be defined by the Secretary in a manner consistent with section 1707(d)(3).

''(16) DIRECT CARE WORKER.—The term 'direct care worker' has the meaning given that term in the 2010 Standard Occupational Classifications of the Department of Labor for Home Health Aides [31–1011], Psychiatric Aides [31–1013], Nursing Assistants [31–1014], and Personal Care Aides [39–9021].

''(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

''(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'frontier health professional shortage area' means an area—

''(A) with a population density less than 6 persons per square mile within the service area; and

''(B) with respect to which the distance or time for the population to access care is excessive.

''(19) GRADUATE PSYCHOLOGY.—The term 'graduate psychology' means an accredited program in professional psychology.

''(20) HEALTH DISPARITY POPULATION.—The term 'health disparity population' has the meaning given such term in section 903(d)(1).

''(21) HEALTH LITERACY.—The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.

''(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term 'mental health service professional' means an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.

''(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term 'one-stop delivery system' means a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).

''(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term 'paraprofessional child and adolescent mental health worker' means an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.

''(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms 'racial and ethnic minority group' and 'racial and ethnic minority population' have the meaning given the term 'racial and ethnic minority group' in section 1707.

''(26) RURAL HEALTH CLINIC.—The term 'rural health clinic' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).''.

(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—

(1) in paragraph (2)—

(A) by striking ''means a'' and inserting ''means an accredited (as defined in paragraph 6)''; and

(B) by striking the period as inserting the following: ''where graduates are—

''(A) authorized to sit for the National Council Licensure EXamination-Registered Nurse (NCLEX–RN); or

''(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become an advanced education nurse as defined by section 811(b).''; and

(2) by adding at the end the following:

''(16) ACCELERATED NURSING DEGREE PROGRAM.—The term 'accelerated nursing degree program' means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing.

''(17) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term 'bridge or degree completion program' means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include, Registered Nurse (RN) to Bachelor's of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.''.

Subtitle B—Innovations in the Health Care Workforce

SEC. 4101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ''Commission'').

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to section 5 of the Federal Advisory Committee Act (5 U.S.C. App.).

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between urban, suburban, rural, and frontier representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professionals;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of health care services and health economics research;

(V) representatives of consumers;

(VI) labor unions;

(VII) State or local workforce investment boards; and

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978. Members of the Commission shall not be treated as special government employees under title 18, United States Code.

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(C) INITIAL APPOINTMENTS.—The Comptroller General shall make initial appointments of members to the Commission not later than September 30, 2010.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of tile 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate. Personnel of the Commission shall not be treated as employees of the Government Accountability Office for any purpose.

(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(d) DUTIES.—

(1) RECOGNITION, DISSEMINATION, AND COMMUNICATION.—The Commission shall—

(A) recognize efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(B) disseminate information on promising retention practices for health care professionals; and

(C) communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce.

(2) REVIEW OF HEALTH CARE WORKFORCE AND ANNUAL REPORTS.—In order to develop a fiscally sustainable integrated workforce that supports a high-quality, readily accessible health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning related policies; and

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area as described in paragraph (4).

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, skill sets, and demands, with projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the education and training infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), with recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq);

(D) the implications of new and existing Federal policies which affect the health care workforce, including titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved community.

(4) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:

(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.

(iii) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.

(II) Oral health care workforce capacity at all levels.

(III) Mental and behavioral health care workforce capacity at all levels.

(IV) Allied health and public health care workforce capacity at all levels.

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.

(VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development areas that require special attention.

(5) GRANT PROGRAM.—The Commission shall—

(A) review implementation progress reports on, and report to Congress about, the State Health Care Workforce Development Grant program established in section 4102;

(B) in collaboration with the Department of Labor and in coordination with the Department of Education and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 4102(b) for grant recipients under section 4102;

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute this information to Congress, relevant Federal agencies, and to the public.

(6) STUDY.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) RECOMMENDATIONS.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about

improving safety, health, and worker protections in the workplace for the health care workforce.

(8) ASSESSMENT.—The Commission shall assess and receive reports from the National Center for Health Care Workforce Analysis established under section 761(b) of the Public Service Health Act (as amended by section 4103).

(e) CONSULTATION WITH FEDERAL, STATE, AND LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZATIONS.—

(1) IN GENERAL.—The Commission shall consult with Federal agencies (including the Departments of Health and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care organizations, professional societies, and other relevant public-private health care partnerships.

(2) OBTAINING OFFICIAL DATA.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch information necessary to enable the Commission to carry out this section.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(f) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an executive director that shall not exceed the rate of basic pay payable for level V of the Executive Schedule and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the internal organization and operation of the Commission.

(g) POWERS.—

(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;

(B) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(C) adopt procedures allowing interested parties to submit information for the Commission's use in making reports and recommendations.

(2) ACCESS OF THE GOVERNMENT ACCOUNTABILITY OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(3) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(3) GIFTS AND SERVICES.—The Commission may not accept gifts, bequeaths, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(i) DEFINITIONS.—In this section:

(1) HEALTH CARE WORKFORCE.—The term ''health care workforce'' includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(2) HEALTH PROFESSIONALS.—The term ''health professionals'' includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;

(B) national representatives of health professionals;

(C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and physician assistants;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.

SEC. 4102. STATE HEALTH CARE WORKFORCE DEVELOPMENT GRANTS.

(a) ESTABLISHMENT.—There is established a competitive health care workforce development grant program (referred to in this section as the ''program'') for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.

(b) FISCAL AND ADMINISTRATIVE AGENT.—The Health Resources and Services Administration of the Department of Health and Human Services (referred to in this section as the ''Administration'') shall be the fiscal and administrative agent for the grants awarded under this section. The Administration is authorized to carry out the program, in consultation with the National Health Care Workforce Commission (referred to in this section as the ''Commission''), which shall review reports on the development, implementation, and evaluation activities of the grant program, including—

(1) administering the grants;

(2) providing technical assistance to grantees; and

(3) reporting performance information to the Commission.

(c) PLANNING GRANTS.—

(1) AMOUNT AND DURATION.—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $150,000.

(2) ELIGIBILITY.—To be eligible to receive a planning grant, an entity shall be an eligible partnership. An eligible partnership shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employer, labor organization, a public 2-year institution of higher education, a public 4-year institution of higher education, the recognized State federation of labor, the State public secondary education agency, the State P–16 or P–20 Council if such a council exists, and a philanthropic organization that is actively engaged in providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries.

(3) FISCAL AND ADMINISTRATIVE AGENT.—The Governor of the State receiving a planning grant has the authority to appoint a fiscal and an administrative agency for the partnership.

(4) APPLICATION.—Each State partnership desiring a planning grant shall submit an application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator may reasonable require. Each application submitted for a planning grant shall describe the members of the State partnership, the activities for which assistance is sought, the proposed performance benchmarks to be used to measure progress under the planning grant, a budget for use of the funds to complete the required activities described in paragraph (5), and such additional assurance and information as the Administrator determines to be essential to ensure

compliance with the grant program requirements.

(5) REQUIRED ACTIVITIES.—A State partnership receiving a planning grant shall carry out the following:

(A) Analyze State labor market information in order to create health care career pathways for students and adults, including dislocated workers.

(B) Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways.

(C) Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships.

(D) Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure.

(E) Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling.

(F) Identify Federal or State policies or rules to developing a coherent and comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers.

(G) Participate in the Administration's evaluation and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before the State partnership receives a planning grant, such partnership and the Administrator of the Administration shall jointly determine the performance benchmarks that will be established for the purposes of the planning grant.

(7) MATCH.—Each State partnership receiving a planning grant shall provide an amount, in cash or in kind, that is not less that 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.

(8) REPORT.—

(A) REPORT TO ADMINISTRATION.—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State's performance of the activities under the grant, including the use of funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) DURATION.—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) ELIGIBILITY.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant; or

(B) completed a satisfactory application, including a plan to coordinate with required partners and complete the required activities during the 2 year period of the implementation grant.

(4) FISCAL AND ADMINISTRATIVE AGENT.—A State partnership receiving an implementation grant shall appoint a fiscal and an administration agent for the implementation of such grant.

(5) APPLICATION.—Each eligible State partnership desiring an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administration may reasonably require. Each application submitted shall include—

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the planning grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of how the State partnership will coordinate with required partners and complete the required partnership activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of how the State partnership will collect data to report progress in grant activities; and

(H) such additional assurances as the Administration determines to be essential to ensure compliance with grant requirements.

(6) REQUIRED ACTIVITIES.—

(A) IN GENERAL.—A State partnership that receives an implementation grant may reserve not less than 60 percent of the grant funds to make grants to be competitively awarded by the State partnership, consistent with State procurement rules, to encourage regional partnerships to address health care workforce development needs and to promote innovative health care workforce career pathway activities, including career counseling, learning, and employment.

(B) ELIGIBLE PARTNERSHIP DUTIES.—An eligible State partnership receiving an implementation grant shall—

(i) identify and convene regional leadership to discuss opportunities to engage in statewide health care workforce development planning, including the potential use of competitive grants to improve the development, distribution, and diversity of the regional health care workforce; the alignment of curricula for health care careers; and the access to quality career information and guidance and education and training opportunities;

(ii) in consultation with key stakeholders and regional leaders, take appropriate steps to reduce Federal, State, or local barriers to a comprehensive and coherent strategy, including changes in State or local policies to foster coherent and comprehensive health care workforce development activities, including health care career pathways at the regional and State levels, career planning information, retraining for dislocated workers, and as appropriate, requests for Federal program or administrative waivers;

(iii) develop, disseminate, and review with key stakeholders a preliminary statewide strategy that addresses short- and long-term health care workforce development supply versus demand;

(iv) convene State partnership members on a regular basis, and at least on a semiannual basis;

(v) assist leaders at the regional level to form partnerships, including technical assistance and capacity building activities;

(vi) collect and assess data on and report on the performance benchmarks selected by the State partnership and the Administration for implementation activities carried out by regional and State partnerships; and

(vii) participate in the Administration's evaluation and reporting activities.

(7) PERFORMANCE AND EVALUATION.—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant.

(8) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

(9) REPORTS.—

(A) REPORT TO ADMINISTRATION.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State of the grant activities, including a description of the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing implementation activities, performance, and fund utilization of the State grantees, including an identification of promising practices and a profile of the activities of each State grantee.

(e) AUTHORIZATION FOR APPROPRIATIONS.—

(1) PLANNING GRANTS.—There are authorized to be appropriated to award planning grants under subsection (c) $8,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

(2) IMPLEMENTATION GRANTS.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 4103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e);

(2) by striking subsection (b) and inserting the following:

''(b) NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.—

''(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health

Workforce Analysis (referred to in this section as the 'National Center').

''(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 4101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

''(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

''(B) carry out the activities under section 792(a);

''(C) annually evaluate programs under this title;

''(D) develop and publish performance measures and benchmarks for programs under this title; and

''(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

''(3) COLLABORATION AND DATA SHARING.—

''(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

''(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with relevant professional and educational organizations or societies.

''(c) STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—

''(1) IN GENERAL.—The Secretary shall award grants to, or enter into contracts with, eligible entities for purposes of—

''(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

''(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

''(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

''(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

''(A) studying practice patterns; and

''(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

''(3) GUIDELINES.—A longitudinal evaluation shall comply with guidelines issued under sections 749(d)(4), 757(d)(4), and 762(a)(4).

''(4) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title.''; and

(3) in subsection (e), as so redesignated—

(A) by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—

''(A) NATIONAL CENTER.—To carry out subsection (b), there are authorized to be appropriated $7,500,000 for each of fiscal years 2010 through 2014.

''(B) STATE AND REGIONAL CENTERS.—To carry out subsection (c), there are authorized to be appropriated $4,500,000 for each of fiscal years 2010 through 2014.

''(C) GRANTS FOR LONGITUDINAL EVALUATIONS.—To carry out subsection (d), there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.''; and

(4) in paragraph (2), by striking ''subsection (a)'' and inserting ''paragraph (1)''.

(b) TRANSFERS.—Not later than 180 days after the date of enactment of this Act, the responsibilities and resources of the National Center for Health Workforce Analysis, as in effect on the date before the date of enactment of this Act, shall be transferred to the National Center for Health Care Workforce Analysis established under section 761 of the Public Health Service Act, as amended by subsection (a).

(c) USE OF LONGITUDINAL EVALUATIONS.—Section 791(a)(1) of the Public Health Service Act (42 U.S.C. 295j(a)(1)) is amended—

(1) in subparagraph (A), by striking ''or'' at the end;

(2) in subparagraph (B), by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) and reports data from such system to the national workforce database (as established under section 761(b)(2)(E)).''.

(d) PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—

(1) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—Section 748(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(2) ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.—Section 756(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(3) ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762(a) of the Public Health Service Act (42 U.S.C. 294o(a)) is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D; and

''(5) recommend appropriation levels for programs under this title, except for programs under part C or D.''.

Subtitle C—Increasing the Supply of the Health Care Workforce

SEC. 4201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE.—Section 723 of the Public Health Service Act (42 U.S.C. 292s) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraph (B) and inserting the following:

''(B) to practice in such care for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.''; and

(B) by striking paragraph (3) and inserting the following:

''(3) NONCOMPLIANCE BY STUDENT.—Each agreement entered into with a student pursuant to paragraph (1) shall provide that, if the student fails to comply with such agreement, the loan involved will begin to accrue interest at a rate of 2 percent per year greater than the rate at which the student would pay if compliant in such year.''; and

(2) by adding at the end the following:

''(d) SENSE OF CONGRESS.—It is the sense of Congress that funds repaid under the loan program under this section should not be transferred to the Treasury of the United States or otherwise used for any other purpose other than to carry out this section.''.

(b) STUDENT LOAN GUIDELINES.—The Secretary of Health and Human Services shall not require parental financial information for an independent student to determine financial need under section 723 of the Public Health Service Act (42 U.S.C. 292s) and the determination of need for such information shall be at the discretion of applicable school loan officer. The Secretary shall amend guidelines issued by the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 4202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 836(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200''; and

(3) by striking ''$13,000'' and all that follows through the period and inserting ''$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate of the loans.''.

(b) LOAN PROVISIONS.—Section 836(b) of the Public Health Service Act (42 U.S.C. 297b(b)) is amended—

(1) in paragraph (1)(C), by striking ''1986'' and inserting ''2000''; and

(2) in paragraph (3), by striking ''the date of enactment of the Nurse Training Amendments of 1979'' and inserting ''September 29, 1995''.

SEC. 4203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart C—Recruitment and Retention Programs

"SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

''(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

''(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

''(1) such qualified health professionals will agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

''(2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than $35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 3 years during the qualified health professional's—

''(A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or

''(B) employment as a pediatric medical subspecialist, pediatric surgical specialist, or child and adolescent mental health professional serving an area or population described in such paragraph.

''(c) IN GENERAL.—

''(1) ELIGIBLE INDIVIDUALS.—

''(A) PEDIATRIC MEDICAL SPECIALISTS AND PEDIATRIC SURGICAL SPECIALISTS.—For purposes of contracts with respect to pediatric medical specialists and pediatric surgical specialists, the term 'qualified health professional' means a licensed physician who—

''(i) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship; or

''(ii) has completed (but not prior to the end of the calendar year in which this section is enacted) the training described in subparagraph (B).

''(B) CHILD AND ADOLESCENT MENTAL AND BEHAVIORAL HEALTH.—For purposes of contracts with respect to child and adolescent mental and behavioral health care, the term 'qualified health professional' means a health care professional who—

''(i) has received specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

''(ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or

''(iii) is a mental health service professional who completed (but not before the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).

''(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an eligible individual unless—

''(A) the individual agrees to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population;

''(B) the individual is a United States citizen or a permanent legal United States resident; and

''(C) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

''(d) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—

''(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

''(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

''(3) demonstrate financial need.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and $20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).''.

SEC. 4204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 4203, is further amended by adding at the end the following:

"SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and have accepted employment with a Federal, State, local, or tribal public health agency, or a related training fellowship, as recognized by the Secretary, to commence upon graduation;

''(B)(i) have graduated, during the preceding 10-year period, from an accredited educational institution in a State or territory and received a public health or health professions degree or certificate; and

''(ii) be employed by, or have accepted employment with, a Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary;

''(2) be a United States citizen; and

''(3)(A) submit an application to the Secretary to participate in the Program;

''(B) execute a written contract as required in subsection (c); and

''(4) not have received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965.

''(c) CONTRACT.—The written contract (referred to in this section as the 'written contract') between the Secretary and an individual shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant degree or certificate in accordance with the terms of the contract;

''(2) an agreement on the part of the individual that the individual will serve in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

''(A) 3 years; or

''(B) such longer period of time as determined appropriate by the Secretary and the individual;

''(3) an agreement, as appropriate, on the part of the individual to relocate to a priority service area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

''(4) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

''(5) a statement of the damages to which the United States is entitled, under this section for the individual's breach of the contract; and

''(6) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(d) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for tuition expenses incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—For each year of obligated service that an individual contracts to serve under subsection (c) the Secretary may pay up to $35,000 on behalf of the individual for loans described in paragraph (1). With respect to participants under the Program whose total eligible loans are less than $105,000, the Secretary shall pay an amount that does not exceed ⅓ of the eligible loan balance for each year of obligated service of the individual.

''(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed 39 percent of the total amount of loan repayments made for the taxable year involved.

''(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of the period of obligated service may be postponed as approved by the Secretary.

''(f) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SEC. 4205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings, as recognized by the Secretary of Health and Human Services by authorizing an Allied Health Loan Forgiveness Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1078–11) is amended—

(1) in subsection (b), by adding at the end the following:

''(18) ALLIED HEALTH PROFESSIONALS.—The individual is employed full-time as an allied health professional—

''(A) in a Federal, State, local, or tribal public health agency; or

''(B) in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''; and

(2) in subsection (g)—

(A) by redesignating paragraphs (1) through (9) as paragraphs (2) through (10), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

''(1) ALLIED HEALTH PROFESSIONAL.—The term 'allied health professional' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

''(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

''(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''.

SEC. 4206. GRANTS FOR STATE AND LOCAL PROGRAMS.

(a) IN GENERAL.—Section 765(d) of the Public Health Service Act (42 U.S.C. 295(d)) is amended—

(1) in paragraph (7), by striking ''; or'' and inserting a semicolon;

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following:

''(8) public health workforce loan repayment programs; or''.

(b) TRAINING FOR MID-CAREER PUBLIC HEALTH PROFESSIONALS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 4204, is further amended by adding at the end the following:

''SEC. 777. TRAINING FOR MID-CAREER PUBLIC AND ALLIED HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, any eligible entity to award scholarships to eligible individuals to enroll in degree or professional training programs for the purpose of enabling mid-career professionals in the public health and allied health workforce to receive additional training in the field of public health and allied health.

''(b) ELIGIBILITY.—

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' indicates an accredited educational institution that offers a course of study, certificate program, or professional training program in public or allied health or a related discipline, as determined by the Secretary

''(2) ELIGIBLE INDIVIDUALS.—The term 'eligible individuals' includes those individuals employed in public and allied health positions at the Federal, State, tribal, or local level who are interested in retaining or upgrading their education.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health mid-career professionals.''.

SEC. 4207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

''(1) For fiscal year 2010, $320,461,632.

''(2) For fiscal year 2011, $414,095,394.

''(3) For fiscal year 2012, $535,087,442.

''(4) For fiscal year 2013, $691,431,432.

''(5) For fiscal year 2014, $893,456,433.

''(6) For fiscal year 2015, $1,154,510,336.

''(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

''(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.''.

SEC. 4208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330A the following:

''SEC. 330A–1. GRANTS TO NURSE-MANAGED HEALTH CLINICS.

''(a) DEFINITIONS.—

''(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term 'comprehensive primary health care services' means the primary health services described in section 330(b)(1).

''(2) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the cost of the operation of nurse-managed health clinics that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an NMHC; and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) assurances that nurses are the major providers of services at the NMHC and that at least 1 advanced practice nurse holds an executive management position within the organizational structure of the NMHC;

''(B) an assurance that the NMHC will continue providing comprehensive primary health care services or wellness services without regard to income or insurance status of the patient for the duration of the grant period; and

''(C) an assurance that, not later than 90 days of receiving a grant under this section, the NMHC will establish a community advisory committee, for which a majority of the members shall be individuals who are served by the NMHC.

''(d) GRANT AMOUNT.—The amount of any grant made under this section for any fiscal year shall be determined by the Secretary, taking into account—

''(1) the financial need of the NMHC, considering State, local, and other operational funding provided to the NMHC; and

''(2) other factors, as the Secretary determines appropriate.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''.

SEC. 4209. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 202 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking ''not to exceed 2,800''.

SEC. 4210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

''SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

''(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without

regard to the Classification Act of 1923, as amended.

''(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

''(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

''(5) WARRANT OFFICERS.—Warrant officers may be appointed to the Service for the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service shall be considered for purposes of this Act and title 37, United States Code, to be a commissioned officer within the Commissioned Corps of the Service.

''(b) ASSIMILATING RESERVE CORP OFFICERS INTO THE REGULAR CORPS.—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as officers in the Reserve Corps under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

''(c) PURPOSE AND USE OF READY RESEARCH.—

''(1) PURPOSE.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service's reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

''(2) USES.—The Ready Reserve Corps shall—

''(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

''(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel;

''(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic; and

''(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

''(d) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps.''.

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 4301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

''SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

''(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;

''(B) to provide need-based financial assistance in the form of traineeships and fellowships to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields defined in subparagraph (A);

''(C) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;

''(D) to plan, develop, and operate a program for the training of physicians teaching in community-based settings;

''(E) to provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;

''(F) to plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs to provide such training;

''(G) to plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act, which may include—

''(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this section);

''(ii) developing tools and curricula relevant to patient-centered medical homes; and

''(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

''(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

''(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(b) CAPACITY BUILDING IN PRIMARY CARE.—

''(1) IN GENERAL.—The Secretary may make grants to or enter into contracts with accredited schools of medicine or osteopathic medicine to establish, maintain, or improve—

''(A) academic units or programs that improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

''(B) programs that integrate academic administrative units in fields defined in subsection (a)(1)(A) to enhance interdisciplinary recruitment, training, and faculty development.

''(2) PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any qualified applicant for such an award that agrees to expend the award for the purpose of—

''(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

''(B) substantially expanding such units or programs.

''(3) PRIORITIES IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to qualified applicants that—

''(A) proposes a collaborative project between academic administrative units of primary care;

''(B) proposes innovative approaches to clinical teaching using models of primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health care settings and integration physical and mental health provision;

''(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

''(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

''(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

''(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

''(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

''(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act; or

''(I) provide training in cultural competency and health literacy.

''(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(c) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For purposes of carrying out this section (other than subsection (b)(1)(B)), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

''(2) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection

(a)(1)(F), which prepare students for practice in primary care.

''(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $750,000 for each of fiscal years 2010 through 2014.''.

SEC. 4302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 4301, the following:

''SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes (as defined in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an institution of higher education (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 1002)) that—

''(A) is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

''(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

''(d) ELIGIBLE INDIVIDUAL.—

''(1) ELIGIBILITY.—To be eligible for assistance under this section, an individual shall be enrolled in courses provided by a grantee under this subsection and maintain satisfactory academic progress in such courses.

''(2) CONDITION OF ASSISTANCE.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatrics, disability services, long term services and supports, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.''.

SEC. 4303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(1) redesignating section 748, as amended by section 4103 of this Act, as section 749; and

(2) inserting after section 747A, as added by section 4302, the following:

''SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

''(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry;

''(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public heath dentistry, or dental hygiene;

''(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

''(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;

''(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);

''(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

''(G) to create a loan repayment program for faculty in dental programs; and

''(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(2) FACULTY LOAN REPAYMENT.—

''(A) IN GENERAL.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which—

''(i) individuals agree to serve full-time as faculty members; and

''(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.

''(B) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.

''(b) ELIGIBLE ENTITY.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

''(c) PRIORITIES IN MAKING AWARDS.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

''(1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.

''(2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.

''(3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.

''(4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.

''(5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

''(6) Qualified applicants that include educational activities in cultural competency and health literacy.

''(7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

''(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.

''(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(e) DURATION OF AWARD.—The period during which payments are made to an entity from an award of a grant or contract under subsection (a) shall be 5 years. The provision of such payments shall be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved to make the payments.

''(f) AUTHORIZATIONS OF APPROPRIATIONS.—For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

''(g) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.''.

SEC. 4304. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECT.

Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. 256f et seq.)

is amended by adding at the end the following:

"SEC. 340G–1. DEMONSTRATION PROGRAM.

"(a) IN GENERAL.—

"(1) AUTHORIZATION.—The Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities.

"(2) DEFINITION.—The term 'alternative dental health care providers' includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

"(b) TIMEFRAME.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.

"(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

"(1) be—

"(A) an institution of higher education, including a community college;

"(B) a public-private partnership;

"(C) a federally qualified health center;

"(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

"(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization providing dental services; or

"(F) a public hospital or health system;

"(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and

"(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(d) ADMINISTRATIVE PROVISIONS.—

"(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project being conducted.

"(2) DISBURSEMENT OF FUNDS.—

"(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disperse to any entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

"(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

"(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

"(f) EVALUATION.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

"(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.".

SEC. 4305. GERIATRIC EDUCATION AND TRAINING; CAREER AWARDS; COMPREHENSIVE GERIATRIC EDUCATION.

(a) WORKFORCE DEVELOPMENT; CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

"(d) GERIATRIC WORKFORCE DEVELOPMENT.—

"(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to entities that operate a geriatric education center pursuant to subsection (a)(1).

"(2) APPLICATION.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(3) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—

"(A) carry out the fellowship program described in paragraph (4); and

"(B) carry out 1 of the 2 activities described in paragraph (5).

"(4) FELLOWSHIP PROGRAM.—

"(A) IN GENERAL.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses (referred to in this subsection as a 'fellowship') that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

"(B) LOCATION.—A fellowship shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with other geriatric education centers, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary with which the geriatric education centers are affiliated.

"(C) CME CREDIT.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements. As a condition of such acceptance, the recipient shall agree to subsequently provide a minimum of 18 hours of voluntary instructional support through a geriatric education center that is providing clinical training to students or trainees in long-term care settings.

"(5) ADDITIONAL REQUIRED ACTIVITIES DESCRIBED.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to carry out 1 of the following 2 activities.

"(A) FAMILY CAREGIVER AND DIRECT CARE PROVIDER TRAINING.—A geriatric education center that receives an award under this subsection shall offer at least 2 courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are designed to provide practical training for supporting frail elders and individuals with disabilities. The Secretary shall require such Centers to work with appropriate community partners to develop training program content and to publicize the availability of training courses in their service areas. All family caregiver and direct care provider training programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate, safe, and effective use of medications for older adults.

"(B) INCORPORATION OF BEST PRACTICES.—A geriatric education center that receives an award under this subsection shall develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, and management of the psychological and behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

"(6) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

"(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of $150,000. Not more than 24 geriatric education centers may receive an award under this subsection.

"(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

"(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,800,000 for the period of fiscal year 2011 through 2014.

"(e) GERIATRIC CAREER INCENTIVE AWARDS.—

"(1) IN GENERAL.—The Secretary shall award grants or contracts under this section to individuals described in paragraph (2) to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management.

"(2) ELIGIBLE INDIVIDUALS.—To be eligible to received an award under paragraph (1), an individual shall—

"(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or student of psychology who is pursuing a doctorate or other advanced degree in geriatrics or related fields in an accredited health professions school; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(3) CONDITION OF AWARD.—As a condition of receiving an award under this subsection, an individual shall agree that, following completion of the award period, the individual will teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years under guidelines set by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal years 2011 through 2013.''.

(b) EXPANSION OF ELIGIBILITY FOR GERIATRIC ACADEMIC CAREER AWARDS; PAYMENT TO INSTITUTION.—Section 753(c) of the Public Health Service Act 294(c)) is amended—

(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively;

(2) by striking paragraph (2) through paragraph (3) and inserting the following:

''(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an Award under paragraph (1), an individual shall—

''(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or licensed dentistry, or have completed any required training in a discipline and employed in an accredited health professions school that is approved by the Secretary;

''(B) have completed an approved fellowship program in geriatrics or have completed specialty training in geriatrics as required by the discipline and any addition geriatrics training as required by the Secretary; and

''(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

''(3) LIMITATIONS.—No Award under paragraph (1) may be made to an eligible individual unless the individual—

''(A) has submitted to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, and the Secretary has approved such application;

''(B) provides, in such form and manner as the Secretary may require, assurances that the individual will meet the service requirement described in paragraph (6); and

''(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment in a health professions institution and documented commitment from such institution to spend 75 percent of the total time of such individual on teaching and developing skills in interdisciplinary education in geriatrics.

''(4) MAINTENANCE OF EFFORT.—An eligible individual that receives an Award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(3) in paragraph (5), as so designated—

(A) in subparagraph (A)—

(i) by inserting ''for individuals who are physicians'' after ''this section''; and

(ii) by inserting after the period at the end the following: ''The Secretary shall determine the amount of an Award under this section for individuals who are not physicians.''; and

(B) by adding at the end the following:

''(C) PAYMENT TO INSTITUTION.—The Secretary shall make payments to institutions which include schools of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, and pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary.''.

(c) COMPREHENSIVE GERIATRIC EDUCATION.—Section 855 of the Public Health Service Act (42 U.S.C. 298) is amended—

(1) in subsection (b)—

(A) in paragraph (3), by striking ''or'' at the end;

(B) in paragraph (4), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(5) establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.''; and

(2) in subsection (e), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

SEC. 4306. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

(a) IN GENERAL.—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(1) striking section 757;

(2) redesignating section 756 (as amended by section 4103) as section 757; and

(3) inserting after section 755 the following:

''SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

''(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

''(1) baccalaureate, master's, and doctoral degree programs of social work, as well as the development of faculty in social work;

''(2) accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

''(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

''(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this section, an institution shall demonstrate—

''(1) participation in the institutions' programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

''(2) knowledge and understanding of the concerns of the individuals and groups described in subsection (a);

''(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

''(4) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require; and

''(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

''(c) INSTITUTIONAL REQUIREMENT.—For grants authorized under subsection (a)(1), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

''(d) PRIORITY.—

''(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

''(A) are accredited by the Council on Social Work Education;

''(B) have a graduation rate of not less than 80 percent for social work students; and

''(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

''(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

''(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

''(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

''(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

''(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

''(D) offer curriculum taught collaboratively with a family on the consumer and family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

''(E) provide services through a community mental health program described in section 1913(b)(1).

''(e) AUTHORIZATION OF APPROPRIATION.—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

''(1) $8,000,000 for training in social work in subsection (a)(1);

''(2) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

''(3) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

''(4) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).''.

(b) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by striking ''sections 751(a)(1)(A), 751(a)(1)(B), 753(b), 754(3)(A), and 755(b)'' and inserting ''sections 751(b)(1)(A), 753(b), and 755(b)''.

SEC. 4307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 293e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) in paragraph (1), by striking ''for the purpose of'' and all that follows through the period at the end and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by striking subsection (b) and inserting the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

''(c) DISSEMINATION.—

''(1) IN GENERAL.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 270 and such other means as determined appropriate by the Secretary.

''(2) EVALUATION.—The Secretary shall evaluate the adoption and the implementation of cultural competency, prevention, and public health, and working with individuals with a disability training curricula, and the facilitate inclusion of these competency measures in quality measurement systems as appropriate.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.''.

(b) TITLE VIII.—Section 807 of the Public Health Service Act (42 U.S.C. 296e–1) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) by striking ''for the purpose of'' and all that follows through ''health care.'' and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by redesignating subsection (b) as subsection (d);

(3) by inserting after subsection (a) the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with the entities described in section 741(b). The Secretary shall coordinate with curricula and research and demonstration projects developed under such section 741.

''(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated and evaluated in the same manner as model curricula developed under section 741, as described in subsection (c) of such section.''; and

(4) in subsection (d), as so redesignated—

(A) by striking ''subsection (a)'' and inserting ''this section''; and

(B) by striking ''2001 through 2004'' and inserting ''2010 through 2015''.

SEC. 4308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296j) is amended—

(1) in subsection (c)—

(A) in the subsection heading, by striking ''AND NURSE MIDWIFERY PROGRAMS''; and

(B) by striking ''and nurse midwifery'';

(2) in subsection (f)—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2); and

(3) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(4) by inserting after subsection (c), the following:

''(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for support under this section are educational programs that—

''(1) have as their objective the education of midwives; and

''(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.''.

SEC. 4309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

(a) IN GENERAL.—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended—

(1) in the section heading, by striking ''**RETENTION**'' and inserting ''**QUALITY**'';

(2) in subsection (a)—

(A) in paragraph (1), by adding ''or'' after the semicolon;

(B) by striking paragraph (2); and

(C) by redesignating paragraph (3) as paragraph (2);

(3) in subsection (b)(3), by striking ''managed care, quality improvement'' and inserting ''coordinated care'';

(4) in subsection (g), by inserting '', as defined in section 801(2),'' after ''school of nursing''; and

(5) in subsection (h), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) NURSE RETENTION GRANTS.—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

''SEC. 831A. NURSE RETENTION GRANTS.

''(a) RETENTION PRIORITY AREAS.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs pursuant to subsection (b) or (c).

''(b) GRANTS FOR CAREER LADDER PROGRAM.—The Secretary may award grants to, and enter into contracts with, eligible entities for programs—

''(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce;

''(2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or

''(3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

''(c) ENHANCING PATIENT CARE DELIVERY SYSTEMS.—

''(1) GRANTS.—The Secretary may award grants to eligible entities to improve the retention of nurses and enhance patient care that is directly related to nursing activities by enhancing collaboration and communication among nurses and other health care professionals, and by promoting nurse involvement in the organizational and clinical decision-making processes of a health care facility.

''(2) PRIORITY.—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection (or section 831(c) as such section existed on the day before the date of enactment of this section).

''(3) CONTINUATION OF AN AWARD.—The Secretary shall make continuation of any award under this subsection beyond the second year of such award contingent on the recipient of such award having demonstrated to the Secretary measurable and substantive improvement in nurse retention or patient care.

''(d) OTHER PRIORITY AREAS.—The Secretary may award grants to, or enter into contracts with, eligible entities to address other areas that are of high priority to nurse retention, as determined by the Secretary.

''(e) REPORT.—The Secretary shall submit to the Congress before the end of each fiscal year a report on the grants awarded and the contracts entered into under this section. Each such report shall identify the overall number of such grants and contracts and provide an explanation of why each such grant or contract will meet the priority need of the nursing workforce.

''(f) ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' includes an accredited school of nursing, as defined by section 801(2), a health care facility, or a partnership of such a school and facility.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2012.''.

SEC. 4310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Section 846(a)(3) of the Public Health Service Act (42 U.S.C. 297n(a)(3)) is amended by inserting before the semicolon the following: '', or in a accredited school of nursing, as defined by section 801(2), as nurse faculty''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 810 (relating to prohibition against discrimination by schools on the basis of sex) as section 809 and moving such section so that it follows section 808;

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part I;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F;

(9) in part H—

(A) by redesignating sections 851 and 852 as sections 861 and 862, respectively; and

(B) by redesignating part H as part G; and

(10) in part I—

(A) by redesignating section 855, as amended by section 4305, as section 865; and

(B) by redesignating part I as part H.

SEC. 4311. NURSE FACULTY LOAN PROGRAM.

(a) IN GENERAL.—Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''ESTABLISHMENT'' and inserting ''SCHOOL OF NURSING STUDENT LOAN FUND''; and

(B) by inserting ''accredited'' after ''agreement with any'';

(2) in subsection (c)—

(A) in paragraph (2), by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,500, during fiscal years 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan;''; and

(B) in paragraph (3)(A), by inserting ''an accredited'' after ''faculty member in'';

(3) in subsection (e), by striking ''a school'' and inserting ''an accredited school''; and

(4) in subsection (f), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.—Title VIII of the Public Health Service Act is amended by inserting after section 846A (42 U.S.C. 297n–1) the following:

''SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

''(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a total period, in the aggregate, of at least 4 years during the 6-year period beginning on the later of—

''(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

''(2) the date on which the individual enters into an agreement under this subsection.

''(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

''(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree;

''(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

''(A) payments may not exceed $10,000 per calendar year; and

''(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan); and

''(3) for an individual who has completed a doctorate or equivalent degree in nursing—

''(A) payments may not exceed $20,000 per calendar year; and

''(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same manner as in paragraph (2)(B)).

''(d) BREACH OF AGREEMENT.—

''(1) IN GENERAL.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

''(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of liability under such paragraph if compliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

''(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

''(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

''(e) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means an individual who—

''(1) is a United States citizen, national, or lawful permanent resident;

''(2) holds an unencumbered license as a registered nurse; and

''(3) has either already completed a master's or doctorate nursing program at an accredited school of nursing or is currently enrolled on a full-time or part-time basis in such a program.

''(f) PRIORITY.—For the purposes of this section and section 846A, funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 4312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 4310, is amended to read as follows:

''SEC. 871. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated $338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016.''.

SEC. 4313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

''(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

''(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

''(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

''(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

''(3) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

''(4) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

''(c) APPLICATION.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to target geographic areas—

''(A) with a high percentage of residents who suffer from chronic diseases; or

''(B) with a high infant mortality rate;

''(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) have documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this

section shall be construed to require such collaboration.

''(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

''(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

''(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker', as defined by the Department of Labor as Standard Occupational Classification [21–1094] means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and healthcare agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health;

''(F) by providing referral and follow-up services or otherwise coordinating care; and

''(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

''(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act)), or a consortium of any such entities.

''(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

''(B) a significant portion of which is a health professional shortage area as designated under section 332.''.

SEC. 4314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 4206, is further amended by adding at the end the following:

''SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

''(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce shortages in State and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

''(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

''(c) OTHER PROGRAMS.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

''(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in contracts under section 338I(j).

''(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $39,500,000 for each of fiscal years 2010 through 2013, of which—

''(1) $5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsections (b) and (c);

''(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b);

''(3) $5,000,000 shall be made available in each such fiscal year for the Public Health Informatics Fellowship Program under subsection (e); and

''(4) $24,500,000 shall be made available for expanding the Epidemic Intelligence Service under subsection (a).''.

SEC. 4315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

''PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

''SEC. 271. ESTABLISHMENT.

''(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK.—

''(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the 'Track'), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

''(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

''(B) 100 dental students annually;

''(C) 250 nursing students annually;

''(D) 100 public health students annually;

''(E) 100 behavioral and mental health professional students annually;

''(F) 100 physician assistant or nurse practitioner students annually; and

''(G) 50 pharmacy students annually.

''(2) LOCATIONS.—The Track shall be located at existing and accredited, affiliated health professions education training programs at academic health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act.

''(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

''(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

''(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

''(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care, to balance urban, tertiary, and inpatient venues.

''SEC. 272. ADMINISTRATION.

''(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The National Health Care Workforce Commission shall assist the Surgeon General in an advisory capacity.

''(b) FACULTY.—

''(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

''(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

''(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

''(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payments for educational services provided students participating in Department of Health and Human Services educational programs.

''(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

''(1) Postdoctoral, postgraduate, and technological programs.

''(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students.

''(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

''(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education for members of the health professions to the end that high standards of health care may be maintained within the United States.

''(f) AUTHORITY OF THE SURGEON GENERAL.—

''(1) IN GENERAL.—The Surgeon General is authorized—

''(A) to enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education;

''(B) to enter into contracts with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

''(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

''(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

''(E) to accept the voluntary services of guest scholars and other persons.

''(2) LIMITATION.—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track to make outlays in advance of the enactment of budget authority for such outlays.

''(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Track under an agreement described in paragraph (1) may be appointed to any position within the Track and may be permitted to perform such duties within the Track as the Surgeon General may approve.

''(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

''SEC. 273. STUDENTS; SELECTION; OBLIGATION.

''(a) STUDENT SELECTION.—

''(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures prescribed by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

''(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.

''(b) CONTRACT AND SERVICE OBLIGATION.—

''(1) CONTRACT.—Upon being admitted to the Track, a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (B), the Surgeon General agrees to provide the student with tuition (or tuition remission) and a student stipend (described in paragraph (2)) in each school year for a period of years (not to exceed 4 school years) determined by the student, during which period the student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution; and

''(ii) subject to subparagraph (B), the student agrees—

''(I) to accept the provision of such tuition and student stipend to the student;

''(II) to maintain enrollment at the Track until the student completes the course of study involved;

''(III) while enrolled in such course of study, to maintain an acceptable level of academic standing (as determined by the Surgeon General);

''(IV) if pursuing a degree from a school of medicine or osteopathic medicine, dental, public health, or nursing school or a physician assistant, pharmacy, or behavioral and mental health professional program, to complete a residency or internship in a specialty that the Surgeon General determines is appropriate; and

''(V) to serve for a period of time (referred to in this part as the 'period of obligated service') within the Commissioned Corps of the Public Health Service equal to 2 years for each school year during which such individual was enrolled at the College, reduced as provided for in paragraph (3);

''(B) a provision that any financial obligation of the United States arising out of a contract entered into under this part and any obligation of the student which is conditioned thereon, is contingent upon funds being appropriated to carry out this part;

''(C) a statement of the damages to which the United States is entitled for the student's breach of the contract; and

''(D) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this part.

''(2) TUITION AND STUDENT STIPEND.—

''(A) TUITION REMISSION RATES.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the established remission rate under this subparagraph.

''(B) STIPEND.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students under this part.

''(3) REDUCTIONS IN THE PERIOD OF OBLIGATED SERVICE.—The period of obligated service under paragraph (1)(A)(ii)(V) shall be reduced—

''(A) in the case of a student who elects to participate in a high-needs speciality residency (as determined by the National Health Care Workforce Commission), by 3 months for each year of such participation (not to exceed a total of 12 months); and

''(B) in the case of a student who, upon completion of their residency, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).

''(c) SECOND 2 YEARS OF SERVICE.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize a balance of hospital and community-based experiences, and training within interdisciplinary teams.

''(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST, BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL, PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAINING.—The Surgeon General shall establish provisions applicable with respect to dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions training institutions that train medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students for some significant period of time together, but at a minimum have a discrete and shared core curriculum.

''(e) ELITE FEDERAL DISASTER TEAMS.—The Surgeon General, in consultation with the Secretary, the Director of the Centers for Disease Control and Prevention, and other appropriate military and Federal government agencies, shall develop criteria for the appointment of highly qualified Track faculty, medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students, and graduates to elite Federal disaster preparedness teams to train and to respond to public

health emergencies, natural disasters, bioterrorism events, and other emergencies.

''(f) STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student who, under regulations prescribed by the Surgeon General, is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the United States for all tuition and stipend support provided to the student.

''SEC. 274. FUNDING.

''Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.''.

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 4401. CENTERS OF EXCELLENCE.

Section 736 of the Public Health Service Act (42 U.S.C. 293) is amended by striking subsection (h) and inserting the following:

''(h) FORMULA FOR ALLOCATIONS.—

''(1) ALLOCATIONS.—Based on the amount appropriated under subsection (i) for a fiscal year, the following subparagraphs shall apply as appropriate:

''(A) IN GENERAL.—If the amounts appropriated under subsection (i) for a fiscal year are $24,000,000 or less—

''(i) the Secretary shall make available $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

''(ii) and available after grants are made with funds under clause (i), the Secretary shall make available—

''(I) 60 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

''(II) 40 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(B) FUNDING IN EXCESS OF $24,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $24,000,000 but are less than $30,000,000—

''(i) 80 percent of such excess amounts shall be made available for grants under subsection (a) to health professions schools that meet the requirements described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e)); and

''(ii) 20 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(C) FUNDING IN EXCESS OF $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

''(i) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining excess amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(D) FUNDING IN EXCESS OF $40,000,000.—If amounts appropriated under subsection (i) for a fiscal year are $40,000,000 or more, the Secretary shall make available—

''(i) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(2) NO LIMITATION.—Nothing in this subsection shall be construed as limiting the centers of excellence referred to in this section to the designated amount, or to preclude such entities from competing for grants under this section.

''(3) MAINTENANCE OF EFFORT.—

''(A) IN GENERAL.—With respect to activities for which a grant made under this part are authorized to be expended, the Secretary may not make such a grant to a center of excellence for any fiscal year unless the center agrees to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the center for the fiscal year preceding the fiscal year for which the school receives such a grant.

''(B) USE OF FEDERAL FUNDS.—With respect to any Federal amounts received by a center of excellence and available for carrying out activities for which a grant under this part is authorized to be expended, the center shall, before expending the grant, expend the Federal amounts obtained from sources other than the grant, unless given prior approval from the Secretary.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) $50,000,000 for each of the fiscal years 2010 through 2015; and

''(2) and such sums as are necessary for each subsequent fiscal year.''.

SEC. 4402. HEALTH CARE PROFESSIONALS TRAINING FOR DIVERSITY.

(a) LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 738(a)(1) of the Public Health Service Act (42 U.S.C. 293b(a)(1)) is amended by striking ''$20,000 of the principal and interest of the educational loans of such individuals.'' and inserting ''$30,000 of the principal and interest of the educational loans of such individuals.''.

(b) SCHOLARSHIPS FOR DISADVANTAGED STUDENTS.—Section 740(a) of such Act (42 U.S.C. 293d(a)) is amended by striking ''$37,000,000'' and all that follows through ''2002'' and inserting ''$51,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014''.

(c) REAUTHORIZATION FOR LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 740(b) of such Act (42 U.S.C. 293d(b)) is amended by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated, $5,000,000 for each of the fiscal years 2010 through 2014.''.

(d) REAUTHORIZATION FOR EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM A DISADVANTAGED BACKGROUND.—Section 740(c) of such Act (42 U.S.C. 293d(c)) is amended by striking the first sentence and inserting the following: ''For the purpose of grants and contracts under section 739(a)(1), there is authorized to be appropriated $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''

SEC. 4403. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended to read as follows:

''SEC. 751. AREA HEALTH EDUCATION CENTERS.

''(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

''(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

''(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term 'Program' refers to the area health education center program.

''(b) ELIGIBLE ENTITIES; APPLICATION.—

''(1) ELIGIBLE ENTITIES.—

''(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term 'eligible entity' means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which no area health education center program is in operation, the Secretary may award a grant or contract under subsection (a)(1) to a school of nursing.

''(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term 'eligible entity' means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

''(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—

''(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

''(A) Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the

Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.

''(B) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, and local workforce investment boards, and in health care safety net sites.

''(C) Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, Federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.

''(D) Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.

''(E) Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

''(F) Propose and implement effective program and outcomes measurement and evaluation strategies.

''(G) Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

''(2) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

''(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally qualified health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.

''(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

''(C) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

''(d) REQUIREMENTS.—

''(1) AREA HEALTH EDUCATION CENTER PROGRAM.—In carrying out this section, the Secretary shall ensure the following:

''(A) An entity that receives an award under this section shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

''(i) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the school; and

''(ii) the entity receiving the award maintains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

''(B) An entity receiving funds under subsection (a)(2) does not distribute such funding to a center that is eligible to receive funding under subsection (a)(1).

''(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

''(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

''(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;

''(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

''(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

''(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

''(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

''(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

''(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs. At least 25 percent of the total required non-Federal contributions shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first 3 years the entity is funded through a grant under subsection (a)(1).

''(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under subsection (a)(1).

''(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the Secretary may reduce the per center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

''(h) PROJECT TERMS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a)(1) may not exceed—

''(A) in the case of a program, 12 years; or

''(B) in the case of a center within a program, 6 years.

''(2) EXCEPTION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

''(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 791(a) shall not apply to an area health education center funded under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

''(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

''(A) not more than 35 percent shall be used for awards under subsection (a)(1);

''(B) not less than 60 percent shall be used for awards under subsection (a)(2);

''(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

''(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

''(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

''(k) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.''.

(b) CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by striking section 752 and inserting the following:

''SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.

''(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance

the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources.

''(b) ELIGIBLE ENTITIES.—For purposes of this section, the term 'eligible entity' means an entity described in section 799(b).

''(c) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $5,000,000 for each of the fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent fiscal year.''.

SEC. 4404. WORKFORCE DIVERSITY GRANTS.

Section 821 of the Public Health Service Act (42 U.S.C. 296m) is amended—

(1) in subsection (a)—

(A) by striking ''The Secretary may'' and inserting the following:

''(1) AUTHORITY.—The Secretary may'';

(B) by striking ''pre-entry preparation, and retention activities'' and inserting the following: ''stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities''; and

(2) in subsection (b)—

(A) by striking ''First'' and all that follows through ''including the'' and inserting ''National Advisory Council on Nurse Education and Practice and consult with nursing associations including the National Coalition of Ethnic Minority Nurse Associations,''; and

(B) by inserting before the period the following: '', and other organizations determined appropriate by the Secretary''.

SEC. 4405. PRIMARY CARE EXTENSION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 4313, is further amended by adding at the end the following:

''SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.

''(a) ESTABLISHMENT, PURPOSE AND DEFINITION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

''(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as 'Health Extension Agents').

''(3) DEFINITIONS.—In this section:

''(A) HEALTH EXTENSION AGENT.—The term 'Health Extension Agent' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

''(B) PRIMARY CARE PROVIDER.—The term 'primary care provider' means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

''(b) GRANTS TO ESTABLISH STATE HUBS AND LOCAL PRIMARY CARE EXTENSION AGENCIES.—

''(1) GRANTS.—The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as 'Hubs').

''(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1)—

''(A) shall consist of, at a minimum, the State health department and the departments of 1 or more health professions schools in the State that train providers in primary care; and

''(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1153 of the Social Security Act, consumer groups, and other appropriate entities.

''(c) STATE AND LOCAL ACTIVITIES.—

''(1) HUB ACTIVITIES.—Hubs established under a grant under subsection (b) shall—

''(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

''(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

''(C) organize and administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and

''(D) organize State-wide or multistate networks of local-level Primary Care Extension Agencies to share and disseminate information and practices.

''(2) LOCAL PRIMARY CARE EXTENSION AGENCY ACTIVITIES.—

''(A) REQUIRED ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) shall—

''(i) assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

''(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of new knowledge and identification of important questions for research;

''(iii) participate in a national network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

''(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning.

''(B) DISCRETIONARY ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) may—

''(i) provide technical assistance, training, and organizational support for community health teams established under section 2002 of the Patient Protection and Affordable Care Act;

''(ii) collect data and provision of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

''(iii) collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

''(iv) develop measures to monitor the impact of the proposed program on the health of practice enrollees and of the wider community served; and

''(v) participate in other activities, as determined appropriate by the Secretary.

''(d) FEDERAL PROGRAM ADMINISTRATION.—

''(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall be—

''(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

''(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

''(2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(3) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

''(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

''(5) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

''(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of

the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To awards grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.''.

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 4501. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS; EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

''SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

''(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

''(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

''(2) REQUIREMENTS.—

''(A) AID AND SUPPORTIVE SERVICES.—

''(i) IN GENERAL.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

''(ii) TREATMENT.—Any aid, services, or incentives provided to an eligible beneficiary participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual's eligibility for, or amount of, benefits under any means-tested program.

''(B) CONSULTATION AND COORDINATION.—An eligible entity applying for a grant to carry out a demonstration project under this section shall demonstrate in the application that the entity has consulted with the State agency responsible for administering the State TANF program, the local workforce investment board in the area in which the project is to be conducted (unless the applicant is such board), the State workforce investment board established under section 111 of the Workforce Investment Act of 1998, and the State Apprenticeship Agency recognized under the Act of August 16, 1937 (commonly known as the 'National Apprenticeship Act') (or if no agency has been recognized in the State, the Office of Apprenticeship of the Department of Labor) and that the project will be carried out in coordination with such entities.

''(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

''(3) REPORTS AND EVALUATION.—

''(A) ELIGIBLE ENTITIES.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

''(B) EVALUATION.—The Secretary shall, by grant, contract, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development, and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

''(C) REPORT TO CONGRESS.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

''(4) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE ENTITY.—The term 'eligible entity' means a State, an Indian tribe or tribal organization, an institution of higher education, a local workforce investment board established under section 117 of the Workforce Investment Act of 1998, a sponsor of an apprenticeship program registered under the National Apprenticeship Act or a community-based organization.

''(B) ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'eligible individual' means a individual receiving assistance under the State TANF program.

''(ii) OTHER LOW-INCOME INDIVIDUALS.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

''(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(D) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given that term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

''(E) STATE.—The term 'State' means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

''(F) STATE TANF PROGRAM.—The term 'State TANF program' means the temporary assistance for needy families program funded under part A of title IV.

''(G) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

''(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

''(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

''(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

''(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

''(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

''(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

''(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

''(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

''(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

''(iv) Personal care skills.

''(v) Health care support.

''(vi) Nutritional support.

''(vii) Infection control.

''(viii) Safety and emergency training.

''(ix) Training specific to an individual consumer's needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

''(x) Self-Care.

''(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

''(i) The length of the training.

''(ii) The appropriate trainer to student ratio.

''(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

''(iv) Trainer qualifications.

''(v) Content for a 'hands-on' and written certification exam.

''(vi) Continuing education requirements.

''(4) APPLICATION AND SELECTION CRITERIA.—

''(A) IN GENERAL.—

''(i) NUMBER OF STATES.—The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

''(ii) REQUIREMENTS FOR STATES.—An agreement entered into under clause (i) shall require that a participating State—

''(I) implement the core training competencies described in paragraph (3)(A); and

''(II) develop written materials and protocols for such core training competencies, including the development of a certification

test for personal or home care aides who have completed such training competencies.

''(iii) CONSULTATION AND COLLABORATION WITH COMMUNITY AND VOCATIONAL COLLEGES.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

''(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

''(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

''(ii) meet the selection criteria established under subparagraph (C); and

''(iii) meet such additional criteria as the Secretary may specify.

''(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

''(i) geographic and demographic diversity;

''(ii) that the existing training standards for personal or home care aides in each participating State—

''(I) are different from such standards in the other participating States; and

''(II) are different from the core training competencies described in paragraph (3)(A);

''(iii) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

''(iv) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

''(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

''(5) EVALUATION AND REPORT.—

''(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

''(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

''(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

''(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what minimum number of hours should be required.

''(B) REPORTS.—

''(i) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(ii) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(6) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term 'eligible health and long-term care provider' means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

''(i) is licensed or authorized to provide services in a participating State; and

''(ii) receives payment for services under a State health security program.

''(B) PERSONAL OR HOME CARE AIDE.—The term 'personal or home care aide' means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

''(C) STATE.—The term 'State' has the meaning given that term for purposes of title XIX.

''(c) FUNDING.—

''(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $85,000,000 for each of fiscal years 2010 through 2014.

''(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

''(d) NONAPPLICATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grant awarded under this section.

''(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title.''.

(b) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is amended by striking ''fiscal year 2009'' and inserting ''each of fiscal years 2009 through 2012''.

SEC. 4502. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.), as amended by section 4303, is further amended by inserting after section 749 the following:

''SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

''(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

''(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

''(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

''(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

''(A) curriculum development;

''(B) recruitment, training and retention of residents and faculty:

''(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

''(D) faculty salaries during the development phase; and

''(2) technical assistance provided by an eligible entity.

''(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(e) PREFERENCE FOR CERTAIN APPLICATIONS.—In selecting recipients for grants under this section, the Secretary shall give preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an organization capable of providing technical assistance including an area health education center program as defined in sections 751 and 799B.

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' means an approved graduate medical residency training program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

''(3) TEACHING HEALTH CENTER.—

''(A) IN GENERAL.—The term 'teaching health center' means an entity that—

''(i) is a community based, ambulatory patient care center; and

''(ii) operates a primary care residency program.

''(B) INCLUSION OF CERTAIN ENTITIES.—Such term includes the following:

''(i) A Federally qualified health center (as defined in section 1905(l)(2)(B), of the Social Security Act).

''(ii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act).

''(iii) A rural health clinic, as defined in section 1861(aa) of the Social Security Act.

''(iv) A health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

''(v) An entity receiving funds under title X of the Public Health Service Act.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this

section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.''.

(b) NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.—Section 338C(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

''(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—Except as provided in section 338D, each individual who has entered into a written contract with the Secretary under section 338A or 338B shall provide service in the full-time clinical practice of such individual's profession as a member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.''.

(c) PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart XX—Support of Graduate Medical Education in Qualified Teaching Health Centers

''SEC. 340A. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

''(a) PAYMENTS.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and for indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing or establishment of new approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with sponsoring approved graduate medical residency training programs.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the amount of funds appropriated under subsection (g) for such payments for that fiscal year.

''(B) LIMITATION.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments as determined under subsection (c) and (d) do not exceed the total amount of funds appropriated in a fiscal year under subsection (g).

''(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

''(A) the updated national per resident amount for direct graduate medical education, as determined under paragraph (2); and

''(B) the average number of full-time equivalent residents in the teaching health center's graduate approved medical residency training programs as determined under section 1886(h)(4) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

''(2) UPDATED NATIONAL PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a qualified teaching health center for a fiscal year is an amount determined as follows:

''(A) DETERMINATION OF QUALIFIED TEACHING HEALTH CENTER PER RESIDENT AMOUNT.—The Secretary shall compute for each individual qualified teaching health center a per resident amount—

''(i) by dividing the national average per resident amount computed under section 340E(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B);

''(ii) by multiplying the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act (but without application of section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)) during the preceding fiscal year for the teaching health center's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(B) UPDATING RATE.—The Secretary shall update such per resident amount for each such qualified teaching health center as determined appropriate by the Secretary.

''(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

''(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

''(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers; and

''(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g).

''(3) INTERIM PAYMENT.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under paragraph (1), the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

''(e) CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS FOR GRADUATE MEDICAL EDUCATION.—Payments under this section—

''(1) shall be in addition to any payments—

''(A) for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act;

''(B) for direct graduate medical education costs under section 1886(h) of such Act; and

''(C) for direct costs of medical education under section 1886(k) of such Act;

''(2) shall not be taken into account in applying the limitation on the number of total full-time equivalent residents under subparagraphs (F) and (G) of section 1886(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and

''(3) shall not include the time in which a resident is counted toward full-time equivalency by a hospital under paragraph (2) or under section 1886(d)(5)(B)(iv) of the Social Security Act, section 1886(h)(4)(E) of such Act, or section 340E of this Act.

''(f) RECONCILIATION.—The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.

''(g) FUNDING.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $230,000,000, for the period of fiscal years 2011 through 2015.

''(h) ANNUAL REPORTING REQUIRED.—

''(1) ANNUAL REPORT.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information for the residency academic year completed immediately prior to such fiscal year:

''(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

''(B) The number of approved training positions for residents described in paragraph (4).

''(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

''(D) Other information as deemed appropriate by the Secretary.

''(2) AUDIT AUTHORITY; LIMITATION ON PAYMENT.—

''(A) AUDIT AUTHORITY.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

''(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such resident positions that is greater than the base level of primary care resident positions, as determined by the Secretary. For purposes of this subparagraph, the 'base level of primary care residents' for a teaching health center is the level of such residents as of a base period.

''(3) REDUCTION IN PAYMENT FOR FAILURE TO REPORT.—

''(A) IN GENERAL.—The amount payable under this section to a qualified teaching

health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

''(i) the qualified teaching health center has failed to provide the Secretary, as an addendum to the qualified teaching health center's application under this section for such fiscal year, the report required under paragraph (1) for the previous fiscal year; or

''(ii) such report fails to provide complete and accurate information required under any subparagraph of such paragraph.

''(B) NOTICE AND OPPORTUNITY TO PROVIDE ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) on the basis of a qualified teaching health center's failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice to the teaching health center of such failure and the Secretary's intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

''(4) RESIDENTS.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center in any approved graduate medical residency training program.

''(i) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

''(j) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' means a residency or other postgraduate medical training program—

''(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary; and

''(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' has the meaning given that term in section 749A.

''(3) QUALIFIED TEACHING HEALTH CENTER.—The term 'qualified teaching health center' has the meaning given the term 'teaching health center' in section 749A.''.

SEC. 4503. GRADUATE NURSE EDUCATION DEMONSTRATION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital's reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

(2) COSTS DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

(1) the obligations of the eligible partners with respect to the provision of qualified training; and

(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

(3) Other items the Secretary determines appropriate and relevant.

(d) FUNDING.—

(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(e) DEFINITIONS.—In this section:

(1) ADVANCED PRACTICE REGISTERED NURSE.—The term ''advanced practice registered nurse'' includes the following:

(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ''applicable non-hospital community-based care setting'' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term ''applicable school of nursing'' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term ''demonstration'' means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term ''eligible hospital'' means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term ''eligible partners'' includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term ''qualified training'' means training—

(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title; and

(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle G—Improving Access to Health Care Services

SEC. 4601. SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS).

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is

amended by striking paragraph (1) and inserting the following:

''(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

''(A) For fiscal year 2010, $2,988,821,592.

''(B) For fiscal year 2011, $3,862,107,440.

''(C) For fiscal year 2012, $4,990,553,440.

''(D) For fiscal year 2013, $6,448,713,307.

''(E) For fiscal year 2014, $7,332,924,155.

''(F) For fiscal year 2015, $8,332,924,155.

''(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(i) one plus the average percentage increase in costs incurred per patient served; and

''(ii) one plus the average percentage increase in the total number of patients served.''.

(b) RULE OF CONSTRUCTION.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by adding at the end the following:

''(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, or a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

''(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

''(i) nondiscrimination based on the ability of a patient to pay; and

''(ii) the establishment of a sliding fee scale for low-income patients.''.

SEC. 4602. NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish, through a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the ''target date for publication'', as referred to in section 564(a)(5) of title 5, United Sates Code, shall be July 1, 2010.

(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 4603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking ''3-year period (with an optional 4th year'' and inserting ''4-year period (with an optional 5th year''; and

(2) in subsection (d)—

(A) by striking ''and such sums'' and inserting ''such sums''; and

(B) by inserting before the period the following: '', $25,000,000 for fiscal year 2010, $26,250,000 for fiscal year 2011, $27,562,500 for fiscal year 2012, $28,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014''.

SEC. 4604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by adding at the end the following:

''SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a qualified community mental health program defined under section 1913(b)(1).

''(2) SPECIAL POPULATIONS.—The term 'special populations' means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

''(b) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

''(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

''(A) the provision, by qualified primary care professionals, of on site primary care services;

''(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

''(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

''(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.

''(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

''(e) EVALUATION.—Not later than 90 days after a grant or cooperative agreement

awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.''.

SEC. 4605. KEY NATIONAL INDICATORS.

(a) DEFINITIONS.—In this section:

(1) ACADEMY.—The term ''Academy'' means the National Academy of Sciences.

(2) COMMISSION.—The term ''Commission'' means the Commission on Key National Indicators established under subsection (b).

(3) INSTITUTE.—The term ''Institute'' means a Key National Indicators Institute as designated under subsection (c)(3).

(b) COMMISSION ON KEY NATIONAL INDICATORS.—

(1) ESTABLISHMENT.—There is established a ''Commission on Key National Indicators''.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) QUALIFICATIONS.—In making appointments under subparagraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) PERIOD OF APPOINTMENT.—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall be for 3 years. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as the original appointment and shall last only for the remainder of that term.

(E) DATE.—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) INITIAL ORGANIZING PERIOD.—Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a schedule for completion of the review and reports required under subsection (d).

(G) CO-CHAIRPERSONS.—The Commission shall select 2 Co-Chairpersons from among its members.

(c) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) REPORTS.—

(A) ANNUAL REPORT TO CONGRESS.—Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the appropriate Committees of Congress and the President a report that contains a detailed statement of the recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicator System.

(B) ANNUAL REPORT TO THE ACADEMY.—

(i) IN GENERAL.—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the Academy and a designated Institute a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators.

(ii) LIMITATION.—The Commission shall not have the authority to direct the Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.

(3) CONTRACT WITH THE NATIONAL ACADEMY OF SCIENCES.—

(A) IN GENERAL.—As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into an arrangement with the National Academy of Sciences under which the Academy shall—

(i) review available public and private sector research on the selection of a set of key national indicators;

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent private nonprofit organization as an Institute to implement a key national indicator system;

(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice to the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and

(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute's budget and operations.

(B) PARTICIPATION.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(C) ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.—

(i) IN GENERAL.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system by—

(I) creating its own institutional capability; or

(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) INSTITUTE.—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of 1986) with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(iii) RESPONSIBILITIES.—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(I) Identifying and selecting issue areas to be represented by the key national indicators.

(II) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(III) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.

(VII) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database.

(VIII) Responding directly to the Commission in response to any Commission recommendations and to the Academy regarding any inquiries by the Academy.

(iv) GOVERNANCE.—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incorporates advisory and control functions. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) MODIFICATION AND CHANGES.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(vi) CONSTRUCTION.—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) ANNUAL REPORT.—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this Act, and annually thereafter, submit to the Co-Chairpersons of the Commission a report that contains the findings and recommendations of the Academy.

(d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.—

(1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) GAO FINANCIAL AUDIT.—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) GAO PROGRAMMATIC REVIEW.—The Comptroller General of the United States

shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commission and to the appropriate authorizing committees of Congress.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out the purposes of this section, $10,000,000 for fiscal year 2010, and $7,500,000 for each of fiscal year 2011 through 2018.

(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.

Subtitle H—General Provisions

SEC. 4701. REPORTS.

(a) REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—On an annual basis, the Secretary of Health and Human Services shall submit to the appropriate Committees of Congress a report on the activities carried out under the amendments made by this title, and the effectiveness of such activities.

(b) REPORTS BY RECIPIENTS OF FUNDS.—The Secretary of Health and Human Services may require, as a condition of receiving funds under the amendments made by this title, that the entity receiving such award submit to such Secretary such reports as the such Secretary may require on activities carried out with such award, and the effectiveness of such activities.

TITLE V—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Physician Ownership and Other Transparency

SEC. 5001. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

''(a) TRANSPARENCY REPORTS.—

''(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—

''(A) IN GENERAL.—On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

''(i) The name of the covered recipient.

''(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

''(iii) The amount of the payment or other transfer of value.

''(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

''(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) cash or a cash equivalent;

''(II) in-kind items or services;

''(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

''(IV) any other form of payment or other transfer of value (as defined by the Secretary).

''(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) consulting fees;

''(II) compensation for services other than consulting;

''(III) honoraria;

''(IV) gift;

''(V) entertainment;

''(VI) food;

''(VII) travel (including the specified destinations);

''(VIII) education;

''(IX) research;

''(X) charitable contribution;

''(XI) royalty or license;

''(XII) current or prospective ownership or investment interest;

''(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;

''(XIV) grant; or

''(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

''(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

''(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

''(B) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

''(2) PHYSICIAN OWNERSHIP.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

''(A) The dollar amount invested by each physician holding such an ownership or investment interest.

''(B) The value and terms of each such ownership or investment interest.

''(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, 'physician' shall be substituted for 'covered recipient' each place it appears.

''(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

''(b) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(c) PROCEDURES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—Not later than October 1, 2011, the Secretary shall establish procedures—

''(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

''(ii) for the Secretary to make such information submitted available to the public.

''(B) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

''(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

''(i) is searchable and is in a format that is clear and understandable;

''(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(iii) contains information that is able to be easily aggregated and downloaded;

''(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

''(v) contains background information on industry-physician relationships;

''(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(vii) contains any other information the Secretary determines would be helpful to the average consumer;

''(viii) does not contain the National Provider Identifier of the covered recipient, and

''(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

''(D) CLARIFICATION OF TIME PERIOD FOR REVIEW AND CORRECTIONS.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

''(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

''(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

''(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(II) Four calendar years after the date such payment or other transfer of value was made.

''(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

''(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

''(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

''(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

''(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

''(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

''(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

''(3) RELATION TO STATE LAWS.—

''(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

''(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

''(i) not of the type required to be disclosed or reported under this section;

''(ii) described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection;

''(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

''(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

''(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

''(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(4) COVERED DEVICE.—The term 'covered device' means any device for which payment is available under a State health security program.

''(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered drug, device, biological, or medical supply' means any drug, biological product, device, or medical supply for which payment is available under a State health security program.

''(6) COVERED RECIPIENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered recipient' means the following:

''(i) A physician.

''(ii) A teaching hospital.

''(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

''(7) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

''(8) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

''(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'manufacturer of a covered drug, device, biological, or medical supply' means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

''(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

''(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of

anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

''(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

''(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

''(ii) Product samples that are not intended to be sold and are intended for patient use.

''(iii) Educational materials that directly benefit patients or are intended for patient use.

''(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

''(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(vii) Discounts (including rebates).

''(viii) In-kind items used for the provision of charity care.

''(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

''(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

''(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of such licensed non-medical professional.

''(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

''(11) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r).''.

SEC. 5002. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 5001, is amended by inserting after section 1128G the following new section:

''SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

''(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

''(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(b) DEFINITIONS.—In this section:

''(1) APPLICABLE DRUG.—The term 'applicable drug' means a drug—

''(A) which is subject to subsection (b) of such section 503; and

''(B) for which payment is available under a State health security program.

''(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term 'authorized distributor of record' has the meaning given that term in subsection (e)(3)(A) of such section.

''(3) MANUFACTURER.—The term 'manufacturer' has the meaning given that term for purposes of subsection (d) of such section.''.

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 5101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

''(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

''(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

''(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 5101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

''(2) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(3) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under a State health security program, that the information reported by the facility in accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

''(4) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

''(5) DEFINITIONS.—In this subsection:

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

''(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

''(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

''(i) a skilled nursing facility (as defined in section 1819(a)); or

''(ii) a nursing facility (as defined in section 1919(a)).

''(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

''(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

''(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

''(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

''(vi) an individual, contact information for the individual; and

''(vii) any other person or entity, such information as the Secretary determines appropriate.''.

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(B) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 5102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 5001 and 5002, is amended by inserting after section 1128H the following new section:

''SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

''(a) DEFINITION OF FACILITY.—In this section, the term 'facility' means—

''(1) a skilled nursing facility (as defined in section 1819(a)); or

''(2) a nursing facility (as defined in section 1919(a)).

''(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

''(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

''(2) DEVELOPMENT OF REGULATIONS.—

''(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

''(C) EVALUATION.—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(3) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subsection, the term 'compliance and ethics program' means, with respect to a facility, a program of the operating organization that—

''(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(B) includes at least the required components specified in paragraph (4).

''(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

''(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(c) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

''(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.''.

SEC. 5104. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(f) STANDARDIZED COMPLAINT FORM.—

''(1) DEVELOPMENT BY THE SECRETARY.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

''(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

''(i) a resident of a facility; and

''(ii) any person acting on the resident's behalf.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5105. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(g) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(2) include resident census data and information on resident case mix;

''(3) include a regular reporting schedule; and

''(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

PART II—TARGETING ENFORCEMENT

SEC. 5111. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

(B) by adding at the end the following new subclauses:

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

(B) by adding at the end the following new subclauses:

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including where evidence suggests that a number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the ''Special Focus Facility'' program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(g) DEFINITIONS.—In this section:

(1) ADDITIONAL DISCLOSABLE PARTY.—The term ''additional disclosable party'' has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(3) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(h) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under this section.

(2) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 5113. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(h) NOTIFICATION OF FACILITY CLOSURE.—

''(1) IN GENERAL.—Any individual who is the administrator of a facility must—

''(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

''(ii) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

''(2) RELOCATION.—

''(A) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

''(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

''(A) shall be subject to a civil monetary penalty of up to $100,000;

''(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

''(C) shall be subject to any other penalties that may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to section 1128I(h), shall terminate''; and

(2) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''subsection (c)(2) and section 1128I(h)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 5121. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

SEC. 5201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ''conviction for a relevant crime'' means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term ''disqualifying information'' means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ''finding of patient or resident abuse'' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under a State health security program:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the

Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 5301. PATIENT-CENTERED OUTCOMES RESEARCH.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''SEC. 1181. (a) DEFINITIONS.—In this section:

''(1) BOARD.—The term 'Board' means the Board of Governors established under subsection (f).

''(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH; RESEARCH.—

''(A) IN GENERAL.—The terms 'comparative clinical effectiveness research' and 'research' mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

''(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

''(3) CONFLICT OF INTEREST.—The term 'conflict of interest' means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual's decisions in matters related to the Institute or the conduct of activities under this section.

''(4) REAL CONFLICT OF INTEREST.—The term 'real conflict of interest' means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

''(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

''(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative's already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

''(b) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

''(1) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be known as the 'Patient-Centered Outcomes Research Institute' (referred to in this section as the 'Institute') which is neither an agency nor establishment of the United States Government.

''(2) APPLICATION OF PROVISIONS.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

''(c) PURPOSE.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

''(d) DUTIES.—

''(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

''(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

''(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

''(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

''(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

''(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

''(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

''(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

''(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

''(i) CONTRACTS.—

''(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

''(aa) Appropriate agencies and instrumentalities of the Federal Government.

''(bb) Appropriate academic research, private sector research, or study-conducting entities.

''(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

''(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

''(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

''(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

''(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

''(IV) subject to clause (iv), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication;

''(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

''(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

''(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

''(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

''(iv) REQUIREMENTS FOR PUBLICATION OF RESEARCH.—Any research published under clause (ii)(IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 5 years).

''(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis as appropriate.

''(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age,

and groups of individuals with different comorbidities, genetic and molecular subtypes, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

''(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as appropriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

''(3) DATA COLLECTION.—

''(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services, as well as provide access to the data networks, as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

''(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

''(4) APPOINTING EXPERT ADVISORY PANELS.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

''(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

''(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

''(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

''(5) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

''(6) ESTABLISHING METHODOLOGY COMMITTEE.—

''(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

''(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

''(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

''(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

''(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

''(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

''(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

''(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

''(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

''(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

''(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

''(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

''(C) USE OF EXISTING PROCESSES.—

''(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

''(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

''(8) RELEASE OF RESEARCH FINDINGS.—

''(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

''(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

''(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

''(iii) include limitations of the research and what further research may be needed as appropriate;

''(iv) not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations; and

''(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

''(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term 'research findings' means the results of a study or assessment.

''(9) ADOPTION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

''(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the

President, and shall make the annual report available to the public. Such report shall contain—

''(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

''(B) the research project agenda and budget of the Institute for the following year;

''(C) any administrative activities conducted by the Institute during the preceding year;

''(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

''(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

''(e) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

''(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

''(f) BOARD OF GOVERNORS.—

''(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

''(A) The Director of Agency for Healthcare Research and Quality (or the Director's designee).

''(B) The Director of the National Institutes of Health (or the Director's designee).

''(C) Fourteen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

''(i) 3 members representing patients and health care consumers.

''(ii) 5 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

''(iii) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

''(iv) 1 member representing quality improvement or independent health service researchers.

''(v) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

''(2) QUALIFICATIONS.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

''(3) TERMS; VACANCIES.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

''(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

''(5) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

''(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

''(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

''(g) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

''(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

''(2) REVIEW AND ANNUAL REPORTS.—

''(A) REVIEW.—The Comptroller General of the United States shall review the following:

''(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

''(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

''(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

''(h) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

''(1) PUBLIC COMMENT PERIODS.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

''(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

''(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

''(A) Information contained in research findings as specified in subsection (d)(9).

''(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducing such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

''(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

''(D) Subsequent comments received during each of the public comment periods.

''(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

''(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

''(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

''(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

''(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

''(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

''(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

''(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

Subtitle F—Elder Justice Act

SEC. 5401. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Elder Justice Act of 2009''.

SEC. 5402. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 5503(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 5403. ELDER JUSTICE.

(a) ELDER JUSTICE.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting ''**AND ELDER JUSTICE**'' after ''**SOCIAL SERVICES**'';

(B) by inserting before section 2001 the following:

''Subtitle A—Block Grants to States for Social Services'';

and

(C) by adding at the end the following:

''Subtitle B—Elder Justice

''SEC. 2011. DEFINITIONS.

''In this subtitle:

''(1) ABUSE.—The term 'abuse' means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

''(2) ADULT PROTECTIVE SERVICES.—The term 'adult protective services' means such services provided to adults as the Secretary may specify and includes services such as—

''(A) receiving reports of adult abuse, neglect, or exploitation;

''(B) investigating the reports described in subparagraph (A);

''(C) case planning, monitoring, evaluation, and other case work and services; and

''(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

''(3) CAREGIVER.—The term 'caregiver' means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

''(4) DIRECT CARE.—The term 'direct care' means care by an employee or contractor who provides assistance or long-term care services to a recipient.

''(5) ELDER.—The term 'elder' means an individual age 60 or older.

''(6) ELDER JUSTICE.—The term 'elder justice' means—

''(A) from a societal perspective, efforts to—

''(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

''(ii) protect elders with diminished capacity while maximizing their autonomy; and

''(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

''(7) ELIGIBLE ENTITY.—The term 'eligible entity' means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

''(8) EXPLOITATION.—The term 'exploitation' means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

''(9) FIDUCIARY.—The term 'fiduciary'—

''(A) means a person or entity with the legal responsibility—

''(i) to make decisions on behalf of and for the benefit of another person; and

''(ii) to act in good faith and with fairness; and

''(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

''(10) GRANT.—The term 'grant' includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

''(11) GUARDIANSHIP.—The term 'guardianship' means—

''(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

''(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

''(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

''(12) INDIAN TRIBE.—

''(A) IN GENERAL.—The term 'Indian tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term 'Indian tribe' includes any Pueblo or Rancheria.

''(13) LAW ENFORCEMENT.—The term 'law enforcement' means the full range of potential responders to elder abuse, neglect, and exploitation including—

''(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

''(B) prosecutors;

''(C) medical examiners;

''(D) investigators; and

''(E) coroners.

''(14) LONG-TERM CARE.—

''(A) IN GENERAL.—The term 'long-term care' means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

''(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term 'loss of capacity for self-care' means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one's financial affairs, and other activities the Secretary determines appropriate.

''(15) LONG-TERM CARE FACILITY.—The term 'long-term care facility' means a residential care provider that arranges for, or directly provides, long-term care.

''(16) NEGLECT.—The term 'neglect' means—

''(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

''(B) self-neglect.

''(17) NURSING FACILITY.—

''(A) IN GENERAL.—The term 'nursing facility' has the meaning given such term under section 1919(a).

''(B) INCLUSION OF SKILLED NURSING FACILITY.—The term 'nursing facility' includes a skilled nursing facility (as defined in section 1819(a)).

''(18) SELF-NEGLECT.—The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

''(A) obtaining essential food, clothing, shelter, and medical care;

''(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

''(C) managing one's own financial affairs.

''(19) SERIOUS BODILY INJURY.—

''(A) IN GENERAL.—The term 'serious bodily injury' means an injury—

''(i) involving extreme physical pain;

''(ii) involving substantial risk of death;

''(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

''(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

''(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

''(20) SOCIAL.—The term 'social', when used with respect to a service, includes adult protective services.

''(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term 'State legal assistance developer' means an individual described in section 731 of the Older Americans Act of 1965.

''(22) STATE LONG-TERM CARE OMBUDSMAN.—The term 'State Long-Term Care Ombudsman' means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.

''SEC. 2012. GENERAL PROVISIONS.

''(a) PROTECTION OF PRIVACY.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

''(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice—

''(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

''(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

''(3) may be unambiguously deduced from the elder's life history.

“PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

“Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

“SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

‘‘(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the ‘Council’).

‘‘(b) MEMBERSHIP.—

‘‘(1) IN GENERAL.—The Council shall be composed of the following members:

‘‘(A) The Secretary (or the Secretary's designee).

‘‘(B) The Attorney General (or the Attorney General's designee).

‘‘(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

‘‘(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

‘‘(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

‘‘(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

‘‘(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

‘‘(f) DUTIES.—

‘‘(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

‘‘(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

‘‘(A) describes the activities and accomplishments of, and challenges faced by—

‘‘(i) the Council; and

‘‘(ii) the entities represented on the Council; and

‘‘(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

‘‘(g) POWERS OF THE COUNCIL.—

‘‘(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

‘‘(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

‘‘(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

‘‘(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

‘‘(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

‘‘(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

“SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

‘‘(a) ESTABLISHMENT.—There is established a board to be known as the ‘Advisory Board on Elder Abuse, Neglect, and Exploitation’ (in this section referred to as the ‘Advisory Board’) to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

‘‘(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

‘‘(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

‘‘(d) TERMS.—

‘‘(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

‘‘(A) 9 shall be appointed for a term of 3 years;

‘‘(B) 9 shall be appointed for a term of 2 years; and

‘‘(C) 9 shall be appointed for a term of 1 year.

‘‘(2) VACANCIES.—

‘‘(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

‘‘(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

‘‘(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

‘‘(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

‘‘(f) DUTIES.—

‘‘(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

‘‘(2) COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

‘‘(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

‘‘(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

‘‘(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

‘‘(A) information on the status of Federal, State, and local public and private elder justice activities;

‘‘(B) recommendations (including recommended priorities) regarding—

‘‘(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

‘‘(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

‘‘(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

‘‘(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

‘‘(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

‘‘(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

‘‘(g) POWERS OF THE ADVISORY BOARD.—

‘‘(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

‘‘(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

‘‘(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in

the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

''SEC. 2023. RESEARCH PROTECTIONS.

''(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

''(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term 'legally authorized representative' means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

''SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this subpart—

''(1) for fiscal year 2011, $6,500,000; and

''(2) for each of fiscal years 2012 through 2014, $7,000,000.

''Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

''SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

''(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

''(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

''(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

''(d) AUTHORIZED ACTIVITIES.—

''(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that receives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

''(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

''(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

''(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

''(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

''(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $4,000,000;

''(2) for fiscal year 2012, $6,000,000; and

''(3) for each of fiscal years 2013 and 2014, $8,000,000.

''PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

''SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

''(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

''(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

''(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

''(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

''(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

''(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

''(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

''(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

''(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

''(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

''(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

''(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

''(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

''(ii) the establishment of motivational and thoughtful work organization practices;

''(iii) the creation of a workplace culture that respects and values caregivers and their needs;

''(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

''(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

''(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

''(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

''(5) DEFINITIONS.—In this subsection:

''(A) COMMUNITY-BASED LONG-TERM CARE.—The term 'community-based long-term care' has the meaning given such term by the Secretary.

''(B) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

''(i) A long-term care facility.

''(ii) A community-based long-term care entity (as defined by the Secretary).

''(b) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.—

''(1) GRANTS AUTHORIZED.—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(2) USE OF GRANT FUNDS.—Funds provided under grants under this subsection may be used for any of the following:

''(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

''(B) Making improvements to existing computer software and hardware.

''(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

''(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

''(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

''(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(c) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

''(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

''(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

''(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

''(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

''(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $20,000,000;

''(2) for fiscal year 2012, $17,500,000; and

''(3) for each of fiscal years 2013 and 2014, $15,000,000.

''SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

''(a) SECRETARIAL RESPONSIBILITIES.—

''(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

''(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

''(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

''(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

''(D) conducts research related to the provision of adult protective services; and

''(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

''(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

''(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

''(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

''(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

''(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to '0.75' were a reference to '0.1'.

''(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

''(3) AUTHORIZED ACTIVITIES.—

''(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

''(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

''(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

''(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

''(c) STATE DEMONSTRATION PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

''(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be used by States and local units of government to conduct demonstration programs that test—

''(A) training modules developed for the purpose of detecting or preventing elder abuse;

''(B) methods to detect or prevent financial exploitation of elders;

''(C) methods to detect elder abuse;

''(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

''(E) other matters relating to the detection or prevention of elder abuse.

''(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

''SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

''(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

''(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

''(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

''(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

''(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

''(A) for fiscal year 2011, $5,000,000;

''(B) for fiscal year 2012, $7,500,000; and

''(C) for each of fiscal years 2013 and 2014, $10,000,000.

''(b) OMBUDSMAN TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

''SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

''(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

''(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the eligible entity may require in order to conduct such evaluation; or

''(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

''(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

''(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

''(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

''(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

''(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

''(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

''(4) APPLICATIONS.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

''(5) REPORTS.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

''(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

''(1) EVALUATIONS.—The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an evaluation of whether the funding provided under the grant is expended only for the purposes for which it is made.

''(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

''SEC. 2045. REPORT.

''Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

''(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

''(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

''SEC. 2046. RULE OF CONSTRUCTION.

''Nothing in this subtitle shall be construed as—

''(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

''(2) creating a private cause of action for a violation of this subtitle.''.

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

''(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

''(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

''(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under a State health security program.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 5005, is amended by inserting after section 1150A the following new section:

''REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

''SEC. 1150B. (a) DETERMINATION AND NOTIFICATION.—

''(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least $10,000 in such Federal funds during the preceding year.

''(2) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

''(3) COVERED INDIVIDUAL DEFINED.—In this section, the term 'covered individual' means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

''(b) REPORTING REQUIREMENTS.—

''(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

''(2) TIMING.—If the events that cause the suspicion—

''(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

''(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

''(c) PENALTIES.—

''(1) IN GENERAL.—If a covered individual violates subsection (b)—

''(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

''(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

''(4) EXTENUATING CIRCUMSTANCES.—

''(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

''(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term 'underserved population' means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

''(i) areas or groups that are geographically isolated (such as isolated in a rural area);

''(ii) racial and ethnic minority populations; and

''(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

''(d) ADDITIONAL PENALTIES FOR RETALIATION.—

''(1) IN GENERAL.—A long-term care facility may not—

''(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

''(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

''(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

''(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

''(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(f) DEFINITIONS.—In this section, the terms 'elder justice', 'long-term care facility', and 'law enforcement' have the meanings given those terms in section 2011.''.

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term ''nurse aide'' has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—

(i) who should be included in the registry;

(ii) how such a registry would comply with Federal and State privacy laws and regulations;

(iii) how data would be collected for the registry;

(iv) what entities and individuals would have access to the data collected;

(v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;

(vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 4301; and

(vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)) would be provided as part of a national nurse aide registry.

(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant resources, including the following:

(i) The Department of Health and Human Services Office of Inspector General Report, Nurse Aide Registries: State Compliance and Practices (February 2005).

(ii) The General Accounting Office (now known as the Government Accountability Office) Report, Nursing Homes: More Can Be Done to Protect Residents from Abuse (March 2002).

(iii) The Department of Health and Human Services Office of the Inspector General Report, Nurse Aide Registries: Long-Term Care Facility Compliance and Practices (July 2005).

(iv) The Department of Health and Human Services Health Resources and Services Administration Report, Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated Data Needs (2004) (in particular with respect to chapter 7 and appendix F).

(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.

(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).

(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the Social Security Act, as added by section 1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed $500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under

paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 5503(a), is amended—

(A) in the heading of section 2001, by striking ''TITLE'' and inserting ''SUBTITLE''; and

(B) in subtitle 1, by striking ''this title'' each place it appears and inserting ''this subtitle''.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears;

(ii) in the heading of paragraph (2), by inserting ''SUBTITLE OF'' before ''TITLE XX''; and

(iii) in the heading of paragraph (3)(B), by inserting ''SUBTITLE OF'' before ''TITLE XX''; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting ''subtitle 1 of'' before ''title XX''; and

(ii) by striking ''such title'' and inserting ''such subtitle''; and

(B) in section 1128A(i)(1), by inserting ''subtitle 1 of'' before ''title XX''.

Subtitle G—Sense of the Senate Regarding Medical Malpractice

SEC. 5501. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VI—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 6001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the ''Biologics Price Competition and Innovation Act of 2009''.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 6002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(l) PATENTS.—

''(1) CONFIDENTIAL ACCESS TO SUBSECTION (k) APPLICATION.—

''(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the 'subsection (k) applicant') and the sponsor of the application for the reference product (referred to in this subsection as the 'reference product sponsor'), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

''(B) IN GENERAL.—

''(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the 'confidential information').

''(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

''(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the 'outside counsel'), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, provided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

''(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

''(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

''(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

''(F) EFFECT OF INFRINGEMENT ACTION.—In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in paragraph (6), the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

''(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

''(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

''(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

''(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

''(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

''(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

''(3) LIST AND DESCRIPTION OF PATENTS.—

''(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

''(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

''(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

''(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

''(i) may provide to the reference product sponsor a list of patents to which the subsection (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application;

''(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

''(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

''(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

''(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

''(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

''(4) PATENT RESOLUTION NEGOTIATIONS.—

''(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

''(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

''(5) PATENT RESOLUTION IF NO AGREEMENT.—

''(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

''(B) EXCHANGE OF PATENT LISTS.—

''(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

''(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

''(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

''(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

''(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

''(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

''(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

''(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

''(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

''(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

''(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k) applicant shall provide the Secretary with notice and a copy of such complaint.

''(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

''(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

''(A) is issued to, or exclusively licensed by, the reference product sponsor after the date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

''(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

''(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

''(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

''(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforcement, and infringement with respect to any patent that is—

''(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

''(ii) not included, as applicable, on—

''(I) the list of patents described in paragraph (4); or

''(II) the lists of patents described in paragraph (5)(B).

''(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

''(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

''(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

''(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under

paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

''(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by adding ''or'' at the end; and

(iii) by inserting after subparagraph (B) the following:

''(C)(i) with respect to a patent that is identified in the list of patents described in section 351(l)(3) of the Public Health Service Act (including as provided under section 351(l)(7) of such Act), an application seeking approval of a biological product, or

''(ii) if the applicant for the application fails to provide the application and information required under section 351(l)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(l)(3)(A)(i) of such Act,''; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product'';

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking ''and'' at the end;

(ii) in subparagraph (C), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking the period and inserting '', and'';

(iii) by inserting after subparagraph (C) the following:

''(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(l)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.''; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking ''and (C)'' and inserting ''(C), and (D)''; and

(C) by adding at the end the following:

''(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

''(i) that is identified, as applicable, in the list of patents described in section 351(l)(4) of the Public Health Service Act or the lists of patents described in section 351(l)(5)(B) of such Act with respect to a biological product; and

''(ii) for which an action for infringement of the patent with respect to the biological product—

''(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(l)(6) of such Act; or

''(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

''(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

''(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act, including as provided under section 351(l)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.''.

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: '', or section 351 of the Public Health Service Act''.

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: ''or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies''.

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

''(n) NEW ACTIVE INGREDIENT.—

''(1) NON-INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for interchangeability with the reference product, shall be considered to have a new active ingredient under this section.

''(2) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.''.

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) FOLLOW-ON BIOLOGICS USER FEES.—

(1) DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review

of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 735(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)(B)) is amended by striking ''section 351'' and inserting ''subsection (a) or (k) of section 351''.

(B) EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) AUDIT.—

(i) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(I) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II)(aa) such ratio determined under subclause (I); to

(bb) the ratio of the costs of reviewing applications for biological products under section 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(ii) ALTERATION OF USER FEE.—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such clause differ by more than 5 percent, then the Secretary shall alter the user fee applicable to applications submitted under such section 351(k) to more appropriately account for the costs of reviewing such applications.

(iii) ACCOUNTING STANDARDS.—The Secretary shall perform an audit under clause (i) in conformance with the accounting principles, standards, and requirements prescribed by the Comptroller General of the United States under section 3511 of title 31, United State Code, to ensure the validity of any potential variability.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2012.

(g) PEDIATRIC STUDIES OF BIOLOGICAL PRODUCTS.—

(1) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

''(m) PEDIATRIC STUDIES.—

''(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (i), (j), (k), (l), (p), and (q) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(3) MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(4) EXCEPTION.—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.''.

(2) STUDIES REGARDING PEDIATRIC RESEARCH.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting '', biological products,'' after ''including drugs''.

(B) INSTITUTE OF MEDICINE STUDY.—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

''(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

''(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

''(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.''.

(h) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the 12-year period described in subsection (k)(7) of such section 351.

SEC. 6003. SAVINGS.

(a) DETERMINATION.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of this subtitle.

(b) USE.—Notwithstanding any other provision of this subtitle (or an amendment made by this subtitle), the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

SEC. 6101. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

''(M) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act), and that meets the requirements of subparagraph (L)(i).

''(N) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.''.

(b) EXTENSION OF DISCOUNT TO INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking ''outpatient'' each place it appears; and

(2) in subsection (b)—

(A) by striking ''OTHER DEFINITION'' and all that follows through ''In this section'' and inserting the following: ''OTHER DEFINITIONS.—

''(1) IN GENERAL.—In this section''; and

(B) by adding at the end the following new paragraph:

''(2) COVERED DRUG.—In this section, the term 'covered drug'—

''(A) means a covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act); and

''(B) includes, notwithstanding paragraph (3)(A) of section 1927(k) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), or (N) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.''.

(c) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) in clause (i), by adding ''and'' at the end;

(B) in clause (ii), by striking ''; and'' and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), as amended by subsection (b)—

(A) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E); respectively; and

(B) by inserting after subparagraph (B), the following:

''(C) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—

''(i) IN GENERAL.—A hospital described in subparagraph (L), (M), or (N) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except as permitted or provided for pursuant to clauses (ii) or (iii).

''(ii) INPATIENT DRUGS.—Clause (i) shall not apply to drugs purchased for inpatient use.

''(iii) EXCEPTIONS.—The Secretary shall establish reasonable exceptions to clause (i)—

''(I) with respect to a covered outpatient drug that is unavailable to be purchased through the program under this section due to a drug shortage problem, manufacturer noncompliance, or any other circumstance beyond the hospital's control;

''(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price; or

''(III) to reduce in other ways the administrative burdens of managing both inventories of drugs subject to this section and inventories of drugs that are not subject to this section, so long as the exceptions do not create a duplicate discount problem in violation of subparagraph (A) or a diversion problem in violation of subparagraph (B).

''(iv) PURCHASING ARRANGEMENTS FOR INPATIENT DRUGS.—The Secretary shall ensure that a hospital described in subparagraph (L), (M), or (N) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, purchasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section and section 6102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(2) EFFECTIVENESS.—The amendments made by this section and section 6102 shall be effective and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 6102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) INTEGRITY IMPROVEMENTS.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

''(d) IMPROVEMENTS IN PROGRAM INTEGRITY.—

''(1) MANUFACTURER COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, which shall include the following:

''(I) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the calculation of ceiling prices under such subsection.

''(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

''(III) Performing spot checks of sales transactions by covered entities.

''(IV) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take, such corrective action as is appropriate in response to such price discrepancies.

''(ii) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge by the manufacturers, including the following:

''(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

''(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment to relevant pricing data and exceptional circumstances such as erroneous or intentional overcharging for covered drugs.

''(iii) The provision of access through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized re-disclosure.

''(iv) The development of a mechanism by which—

''(I) rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

''(II) appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

''(v) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

''(vi) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act;

''(II) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

''(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

''(2) COVERED ENTITY COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements specified under subsection (a)(5).

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of procedures to enable and require covered entities to regularly update (at least annually) the information on the Internet website of the Department of Health and Human Services relating to this section.

''(ii) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (i).

''(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing

covered drugs to State health security programs in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

''(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

''(v) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those to which covered entities are subject under subsection (a)(5)(E), through one or more of the following actions:

''(I) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturers in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

''(II) Where the Secretary determines a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such program for a reasonable period of time to be determined by the Secretary.

''(III) Referring matters to appropriate Federal authorities within the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 353).

''(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—

''(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under this section, and claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(A) or (a)(5)(B), including appropriate procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

''(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

''(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the ceiling price described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(A) or (a)(5)(B) have occurred;

''(ii) establish such deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

''(iii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer's product have exceeded the applicable ceiling price under this section, and may submit such documents and information to the administrative official or body responsible for adjudicating such claim;

''(iv) require that a manufacturer conduct an audit of a covered entity pursuant to subsection (a)(5)(D) as a prerequisite to initiating administrative dispute resolution proceedings against a covered entity;

''(v) permit the official or body designated under clause (i), at the request of a manufacturer or manufacturers, to consolidate claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

''(vi) include provisions and procedures to permit multiple covered entities to jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entities are members.

''(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated under subparagraph (A) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.''.

(b) CONFORMING AMENDMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: ''Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price'), and shall require that the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price.''; and

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 6101(c), by inserting ''after audit as described in subparagraph (D) and'' after ''finds,''.

SEC. 6103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM.

(a) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that examines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the ''340B program'') are receiving optimal health care services.

(b) RECOMMENDATIONS.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000,000 individuals who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is implemented.

(2) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

SA 2838. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 11 on page 183, and insert the following:

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health

Beginning on page 187, strike line 17 and all that follows through line 8 on page 188, and insert the following:

(6) REIMBURSEMENT RATES.—

(A) RATES ESTABLISHED BY SECRETARY.—

(i) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.

(ii) INITIAL PAYMENT RULES.—

(I) IN GENERAL.—Except as provided in subclause (II), during the first 3 years in which the community health insurance option if offered, the Secretary shall base the payment rates under this section for services and providers described in subparagraph (A) on the payment rates for similar services and providers under parts A and B of Medicare under title XVIII of the Social Security Act.

(II) EXCEPTIONS.—

(aa) PAYMENT RATES FOR PRACTITIONERS SERVICES.—Payment rates for practitioners services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(bb) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this section.

(iii) FOR NEW SERVICES.—The Secretary shall modify payment rates described in clause (ii) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(iv) PRESCRIPTION DRUGS.—Payment rates under this paragraph for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(B) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(i) INITIAL INCENTIVE PERIOD.—

(I) IN GENERAL.—The Secretary shall provide, in the case of services described in subclause (II) furnished during the first 3 years in which a community health insurance option is offered, for payment rates that are 5 percent greater than the rates established under subparagraph (A).

(II) SERVICES DESCRIBED.—The services described in this subclause are items and professional services, under the community health insurance option by a physician or other health care practitioner who participates in both Medicare and the community health insurance option.

(III) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subclause (I).

(ii) SUBSEQUENT PERIODS.—Beginning with the fourth year in which the community health insurance option is offered, and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordability and the efficient delivery of medical care. Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subparagraph (A)(ii) and clause (i) of this subparagraph were continued.

(iii) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subtitle shall be construed—

(i) as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating qualified health plans.

(ii) as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2839. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 8 on page 188, and insert the following:

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.

(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term ''community health insurance option'' means health insurance coverage that—

(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;

(B) provides high value for the premium charged;

(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

(D) promotes high quality clinical care;

(E) provides high quality customer service to beneficiaries;

(F) offers a sufficient choice of providers; and

(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).

(3) ESSENTIAL HEALTH BENEFITS.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).

(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.

(C) CREDITS.—

(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner as an individual who is enrolled in a qualified health plan.

(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).

(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.

(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

(4) COST SHARING.—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).

(5) PREMIUMS.—

(A) PREMIUMS SUFFICIENT TO COVER COSTS.—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.

(B) APPLICABLE RULES.—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) NATIONAL POOLING.—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

(6) REIMBURSEMENT RATES.—

(A) RATES ESTABLISHED BY SECRETARY.—

(i) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.

(ii) INITIAL PAYMENT RULES.—

(I) IN GENERAL.—Except as provided in subclause (II), during the first 3 years in which the community health insurance option if offered, the Secretary shall base the payment rates under this section for services and providers described in subparagraph (A) on the payment rates for similar services and providers under parts A and B of Medicare under title XVIII of the Social Security Act.

(II) EXCEPTIONS.—

(aa) PAYMENT RATES FOR PRACTITIONERS SERVICES.—Payment rates for practitioners services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(bb) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this section.

(iii) FOR NEW SERVICES.—The Secretary shall modify payment rates described in clause (ii) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(iv) PRESCRIPTION DRUGS.—Payment rates under this paragraph for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(B) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(i) INITIAL INCENTIVE PERIOD.—

(I) IN GENERAL.—The Secretary shall provide, in the case of services described in subclause (II) furnished during the first 3 years in which a community health insurance option is offered, for payment rates that are 5 percent greater than the rates established under subparagraph (A).

(II) SERVICES DESCRIBED.—The services described in this subclause are items and professional services, under the community health insurance option by a physician or

other health care practitioner who participates in both Medicare and the community health insurance option.

(III) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subclause (I).

(ii) SUBSEQUENT PERIODS.—Beginning with the fourth year in which the community health insurance option is offered, and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordablility and the efficient delivery of medical care. Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subparagraph (A)(ii) and clause (i) of this subparagraph were continued.

(iii) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subtitle shall be construed—

(i) as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating qualified health plans.

(ii) as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2840. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 11 on page 183, and insert the following:

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health

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SA 2841. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 187, strike line 17 and all that follows through line 8 on page 188, and insert the following:

(6) REIMBURSEMENT RATES.—

(A) RATES ESTABLISHED BY SECRETARY.—

(i) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.

(ii) INITIAL PAYMENT RULES.—

(I) IN GENERAL.—Except as provided in subclause (II), during the first 3 years in which the community health insurance option if offered, the Secretary shall base the payment rates under this section for services and providers described in subparagraph (A) on the payment rates for similar services and providers under parts A and B of Medicare under title XVIII of the Social Security Act.

(II) EXCEPTIONS.—

(aa) PAYMENT RATES FOR PRACTITIONERS SERVICES.—Payment rates for practitioners services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(bb) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this section.

(iii) FOR NEW SERVICES.—The Secretary shall modify payment rates described in clause (ii) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(iv) PRESCRIPTION DRUGS.—Payment rates under this paragraph for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(B) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(i) INITIAL INCENTIVE PERIOD.—

(I) IN GENERAL.—The Secretary shall provide, in the case of services described in subclause (II) furnished during the first 3 years in which a community health insurance option is offered, for payment rates that are 5 percent greater than the rates established under subparagraph (A).

(II) SERVICES DESCRIBED.—The services described in this subclause are items and professional services, under the community health insurance option by a physician or other health care practitioner who participates in both Medicare and the community health insurance option.

(III) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subclause (I).

(ii) SUBSEQUENT PERIODS.—Beginning with the fourth year in which the community health insurance option is offered, and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordablility and the efficient delivery of medical care. Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subparagraph (A)(ii) and clause (i) of this subparagraph were continued.

(iii) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subtitle shall be construed—

(i) as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating qualified health plans.

(ii) as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2842. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 249, strike lines 3 through 12, and insert the following:

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE AND ESSENTIAL BENEFITS.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and—

(I) the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, or

(II) the plan does not provide coverage for at least the essential health benefits required to be provided by a qualified health plan under section 1302(b) of the Patient Protection and Affordable Care Act.

SA 2843. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 268, after line 19, insert the following:

SEC. 1403. EMPLOYEES ELIGIBLE FOR CREDIT AND REDUCTIONS IF EMPLOYER'S PLAN DOESN'T COVER ESSENTIAL HEALTH BENEFITS.

(a) IN GENERAL.—Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986, as added by section 1401, is amended to read as follows:

''(ii) COVERAGE MUST PROVIDE MINIMUM VALUE AND ESSENTIAL BENEFITS.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and—

''(I) the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, or

''(II) the plan does not provide coverage for at least the essential health benefits required to be provided by a qualified health plan under section 1302(b) of the Patient Protection and Affordable Care Act.''.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

"PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

"SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(3) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2010.

SA 2844. Mr. SANDERS (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1979, line 20, strike all through page 1996, line 3, and insert the following:

SEC. 9001. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

"PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

"SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SA 2845. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 212, line 18, strike ''2017'' and insert ''2014''.

On page 214, line 12, insert '', except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments to correct errors in earlier payments that were based on such estimates'' after ''States''.

On page 219, strike lines 12 through 20, and insert:

(e) TERM OF WAIVER.—

(1) IN GENERAL.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver and such request is granted by the Secretary under paragraph (2).

(2) APPROVAL OF REQUEST.—A request under paragraph (1) shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. The Secretary may deny such a request only if the Secretary—

(A) determines that the State plan under the waiver to be continued did not meet the requirements under subsection (b);

(B) notifies the State in writing of the requirements under subsection (b) that the State plan did not meet and provides to the State the information used by the Secretary in making that determination; and

(C) provides the State with an opportunity to appeal such determination and provide information as to how such requirements were met.

The Secretary shall consider any information provided under subparagraph (C) and reconsider its determination under subparagraph (A). The Secretary shall grant the request if the Secretary determines upon reconsideration that the State plan met such requirements.

SA 2846. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 1332 and insert the following:

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2014. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States, except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments to correct errors in earlier payments that were based on such estimates.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term ''Secretary'' means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) GRANTING OF WAIVERS.—

(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—

(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—

(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) TERM OF WAIVER.—

(1) IN GENERAL.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver and such request is granted by the Secretary under paragraph (2).

(2) APPROVAL OF REQUEST.—A request under paragraph (1) shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. The Secretary may deny such a request only if the Secretary—

(A) determines that the State plan under the waiver to be continued did not meet the requirements under subsection (b);

(B) notifies the State in writing of the requirements under subsection (b) that the State plan did not meet and provides to the State the information used by the Secretary in making that determination; and

(C) provides the State with an opportunity to appeal such determination and provide information as to how such requirements were met.

The Secretary shall consider any information provided under subparagraph (C) and reconsider its determination under subparagraph (A). The Secretary shall grant the request if the Secretary determines upon reconsideration that the State plan met such requirements.

SA 2847. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 212, line 18, strike ''2017'' and insert ''2014''.

SA 2848. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 214, line 12, insert '', except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments to correct errors in earlier payments that were based on such estimates'' after ''States''.

SA 2849. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 219, strike lines 12 through 20, and insert:

(e) TERM OF WAIVER.—

(1) IN GENERAL.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver and such request is granted by the Secretary under paragraph (2).

(2) APPROVAL OF REQUEST.—A request under paragraph (1) shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. The Secretary may deny such a request only if the Secretary—

(A) determines that the State plan under the waiver to be continued did not meet the requirements under subsection (b);

(B) notifies the State in writing of the requirements under subsection (b) that the State plan did not meet and provides to the State the information used by the Secretary in making that determination; and

(C) provides the State with an opportunity to appeal such determination and provide information as to how such requirements were met.

The Secretary shall consider any information provided under subparagraph (C) and reconsider its determination under subparagraph (A). The Secretary shall grant the request if the Secretary determines upon reconsideration that the State plan met such requirements.

SA 2850. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, add the following:

SEC. ___. REVISION OF EFFECTIVE DATES.

(a) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act shall be implemented by substituting ''2012'' for ''2014'' in each of the following:

(1) Section 2794 of the Public Health Service Act (as added by section 1003.

(2) Section 1001.

(3) Section 1101.

(4) Section 1002.

(5) Section 1253.

(6) Section 1302.

(7) Section 1311.

(8) Section 1321.

(9) Section 1322.

(10) Section 1332.

(11) Section 1341.

(12) Section 36B of the Internal Revenue Code of 1986 (as added by section 1401).

(13) Section 45R of the Internal Revenue Code of 1986 (as added by section 1421).

(14) Section 5000A of the Internal Revenue Code of 1986 (as added by section 1501(b)).

(15) Section 4980H of the Internal Revenue Code of 1986 (as added by section 1513.

(16) The provisions of title II including the amendments made by such title.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

''PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

''SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(3) SECTION 15 NOT TO APPLY.—The amendment made by paragraph (1) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2010.

SA 2851. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, add the following:

SEC. ___. REVISION OF EFFECTIVE DATES.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act shall be implemented by substituting ''2012'' for ''2014'' in each of the following:

(1) Section 2794 of the Public Health Service Act (as added by section 1003.

(2) Section 1001.

(3) Section 1101.

(4) Section 1002.

(5) Section 1253.
(6) Section 1302.
(7) Section 1311.
(8) Section 1321.
(9) Section 1322.
(10) Section 1332.
(11) Section 1341.
(12) Section 36B of the Internal Revenue Code of 1986 (as added by section 1401).
(13) Section 45R of the Internal Revenue Code of 1986 (as added by section 1421).
(14) Section 5000A of the Internal Revenue Code of 1986 (as added by section 1501(b)).
(15) Section 4980H of the Internal Revenue Code of 1986 (as added by section 1513.
(16) The provisions of title II including the amendments made by such title.

SA 2852. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2001 and insert the following:

SEC. 2001. MEDICAID ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) FULL MEDICAID BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by adding at the end the following new subclause:

''(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures specified by the Secretary) does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(E) of such Act (42 U.S.C. 1396b(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by adding ''and'' at the end; and

(C) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3), for individuals under 65 years of age who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in such section) for a family of the size involved; and''.

(3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods before 2015 and 91 percent for periods beginning with 2015) with respect to amounts described in subsection (y)''; and

(B) by adding at the end the following new subsection:

''(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and (2), or an increased FMAP under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(5) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''; and

(ii) by inserting ''1902(a)(10)(E)(v),'' before ''1905(p)(1)''.

(B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), is amended, in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xii);

(ii) by adding ''or'' at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL .—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking ''or'' at the end of subclause (VII); and

(B) by adding at the end the following new subclauses:

''(IX) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(X) beginning with 2014, who are under 19, years of age, who would be eligible for medical assistance under the State plan under subclause (I), (IV) (insofar as it relates to subsection (l)(1)(B)), (VI), or (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or''.

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) INCREASED FMAP FOR ADULTS.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting ''or (IX)'' after ''(VIII)''.

(B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inserting ''1902(a)(10)(A)(i)(X), or'' after ''on the basis of section''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (IX) or (X) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting ''1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(i)(X),'' after ''1902(a)(10)(A)(i)(VIII),''.

(c) NETWORK ADEQUACY.—Section 1932(a)(2) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2013, and shall apply with respect to items and services furnished on or after such date.

(e) DEFINITIONS.—In this section:

(1) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for medical assistance under Medicaid.

(2) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''traditional Medicaid eligible individual'' means a Medicaid eligible individual other than an individual who is—

(A) a Medicaid eligible individual by realson of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or

(B) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

(3) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''non-traditional Medicaid eligible individual'' means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

SA 2853. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain

other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2001 and insert the following:

SEC. 2001. MEDICAID ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) FULL MEDICAID BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by adding at the end the following new subclause:

''(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures specified by the Secretary) does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(E) of such Act (42 U.S.C. 1396b(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by adding ''and'' at the end; and

(C) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3), for individuals under 65 years of age who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in such section) for a family of the size involved; and''.

(3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods before 2015 and 91 percent for periods beginning with 2015) with respect to amounts described in subsection (y)''; and

(B) by adding at the end the following new subsection:

''(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and (2), or an increased FMAP under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(5) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''; and

(ii) by inserting ''1902(a)(10)(E)(v),'' before ''1905(p)(1)''.

(B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), is amended, in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xii);

(ii) by adding ''or'' at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL .—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking ''or'' at the end of subclause (VII); and

(B) by adding at the end the following new subclauses:

''(IX) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(X) beginning with 2014, who are under 19, years of age, who would be eligible for medical assistance under the State plan under subclause (I), (IV) (insofar as it relates to subsection (l)(1)(B)), (VI), or (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or''.

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) INCREASED FMAP FOR ADULTS.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting ''or (IX)'' after ''(VIII)''.

(B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inserting ''1902(a)(10)(A)(i)(X), or'' after ''on the basis of section''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (IX) or (X) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting ''1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(i)(X),'' after ''1902(a)(10)(A)(i)(VIII),''.

(c) NETWORK ADEQUACY.—Section 1932(a)(2) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2013, and shall apply with respect to items and services furnished on or after such date.

(e) DEFINITIONS.—In this section:

(1) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for medical assistance under Medicaid.

(2) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''traditional Medicaid eligible individual'' means a Medicaid eligible individual other than an individual who is—

(A) a Medicaid eligible individual by realson of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or

(B) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

(3) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''non-traditional Medicaid eligible individual'' means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

SEC. 2001A. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

"PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

"SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts

taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SA 2854. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 103, line 10, insert before the period the following: '', including oral and vision care''.

SA 2855. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. ORAL AND VISION CARE.

(a) TECHNICAL AMENDMENT.—Section 1302(b)(1)(A) of this Act is amended by inserting '', including oral and vision care'' before the period.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

''PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

''SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(3) SECTION 15 NOT TO APPLY.—The amendment made by paragraph (1) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2010.

SA 2856. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 97, between lines 6 and 7, insert the following:

SEC. 2709. APPLICATION OF PREMIUM AND COVERAGE RULES TO GRANDFATHERED GROUP PLANS AND OTHER LARGE GROUP PLANS.

Notwithstanding section 2701 or 2707, or section 1251 of the Patient Protection and Affordable Care Act, in the case of plan years beginning after December 31, 2014, sections 2701 and 2707 shall apply to a group health plan, and a health insurance issuer offering group health insurance coverage, which is—

(1) a grandfathered health plan (as defined in section 1251(e) of such Act); or

(2) health insurance coverage offered in the large group market.

SA 2857. Mr. SANDERS submitted an amendment intended t be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 162, after line 25, add the following:

(7) CAP ON PRIVATE INSURANCE COMPANY EXECUTIVE COMPENSATION.—

(A) LIMITS ON COMPENSATION FOR EXECUTIVES OF PRIVATE INSURANCE COMPANIES PARTICIPATING IN AN EXCHANGE.—

(i) IN GENERAL.—Notwithstanding any other provision of law or agreement to the contrary, no employee or executive of a private health insurance issuer that offers coverage through an Exchange may receive aggregate annual compensation, in any form, from the issuer in an amount in excess of $1,000,000.

(ii) DEFINITION.—For purposes of this paragraph, the term ''aggregate annual compensation'' includes bonuses, deferred compensation, stock options, securities, or any other form of compensation provided to an employee or executive.

(B) BAR FROM PARTICIPATION IN EXCHANGE.—If a private health insurance issuer offering coverage through an Exchange fails to comply with the requirement of subparagraph (A), such issuer shall be prohibited from offering coverage through the Exchange.

SA 2858. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for Mr. BAUCUS. Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1925, between lines 14 and 15, insert the following:

Subtitle C—Ethical Pathway for Pharmaceutical Products

SEC. 7201. ETHICAL PATHWAY FOR THE APPROVAL AND LICENSURE OF GENERIC PHARMACEUTICAL PRODUCTS.

(a) DEFINITIONS.—In this section—

(1) the term ''abbreviated new drug application'' means an abbreviated application for a new drug submitted under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j);

(2) the term ''Commissioner'' means the Commissioner of Food and Drugs; and

(3) the term ''Secretary'' means the Secretary of Health and Human Services.

(b) ETHICAL PATHWAY.—As soon as practicable after the date of enactment of this Act, the Secretary, acting through the Commissioner, shall establish a mechanism by which the filer of an abbreviated new drug application for approval of a drug or an application for licensure of a biological product under section 351(k) of the Public Health Service Act may request a cost-sharing arrangement described in subsection (c). Such a filer may request such an arrangement if, but for the arrangement, such filer would be required to conduct clinical investigations involving human subjects that violate Article 20 of the Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects in order to obtain such approval or licensure from the Secretary.

(c) COST-SHARING ARRANGEMENT.—The cost-sharing arrangement described in this subsection is an arrangement in which—

(1) the filer of the abbreviated new drug application or the application under section 351(k) of the Public Health Service Act pays a fee to the Commissioner;

(2) notwithstanding any other provision of law, the Commissioner provides such reports to such filer;

(3) such filer may, notwithstanding any provision of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) or of the Public Health Service Act (42 U.S.C. 301 et seq.), rely in such application on reports of investigations, conducted by a holder of an approved application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or a holder of a license under section 351(a) of the Public Health Service Act, which have been made to show whether or not such drug or biological product is safe for use and whether such drug or biological product is effective in use; and

(4) the Commissioner remits the amount of such fee to the holder of the approved application under such section 505(b) or of the license under such section 351(a), as appropriate.

SA 2859. Ms. SNOWE (for herself, Ms. LANDRIEU, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 223, strike lines 6 through 10.

On page 224, line 2, insert after ''Act'' the following: '', including the rating requirements of such part A (except that the State may subsequent to the date of enactment of this Act enact more restrictive rating requirements),''.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Public Lands and Forests.

The hearing will be held on Thursday, December 17, 2009, at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the following bills:

S. 1470, to sustain the economic development and recreational use of National Forest System land and other public land in the State of Montana, to add certain land to the National Wilderness Preservation System, to release certain wilderness study areas, to designate new areas for recreation, and for other purposes;

S. 1719, to provide for the conveyance of certain parcels of land to the town of Alta, Utah;

S. 1787, to reauthorize the Federal Land Transaction Facilitation Act, and for other purposes;

H.R. 762, to validate final patent number 27–2005–0081, and for other purposes; and

H.R. 934, to convey certain submerged lands to the Commonwealth of the Northern Mariana Islands in order to give that territory the same benefits in its submerged lands as Guam, the Virgin Islands, and American Samoa have in their submerged lands.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send it to the Committee on Energy and Natural Resources, United States Senate, Washington, DC 20510–6150, or by e-mail to allison_seyferth@energy.senate.gov.

For further information, please contact Scott Miller or Allison Seyferth.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on December 2, 2009, at 9:30 a.m. in room 216 of the Hart Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, December 2, 2009, at 9 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 2, 2009, at 10 a.m. in room 253 of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate to conduct a hearing on December 2, 2009, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS AND THE SUBCOMMITTEE ON SUPERFUND, TOXICS, AND ENVIRONMENTAL HEALTH

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works and the Subcommittee on Superfund, Toxics, and Environmental Health be authorized to meet during the session of the Senate on December 2, 2009, at 2:30 p.m. in Room 406 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DURIBN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 2, 2009, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Has the Supreme Court Limited Americans' Access to Courts?''

The PRESIDING OFFICER. Without objection, it is so ordered.

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Ad Hoc Subcommittee on Disaster Recovery of the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 2, 2009, at 2:30 p.m. to conduct a hearing entitled, ''Disaster Case Management: Developing a Comprehensive National Program Focused on Outcomes.''

The PRESIDING OFFICER. Without objection, it is so ordered.

EXTENDING CONDOLENCES TO SLAIN WASHINGTON OFFICERS' FAMILIES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 366, submitted earlier today.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

A resolution (S. Res. 366) extending condolences to the families of Sergeant Mark Rennigner, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 366) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 366

Whereas on the morning of November 29, 2009, 4 members of the Lakewood Police Department were slain by gunfire in a senseless act of violence while preparing for their shift in Lakewood, Washington;

Whereas the 4 officers have been members of the Lakewood Police Department since its founding 5 years ago, were valuable members of the community, and were deeply respected for their service;

Whereas Sergeant Mark Renninger, who served 13 years in law enforcement, first with the Tukwila Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas Officer Tina Griswold, who served 14 years in law enforcement, first with the Lacey Police Department and most recently with the Lakewood Police Department, is survived by her husband and 2 children;

Whereas Officer Ronald Owens, who served 12 years in law enforcement, first with the Washington State Patrol and most recently with the Lakewood Police Department, is survived by his daughter;

Whereas Officer Greg Richards, who served 8 years in law enforcement, first with the Kent Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas the senseless violence against and murder of law enforcement officers, who are sworn to serve, protect, and preserve the peace of the communities, is a particularly heinous crime; and

Whereas in the face of this senseless tragedy, the people of the City of Lakewood, the surrounding communities, and the State of Washington have come together in support of the law enforcement community and the families of the victims: Now, therefore, be it

Resolved, That the Senate—

(1) extends its condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; and

(2) stands with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they celebrate the lives and mourn the loss of these 4 dedicated public servants and law enforcement heroes.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. DURBIN. Mr. President, I ask unanimous consent that the previous order with respect to H.R. 3590 be modified to provide that the time until 11:45 a.m. be equally divided between Senator MIKULSKI and the minority leader or their designees.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR THURSDAY, DECEMBER 3, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m. tomorrow, Thursday, December 3; that following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, as provided for under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. DURBIN. Mr. President, under a previous order, at 11:45 a.m., there will be a series of two rollcall votes and two more votes at 2:40 p.m. Those votes will be in relation to the Mikulski amendment, as amended, the Murkowski amendment, the Bennet of Colorado amendment, and the McCain motion to commit.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. DURBIN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate adjourn under the previous order.

There being no objection, the Senate, at 8:31 p.m., adjourned until Thursday, December 3, 2009, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF COMMERCE

DAVID W. MILLS, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE DARRYL W. JACKSON, RESIGNED.

INTERNATIONAL MONETARY FUND

DOUGLAS A. REDIKER, OF MASSACHUSETTS, TO BE UNITED STATES ALTERNATE EXECUTIVE DIRECTOR OF THE INTERNATIONAL MONETARY FUND FOR A TERM OF TWO YEARS, VICE DANIEL D. HEATH, TERM EXPIRED.

FEDERAL MARITIME COMMISSION

MICHAEL A. KHOURI, OF KENTUCKY, TO BE A FEDERAL MARITIME COMMISSIONER FOR A TERM EXPIRING JUNE 30, 2011, VICE STEVEN ROBERT BLUST, RESIGNED.

IN THE COAST GUARD

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES COAST GUARD TO THE GRADE INDICATED UNDER SECTION 271, TITLE 14, U.S.C.:

To be rear admiral

REAR ADM. (LH) JOSEPH R. CASTILLO
REAR ADM. (LH) DANIEL R. MAY
REAR ADM. (LH) ROY A. NASH
REAR ADM. (LH) PETER F. NEFFENGER
REAR ADM. (LH) CHARLES W. RAY
REAR ADM. (LH) KEITH A. TAYLOR

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND AS PERMANENT PROFESSOR AT THE UNITED STATES AIR FORCE ACADEMY, UNDER TITLE 10, U.S.C., SECTIONS 9333(B) AND 9336(A):

To be colonel

JOSEPH E. SANDERS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be lieutenant colonel

CHINMOY MISHRA

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

CHARLES F. KIMBALL

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

MINH THU NGOC LE
ROBERT C. POPE

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

MATTHEW S. FLEMMING

EXTENSIONS OF REMARKS

IN HONOR AND RECOGNITION OF SISTER DONNA L. HAWK

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. KUCINICH. Madam Speaker, I rise today in honor and recognition of Sister Donna L. Hawk of Cleveland, Ohio, as she is named the West Side Catholic Center's Walk in Faith recipient of 2009.

Throughout her life, Sister Donna Hawk has turned her faith into action, uplifting the lives of those living on the streets. Sister Donna has become a nationally-known leader by creating and operating transitional housing for the homeless, especially for women and their children fleeing domestic violence. While working for many years as a volunteer at the West Side Catholic Shelter, Sister Donna developed a special compassion for women, many of whom had young children seeking refuge from abusive situations.

In 1986, without funding, Sister Donna teamed with Sister Loretta Schulte to rally community leaders and developers in order to transform a motel on Cleveland's west side into Transitional Housing, Inc.—a place of shelter and source of counseling and resources for women and children in need. For more than twenty years, Transitional Housing, Inc. has served as a model for similar programs throughout the nation and across the world.

Madam Speaker, please join me in honor and recognition of Sister Donna L. Hawk, whose faith in action, unwavering belief in the possibility of transformation, and staunch advocacy has given strength and hope to countless women and children.

IN MEMORY OF HOWARD JACOBS

HON. HENRY A. WAXMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. WAXMAN. Madam Speaker, as the city of West Hollywood gathers to celebrate the life of Howard Jacobs, I am proud to join the community in recognizing his accomplishments and sharing in the sadness that he was taken from us at such a young age.

Howard Jacobs dedicated his life to helping people in need. His work with the West Hollywood City Council, the City's Disability Advisory Board, the Rent Stabilization Committee and most recently with First 5 LA, demonstrates the depth and breadth of his devotion to every segment of society. Perhaps he will be best remembered for his activism to fight HIV/AIDS discrimination and educate people about prevention, detection and treatment.

Howard experienced many serious health challenges in his life. When he was first diagnosed with HIV/AIDS in 1989, scientific understanding of the disease was still emerging, societal stigma was pervasive and a diagnosis was a death sentence. But Howard always rallied. He helped West Hollywood design model policies to reduce HIV transmission in the gay community. To many he seemed invincible. Even with his passing it is clear that he will continue to serve as an inspiration.

In my career in public service, I have seen so many instances when one person—one vote—one voice can make a world of difference. Howard Jacobs filled that role so many times and in so many ways. We will forever be in his debt for the world of good he brought in the short time he had to give.

A TRIBUTE TO MS. PEGGY E. WHITEHEAD

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Ms. Peggy E. Whitehead.

Peggy E. Whitehead is originally from Virginia but relocated to New York to start her career after graduating from high school. Ms. Whitehead has worked over two decades as a bacteriologist in the lab of the Howard Johnson Corporation. Upon the closing of the facility, she hit the ground running. Determination has always been a major player in her life.

Through the years, she was promoted several times to where she is today. She holds the title of Assistant Coordinating Manager in the Ambulatory Care Department (Sub-Specialty) at Queens Hospital, where she is responsible for day to day operations of twenty clinics.

Ms. Whitehead has received the prestigious Ace Award which signifies excellence, leadership and innovation. In addition, she also received the employee of the month award on the same day. She is a member of the Greenway Angels, an organization founded by her sister, Rosetta Garrett, eight years ago. She has been a volunteer for over six years, within the American Cancer Society. She works on many events, from Making Strides, to RELAY FOR LIFE, to helping with health fairs, all of which are so vital to getting information out to the community. The Ronald McDonald House of New Hyde Park, NY has been an ongoing labor of love event for her in the past seven years. She prepares a feast for the families of the children confined to the Snyder Hospital.

She also participates in the annual New York Aids Walk. New York has the largest Aids Walk in the world, raising millions of dollars each year. Peggy has volunteered her services for eight years.

Ms. Whitehead worked with pride on the Obama Campaign and traveled to Washington, DC for the historic inauguration. Whether doing work for the Diabetic Walk or coordinating a drive to help the homeless, she goes about each project with relentless vigor and vitality that speaks to who she is.

She has three children—Jerry, Jennifer, and Karen, and seven grandchildren.

Madam Speaker, I urge my colleagues to join me in recognizing Ms. Peggy E. Whitehead.

HONORING END THE SILENCE

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to commend and congratulate End the Silence upon being awarded with the "Community Health Champions Award" at the 2009 West Fresno Health Care Coalition's 5th annual "This is Your Life of Service" lunch and awards ceremony. This year the ceremony will be held at the Radisson Hotel Conference Center in Fresno, California on Tuesday, November 3rd.

End the Silence is a breast cancer awareness project that has been created as a community-based program specifically designed for targeting the African American community, especially in West Fresno, California. The goal and purpose is to increase education, promote and heighten awareness, create support services and resources for the underserved African American population in West Fresno regarding breast cancer and overall breast health.

The need for End the Silence was discovered when national, state and local statistics were pointing to the high risk of African American women developing, and dying from, breast cancer. Studies have shown that African American women are more likely to pass away from breast cancer than white women. Further, the National Cancer Institute found that breast cancer is the leading cause of cancer deaths among African American women. This reality is often due to economic, social and cultural factors; including misinformation about breast cancer, treatments and lack of access to health which ultimately leads to late diagnosis.

End the Silence targets West Fresno's underserved and underinsured African American community. Over the span of the project, the organizers intend on reducing high breast cancer mortality risk. They expect to serve more than three hundred African American women and their families who will benefit from program services, including culturally competent and trained staff and advocates, specialized

support groups and services, culturally appropriate health education, materials and resources and the opportunity for making their voices heard through advocacy activities. Five people that have made End the Silence successful are Charyce Haynes, Wilma Ruth Johnson, Edna Overall, Frances Davis and Adrian Carter.

Madam Speaker, I rise today to commend and congratulate End the Silence upon being award the "Community Health Champions Award." I invite my colleagues to join me in wishing End the Silence many years of continued success.

IN HONOR OF LAWRENCE HALPRIN

HON. LYNN C. WOOLSEY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Ms. WOOLSEY. Madam Speaker, I rise with sadness today to honor a true American icon, landscape architect Lawrence Halprin, who passed away on October 25, 2009, at the age of 93. Mr. Halprin's legendary work profoundly influenced concepts of landscape design in this country and around the world.

A long-time resident of Kentfield in Marin County, California, Mr. Halprin's mark on the Bay Area is particularly evident. From the groundbreaking Sea Ranch development on our Sonoma Coast to Ghirardelli Square and George Lucas' Letterman Digital Arts Center, he designed memorable spaces that create harmony between people and environment.

Nationally, his best known work is the Franklin D. Roosevelt Memorial in Washington, DC, which artfully invokes Roosevelt's life and work as visitors stroll through a sculptured plaza in a natural setting. Throughout his career, Larry Halprin was adept at revitalizing perceptions of urban areas and involving the community in his public projects.

Mr. Halprin often worked in partnership with his wife, the well-known dancer Anna Halprin. The two met while attending the University of Wisconsin and were married in 1940. While in Wisconsin, they met Frank Lloyd Wright at Taliesin, and his ideas inspired Mr. Halprin to study landscape architecture at Harvard.

Their collaboration was based on a shared vision of crafting interactive, creative experiences that connect with people on a deep level. Halprin also joined Anna's dance work, most famously in their 1979 "planetary dance" on Mount Tamalpais. The goal was to take back the mountain for people frightened away by the notorious Trailside Killer. The dance is now performed annually in 36 countries.

While serving in the Navy in World War II, Halprin recuperated in San Francisco from a Japanese attack which had destroyed his ship. After the war, the couple relocated to the Bay Area.

Widely recognized as a man whose genius revolutionized landscape architecture, Mr. Halprin also won a number of awards. These included a Presidential Design Award for the FDR Memorial, the University of Virginia Thomas Jefferson Medal in Architecture, and the prestigious National Medal of the Arts. A man of many talents, he was also recognized for his documentary on Salvador Dali, "Le Pink Grapefruit."

In addition to his wife, Mr. Halprin is survived by his daughters Dana and Rana and four grandchildren.

Madam Speaker, it is not easy to summarize the scope of Lawrence Halprin's influence and accomplishments. As we enjoy his urban environments or the spaciousness of Sea Ranch, we can understand how much his vision and creativity have enriched our lives.

HONORING JOHN C. HARRIS WITH THE DISTINGUISHED CITIZEN AWARD

HON. JIM COSTA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. COSTA. Madam Speaker, I rise today to pay special tribute to John C. Harris for receiving the Distinguished Citizen Award, in recognition of his strong dedication to the Boy Scouts of America in the San Joaquin Valley. Mr. Harris has hosted the Westside Luncheon at Harris Ranch for nearly twenty years. This casual and friendly fund raising lunch supports the Scouting programs in western Fresno and Kings Counties. The Luncheon has become a model for other Scout Councils to emulate. In fact, the Monterey Bay Area Council borrowed the Harris model and began a similar event in King City years ago. John's concern for the youth of our area and his love of Scouting have kept his efforts concentrated in the Sequoia Council, and in the growth of the Scouting in the San Joaquin Valley.

John has been involved in the Agriculture and Thoroughbred business all of his life, as he and his family have worked to create one of the nation's largest Agribusinesses. A diversified family farming operation, this successful business consists of the Harris Ranch Beef Company, Harris Ranch Inn & Restaurant, Harris Feeding Company, Harris Fresh, and the Harris Farms Horse Division. Much has contributed to California's bountiful agriculture industry and economic well-being, but one significant underlying factor in California's agricultural success has been the presence of families such as the Harris family.

We are fortunate to have generous and giving individuals like John Harris, who help to make our Valley a better place. John's commitment to excellence and hard work reflect much of the same values the Boy Scouts embody in their scout oath: to do your best, help other people at all times, and to serve your country. John Harris certainly lives up to these values as is evident in his business success and devotion to serving others in our community.

For all these reasons, it is without a doubt an honor to recognize John Harris today for his leadership in our Valley, as he continues to touch the lives of many people and leave his mark of good will in our community. We are especially thankful today for his service to the Boy Scouts of America in the Central Valley.

CONGRATULATING GIUSEPPE AND CATERINA TIBERI

HON. JOHN A. BOEHNER

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. BOEHNER. Madam Speaker, it is a pleasure for me to offer my best wishes to the dear mom and dad of Congressman PATRICK J. TIBERI who will be celebrating their golden wedding anniversary on December 8th.

Giuseppe and Caterina Tiberi were married in 1959 in Introdacqua, Italy and have now spent 50 years of marriage together.

"Joe" and "Rina" have been outstanding parents, rearing PAT and his two sisters Ida and Tania. They are also proud grandparents of six wonderful children: Anthony, Alex, Angelina, Cristina, Daniela and Gabriela.

As loving parents and grandparents, they continue to set an amazing example for others to follow. I join with all of the Tiberi family and their many friends in wishing Joe and Rina all the best on this joyous occasion.

RECOGNIZING THE NEW HARRISON TOWNSHIP PUBLIC LIBRARY

HON. CANDICE S. MILLER

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mrs. MILLER of Michigan. Madam Speaker, it is my honor to acknowledge the recent grand opening celebration of the new Harrison Township Public Library (HTPL) which was held on October 24th, 2009. I had the privilege to attend this special occasion along with other public officials, library staff and community leaders. The HTPL truly is a remarkable story and is a shining example of what can occur when people come together to accomplish a common goal.

The HTPL is an all-volunteer library and operates on a budget from the sales of used books and other promotional items and also the collection of private donations. Not a single dollar of tax-payer money was used to open the new facility.

It took the will power of very dedicated individuals who worked as a team to ensure Harrison Township would no longer be the only municipality in Macomb County without a library. However, the road to complete this project was anything but easy to navigate. The economic challenges were extremely difficult to overcome, and there were many road blocks along the way. At times it appeared that the dream was all but lost.

In fact, many would have given up on this project. But the community volunteers would not let this dream fade away, and instead rolled up their sleeves and went back to the drawing board to get the job done. Only through hard work and determination was Harrison Township finally able to open the doors on its new library.

Numerous organizations and people helped make this dream come true: The Township offered the space to house the library; Macomb County donated materials and books to stock

shelves; partners from the private sector and academia provided other key resources to furnish the library with proper information technology.

I certainly want to commend the numerous library volunteers for all the hours they contributed and the personal sacrifices they made to assist with this effort. I too was more than happy to lend a helping hand by donating books obtained through the Library of Congress' Surplus Book Program.

Now I am pleased to say that the residents of Harrison Township have their own library! Senior citizens now have a place to read the newspaper or check out a book. Students now have a quiet place to do research, finish their homework or use the Internet. There is even a children's section that has games, toys and books for families to utilize to help their children learn.

I would like to name for the record the key volunteers who made this dream a reality, for without them, this project would have never come to fruition: Marge Swiatkowski, the Director of Library Volunteer Committee, and her husband Jack; we need to also recognize Joyce Bane, John and Carolyn Bicsak, Jim and Mary Lou Bilen, Gale Brady, Tracy Champine, Natalie Cruz, Donna Dertinger, Phil and Marsh Devergillo, Julie Dries, Bobbi Gust, Ann Marie Hergott, Toni Hindman, Kathy Hunt, Jane Jones, Althea Lanuzza, Mary LaPlante, Joan Lavey, Katie LeBlanc, Madaline Mannino, Diane Marvaso, Jean McKay, Kathy McRae, Ellen McKee, Jo Mitchell, Nancy Motring, Mary Oberliesin, Beverly Ortman, Joan Schmidt, Sandy Schwab, Marty Shadel, Stephanie Simon, Thomas Sycko, Chris Hearns, Nancy Trompics, Mary Mahoney, Sheri Mathison, Jane Roda and Dee Turowski.

I applaud each of you for your tireless efforts! Your display of leadership and teamwork are something to be emulated throughout the community.

HONORING THE JUILLIARD SCHOOL'S MUSIC ADVANCEMENT PROGRAM

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of the Music Advancement Program at The Juilliard School.

The Music Advancement Program (MAP) is a Saturday instrument-instruction program that was created in 1990. MAP targets students, ages eight to fourteen, who are underrepresented in the performing arts. The program is designed to help students at the early stage of their musical development on violin, viola, cello, double bass, flute, clarinet, trumpet, trombone, percussion, and piano. MAP has served families by providing education workshops on diverse topics, information about various concert opportunities and a literacy program for younger siblings of MAP students. MAP has also supported New York City public school music teachers by building upon their work, starting where most school instrumental programs must end, and by motivating students to excel in all of their endeavors. Through MAP, The Juilliard School has demonstrated its commitment to being a cultural citizen in New York City by reaching out to underrepresented communities and investing in a future arts community that is diverse in its performers, educators, audiences, and patrons. This exemplary program has enriched the lives of countless students, and will continue to provide valuable opportunities in the performing arts for underprivileged students in New York City schools.

Madam Speaker, I urge my colleagues to join me in recognizing the Music Advancement Program at The Juilliard School.

HONORING CITY OF GRAND PRAIRIE

HON. KENNY MARCHANT

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. MARCHANT. Madam Speaker, I rise today to honor the City of Grand Prairie. The city is celebrating its 100th anniversary, and I would like to take a moment to speak about the history of the city and its great future.

In 1841, the area that is now Grand Prairie began to be settled by people accepting Republic of Texas land grants. In 1861, Alexander MacRae Dechman traded his wagon and oxen for 239.5 acres in what is now downtown Grand Prairie. He filed for a town plat in 1876, and named the town Dechman. That same year Alexander gave a portion of his land to the Texas and Pacific Railroad in exchange for operating a depot. In 1877, the railroad renamed Dechman to Grand Prairie because of its location on the eastern edge of the prairie that stretched into West Texas. On March 20, 1909 the citizens of Grand Prairie voted to establish a local city government in order to create the civic infrastructure necessary for public safety, growth and prosperity.

In 1909, the City of Grand Prairie had roughly 1,000 citizens. The city's growth accelerated during and after World War II when its population changed from 1,595 in 1940 to 14,594 in 1950. The population then doubled to 30,386 by 1960. Today the city is home to more than 168,000 citizens. The growth is symbolic of the city's strength and success over the last hundred years.

Grand Prairie has created a strong infrastructure to ensure continued growth. The city has constructed attractions for both economic development and tourism such as Lone Star Park in 1992, Nokia Theatre in 2001, the Ruthe Jackson Conference Center in 2002, the Uptown Theater, QuikTrip Ballpark and the AirHogs in 2008 and Market Square in 2009.

The city's success is also demonstrated by its long list of awards. Some recent awards include the Money Magazine 2008 Best Places to Live in USA, Today Newspaper 2008 Readers' Choice Award—Best Place to Live, the 2008 National Recreation and Parks Association Gold Medal Award for best parks system in America and named a Playful City USA in both 2008 and 2009.

Under the able leadership of Mayor Charles England, the City Council and City Manager's Office, Grand Prairie plans to continue growing stronger for their citizens and businesses. In 2010, the city will open a new Lake Rescue Center, Summit Activity Center for senior citizens and Public Safety Headquarters. A city known for being comfortably casual and incredibly friendly, Grand Prairie looks forward to the next 100 years of dreaming big and making it happen.

I am honored to represent the City of Grand Prairie and I ask my colleagues to join me in congratulating the city upon their 100th anniversary.

HONORING ELI WARREN

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Eli Warren, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 1179, and in earning the most prestigious award of Eagle Scout.

Eli has been very active with his troop participating in many scout activities. Over the many years Eli has been involved with scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Eli Warren for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

PERSONAL EXPLANATION

HON. DENNY REHBERG

OF MONTANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. REHBERG. Madam Speaker, on rollcall number 911, 912, and 913 I was unavoidably detained due to flight complications from Billings, MT to Washington, DC.

Had I been present, I would have voted "nay" on rollcall 911, "yea" on rollcall 912, and "aye" on rollcall 913.

CONGRATULATING KIM JAKOVICS

HON. JOHN P. SARBANES

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. SARBANES. Madam Speaker, I would like to commend Kim Jakovics, a social studies teacher at Annapolis High School in Maryland, for winning the Milken Educator Award. Since 1987, this prestigious award has been given annually to honor teachers who have distinguished themselves in their incredibly important and challenging field. Of the fifty-three teachers across the nation to be awarded this prize, she is the sole recipient from Maryland.

Mrs. Jakovics was selected because of the immeasurable impact she has had on her students. Michael Milken, co-founder of the foundation, said of her instruction, "Students' self-image changed, their aspirations changed. Students were different after that experience."

For the past six years, Mrs. Jakovics' dedication to her students has made them feel more confident to aim for loftier goals. She has been effective in leading classrooms full of students at different skill levels and embraced the challenge of teaching diverse groups.

Because of teachers like Mrs. Jakovics, Annapolis High School has experienced a dramatic improvement in student results. For five years the school failed to meet state testing standards. Over the last two years, however, the school has met standards and been removed from Maryland's troubled schools watch list. The dedication of teachers like Mrs. Jakovics is what makes such a dramatic turnaround possible.

I hope Mrs. Jakovics will inspire other talented individuals to enter the field of teaching. Once again, I congratulate Mrs. Jakovics and wish her the best of luck.

HONORING DOLPHAS TROTTER

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to posthumously honor Dolphas Trotter upon being awarded the "Community Health Champions Award" at the 2009 West Fresno Health Care Coalition's 5th annual "This Is Your Life of Service" lunch and awards ceremony. This year the ceremony will be held at the Radisson Hotel Conference Center in Fresno, California on Tuesday, November 3rd.

Mr. Dolphas Trotter was born in 1940 in Idabel, Oklahoma. In 1945 the Trotter family moved cross-country and settled in Southwest Fresno, California. Mr. Trotter attended Washington Union High School where he played football. During his senior year, he participated in the annual Fresno City-County All-Star game, which earned him a football scholarship to College of the Pacific, known today as University of the Pacific. Mr. Trotter graduated in 1962 with a Bachelor's degree and returned to Fresno and began working for Fresno County Department of Social Services.

Shortly after his return to Fresno, Mr. Trotter was drafted into the United States Army and was honorably discharged in 1969. This experience affirmed his belief in the value of education and community. When he returned to Fresno from his military service, he began a career in education. The first of many positions Mr. Trotter held in education was at Franklin Elementary School as a fifth grade teacher. He moved on to teach at Edison High School, where he later became the Vice Principal and the first African American principal of the school. Mr. Trotter had a successful career in the Fresno school system, including serving as Principal at Tioga Middle School and Cooper Middle School. For a brief time he served as the first African American interim superintendent of the Fresno Unified School District and then served as the Superintendent at New Millennium Charter Schools.

Mr. Trotter was also a firm believer in community service. He sat on many boards and worked with many organizations, including the African American Historical and Cultural Museum Board of Directors, the Association of California School Administrators, Cedar Vista Hospital Advisory Board, Channel 24 Portrait of Success Board member, National Alliance of Black School Educators, State Center Community College Foundation and Washington Union School Board. For his service to these organizations Mr. Trotter has received many accolades.

Mr. Trotter and his wife met while working at the Fresno County Department of Social Services. They were married in 1972 and raised four children, including two adopted daughters. Mr. Trotter passed away on March 18, 2009. He was a strong advocate and will be remembered as an inspirational role model for the people of Fresno and the residents of Southwest Fresno.

Madam Speaker, I rise today to honor the life of Dolphas Trotter and recognize him upon being awarded the "Community Health Champions Award." I invite my colleagues to join me in honoring his life and wishing the best for his family.

HONORING THE NORTHERN CAMBRIA LADY COLTS VOLLEYBALL TEAM

HON. BILL SHUSTER

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. SHUSTER. Madam Speaker, I rise today to honor and celebrate the Northern Cambria Lady Colts volleyball team for their remarkable season that ended with a Pennsylvania Interscholastic Athletic Association (PIAA) Class A State Championship title.

The Lady Colts, who concluded their season with an impressive 26–1 record, swept the defending champions, Holy Name—25–14, 30–28, and 25–22 in the championship match on November 14, 2009. The State Champions title capped off an extraordinary season, with the Lady Colts also winning their 100th consecutive conference match. Additionally, these young women also posted their sixth consecutive District VI title as the team completed their season without a single conference loss.

Led by Coach Mike Hogan, the new state champs will be graduating four outstanding seniors: Janae Dunchack, Breanna Kochinsky, and cousins Arie & Jess Rocco. However, this tight-knit team will have twenty-two girls returning next season to follow in the footsteps of their leaders.

I am extremely proud of the hard work and dedication that these young women from Northern Cambria have displayed. I would like to extend my most sincere congratulations to the team, the coaching staff, and their fans on a fantastic season. I wish them the best of luck in all of their future endeavors.

HONORING TUCKER CAMPBELL SEISE

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Tucker Campbell Seise, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 1179, and in earning the most prestigious award of Eagle Scout.

Tucker has been very active with his troop participating in many scout activities. Over the many years Tucker has been involved with scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Tucker Campbell Seise for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

PERSONAL EXPLANATION

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. GERLACH. Madam Speaker, unfortunately, on Tuesday, December 1, 2009, I missed three recorded votes on the House floor. Had I been present, I would have voted "yea" on rollcall 911, "yea" on rollcall 912, and "yea" on rollcall 913.

IN RECOGNITION OF FREIGHTLINER CUSTOM CHASSIS CORPORATION

HON. JOHN M. SPRATT, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. SPRATT. Madam Speaker, I am proud to claim Freightliner Custom Chassis Corporation (FCCC) as a corporate constituent. On October 29, 2009, Freightliner hosted a plant-wide celebration to announce that its facility in Gaffney, South Carolina is now operating as a Zero-Waste-to-Landfill manufacturing plant. FCCC has been working diligently for years to achieve this goal, which underscores its strong commitment to a better environment. Freightliner is the first company in the trucking industry to achieve Zero-Waste-to-Landfill status.

Before undertaking this initiative, FCCC disposed of some 250,000 pounds of solid waste every month. It now disposes of zero pounds. FCCC's parent company, Daimler Trucks North America LLC, began the Zero-Waste-to-Landfill program as a means of reducing the carbon footprint of its manufacturing facilities. FCCC's facility in Gaffney was selected as the pilot site beginning in September 2007 and will now serve as an example for other facilities to emulate.

FCCC's move to the forefront environmentally reflects well on it, and shows that other manufacturers can do the same.

HONORING JEANNE-CLAUDE

HON. LYNN C. WOOLSEY
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Ms. WOOLSEY. Madam Speaker, I rise with sadness today to honor my friend Jeanne-Claude, who passed away November 18 at the age of 74. In partnership with her husband Christo, she created some of the most exciting art projects of our time. The couple is known for large-scale temporary environmental works of stunning beauty that transform our perceptions of building and landscapes, while creating community dialogue.

I was fortunate to meet the couple in connection with The Running Fence, one of their most spectacular projects that snaked through 24 miles of my district in California's Sonoma and Marin Counties. Installed in 1976, The Running Fence featured over two million square feet of billowing nylon across the golden brown hills of 59 ranches to the Pacific Ocean. The sheer logistics of the endeavor became part of the artistic process as Jeanne-Claude and Christo brought disparate members of the local community together over four-and-a-half years of planning and prodding to bring it to fruition.

The pair returned to Sonoma County in September for a reunion event where I saw that Jeanne-Claude exhibited the same flamboyant, warm style that won her friends and supporters for the project 33 years ago. The reunion laid the groundwork for an upcoming Smithsonian exhibition on The Running Fence that will serve as a tribute to her partnership with Christo on this remarkable collaboration.

Born in Morocco, Jeanne-Claude met Christo, a Bulgarian refugee who shared her birth date, in Paris in 1958. At that time, Christo was wrapping small objects, and they soon began collaborating on wrapping larger outdoor installations which led to the most famous—Paris's Pont Neuf (1975–1985) and Berlin's Reichstag (1971–1995). Many other projects included natural settings such as a Surrounded Islands in Biscayne Bay, Florida; Valley Curtain in Rifle, Colorado; The Umbrellas on hillsides in both California and Japan; and The Gates in Central Park, New York.

Sponsorships were never accepted for these and other installations which were financed through sales of plans, models, drawings, photos, and other documents. The works were always a team effort, with the resulting objects signed with the joint name, ''Christo and Jeanne-Claude.''

In addition to her husband, Jeanne-Claude is survived by their son, poet Cyril Christo, and a grandson.

Madam Speaker, Christo will be carrying on the couple's work, and I am sure that memories of Jeanne-Claude's vibrancy and love will be a comfort to him during this time. Marin and Sonoma residents will remember her glitzy red hair and her wit and charm, but it is her friendship that we will cherish the most.

PERSONAL EXPLANATION

HON. CHRISTOPHER P. CARNEY
OF PENNSYLVANIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. CARNEY. Madam Speaker, on Tuesday, December 1, I was unable to cast my vote on three suspension bills due to my attendance of the President's address to the Nation from the United States Military Academy.

Had I been present,I would have voted: ''yes'' on rollcall vote 911, ''yes'' on rollcall vote 912, and ''yes'' rollcall vote 913.

COLONEL HAL HOXIE RETIRES AFTER 27 YEARS SERVICE WITH THE UNITED STATES AIR FORCE

HON. CATHY McMORRIS RODGERS
OF WASHINGTON
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mrs. MCMORRIS RODGERS. Madam Speaker, I rise today to recognize COL Hal Hoxie on the occasion of his retirement from the United States Air Force.

Colonel Hoxie was born November 6, 1958 in Chewelah, Washington, and went to college at Eastern Oregon State University, graduating with a bachelor's degree in business in 1983. He received his commission through Officer Training School at Maxwell Air Force Base in Montgomery, Alabama, in 1983 and was selected to attend pilot training at Vance Air Force Base, Oklahoma. During pilot training at Vance Air Force Base, Colonel Hoxie's professionalism and attention to detail marked him as a natural leader and upon graduation he was selected to remain a T–38 instructor and chief flight examiner. Subsequently, Colonel Hoxie was recognized as the distinguished graduate from his pilot instructor training course. In May 1988, Colonel Hoxie converted to the F–15C at the 60th Tactical Fighter Squadron at Eglin Air Force Base, Florida, and was immediately called upon to fly in support of Operation JUST CAUSE in Panama. During his time at Eglin Air Force Base, Colonel Hoxie attended Squadron Officer School at Maxwell Air Force Base in Montgomery, Alabama, where he was recognized as a top graduate for his academic and military achievement. Also during this tour, Colonel Hoxie deployed in direct support of Operation DESERT SHIELD/DESERT STORM and flew 66 missions helping to consolidate a swift and complete victory for the allied forces.

Colonel Hoxie went on to work in various staff positions including executive officer to the Athletic Department Director at the United States Air Force Academy, executive officer to the Vice Commander Headquarters, Air Combat Command, and Senior Operations Duty Officer at Osan Air Base, Korea. He also commanded the 94th Flying Training Squadron at the Air Force Academy, led as the Deputy Operations Group Commander at the 34th Operations Group, United States Air Force Academy, utilizing his skill as a trainer and mentor, and was the Chief of Homeland Defense and Security at Headquarters, Air Combat Command, Langley Air Force Base, Virginia. Following this assignment, Colonel Hoxie went on to command the 355th Mission Support Group at Davis Monthan Air Force Base, Arizona.

For the past 2 years, Colonel Hoxie has performed with distinction in the Legislative Liaison Directorate. From May 2008 to March 2009, he led the Programs and Legislative Division, ensuring prompt and thorough response to the Congress on policy and personnel issues concerning the United States Air Force. From March 2009 to the present, Colonel Hoxie led the Congressional Inquiry division, providing efficient and thorough response to over 5,000 congressional inquiries.

Madam Speaker, on behalf of Congress and the United States of America, I thank COL Hal Hoxie, his wife Kathy, to whom he's been married for 31 years, and their four sons: Aaron, Allen, Austin, and Andrew. The Hoxies have been a proud Air Force family for the duration of Colonel Hoxie's career and I salute the entire family for their continued commitment, sacrifice, and contribution to this great Nation. Again, I congratulate Colonel Hoxie on his retirement and wish him Godspeed as he transitions into his new job as president of Central Christian College in McPherson, Kansas.

SUPPORTING CJ'S HOME PROTECTION ACT

HON. KAY GRANGER
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Ms. GRANGER. Madam Speaker, as the House considers H.R. 320, ''CJ's Home Protection Act,'' I encourage my colleagues to support its passage. As a cosponsor of this bill, I believe it is important to reflect back on why this legislation is crucial to saving lives in our communities.

In June 2007, devastating storms, tornadoes and flooding hit my district over a few days' time and left large amounts of property damaged and displaced thousands of families. Tragically, the flooding also took the lives of 11 individuals and injured others.

At Skyline Mobile Home Estates in Haltom City, I met with Haltom City Mayor Bill Lanford after the floods to see the damage and to also meet with local residents. About 100 mobile homes were impacted by the storms because there was not enough time for residents to know what was happening and to prepare for the coming disaster.

One of the most devastating impacts to this community was the death of 4-year-old Alexandria Collins. She was torn from her mother's grasp by the water's current as they fled to a neighbor's boat.

CJ's Home Protection bill requires that NOAA weather radios be installed in new mobile homes as they are being manufactured in order for residents to receive emergency broadcasting information and alerts. This bill will help save lives during emergency situations by providing people with the time and the information they need to take care of themselves and their families.

Thank you, and I urge the House to pass this legislation.

INTRODUCING THE HONEST AND OPEN TESTIMONY ACT

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. HASTINGS of Florida. Madam Speaker, I rise today to introduce the Honest and Open Testimony Act, a bill that helps provide for an honest and open discussion regarding Don't Ask, Don't Tell by allowing active-duty members of the Armed Forces, including gay, lesbian, bisexual, and transgender (GLBT) members, to openly testify in Congressional hearings without fear of retribution. The Honest and Open Testimony Act expands existing whistleblower protections between members of the Armed Forces and Members of Congress to include communications from active-duty service members who testify concerning Don't Ask, Don't Tell in a Congressional hearing, as well as those who do so and disclose their sexual orientation.

The United States of America prides itself on having the finest military in the world because of the hard work, dedication, and sacrifices of its brave men and women in uniform. And yet, under the discriminatory law known as Don't Ask, Don't Tell, the talents and contributions of our GLBT service members continue to be ignored simply because of who they are. As you know, Don't Ask, Don't Tell was signed into law in 1993 by former President Bill Clinton as a compromise to allow gay and lesbian service members to serve in the military. To the contrary, Don't Ask, Don't Tell compromises the integrity of our troops and kicks them out to boot. For more than fifteen years, Don't Ask, Don't Tell has negatively impacted the lives and livelihoods of these military professionals and deprived our Armed Forces of their honorable service. This is not only a disservice to them, but to our country as a whole.

Don't Ask, Don't Tell hurts our troops, runs counter to the values of our Armed Forces, and threatens our national security. Since the law was implemented in 1994, over 13,500 qualified service members have been lost to Don't Ask, Don't Tell, and counting. With each passing day, we lose approximately two service members to this misguided, unjust, and debilitating policy. Furthermore, Don't Ask, Don't Tell continues to undermine and demoralize the more than 65,000 GLBT Americans currently serving on active duty.

Keeping good troops is good policy, and our GLBT troops are among our most talented and dedicated. As the United States continues to work toward responsibly ending the war in Iraq and reengages the threat from al Qaeda in Afghanistan, our GLBT service members offer invaluable skills that enhance our military's potency and readiness. They are linguists, aviators, medics, and highly trained soldiers who are involved in valuable operations that have nothing to do with their sexual orientation and everything to do with protecting our freedom and advancing our national security interests. Above all, however, they offer their lives to serve their country.

I am extremely proud of the men and women who serve in our Armed Forces and truly appreciate the countless sacrifices they continue to make every single day to protect this nation and the American people. They deserve better than Don't Ask, Don't Tell. In order for Congress to have an honest and open discussion about the relevance of the current law, as well as on how to best implement its repeal, its members must hear from those about whom Don't Ask, Don't Tell was written—active-duty GLBT troops. Now is the time to take action.

Madam Speaker, I realize that this issue is considered controversial, but it should not be. As Congress prepares to debate the future of Don't Ask, Don't Tell with hearings in the Senate and in the House of Representatives, we must ensure that we hear all sides of the issue and especially from active-duty GLBT service members. The Honest and Open Testimony Act helps achieve this by addressing a major barrier to an inclusive, transparent, and complete hearing process—fear of retribution for testifying honestly and openly about the consequences of Don't Ask, Don't Tell in the Armed Forces. I urge my colleagues to support this important bill, which would bring us one step closer to repealing Don't Ask, Don't Tell once and for all and replacing it with a policy of inclusion and non-discrimination.

INTRODUCING THE END DISCRIMINATORY STATE TAXES FOR AUTOMOBILE RENTERS ACT OF 2009

HON. RICK BOUCHER

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. BOUCHER. Madam Speaker, I rise today to introduce the End Discriminatory State Taxes for Automobile Renters Act. I am pleased to be joined by my colleague from Missouri TODD AKIN as the lead Republican cosponsor of the legislation.

Our legislation addresses a situation that most of our constituents have faced at least once and perhaps several times. An individual rents a car from a car rental company and is told the daily rate will be about $25.00. At the end of the rental, the charges from the car rental company are closer to $35.00 or $40.00 per day. Questions inevitably arise about the source of these additional charges.

A small portion of the difference between the car rental company's daily rate and the amount charged is state or local sales taxes, which consumers pay on most goods and services they purchase. Increasingly, however, the bulk of these additional charges are state and local discriminatory excise taxes on car rental consumers—local taxes imposed to build sport stadiums, convention centers, etc. No matter what the size or scope of a local project, states or localities have sought to ''export'' the burden of funding these local initiatives by taxing ''out-of-town'' visitors renting cars in their state, city, or county.

These discriminatory excise taxes on travelers have become increasingly popular in recent years. In 1976, there was one such tax. Since 1990, more than 115 special rental car taxes have been enacted in 43 states and the District of Columbia. As a result, car rental customers have paid more than $7.5 billion in special taxes to fund projects with no direct connection to renting a car. In addition to stadiums, car rental customers are also footing the bill for performing arts centers and a culinary institute. A recent study found that the taxes fall disproportionately on minority households; the taxes raise auto insurance costs; and these taxes reduce purchases of cars by rental companies—an increase of 10% in tax relative to the base rental rate reduces rental demand, and, therefore, purchases of new cars by rental car companies, by approximately 12%.

The End Discriminatory State Taxes for Automobile Renters Act would impose a permanent moratorium on discriminatory excise taxes on car rental customers by declaring these taxes an undue burden on interstate commerce. In the past, Congress has enacted similar protections from discriminatory state and local excise taxes for other interstate travelers such as airline, train, and bus passengers, and for the property of interstate transportation industries such as the airlines, buses, trains, and motor freight. Our measure would extend this protection to car rental consumers.

The legislation's moratorium is prospective only. The bill ''grandfathers'' existing car rental excise taxes to prevent a cut-off of funding for projects financed through these taxes that are already underway, as long as the state or local authorization for the existing taxes does not expire or governments do not try to increase the rate of the tax. And the bill would not in any way restrict the ability of local governments to enact non-discriminatory, general taxes such as sales and income taxes.

Our legislation has been endorsed by a wide range of stakeholders, including the National Consumers League, UAW, and the Big Three automobile manufacturers.

I hope my colleagues will join with us in enacting into law the End Discriminatory State Taxes for Automobile Renters Act of 2009.

A TRIBUTE TO THE LIFE OF NATIVE ELDER AND LEADER PHILIP D. HUNTER

HON. JIM COSTA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. COSTA. Madam Speaker, I rise today during Native American Heritage Month, to honor and remember the life of Native Elder and Leader Philip D. Hunter.

Mr. Philip Daryl Hunter was a citizen of the Tule River Tribe. He was an exemplary leader and a powerful advocate for the needs and rights of Native people; especially those throughout the great state of California and the San Joaquin Valley. Mr. Hunter was a strong spiritual and political leader for his tribe.

Philip Hunter graduated from Porterville Union High School in 1966 and attended Porterville College, where he excelled not only in academics, but also in baseball. During breaks from school he would work for the Tribe as a fire fighter. He went on to serve our

nation in the United States Army as a paratrooper in the 82nd Airborne Division.

Following his military service, Mr. Hunter graduated from Columbia College with an Associate of Arts Degree, focusing his interests on helping others. He spent fourteen years as a Drug and Alcohol Counselor, consistently placing the needs of others above his own. Demonstrating a strong dedication to his tribe, Mr. Hunter served on the Tule River Tribal Council for over twelve years, with five years in the position of Tribal Chairman. He was the longest-serving member on the Tule River Tribal Council. During his time on the council, Mr. Hunter became a familiar and strong voice in our state's and nation's capitols as he worked to shape federal, state and international California Indian policy, including protections for Native Sacred Places. He represented the Tule River Tribe on the Bureau of Indian Affairs, Central California Agency Policy Committee, BIA/Pacific Regional Offices Fee to Trust Consortium, Council of Energy Resources Tribes and the National Congress of American Indians. He was a proud member of the Tule River AMVETS Post 1988 and respectfully honored veterans during times of remembrances.

Philip D. Hunter was acclaimed for being an effective and traditional cultural leader. His knowledge and dedication to tribal members ran deep throughout Indian Country. He was devoted to his wife, Beverly J. Hunter and loved his family, his tribe and his country. Mr. Hunter will always be remembered as a true champion for Native Americans.

A TRIBUTE TO THE LIFE OF MRS. NETTIE DURANT DICKSON

HON. JOHN M. SPRATT, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. SPRATT. Madam Speaker, I would like to call the attention of the House to the death of a remarkable woman. On November 29, Mrs. Nettie DuRant Dickson of Darlington, South Carolina, died at the age of 106. Remarkable not only for her age, but for a life full of accomplishment, Mrs. Dickson and her late husband, William James Dickson, owned the Darlington Hardware. Mrs. Dickson was a member of the Darlington Presbyterian Church and active for years with the American Legion Auxiliary. In the past few years she resided at the Methodist Manor in Florence, South Carolina and then at Agape Senior Care in Irmo, South Carolina.

One of twelve children, Nettie DuRant Dickson is survived by sibling Marion DuRant, daughters Elizabeth Betty DuPre and Jeanette D. Renfrow, numerous nieces and nephews, four grandsons, and three great-grandsons.

In the end, what counts most is not how long we lived, but how well. On both counts, Nettie DuRant Dickson lived a good and fruitful life.

CONGRATULATING BRIAN KLOCK

HON. PETE OLSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. OLSON. Madam Speaker, I rise today to congratulate a great public servant upon his retirement from the United States Navy—a man who has served his country diligently, my friend Brian Klock.

After 28 years of service to his country, Brian retired from his post as a Commander in the Navy on July 1, 2009. Throughout his career he served as an intelligence officer working as an analyst, an aviation intelligence officer in a P3 Squadron, and as a Naval Criminal Investigative Service (NCIS) Agent. On many occasions his service took him overseas, including during the Cold War and the Bosnian conflict.

After September 11, 2001, Brian was called to serve in NCIS and was assigned to counter intelligence operations overseas. Upon his return to the United States, Brian was asked to join the Protective Services Division. It was here that he spent two years protecting the leadership of the Department of Defense and visiting foreign military dignitaries. At the conclusion of his career, Brian was serving as the operations officer for a CENTCOM intelligence unit.

It is with great pleasure that I congratulate Brian for his years of exemplarily service to our nation. I wish him the best in his years to come and hope he lives life to the fullest during his retirement years.

EMERGENCY MEDICINE AND MEDICAL MALPRACTICE REFORM

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. GORDON of Tennessee. Madam Speaker, as we debate and move forward on this historic endeavor—passage of health care reform with a goal of improving access and coverage for the millions of uninsured and underinsured individuals—I would like to take a moment to discuss the role of emergency medicine and review the various provisions in this bill which strengthen access to emergency care. As we work to improve coverage and enhance preventive and chronic care, we must remember to balance the acute care needs of patients, especially those treated in emergency departments.

Emergency medicine is an essential part of our safety net and must be supported. Whether a patient ends up in the emergency room as the result of a suspected H1N1 influenza case, trauma, a natural or manmade disaster, or because they've lost their job and health insurance and a health condition escalates to the point of needing to seek emergency care, we all rely on quality emergency care to be there. In fact, the federal government demands it—unlike other doctors who can choose not to participate with various health insurance plans, Medicare or Medicaid, emergency physicians are required by federal law to treat every patient who walks through the door, regardless of their ability to pay. But, our emergency medical system is in crisis, and the severe problems facing emergency patients affect everyone.

Earlier this year, the American College of Emergency Physicians (ACEP) released its annual report card on emergency care. The nation was graded a C minus overall, with 90 percent of states earning mediocre or near-failing grades. America earned a near-failing D minus grade in the "Access to Emergency Care" category. This is unacceptable and also terrifying news for the more than 300,000 people each day who need emergency care.

Although my own state of Tennessee outperformed most states in some areas, we have a long way to go. The report states that Tennessee has only 8.9 emergency physicians per 100,000 people and needs an additional 60.2 full-time equivalent mental health care providers to serve the state's population. Also, it points out that these issues may contribute to hospital crowding and patient transfers, problems that have been identified as priorities among emergency physicians in Tennessee. Further, Tennessee has serious public health and injury prevention challenges. We have among the highest rates of infant mortality in the nation (8.9 deaths per 1,000 births), as well as high percentages of obese adults (28.8 percent) and adults who smoke (22.6 percent). Tennessee has relatively high fatal injury rates: 22.7 homicides and suicides per 100,000 people and 2.2 deaths due to unintentional fire and burn-related injuries per 100,000.

Although the "Affordable Health Care for America Act" included provisions to improve coverage for preventive and chronic care, statistics like these for Tennessee demonstrate that access to quality emergency care will always be a priority and should not be taken for granted.

The health care reform bill passed by the House on November 7 included a number of provisions that would strengthen emergency care in the United States:

Required Coverage for Emergency Services. Specifically, it would require that emergency services are part of any essential benefits package for all eligible health insurance plans.

Emergency Care Coordination Center. Section 2552 would establish an Emergency Care Coordination Center. The Center will promote and fund research in emergency medicine and trauma health care, promote regional partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients; and promote local, regional, and State emergency medical systems' preparedness for and response to public health events. It would also authorize a Council of Emergency Medicine.

Pilot Programs to Improve Emergency Medical Care. Section 2553 would establish demonstration programs that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care systems.

Demonstration Project for Stabilization of Emergency Medical Conditions by Institutions

for Mental Diseases. Section 1787 would establish a demonstration project to reimburse psychiatric hospitals that provide required medical assistance to stabilize an emergency medical condition for individuals enrolled in Medicaid.

Hopefully the emergency medicine provisions will be further strengthened as they move through the legislative process to include provisions based on legislation I've introduced to address the issue of emergency department boarding, ambulance division standards, and medical malpractice liability coverage for emergency providers and on-call specialists. The ''Access to Emergency Medical Services Act,'' H.R. 1188, and the ''Health Care Safety Net Enhancement Act,'' H.R. 1998, are two bills I've introduced to address these issues.

Overcrowded emergency departments are compromising patient safety and threatening everyone's access to lifesaving emergency care. The number of emergency departments has decreased by 5 percent in 10 years, but the demand for care is up by 32 percent—up to 119.2 million visits in 2006 (one in three Americans). Hundreds of emergency departments have closed.

According to the Centers for Medicare and Medicaid Services (CMS), half of emergency services go uncompensated. To compensate for cutbacks in reimbursement, hospitals closed 198,000 staffed beds between 1993 and 2003. As a result, fewer beds are available to accommodate admissions from the emergency department.

Ambulances are diverted, on average, once a minute in the United States, away from the closest emergency department because they are so crowded they cannot handle any more patients. For patients with life-threatening illnesses or injuries, those minutes can make the difference between life and death.

Last year, the American College of Emergency Physicians released a report by its Task Force on Boarding titled, ''Emergency Department Crowding: High-Impact Solutions.'' ACEP established the task force to develop low-cost or no-cost solutions to boarding. The report is intended to help emergency physicians stop boarding in their own hospitals and ultimately improve patient care. The report identifies those strategies to reduce crowding that have a ''high impact,'' as well as those that have not proven effective. The report identifies the boarding of admitted patients as the main cause of emergency department crowding. The report outlines the impact of boarding on patient care stating that ''evidence-based research demonstrates that boarding results in the following: delays in care, ambulance diversion, increased hospital lengths of stay, medical errors, increased patient mortality, financial losses to hospital and physician, and medical negligence claims.''

Madam Speaker, to ensure our access to emergency care is protected, we must address this issue. I believe the provisions in my bill, H.R. 1188, ''Access to Emergency Medical Services Act'' will help by developing emergency department boarding and ambulance diversion standards and quality measures. I urge their consideration as the bill moves forward through the legislative process.

Emergency care is the most overlooked part of the health care system. But it is the number one service that everyone depends on in their hour of need. It needs our attention now.

In addition, we need to think forward to ensure that our system also accommodates future needs. To do so, we must address the shortage of board-certified emergency physicians. The Society for Academic Emergency Medicine, in 2008, published an Assessment of Emergency Physician Workforce Needs in the United States. The authors reviewed 2005 data and found that the supply of emergency medicine residency-trained, board-certified emergency physicians will not meet future demand. Specifically, they found that only 55% of the demand for emergency medical board-certified physicians currently is met.

I agree with the need to enhance our prevention efforts and have introduced H.R. 3851, the ''Physical Activity Guidelines for Americans Act'' to help educate Americans of all ages regarding the need for physical activity, taking responsibility for one's health and staying fit. However, experience shows that not everyone will adhere to recommended guidelines, and genetic predisposition, trauma and seasonal flu or other illnesses such as H1N1 will continue to bring people to our nation's emergency rooms. Therefore, we must be sure emergency departments are equipped to handle our needs.

In June 2006, the Institute of Medicine (IOM) released three landmark reports on the ''Future of Emergency Care in the United States Health System,'' detailing the challenges and concerns this nation faces in maintaining access to emergency medical services. The IOM reported that the nation's emergency medical system as a whole is overburdened, underfunded and highly fragmented.

Emergency care has long been overlooked and as a result it is stretched to a breaking point. As Congress focuses on health reform this year, I urge my colleagues to recognize the role emergency medicine plays in our safety net and support the provisions in the health reform bill that strengthen emergency care. Further, I urge my colleagues to work to adequately support our emergency medical system by further addressing boarding and diversion as the bill moves forward.

IN APPRECIATION OF SAN BRUNO MAYOR LARRY FRANZELLA

HON. JACKIE SPEIER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Ms. SPEIER. Madam Speaker, this week the City of San Bruno will see a changing of the guard as Mayor Larry Franzella steps down from the post he has held for a decade.

A native of San Francisco, Mayor Franzella moved to San Bruno as a boy and attended local schools, including Crestmoor High School, Skyline College and the College of San Mateo. He's a classic example of ''local boy makes good.'' He began a successful real estate career in 1975 and over three decades has risen through the ranks of his profession, serving as President of the San Bruno Chamber of Commerce, the Rotary Club of San Bruno and the San Mateo County Association of Realtors, and as Regional Vice-President of the California Association of Realtors. He currently serves as President of Prudential California Realty in San Bruno.

Larry Franzella has served his adopted city of San Bruno in a myriad of ways. Besides his aforementioned community and business associations, Larry served as a member of the Personnel Board and was a founding member of the city's Citizens Crime Prevention Committee. In 1987, the people of San Bruno elected Larry to his first of two terms on the city council. Then in 1999, after a two-year hiatus, voters chose Larry to serve as Mayor—a post he held for five consecutive two-year terms. In this role, he also represented San Bruno as a member of the regional Airport Roundtable.

Madam Speaker, everyone in this chamber knows how important it is to have dedicated, intelligent people serve on local boards, commissions and city councils. The work can be difficult, the hours long and the pay virtually non-existent, yet we ask these selfless public servants to give far more than they receive to assure that the residents and taxpayers under their care are provided for. Mayor Larry Franzella is one of those dedicated and selfless leaders.

Larry has certainly earned his retirement. However, knowing Larry like I do, I am sure that he will never retire from community service. On behalf of my colleagues in the United States House of Representatives, I want to thank Mayor Larry Franzella for his longtime service to the people of San Bruno and the County of San Mateo.

CELEBRATING THE 60TH WEDDING ANNIVERSARY OF HERMAN AND MARJORIE WILLIAMS

HON. ELIJAH E. CUMMINGS

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. CUMMINGS. Madam Speaker, I rise today along with my esteemed colleague from California, Barbara Lee, in order to congratulate Herman and Marjorie Williams of Baltimore, Maryland, as they celebrate sixty years of marriage. Since they exchanged their vows on November 24, 1949, these high school sweethearts have been extraordinary parents, friends, and members of their community.

Over the decades of their marriage, they contended against racism and segregation as they pursued their careers, Herman as one of the first black firefighters in Baltimore and Marjorie at Westinghouse. Their commitment to hard work and to their family never wavered.

Herman eventually became the nation's first African-American major-city fire chief and Marjorie retired after a long and exemplary career. Even after her retirement, Marjorie has volunteered her time with many charitable organizations, dedicating herself to helping the less fortunate. Always an adventuresome spirit, she has also continued to pursue her love of travel.

The two of them together raised four wonderful and successful children: Marjorie,

Clolita, Montel, and Herman. Marjorie and Herman have a fierce dedication to their family, and the values they instilled led their children to prominent careers in the arts, education, civil service, and broadcast media.

The Williams have been an inspiration to their friends, their family, to their community, and to everyone determined to triumph in the face of adversity.

On November 28, 2009, they celebrated their anniversary along with family and friends. Please join us in wishing them the best of luck as they continue to spend their lives loving and supporting each other and bringing joy and happiness to their family and friends.

HONORING BRIAN AND DORIE BARKEY

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. KILDEE. Madam Speaker, on Wednesday, December 2nd, the Tall Pine Council—Boy Scouts of America is bestowing its Distinguished Citizen Award on Brian and Dorie Barkey. A dinner will be held in their honor in Grand Blanc, Michigan.

Dorie Barkey retired from the Red Cross in 1999 and the Crim Race Director asked her to direct the Crim Adult Training Program. Brian became the volunteer training program coordinator about the same time. Under their leadership the training program set all time records for the following 8 years. Between 1999 and 2008 Dorie and Brian had enrolled 7200 trainees in the program. The training program is known nationally as the largest training program for a single event in the world.

Brian, a Genesee County attorney with over 37 years of law practice, served on the Crim Board of Directors for 15 years and was President of the Board for 4 years. Active with the Genesee County Bar Association, he served as editor of its publication, Bar Beat, for 3 years. He was recognized for his work in 2002 and was awarded the Genesee County Distinguished Mediator of the Year Award. The following year he served as the Genesee County Bar Association's President and he currently serves as the "chairman for life" of the Bar Association's Community Holiday Dinner. The Michigan State Bar Association bestowed its Unsung Hero Award on Brian for his work with the Crim Race in 2009.

Madam Speaker, I ask the House of Representatives to join me in congratulating Dorie and Brian Barkey as they receive the Distinguished Citizen Award. The Tall Pine Council grants the award to those persons that exemplify Scouting values and have made a significant impact in the community. Both Dorie and Brian Barkey have spent their lives working to build a better community and I wish them the best as they continue to assist the people of the Flint area.

SPECIAL OLYMPICS MASSACHUSETTS AND MR. DON DOWD

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. KENNEDY. Madam Speaker, today I rise to commend Special Olympics, Massachusetts and longtime friend Donald J. Dowd. Both Special Olympics, Massachusetts and Mr. Dowd have been fixtures in New England and wonderful contributors to the people and culture of our region.

As my colleagues know, Special Olympics provides year-round sports training, athletic competition and other related programming for athletes with intellectual disabilities.

This organization founded by my Aunt Eunice Kennedy Shriver in 1968, contributes to the physical, social, and psychological development of people with intellectual disabilities. It is a global force for change with over 2.5 million athletes participating world wide representing over 140 countries.

In Massachusetts and Rhode Island, Special Olympics does amazing things for the people of New England. Special Olympics Massachusetts also offers Unified Sports, an initiative that combines approximately equal numbers of Special Olympics athletes and athletes without intellectual disabilities, called Partners, on sports teams for training and competition.

One of Special Olympics' greatest supporters has been Donald Dowd, or Don as I affectionately call him. He worked for and volunteered for my Father in the Other Body for over 40 years, as well as for my uncles. He was responsible for coordinating the opening of the John F. Kennedy Presidential Library and has served as a member of the John F. Kennedy Library Foundation Board since its inception, helping to found the Friends of the Kennedy Library.

He is a lifelong resident of Springfield, Massachusetts, began his career in public service as President Kennedy's Assistant Regional Director of the U.S. Postal Service for the six New England States, and was a political advisor to U.S. Senator Robert F. Kennedy. I am proud to call him a friend and thank him for his dedication to my family, to Special Olympics, to our region and to our country.

PERSONAL EXPLANATION

HON. NEIL ABERCROMBIE

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. ABERCROMBIE. Madam Speaker, I regret that I missed rollcall vote No. 902–904 and vote No. 911–913. Had I been present, I would have voted "yea" on all rollcall votes.

HONORING WORLD AIDS AWARENESS DAY

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. RANGEL. Madam Speaker, I rise today to recognize World AIDS Awareness Day. This awareness initiative started on December 1, 1988 with the purpose of raising money, increasing awareness, fighting prejudice, and improving education on HIV/AIDS topics. The World AIDS Day theme for 2009 is "Universal Access and Human Rights," serving as an important reminder that HIV/AIDS has not gone away, and that there are many things still to be done.

According to the United Nations Joint Programme on HIV/AIDS, there are 33.4 million cases of HIV/AIDS worldwide. Approximately 1.1 million of these cases are in the United States, according to the Centers for Disease Control and Prevention, and there are more than 50,000 new HIV/AIDS infections reported each year in America. Sadly, minority communities face the brunt of its reach. African American are the most affected, representing half of the total 1.1 million cases in the United States. Blacks are 8 times more likely to have AIDS than their White counterparts. The racial disparities are clear, with HIV being the main cause of death for both Black men and women between the ages of 25 to 44. It is of utmost importance that we take action and stand together to stop this pandemic from spreading further.

Congress has played its part in trying to stop the HIV/AIDS epidemic. I applaud the House for passing the Ryan White HIV/AIDS Treatment Extension Act. The Ryan White program has been serving people with AIDS and HIV for nearly two decades. It provides care, treatment, and support services to nearly half a million people—most of whom are low-income. This bill increases the authorization level for each part of the Ryan White program by 5 percent a year for the next four years, making important investments in care and treatment services to ensure the highest quality of life for HIV/AIDS patients, while also funding prevention and outreach programs. I have myself introduced H.R. 1964, The National Black Clergy for the Elimination of HIV/AIDS Act of 2009, which seeks funds for the prevention, testing, education, treatment and care of HIV/AIDS.

Although great efforts have been made to fight HIV/AIDS, much is left to be done by both, the government and citizens. World AIDS Awareness Day is about prevention, education, and increasing awareness of this pandemic that is affecting millions around the globe. This day will bring to many the education necessary to create the awareness necessary to prevent HIV/AIDS, as well as give us a moment to recognize and remember those who have suffered from this disease.

HONORING THE RESOLVE AND TEAMWORK OF THE NORTH BRANCH HIGH SCHOOL VARSITY GIRLS VOLLEYBALL TEAM

HON. CANDICE S. MILLER

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mrs. MILLER of Michigan. Madam Speaker, I rise today to acknowledge the hard work, determination and teamwork displayed by the 2009 North Branch Varsity Girls Volleyball Team. These young women endured a grueling 83 match season and in the end came out on top as the Class B Michigan State Champions! They collected an impressive overall record of 76–5–2. This was a historic accomplishment because it was the first sports title ever in the school's history.

Coach Jim Fish did a tremendous job leading the team and bringing them together as a cohesive unit to accomplish a common goal—winning a state title. I commend all the assistant coaches, support staff, teachers, parents and fans in the community for their help and making this a season to remember.

However, the road to the state finals at Kellogg Arena in Battle Creek was anything but a walk in the park. Despite graduating eight players from the 2008 squad, the Lady Broncos rolled through the regular season winning the Tri-Valley East Conference Title. Nonetheless, the Lady Broncos did hit a slight speed bump when they fell to Bloomfield Hills Marian. But in all fairness, I must state that Bloomfield did go on to win the Class A State Title. Now some teams might have taken this defeat as a negative experience, but not the Lady Broncos. They learned from this loss and rebounded to attain a number one ranking for most of the season.

North Branch realized the conference championship brought them just a step closer to their ultimate goal so the team once again pulled up their sleeves, laced up their shoes and got back to work.

The Lady Broncos continued their memorable quest as they picked additional trophies for the school's display case winning the district title and regional title and an eventual spot in the state quarterfinals.

Here the team faced-off against a feisty Cadillac Team. The Lady Broncos proved their tenacity and resilience as they beat Cadillac in four hard fought sets. Next North Branch was matched up against Delton Kellogg. But unfortunately for Kellogg, it just was not in the cards for them to win on this Saturday because destiny was on the side of the Lady Broncos. There was nothing Kellogg could do on the court to prevent North Branch from raising the championship trophy in glorious triumph. The Lady Broncos were determined to finish what they had started since the first practice of the season. And through all the sweat, injuries and difficult training sessions, the Lady Broncos saw their dreams come to fruition as they were crowned the Michigan Volleyball Class B State Champs!

Teamwork, dedication and friendship all helped deliver this first-ever championship in the schools sports history. The entire North Branch community and Lapeer County should take pride in what these young women accomplished.

I certainly share that pride and want to offer my congratulations to everyone who contributed to this team effort. First starting with the co-captains Kara Stuewer and Jordan Fish and team members—Katie Smillie, Danika Racknor, Taylor Wiegele, Layne Molosky, Samantha Garza, Hailey Smillie, Catherine Brusie, Laura Johnson, Macaela Deshetsky, Shanel Johnstone, Katie Owens, Stephanie Marsh, and Angela Root. You all should be extremely proud of this achievement.

In addition, I must mention that not only were these young women champions on the court but in the classroom as well. The volleyball team compiled an outstanding 3.49 GPA and achieved an all-state academic recognition.

My hat also goes off to Head Coach Jim Fish—Assistant Coaches Curt June, Chris Schlaud, Marian Somerville, and Sue Fish—Athletic Trainers Mike Kohler and Brian Curtis and Team Managers Jacqueline Ken and Ali Ruhlman.

Great job North Branch on a successful season and I look forward to a repeat in 2010! Go Broncos!

A TRIBUTE TO REGINA MAINOR

HON. ROBERT A. BRADY

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. BRADY. Madam Speaker, I rise today to honor Regina Mainor. For years, Ms. Mainor has served he people of Philadelphia as the Director of North Central Victim Services. In December she will celebrate her retirement after many years of service to her community.

Regina Mainor was a hard worker from the beginning, obtaining her Bachelors Degree in Business Education and Masters Degree in Social Work from Temple University. Ms. Mainor obtained a position as Director of North Central Victims Services in 1999, and becoming Executive Director of the agency in 2002. The National Crime Victimization Services (NCVS) is a neighborhood victim service agency which specializes in working with victims of all ages, especially seniors. The NCVS provides crime victims compensation, crisis response, education, counseling, criminal justice/legal advocacy, court accompaniment, case management, and legal services, all of which are free of charge. Ms. Mainor helped the NCVS to get recognized as a federal non profit organization in 2002.

Ms. Mainor has been recognized by the NAACP with the NAACP Award for Community Service, and she was honored again in 2006 for the National Crime Victims Services Award for Professional Innovation in Victims Services.

Regina Mainor's long and impressive career showcases her commitment and service to her community. Her contributions to the area of Victim Services will be felt for many years to come. Madam Speaker, I ask that you and my other distinguished colleagues join me in thanking Regina Mainor for her work and congratulate her on the occasion of her retirement.

CONGRATULATING HERMAN AND MARJORIE WILLIAMS ON 60TH ANNIVERSARY

HON. BARBARA LEE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Ms. LEE of California. Madam Speaker, I rise today along with my esteemed colleague from Maryland, ELIJAH CUMMINGS, in order to congratulate Herman and Marjorie Williams of Baltimore, Maryland, as they celebrate sixty years of marriage. Since they exchanged their vows on November 24, 1949, these high school sweethearts have been extraordinary parents, friends, and members of their community.

Over the decades of their marriage, they contended against racism and segregation as they pursued their careers, Herman as one of the first black firefighters in Baltimore and Marjorie at Westinghouse. Their commitment to hard work and to their family never wavered.

Herman eventually became the nation's first African-American major-city fire chief and Marjorie retired after a long and exemplary career. Even after her retirement, Marjorie has volunteered her time with many charitable organizations, dedicating herself to helping the less fortunate. Always an adventuresome spirit, she has also continued to pursue her love of travel.

The two of them together raised four wonderful and successful children: Marjorie, Clolita, Montel, and Herman. Marjorie and Herman have a fierce dedication to their family, and the values they instilled led their children to prominent careers in the arts, education, civil service, and broadcast media.

The Williams have been an inspiration to their friends, their family, to their community, and to everyone determined to triumph in the face of adversity.

On November 28, 2009, they celebrated their anniversary along with family and friends. Please join us in wishing them the best of luck as they continue to spend their lives loving and supporting each other and bringing joy and happiness to their family and friends.

IN MEMORY OF MRS. SARA BISSELL

HON. SUE WILKINS MYRICK

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mrs. MYRICK. Madam Speaker, I rise today in memory of one of my constituents, Mrs. Sara Bissell, of Charlotte, North Carolina. Mrs. Bissell passed away after a brave 11-year battle with cancer on November 8, 2009 at the age of 71. Born in Charlotte and the granddaughter of former North Carolina Governor Cameron Morrison, Mrs. Bissell attended Charlotte Country Day School and graduated from Bennett Junior College in New York.

Mrs. Bissell took over her mother's fine furnishing store in 1964 and ran it until recently. Her interior design influence can be seen

throughout Charlotte's buildings and landmarks. Sara's contributions to her community were many and varied. She worked tirelessly, both out front and behind the scenes, to make Charlotte a better place. She served on the board of directors for Charlotte Country Day School, University of North Carolina—Charlotte, YMCA of Greater Charlotte, and Queens University. The Chancellor's residence at UNCC is named in her honor.

Sara married H.C. ''Smoky'' Bissell, a successful developer, in 1960. Together they had four children and nine grandchildren whom they loved and cherished. She was also the sister of Charlotte businessmen, Johnny and Cameron Harris. Mrs. Bissell will be greatly missed by her family, friends, and the Charlotte community.

OUR UNCONSCIONABLE NATIONAL DEBT

HON. MIKE COFFMAN

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. COFFMAN of Colorado. Madam Speaker, this morning our national debt was $12,089,226,465,642.57.

On January 6th, 2009, the start of the 111th Congress, the national debt was $10,638,425,746,293.80.

This means the national debt has increased by $1,450,800,719,348.77 so far this year.

According to the non-partisan Congressional Budget Office, the forecast deficit for this year is $1.6 trillion. That means that so far this year, we borrowed and spent an average $4.4 billion a day more than we have collected, passing that debt and its interest payments to our children and all future Americans.

HONORING DR. AIDA LEVITAN, EMILIO ESTEFAN AND DR. EDUARDO PADRON: SOUTH FLORIDA MEMBERS OF THE NATIONAL MUSEUM OF THE AMERICAN LATINO COMMISSION

HON. ILEANA ROS-LEHTINEN

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Ms. ROS-LEHTINEN. Madam Speaker, I would like to recognize several outstanding individuals from my South Florida community who have been named to serve on the National Museum of the American Latino Commission: President of Hispanic Events Dr. Aida Levitan, world-renowned musician and producer Emilio Estefan and Dr. Eduardo Padron, President of Miami-Dade College.

The Commission is charged with the planning, construction and design of the museum. The Commission's members will also help formulate the museum's organizational structure and how to engage the Hispanic community in its development and design.

These individuals are not only dedicated to the mission of making a National Museum of the American Latino a reality, but they are also representative of the great diversity of the Hispanic community that the museum will showcase.

The story and history of Hispanic-Americans is part of the rich tapestry of this nation's history. Hispanics have enriched our great nation in a myriad of ways. Hispanics have served proudly in America's defense from the American Revolution to our current engagement in Iraq and Afghanistan. The number of Hispanic-owned businesses approached 3 million in 2008 and they contribute approximately $389 billion dollars annually to the U.S. economy.

The Hispanic-American experience is part and parcel of the American story. I will be honored to join these talented men and women tomorrow with the rest of the members of the Commission. Through their efforts, Americans from all walks of life will one day be able to see and appreciate the contributions of Hispanic-Americans to our great nation.

LEGISLATION TO EXPAND THE ARMY CORPS OF ENGINEERS' ROLE IN CHESAPEAKE BAY RESTORATION

HON. JOHN P. SARBANES

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. SARBANES. Madam Speaker, I rise today to re-introduce legislation that would strengthen and expand the Army Corps of Engineers' role in Chesapeake Bay restoration—a mission they first began in 1996. This legislation would provide the Corps with continuing authority to engage in this work; expand the Corps' work to all six States in the Bay watershed and the District of Columbia; and provide flexibility for the Corps to work with other Federal agencies, State and local governments, and not-for-profit groups engaged in Bay cleanup.

As the Congress begins to consider the reauthorization of the Water Resources Development Act, we must take this opportunity to strengthen the role that the Army Corps of Engineers plays in Chesapeake Bay cleanup. We must turn the tide in the Bay cleanup effort so future generations can continue to enjoy the cultural, historic, and recreational benefits of the Bay and so it can continue to be an economic driver for the Mid-Atlantic region. The Corps can play an important role in that effort.

The Chesapeake Bay Environmental Restoration and Protection Program, which was established in section 510 of WRDA 1996, authorizes the Army Corps of Engineers to provide design and construction assistance to State and local authorities in the environmental restoration of the Chesapeake Bay. These projects range from shoreline buffers to oyster reef construction. As it is currently structured however, the program has been limited in its scope for several reasons. First, the Corps' restoration efforts have been limited to Maryland, Virginia, and Pennsylvania, which has precluded a comprehensive, watershed-wide plan that adequately prioritizes projects. Second, unlike all other major Federal agencies engaged in Bay restoration, the Corps has no small watershed grants program that engages State and local governments or non-profits in small scale restoration projects. This limitation is compounded by the Corps' intricate procurement processes. Finally, the matching fund requirements of the section 510 program does not allow for the use of in-kind services or contributions, which limits collaboration.

The Chesapeake Bay Commission, a multi-State legislative assembly dedicated to the restoration of the Bay, has previously identified these deficiencies and has recommended the several improvements to the program that are the basis for this legislation. For these reasons, I believe the bill would strengthen the section 510 program so that the Army Corps of Engineers can continue to be a strong partner in Chesapeake Bay cleanup.

I hope my colleagues will continue to support this legislation through the upcoming WRDA process.

H1N1 VACCINE FOR PRISONERS

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. POE of Texas. Madam Speaker, as we all know there is limited supply of the H1N1 vaccines all over our country. In Texas, there was news that prisoners could receive the swine flu vaccine before children and pregnant women. There are over 45,000 inmates who are evidently in the ''high-risk'' group in Texas. The correctional institutions believe that the convicts deserve to be vaccinated. Due to the limited number of vaccines available for Texas, the inmates may not receive them as soon as they wish.

By what logic do you justify having inmates receive vaccinations as a higher priority than pregnant women and children? These individuals are the most vulnerable among us and should be of great concern; not to mention senior adults, caregivers, and many others that should be high on the list. When these vaccines are provided to the states it should go to our taxpayers before our ''high risk'' convicts. The government needs to step up to the plate and provide the available vaccines to the people who need them the most—the children.

RECOGNIZING NOVEMBER AS NATIONAL DIABETES MONTH

HON. DIANA DeGETTE

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Ms. DEGETTE. Madam Speaker, this week the co-chairs of the Congressional Diabetes Caucus joined with 129 original cosponsors to introduce H. Res. 914, a resolution supporting the observance of National Diabetes Month.

The resolution encourages people in the United Sates to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease. It also

recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for type 2 diabetes. Finally, it supports decreasing the prevalence of diabetes, developing better treatments and working toward an eventual cure for type 1 and type 2 diabetes.

Since diabetes afflicts nearly 24 million Americans and is the seventh leading cause of death, we must increase awareness and encourage the research to find cures. National Diabetes Month is observed every November and is an excellent way to build awareness about both type 1 and type 2 diabetes. Too many people are not familiar with the differences between type 1 and type 2 diabetes and how they are treated, what the risk factors are, and what sort of research is needed to make progress in the fight against this disease.

That is why the mission of the Congressional Diabetes Caucus is to educate Members of Congress and their staff about diabetes. It is also our mission to support legislation and other efforts to improve diabetes research, education, and treatment.

The legislative priorities of the Congressional Diabetes Caucus support the goals and ideals of National Diabetes Month. For example, H.R. 1995, The Eliminating Disparities in Diabetes Prevention, Access and Care Act, is designed to promote research, treatment, and education regarding diabetes in minority populations. This specific focus will help us address the unique challenges faced by minority populations and provide more effective treatment and education.

H.R. 1625, the Equity and Access for Podiatric Physicians Under Medicaid Act, would classify podiatrists as physicians for purposes of direct reimbursement through the Medicaid program. Podiatry is critical to the treatment and understanding of diabetes.

The Medicare Diabetes Self-Management Training Act, H.R. 2425, would make a technical clarification to recognize certified diabetes educators (CDE) as providers for Medicare diabetes outpatient self-management training services (DSMT). CDEs are the only health professionals who are specially trained and uniquely qualified to teach patients with diabetes how to improve their health and avoid serious diabetes-related complications. The 1997 authorizing DSMT statute did not include CDEs as Medicare providers. This exclusion has made it increasingly difficult to ensure that DSMT is available to patients who need these services, particularly those with unique cultural needs or who reside in rural areas.

Another bill that is a priority of the caucus is the Preventing Diabetes in Medicare Act, H.R. 2590. This bill would extend Medicare coverage to medical nutrition therapy (MNT) services for people with pre-diabetes and other risk factors for developing type 2 diabetes. Under current law, Medicare pays for MNT provided by a Registered Dietitian for beneficiaries with diabetes and renal diseases. Unfortunately, Medicare does not cover MNT for beneficiaries diagnosed with pre-diabetes. Nutrition therapy services have proven very effective in preventing diabetes by providing access to the best possible nutritional advice about how to handle their condition. By helping people with pre-diabetes manage their condition, Medicare will avoid having to pay for the much more expensive treatment of diabetes.

In addition, we are working hard to pass, H.R. 3668, and reauthorize the Special Diabetes Programs for Type I Diabetes and Indians. This program provides federal funding for the Special Statutory Funding Program for Type 1 Diabetes Research at the National Institutes of Health and the Special Diabetes Program for Indians at the Indian Heath Service. H.R. 3668 would extend these critical programs through 2016 and increase funding for both programs to $200 million a year.

I want to thank my colleague, Congressman MIKE CASTLE, for his many years of leadership working together with me as Co Chair of the Diabetes Caucus. I also want to thank the many Members who are supporting this effort and both sides of the House leadership for their bipartisan support of diabetes issues. I look forward to working with the Congressional Diabetes Caucus to pass the important legislation we are promoting and continuing to further the goals of National Diabetes Month.

RECOGNITION OF THE PILOT CLUB OF COLUMBUS ON ITS 70TH YEAR OF SERVICE

HON. MARY JO KILROY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Ms. KILROY. Madam Speaker, I rise today to honor the Pilot Club of Columbus for seventy years of service to the Columbus community. The Pilot Club is a volunteer service organization that focuses on helping those with brain-related disorders, such as Alzheimer's disease, autism, chemical dependency, traumatic brain injuries, and other disabilities.

Pilot International was founded in Macon, Georgia in October 1921 to provide volunteer services and to raise funds for those with brain-related disorders. In 1939, Pilot International chartered the Pilot Club of Columbus. Over the last seven decades, this organization has promoted awareness and prevention of brain-related disorders in Central Ohio and has provided support for countless individuals and families who are living with developmental, emotional, and mental disabilities.

The Pilot Club of Columbus creates a valuable network of service-minded individuals who have contributed to our community in numerous ways. In recent years, Columbus Pilots have provided furniture for a new senior citizen center and organized celebrations for patients at the former Ohio Psychiatric Hospital who have suffered from brain-related disorders such as Alzheimer and autism. The Pilot Club also has raised money to help individuals with autism and other neurological disorders and supports the BrainMinders project, which spreads information about preventing traumatic brain injury.

The Pilot Club has spent seven decades serving those who are struggling with the painful and complicated challenges associated with brain-related disorders. The Columbus Pilots have demonstrated their generosity, compassion, and commitment to making a difference in the city of Columbus. I am proud to recognize and honor the Pilot Club of Columbus and all of its dedicated volunteers for 70 years of valuable service.

HONORING EARL HALL

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to commend and congratulate Earl Hall upon being awarded with the "Community Health Champions Award" at the 2009 West Fresno Health Care Coalition's 5th annual "This is Your Life of Service" lunch and awards ceremony. This year the ceremony will be held at the Radisson Hotel Conference Center in Fresno, California on Tuesday, November 3rd.

Mr. Earl Hall was born in Oklahoma. When he was just six months old, the 1940's "Dust Bowl" hit his family's farm and they were forced to leave the area. Upon migrating to California, his family settled in Wasco, California. Mr. Hall's father was finally able to find employment as a farm manager for a family farm. Mr. Hall graduated from Wasco High School then attended Bakersfield Junior College and Fresno City College, where he earned his Associates degree. He transferred to California State University, Fresno and graduated with a Bachelor's degree in Agricultural Business in 1964.

Mr. Hall has dedicated his career to establishing and developing his business, Hall Ag Enterprises. For the past forty-four years he has provided labor services with a safe and secure environment for his employees. During periods of water shortages, he has searched for other opportunities to place his workers to ensure that they are able to work and are able to provide for their families. Mr. Hall holds licenses that allow him to provide farm labor in twenty-nine countries. His business provides services to more than three hundred thousand acres and employs nearly thirty thousand people through out the state of California.

Beyond his generosity to his employees, Mr. Hall is dedicated to his community as well. He has provided financial assistance to various causes including health care, charitable organizations and child services. Mr. Hall is part of the Farm Labor Contractors Alliance, the California Association of Agricultural Labor and an active member of Ag SAFE. He is currently serving as the Chairman for the Fresno County Farm Bureau Labor Committee and the Rural Health and Safety Committee. In 2003, Mr. Hall was awarded the "Central California Excellence in Business Award" by The Fresno Bee.

As a young man, Mr. Hall was turned pro in the rodeo circuit; he is a lifetime member of the Professional Rodeo Cowboy's Association and is a "gold card" holder which allows him to compete in the over-fifty age group. He is involved in rodeo events by assisting and providing advice and sponsorship to youth preparing for rodeo events.

Madam Speaker, I rise today to commend and congratulate Earl Hall upon being awarded with the "Community Health Champions

Award.'' I invite my colleagues to join me in wishing Mr. Hall many years of continued success.

IN RECOGNITION OF STRAFFORD HIGH SCHOOL FLAMING ARROW INDIAN PRIDE MARCHING BAND

HON. ROY BLUNT

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. BLUNT. Madam Speaker, I rise today with pleasure and pride to pay tribute to the achievements of the Music Department at Strafford High School in Strafford, Missouri. The Strafford High Flaming Arrow Indian Pride Marching Band and choir will participate in the events surrounding the December 31, 2009, Chick-fil-A Bowl in Atlanta, Georgia. A long-standing event at the bowl game is the National Chick-fil-A Bowl Band Festival.

The music festival has clinics and competition for choir, concert band, jazz band and marching band. The Strafford marching band and choir will compete against other schools while the Marching Band will march in the National Chick-fil-A Bowl Parade in downtown Atlanta on New Year's Eve. Game day, the Strafford band will participate in a pre-game and halftime massed band ''extravaganza'' of 2,000 members performing in the Georgia Dome Olympic Stadium.

Strafford, Missouri, is my hometown. Today, Strafford has a population of 1,845 citizens, and the high school has approximately 400 students. The band and choir are made up of 55 motivated, hardworking teens in concert and marching band, 20 students in jazz band and 36 students in choir. The music department is under the direction of Shane Harmon.

The Strafford High Flaming Arrow Indian Pride Marching Band consistently ranks among the best bands in Missouri, earning first place at six judged events this year. At the 2007 Outback Bowl in Tampa, Florida, the Strafford concert band, jazz band and marching band each earned a 1st place Silver rating, and the concert choir earned a 1st place Gold rating. These achievements led to the invitation to participate at the band festival at the Chick-fil-A Bowl. This recognition is the result of long hours of practice, and dedication to excellence by Strafford students, faculty and their families.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, December 3, 2009 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

DECEMBER 4

9:30 a.m.

Joint Economic Committee

To hold hearings to examine the employment situation for November 2009.

SH–216

DECEMBER 8

10 a.m.

Environment and Public Works

To hold an oversight hearing to examine Federal drinking water programs.

SD–406

1:30 p.m.

Armed Services

To hold hearings to examine Afghanistan.

SH–216

2:15 p.m.

Foreign Relations

Business meeting to consider S. 1559, to consolidate democracy and security in the Western Balkans by supporting the Governments and people of Bosnia and Herzegovina and Montenegro in reaching their goal of eventual NATO membership, and to welcome further NATO partnership with the Republic of Serbia, and the nominations of Rajiv J. Shah, of Washington, to be Administrator of the United States Agency for International Development, and Mary Burce Warlick, of Virginia, to be Ambassador to the Republic of Serbia, James B. Warlick, Jr., of Virginia, to be Ambassador to the Republic of Bulgaria, Eleni Tsakopoulos Kounalakis, of California, to be Ambassador to the Republic of Hungary, Leslie V. Rowe, of Washington, to be Ambassador to the Republic of Mozambique, Alberto M. Fernandez, of Virginia, to be Ambassador to the Republic of Equatorial Guinea, Mary Jo Wills, of the District of Columbia, to be Ambassador to the Republic of Mauritius, and to serve concurrently and without additional compensation as Ambassador to the Republic of Seychelles, Jide J. Zeitlin, of New York, to be Alternate Representative of the United States of America to the Sessions of the General Assembly of the United Nations during his tenure of service as Representative of the United States of America to the United Nations for U.N. Management and Reform, and to be Representative of the United States of America to the United Nations for U.N. Management and Reform, with the rank of Ambassador, and Bill Delahunt, of Massachusetts, Elaine Schuster, of Florida, and Christopher H. Smith, of New Jersey, all to be a Representative, and Laura Gore Ross, of New York, and Wellington E. Webb, of Colorado, both to be an Alternate Representative, all of the United States of America to the Sixty-fourth Session of the General Assembly of the United Nations, all of the Department of State.

S–116, Capitol

2:30 p.m.

Energy and Natural Resources

Energy Subcommittee

To hold hearings to examine H.R. 957, to authorize higher education curriculum development and graduate training in advanced energy and green building technologies, H.R. 2729, to authorize the designation of National Environmental Research Parks by the Secretary of Energy, H.R. 3165, to provide for a program of wind energy research, development, and demonstration, H.R. 3246, to provide for a program of research, development, demonstration and commercial application in vehicle technologies at the Department of Energy, H.R. 3585, to guide and provide for United States research, development, and demonstration of solar energy technologies, S. 737, to amend the Energy Independence and Security Act of 2007 to authorize the Secretary of Energy to conduct research, development, and demonstration to make biofuels more compatible with small nonroad engines, S. 1617, to require the Secretary of Commerce to establish a program for the award of grants to States to establish revolving loan funds for small and medium-sized manufacturers to improve energy efficiency and produce clean energy technology, S. 2744, to amend the Energy Policy Act of 2005 to expand the authority for awarding technology prizes by the Secretary of Energy to include a financial award for separation of carbon dioxide from dilute sources, and S. 2773, to require the Secretary of Energy to carry out a program to support the research, demonstration, and development of commercial applications for offshore wind energy.

SD–366

Intelligence

To hold closed hearings to consider certain intelligence matters.

S–407, Capitol

DECEMBER 9

9:30 a.m.

Indian Affairs

Business meeting to consider pending calendar business; to be immediately followed by a hearing to examine S. 1690, to amend the Act of March 1, 1933, to transfer certain authority and resources to the Utah Dineh Corporation; to be immediately followed by an oversight hearing to examine Department of the Interior backlogs.

SD–628

Veterans' Affairs

To hold hearings to examine the nominations of Robert A. Petzel, of Minnesota, to be Under Secretary for Health, and Raul Perea-Henze, of New York, to be Assistant Secretary for Policy and Planning, both of the Department of Veterans Affairs.

SR–418

10 a.m.

Health, Education, Labor, and Pensions

Business meeting to consider the nominations of Jacqueline A. Berrien, of New York, Victoria A. Lipnic, of Virginia, Chai Rachel Feldblum, of Maryland, all to be a Member of the Equal Employment Opportunity Commission,

P. David Lopez, of Arizona, to be General Counsel of the Equal Employment Opportunity Commission, Patrick Alfred Corvington, of Maryland, to be Chief Executive Officer of the Corporation for National and Community Service, Adele Logan Alexander, of the District of Columbia, to be a Member of the National Council on the Humanities, and Lynnae M. Ruttledge, of Washington, to be Commissioner of the Rehabilitation Services Administration, Department of Education.

SD–430

Homeland Security and Governmental Affairs

To hold hearings to examine five years after the Intelligence Reform and Terrorism Prevention Act, focusing on stopping terrorist travel.

SD–342

Judiciary

To hold an oversight hearing to examine the Department of Homeland Security.

SD–216

2 p.m.

Banking, Housing, and Urban Affairs

Economic Policy Subcommittee

To hold hearings to examine creating jobs in the recession.

SD–538

Judiciary

To hold hearings to examine mortgage fraud, securities fraud, and the financial meltdown, focusing on prosecuting those responsible.

SD–226

2:30 p.m.

Commerce, Science, and Transportation

To hold hearings to examine research parks and job creation, focusing on innovation through cooperation.

SR–253

Finance

International Trade, Customs, and Global Competitiveness Subcommittee

To hold hearings to examine exports' place on the path of economic recovery.

SD–215

Homeland Security and Governmental Affairs

Oversight of Government Management, the Federal Workforce, and the District of Columbia Subcommittee

To hold hearings to examine the diplomat's shield, focusing on diplomatic security today.

SD–342

DECEMBER 10

10 a.m.

Energy and Natural Resources

To hold hearings to examine the role of grid-scale energy storage in meeting our energy and climate goals.

SD–366

Foreign Relations

To hold hearings to examine Treaty Between the Government of the United States of America and the Government of the United Kingdom of Great Britain and Northern Ireland Concerning Defense Trade Cooperation, done at Washington and London on June 21 and 26, 2007 (Treaty Doc. 110–07), and Treaty Between the Government of the United States of America and the Government of Australia Concerning Defense Trade Cooperation, done at Sydney, September 5, 2007 (Treaty Doc. 110–10).

SD–419

Homeland Security and Governmental Affairs

To hold hearings to examine the nominations of Grayling Grant Williams, of Maryland, to be Director of the Office of Counternarcotics Enforcement, and Elizabeth M. Harman, of Maryland, to be an Assistant Administrator of the Federal Emergency Management Agency, both of the Department of Homeland Security.

SD–342

2:30 p.m.

Homeland Security and Governmental Affairs

Disaster Recovery Subcommittee

To hold hearings to examine children and disasters, focusing on a progress report on addressing needs.

SD–342

Intelligence

To hold closed hearings to consider certain intelligence matters.

S–407, Capitol

DECEMBER 15

10 a.m.

Energy and Natural Resources

To hold hearings to examine S. 2052, to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out a research and development and demonstration program to reduce manufacturing and construction costs relating to nuclear reactors, and S. 2812, to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs.

SD–366

2:30 p.m.

Commerce, Science, and Transportation

To hold hearings to examine certain nominations.

SR–253

DECEMBER 17

10 a.m.

Commerce, Science, and Transportation

Business meeting to consider pending calendar business.

SR–253

2:30 p.m.

Energy and Natural Resources

Public Lands and Forests Subcommittee

To hold hearings to examine S. 1470, to sustain the economic development and recreational use of National Forest System land and other public land in the State of Montana, to add certain land to the National Wilderness Preservation System, to release certain wilderness study areas, to designate new areas for recreation, S. 1719, to provide for the conveyance of certain parcels of land to the town of Alta, Utah, S. 1787, to reauthorize the Federal Land Transaction Facilitation Act, H.R. 762, to validate final patent number 27–2005-0081, and H.R. 934, to convey certain submerged lands to the Commonwealth of the Northern Mariana Islands in order to give that territory the same benefits in its submerged lands as Guam, the Virgin Islands, and American Samoa have in their submerged lands.

SD–366